Audit of the Calendar Year 2008 through 2011 Medical Benefits Eligibility and Claims Processing

Report by the
Office of County Comptroller

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July 3, 2013

Teresa Jacobs, County Mayor
And
Board of County Commissioners

We have conducted an audit of the calendar years 2008 through 2011 medical benefits eligibility and claims processing. The audit was limited to a review of the claims paid under the terms of the United Healthcare Administrative Services Only and Express Scripts, Inc. (ESI) Pharmacy Benefit Management agreements with Orange County and the reporting of eligibility by participating organizations to United Healthcare (UHC). The period audited for claims processing was January 1, 2008 to December 31, 2011.

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.

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 Human Resources Division and Comptroller's Payroll Department during the course of the audit.

Martha O. Haynie, CPA
County Comptroller

c: Ajit Lalchandani, County Administrator
Eric Gassman, Deputy County Administrator
Ricardo Daye, Director of Human Resources

EXECUTIVE SUMMARY

Executive Summary

We conducted a review of the medical benefits eligibility and claims processing. The audit was limited to a review of the claims paid under the terms of the United Healthcare Administrative Services Only (ASO) and Express Scripts, Inc. (ESI) Pharmacy Benefit Management agreements with Orange County and the reporting of eligibility by participating organizations to United Healthcare (UHC). The period audited for claims processing was January 1, 2008 to December 31, 2011. Testing of the accuracy of eligibility reporting of members included claims paid for the 2009 and 2010 Plan years. The audit objectives were to determine whether:

- UHC and ESI are complying with the contractual terms of the agreement with BCC;
- Claims were paid only for services allowed in the Plan documents; and,
- Claims paid were for active subscribers.

Based on the results of the testing performed, UHC and ESI are materially complying with the contractual terms of the agreement, including paying for services allowed in the Plan documents for active subscribers. Specifically, we noted the following:

Hospital bill audits were performed by subcontractors for UHC under the Recovery Audit provision of the ASO contract between the County and UHC. We attempted to obtain sufficient data to conduct hospital bill audits for claims under our Plan; however, UHC would not provide any data to allow us to perform this audit. UHC provided a status report of its activities related to hospital claim recovery services from January 2009 through October 9, 2012. The report, provided in November 2012, showed that seven claims were selected for audit during this period with one recovery for $545 (a second recovery for $275 was recorded as pending). Although requested, UHC did not provide any documentation to substantiate any recoveries prior to 2009. After further discussing the above report and process with UHC in April 2013, we were informed and provided a report for calendar year 2012 to the first quarter of 2013 that showed an additional $124,000 in gross recoveries. However, the County has not received sufficient information from UHC to evaluate recovery audit services provided under the ASO contract.

The 2008-2010 claims audit identified a number of subrogation cases that were closed without the injury investigation inquiry letters being returned by the members. In addition, the 2011 claims audit noted additional cases where the response from UHC indicates the members did not reply to the injury investigation inquiry letters. These potential subrogation cases totaled in excess of $1 million.

Claims selected and investigated for possible subrogation, as well as the final disposition, are not reviewed by the County. We were informed UHC has been providing monthly reports (since March 2012) on their secure website used for

information sharing with the County. However, the County was not informed and was unaware these reports were being provided; as such, no review procedures or reconciliation was performed to ensure all reported recovered amounts were received.

During our claims testing procedures, certain inconsistences regarding eligibility and entitlement to Medicare for Plan members diagnosed with end stage renal disease (ESRD) were noted during our review (one issue resulted in UHC refunding over $45,000 to the County). Plan members with diagnosed ESRD are eligible to apply for Medicare as a result of this condition (regardless of age or other factors). After a specified time-period, Medicare provides primary coverage for medical claims related to ESRD for enrolled members. However, medical conditions, treatments, and whether a person is enrolled in insurance (including Medicare) is protected information under Federal HIPAA laws (including specific data relating to ESRD). As such, it is challenging for the County to establish a program to encourage members to enroll in Medicare.

The Contract between UHC and the County places the responsibility (and financial risk for ineligible payments) for inputting and maintaining member eligibility information for claim payment processing with the County. During our review, we noted the following:

- We noted approximately $270,000 of claims were paid for members with a claim date of service between the member's actual Plan termination date and the date the termination was entered into the system (referred to as retroactive eligibility terminations). In addition, we noted approximately $47,500 of claim payments paid for members because an incorrect (later) termination date was entered into eServices; thereby, leaving members active in eServices for several weeks or months after termination.

- Our testing during the 2009 and 2010 claim years found that a number of members had claims paid with a date of service during an approved leave of absence without pay. County and Comptroller policies both state employees on a leave without pay are not covered by County benefits. Claims paid for these employees totaled approximately $44,000 during the identified leave periods.

During the claims audits for the 2008 through 2011 Plan years, we noted UHC processed claims related to health services that were listed as not covered services or were specifically listed as excluded services in the Plan documents. Additionally, claims were noted in the pharmaceutical claims audit for prescriptions that were not allowed under the Summary Plan Description based on the documentation provided. During our review, we discussed the specifics of the non-covered claim payments with representatives from UHC and the County. We were informed by the Plan Administrator that many of the non-covered health services noted were for services the Plan Administrator understood were covered

and in the circumstances noted, should be covered but the plan documents did not reflect this.

Management concurred or partially concurred with all of the Recommendations for Improvement and steps to implement the recommendations are underway or planned. Responses to each of the Recommendations for Improvement are included herein.

ACTION PLAN

CALENDAR YEARS 2008 THROUGH 2011
MEDICAL BENEFITS ELIGIBILITY AND CLAIMS PROCESSING REVIEW
ACTION PLAN

NO.	RECOMMENDATIONS	MANAGEMENT RESPONSE			IMPLEMENTATION STATUS	
		CONCUR	PARTIALLY CONCUR	DO NOT CONCUR	UNDERWAY	PLANNED
1.	We recommend the County evaluates the current hospital bill recovery audit services for adequacy and works with UHC to modify the contract language and procedures as needed. Further, the County should take the necessary steps to modify future contract language to allow the County, County Comptroller, or designated representative to conduct hospital claim audits.	✓				✓
2.	We recommend the County reviews the subrogation process to determine whether the current contract arrangement is in the best interest of the Plan. In addition, the County should perform the following:	✓				✓
A)	Ensures all reported subrogation collections are received;	✓				✓
B)	Works with UHC to institute procedures to ensure members provide timely and accurate information for all cases submitted for subrogation; and,	✓				✓
C)	Takes the appropriate steps to amend future Administrative Services Agreements to allow the County to subcontract the subrogation process without requiring approval.	✓				✓
3.	We recommend the County works with UHC to institute additional procedures to assist the County in educating and enrolling members that are eligible for Medicare Coverage as a result of a specifically covered condition.		✓			✓

CALENDAR YEARS 2008 THROUGH 2011
MEDICAL BENEFITS ELIGIBILITY AND CLAIMS PROCESSING REVIEW
ACTION PLAN

NO.	RECOMMENDATIONS	MANAGEMENT RESPONSE			IMPLEMENTATION STATUS	
		CONCUR	PARTIALLY CONCUR	DO NOT CONCUR	UNDERWAY	PLANNED
4.	We recommend the Plan Administrator performs the following:					
A)	Analyzes the ineligible claims and specific data issues related to the claims and works with the Comptroller's Office to take the appropriate steps to reduce the ineligible claim payments; and,	✓				✓
B)	Continues to work with UHC to identify and reprocess all claims paid within 60 days of a Retroactive Eligibility Termination. Further, the Plan Administrator should work with the Comptroller's Office to ensure a process is in place to verify refunded claims were credited to the County's bank account.	✓			✓	
5.	We recommend the Plan Administrator reviews the claims paid for health services not in compliance with the MBB and request reimbursement from UHC or modifies the MBB, as appropriate.	✓				✓

INTRODUCTION

Background

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 Plan 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.

The Plan is administered by United Healthcare Insurance Company (UHC), which provides Administrative Services Only (ASO) for medical services. This ASO contract includes access to UHC's provider network, benefit determination, and claims processing, including payment. UHC invoices the County for standard medical ASO fees, which the County pays on a monthly basis. The pharmaceutical portion was with UHC for 2007 and 2008 plan years. For the 2009, 2010, and 2011 plan years, Express Scripts, Inc. was contracted to administer the pharmaceutical portion of the services.

The chart below shows the claims volume and the amount spent on claims per year:

YEAR	PAID CLAIMS (in Millions)	MEDICAL CLAIM TRANSACTIONS	PHARM CLAIM TRANSACTIONS
2007	$60.5	367,217	151,372
2008	73.0	247,273	217,356
2009	81.7	257,961	214,867
2010	88.8	269,119	207,161
2011	54.6	185,818	146,514

The table on the following page lists the participating organizations and the average number of subscribers and dependents (members) under the County's Plan by year:

Participating Organization	2007	2008	2009	2010	2011
Board of County Commissioners (Board)	15,340	13,981	13,814	13,547	11,950
Comptroller's Office	478	434	408	401	342
LYNX	1,859	1,770	1,727	1,644	1,423
Central Florida Research Park	2	2	2	2	X*
Supervisor of Elections	112	101	98	93	98
Orlando Orange County Expressway Authority	116	123	136	139	X*
Metroplan (Metro)	38	32	31	32	31
Orange County Clerk of Courts	1,264	1,138	1,223	1,001	847
Property Appraiser's Office	312	254	252	235	204
S.O.B.T. Development Board	15	10	11	11	9
Orange County Tax Collector's Office	410	369	365	377	342
Housing & Finance Authority	24	24	20	17	14
International Drive Master Transit & Improvement District	19	21	20	19	18
Orlando Housing Authority	160	X*	X*	X*	X*
COBRA	164	64	50	37	39
Retiree	704	551	676	726	658
Survivor	6	6	2	3	5
TOTAL	21,023	18,880	18,835	18,284	15,980

*Organization no longer part of plan.

Member eligibility is maintained and reported by each participating organization. Eligibility data is updated by the County and Participating Organizations on a biweekly basis. 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. Prior to 2011, subscribers had 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. In 2011, the County moved to only allowing employees to join a High Deductible Plan with the Health Savings Account option at the same levels listed above.

Scope, Objectives, and Methodology

The audit scope included a review of the medical benefits eligibility and claims processing. The audit was limited to a review of the claims paid under the terms of the United Healthcare Administrative Services Only and Express

Scripts, Inc. (ESI) Pharmacy Benefit Management agreements with Orange County and the reporting of eligibility by participating organizations to United Healthcare (UHC). The period audited for claims processing was January 1, 2008 to December 31, 2011. Testing of the accuracy of eligibility reporting of members included claims paid for the 2009 and 2010 Plan years. The audit objectives were to determine whether:

- UHC and ESI are complying with the contractual terms of the agreement with the County;
- Claims were paid only for services allowed in the Plan documents; and,
- Claims paid were for active subscribers.

To achieve our objectives, we performed the following tests:

We created an historical eligibility file by obtaining a list of all eligible subscribers and dependents, referred to as members, submitted biweekly to the County's Human Resources Division (Plan Administrator) from each participating organization for the 2009 and 2010 plan years audited, as no historical eligibility file was available. The files were combined and all conflicting data for each member (such as dates of birth and Social Security numbers) were researched by the participating organizations and adjustments were made as necessary. Payroll data (PeopleSoft) was used to research conflicting data for County and Comptroller members. Additionally, a count was performed on the combined data and any members that were not in all the files for the year were researched by the participating organizations to determine accurate start and end dates, as well as breaks in coverage. PeopleSoft was also used to research data for County and Comptroller members.

We requested a new hire and termination report from each participating organization. The employee identification number was then matched to the eligibility file developed

above. Any termination dates that did not match were researched by the participating organization.

The paid medical and pharmaceutical claims files were obtained from UHC. First, we verified that the members reported in the claims files were in the eligibility file developed above. We then determined whether the date of service reported in the claims files fell in between the eligibility dates reported by the participating organizations in the eligibility file. For the members 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 members 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 claims that fell outside a member's eligibility dates were deemed ineligible.

We prepared and issued an RFP for medical and pharmaceutical claims auditing services. We contracted with a claims auditing firm (Claims Auditor) to review and evaluate the claims processing services provided by UHC and ESI. The main objective of the engagement was to determine whether medical and pharmaceutical claims were accurately processed according to plan documents. The firm used its professional judgment to select claims with the highest risk of processing errors. Some of the areas included the timeliness of claims processing, payment accuracy, and a determination of whether medical and pharmaceutical services provided to members were in accordance with the Plan.

Once the report was received, we researched all noted errors and discussed it with the County.

Overall Evaluation

Based on the results of the testing performed, UHC and ESI are materially complying with the contractual terms of the agreement, including paying for services allowed in the Plan documents for active subscribers. Opportunities for Improvement were noted and are described herein.

RECOMMENDATIONS FOR IMPROVEMENT

1. The County Should Continue to Work With the Comptroller's Office To Ensure the Most Effective Claims Recovery Audit Services Are Performed

Recovery audit services conducted for medical claims are designed to identify billing and coding inaccuracies. Procedures include a detailed review of important claim elements which are not submitted on the standard billing forms (UB-92 or UB-04) used for payment, including medical records, itemized bills, and manufacturer invoices. Section 4.7 of the Contract between UHC and the County provides that "…[UHC] will provide recovery services for Overpayments, but We [UHC] will not be responsible for recovery costs except…to the extent the Overpayment was due to Our [UHC] failure to meet the Standard of Care..." Section 4.9 of the contract provides that the County will be charged fees when the services are provided, "…through a subcontractor or affiliate…[at a rate not] more than 33.3% of the recovered amount." According to UHC, the current operational audit program can be performed onsite at a hospital or offsite and includes:

- Standard Hospital Bill Audit (HBA): Line-by-line comparison of the itemized bill to the medical record to ensure billing accuracy.
- Diagnosis Related Groups (DRG): Review of medical records validating the diagnosis and procedures to ensure DRG coding accuracy.
- Pass-through provision (Implants, High Cost Drugs): Review of itemized bill, operative record and implant or high cost drug manufacturer invoices to ensure billing in accordance with contract terms.

During the course of our review, we had the following concerns:

A) As part of our review process, we requested data that we could utilize to select a sample of claims to conduct a scheduled onsite hospital claim audit at two local hospitals. This audit was to be conducted by an

independent firm, with no affiliate relationship with UHC, selected with an open and competitive process. This review was designed to detect and seek recovery for claim overpayments. Among the areas to be covered were the following:

- Duplicate orders – billing twice for the same service.
- Operating-room billings - Inaccurate use times and subsequent billing for operating room use.
- Unbundled fees – billing for supplies already billed in bundled amounts.
- Upcoding – inflating a patient's diagnosis code to a more serious condition that requires more costly procedures.
- Upselling –inflating a charge such as using brand name when generic is available.

In March 2012, after several discussions with UHC on our proposed review, UHC stated, "We do not permit outside, non-approved vendors to conduct hospital bill audits." In November 2012, UHC agreed that we could audit our hospital billing claims, but also informed us they would not provide any assistance or data reports of claims paid to hospitals that would allow us to select a sample. Based on our review, the current contract does not include language clearly requiring this data to be provided. Without the required hospital claims data, it would not be feasible to select an adequate sample.

B) Upon request, UHC provided a status report of its activities related to hospital claim recovery services from January 2009 through October 9, 2012. The report, provided in November 2012, showed that seven claims were selected for audit during this period with one recovery for $545 (a second recovery for $275 was recorded as pending). The remaining

claims with a claim paid value of $843,000 was listed as pending - audit scheduled.

Further, as of the report date, no onsite reviews had been conducted. We requested additional reports since the inception of the contract in January 2007 to December 2008 (as noted above the reports provided only noted work performed from January 2009), but none were provided. Therefore, the County has no assurance recovery audit services were performed for this period.

After further discussing the above report and process with UHC in April 2013, we were provided a report for calendar year 2012 to the first quarter of 2013 that showed an additional $124,000 in gross recoveries [as noted in A) above, we requested to perform Recovery Audit Services in late 2011]. Further, no detail as to the type of errors, agreed-to charges, disputed charges, and agreed-to errors was provided in either of the reports.

The County has not received sufficient information from UHC to evaluate recovery audit services provided under the ASO contract. Periodic reports should be provided by UHC to detail the collection efforts, including the type of errors, agreed-to charges, disputed charges, and agreed-to errors. The County should evaluate this information to determine whether it would be more effective to work with the Comptroller's Office to select an independent vendor (without a potential affiliation with UHC) to conduct these audits.

The Centers for Medicare and Medicaid Services (CMS), estimates that 7.0 percent of all Part A (inpatient care) and Part B (Outpatient Services) paid in 2011 were improper. According to data provided by the County's health care consultant, the County paid approximately $27.5 million for inpatient/outpatient hospital claims in 2011. Although the dynamics of Medicare billings and insurance billings are different, the amount of improper payments made on the County's Plan could be significant.

We Recommend the County evaluates the current hospital bill recovery audit services for adequacy and works with UHC to modify the contract language and procedures as needed. Further, the County should take the necessary steps to modify future contract language to allow the County, County Comptroller, or designated representative to conduct hospital claim audits.

Management's Response:

Concur. The County is currently evaluating proposals for a new Group Medical and Pharmacy Plan contract that will go into effect for the 2014 plan year. Under the terms of this current RFP solicitation, we have strengthened the audit requirements to allow the County and/or Comptroller's Office to conduct annual claims audits and periodic hospital bill recovery audits.

As you note, under the current agreement UHC is responsible for performing the hospital recovery audits through a sub-contractor or an affiliated company. We have been discussing the concerns raised in your report with UHC and are continuing to receive additional information to evaluate the effectiveness of their hospital bill audits. Although we don't believe that CMS is the best benchmark for these audits, we do recognize the importance and significant dollar amounts involved with hospital billings and we will continue to work to improve this process.

2. The County Should Evaluate the Current Subrogation Process and Consider Changes to Provide Greater Accountability and Control

Subrogation is the legal right for an insurer to pursue a third party that may be liable for a claim paid on behalf of a member. As a matter of procedure, UHC electronically identifies medical claims with indicators it may be related to an incident that potentially involves a third-party (e.g., car accidents, negligence claims). The claims identified are then further investigated by a subsidiary of UHC that assists in

the investigation to determine if there is a liable third-party and request payment when necessary.

Part of the process involves an investigation inquiry letter which is sent to members with claims that were identified during the electronic review. The letter contains specific questions about the incident causing the claim. This is to assist in determining if a third-party is potentially liable. Additionally, a search may be performed on a property and casualty claims database to look for legal claims associated with the participants. As in the Recovery Audit Services described in Recommendation for Improvement No. 1 above, Section 4.8 of the contract provides that the County will be charged fees when the services are provided, "…through a subcontractor or affiliate…[at a rate not] more than 33.3% of the recovered amount."

If a third-party is ultimately determined to be liable, medical payments made on behalf of the member would be reimbursed by the liable party. Relating to this, we had the following concerns:

A) The 2008-2010 claims audit identified a number of subrogation cases that were closed without the injury investigation inquiry letters being returned by the members. In addition, the 2011 claims audit noted additional cases where the response from UHC indicates the members did not reply to the injury investigation inquiry letters. These potential subrogation cases totaled in excess of $1 million. In response to the audit questions, UHC stated that investigation letters were sent to the members and a property and casualty claims database was searched to determine if any claims had been filed for these incidents. Since none were found the case was closed.

The County's Medical Benefits Booklet requires that persons covered under the County's Plan provide the necessary information to determine if a claim(s) are eligible for subrogation. Section 9 states, "As a covered person, you agree to…cooperate with the

Plan and its agents in a timely manner to protect its [the County's] legal and equitable rights to subrogation and reimbursement." As such, the County could have the right to require the employee to answer the interrogatories or risk being terminated from the Plan.

Further, these cases were closed within two years of the incident date despite not having received a reply from the member. We were informed by a County Risk expert that it is not unusual for lawsuits involving third-party liability to be filed up to four years after the incident. Under Florida Statute 95.11, injured persons are allowed to file negligence claims for damages related to an accident up to four years after the incident.

Therefore, for the cases above, it does not appear that sufficient information, including injury details from the injured person, was received before these cases were closed. As such, it is possible a legal action with recovery could occur without the County receiving reimbursement for the claims amounts paid.

B) Claims selected and investigated for possible subrogation as well as the final disposition are not reviewed by the County. We were informed UHC has been providing monthly reports (since March 2012) on their secure website used for information sharing with the County. However, the County was not informed and was unaware these reports were being provided; as such, no review procedures or reconciliation was performed to ensure all reported recovered amounts were received. In addition, no reports were provided for prior dates. Based on these reports, approximately $91,000 was recovered and returned to the County for the eight month period from March 2012 to October 2012 (net of the fee charged by the UHC subsidiary as a percentage of recovery).

C) The Contract between UHC and the County provides that UHC will provide the subrogation services for the

claims paid by the County. Further, Section 4.8 states, "You [the County] will not engage any entity except Us to provide the services described herein without Our [UHCs] prior approval. Further, Section 4.9 states, "You [the County] delegate to Us [UHC] the discretion and authority to develop and use standards and procedures for any recovery… including but not limited to, whether or not to seek recovery, what steps to take if We decide to seek recovery, and the circumstances under which a claim may be compromised or settled for less than the full amount of the claim." This clause restricts the authority of the County to perform or subcontract these services or to participate in the decision of what is in the best interest of the County; including, accepting (or settling) an amount or seeking legal action on behalf of the plan member in circumstances where the member does not take actions which are in the best interest of the Plan.

The County should take the appropriate steps to amend future contracts to allow the subrogation services to be directly subcontracted without requiring approval from the third-party administrator. Further, the County should monitor the periodic reports and request additional information as needed to determine whether the County's interests are being protected; including documentation to ensure all members contacted for information about a medical claim responded. If sufficient documentation to determine that the County's interests are being adequately protected is not received, the County should consider subcontracting these services directly with a vendor. This would give the County assurance that the decisions made are in the best interest of the Plan and whether additional amounts should be recovered.

We Recommend the County reviews the subrogation process to determine whether the current contract arrangement is in the best interest of the Plan. In addition, the County should perform the following:

A) Ensures all reported subrogation collections are received;

B) Works with UHC to institute procedures to ensure members provide timely and accurate information for all cases submitted for subrogation; and,

C) Takes the appropriate steps to amend future Administrative Services Agreements to allow the County to subcontract the subrogation process without requiring approval.

Management's Response:

Concur. The County is currently evaluating proposals for a new Group Medical and Pharmacy Plan contract that will go into effect for the 2014 plan year. Under the terms of this current RFP solicitation, we have incorporated subrogation language similar to the County's workers' compensation contract. Among other things, the new subrogation process will require the County to sign off on all potential subrogation actions before the cases are closed. This will give the County the ability to get directly involved with any employee that does not respond to the subrogation letters.

A) The County will work with UHC to ensure we are receiving appropriate documentation so that we can validate that we are receiving all subrogation collections that are due to the County.

B) The County is changing the subrogation process, which will allow us to get directly involved with members that fail to respond to and provide requested information on potential subrogation claims.

C) See response B) above.

3. The County Should Work With UHC to Develop Procedures to Address Coordination of Benefits Relating to Certain Medical Conditions

As a matter of procedure, UHC routinely identifies claims where there is opportunity for coordination of benefits (COB) (the employee or employee's family is covered under another insurance policy or Medicare). When a member is covered by more than one policy, established rules contained in the Plans' documents determine which policy pays claims as the primary insurer and which policy pays claims as secondary insurer. Generally, the entity that pays a member's claims as the secondary insurer realizes significant savings for that member.

Plan members diagnosed with end stage renal disease (ESRD) are eligible to apply for Medicare as a result of this condition (regardless of age or other factors). The Medicare eligibility rules provide that after a four month waiting period (if receiving Medicare because of the diagnosis, not age) the Plan would be the primary payer for the dialysis treatment for the next 30 months. After 30 months of dialysis treatment, Medicare would become the primary payer. However, eligible persons being treated for this condition must go through the Medicare enrollment process (including having sufficient quarters of employment) to be entitled for Medicare. During our claims testing procedures, certain inconsistences regarding eligibility and entitlement to Medicare were noted (One issue resulted in UHC refunding over $45,000 to the County).

Medical conditions, treatments, and whether a person is enrolled in insurance (including Medicare) is protected information under Federal HIPAA laws (including specific data relating to ESRD). As such, it is challenging for the County to establish a program to encourage members to enroll in Medicare. During the course of this audit, the County has been discussing the specific procedures employed by UHC for ESRD related claims. It appears

much is done by UHC to mitigate the financial effect to the County. However, the County should continue to research any additional steps that could be taken and work with the UHC to enroll members with this condition in Medicare. For example, it is possible that additional education of the entire Plan membership (which would include those diagnosed with the medical condition) could increase membership in Medicare. Enrolling members with the condition in Medicare saves the Plan significant funds as on-going treatments for this condition can exceed $100,000 per year.

We Recommend the County works with UHC to institute additional procedures to assist the County in educating and enrolling members that are eligible for Medicare Coverage as a result of a specifically covered condition.

Management's Response:

Partially Concur. We agree with the spirit of this recommendation in that to the extent possible employees eligible for Medicare or other primary insurance coverage should be encouraged to enroll for coverage. Based on discussions with UHC, they currently have a proactive approach to inform and encourage members with ESRD to enroll in Medicare. The County will continue to explore other ways to encourage members to enroll in Medicare or other insurance coverage when they are eligible given the limitation that we cannot force them to enroll and the County does not have access to individual health information.

4. The Plan Administrator Should Work With the Comptroller's Office to Further Reduce Ineligible Claims Paid

The Contract between UHC and the County places the responsibility (and financial risk for ineligible payments) for inputting and maintaining member eligibility information for claim payment processing with the County. As part of our testing, we reviewed the date of service for all reported claims paid for each member during the 2009 and 2010 claim years (approximately 873,000 line items) to determine

whether the member was an active member of the Plan on date of service for each paid claim. During our review, we noted the following:

A) The actual termination date of the member from the plan was not always entered into eService until several weeks or months after the member terminated. As a result, we noted approximately $270,000 of claims were paid for members with a claim date of service between the member's actual Plan termination date and the date the termination was entered into the system (referred to as retroactive eligibility terminations). In addition, we noted approximately $47,500 of claim payments paid for members because an incorrect (later) termination date was entered into eServices; thereby, leaving members active in eServices for several weeks or months after termination.

Section 3.1, of the contract between the County and UHC allows the County to request claims paid within 60 days of the date of a retroactive eligibility termination in eServices to be reprocessed with the new eligibility date. Therefore, any claims paid for a member with a date of service that falls in this period should be refunded to the County. However, this provision is restricted to include only the claims paid for the 60 days preceding the date the retroactive eligibility termination was entered into eServices.

After discussing this with the County's Plan Administrator (Human Resources Division) in early 2011, we were informed that UHC was asked to reprocess all retroactively eligibility terminations on a prospective basis automatically (the claims paid for ineligible members noted during our review were prior to this agreement). Further, incorrect termination dates entered into eServices would not reflect a retroactive period eligible for reprocessing.

B) Our testing during the 2009 and 2010 claim years further found that a number of ineligible claims were

paid for a member with a claim date of service during the enrollee's (County employee covered under the Plan) approved leave of absence without pay (LOA). Only one of these employees had been required to provide a premium payment, and thus was eligible for coverage (employees on LOA neither receive paid-hours to allow the deduction of the required premium payments nor are eligible for the employer share of the premium payment). Further, some of these employees had waived coverage during the approved leave of absence, yet coverage still remained active and claims were paid. County and Comptroller employee policies both provide that employees on a LOA status are not covered by County benefits. Under both office rules, any employee on LOA that elects to retain benefits must utilize the COBRA contractor to continue benefits. None of the exceptions noted above utilized this contractor. There is no other process or procedures to track and collect this payment should the employee elect to retain coverage. Claims paid for these employees totaled approximately $44,000 during the identified leave periods.

Our testing did not determine the total number of claims paid during all LOAs for County and Comptroller employees and we did not perform any testing of the Participating Agencies procedures for LOAs, and as such, the dollar of claims paid to ineligible participants is likely greater.

Although the ineligible claim payments are not material to the claim payments paid (approximately one-quarter of one percent of the claim payments during the two-year period tested), steps should be taken to eliminate the causes of inaccurate reporting and reduce the claims paid for ineligible individuals. In addition, procedures should be developed to ensure all terminations are entered within 60 days of the actual termination date. This will ensure all claims paid during this period can be reprocessed by UHC and the payments refunded to the County. Accurate claim eligibility reporting and maintenance is dependent upon timely

notification and data entry of situations affecting employee eligibility by departments and the Human Resources Division. In addition, the accuracy is dependent upon the processing rules contained within eServices.

Eligibility reporting procedures for plan members involve processes carried out by the member's department, human resources departments, the Comptroller's Payroll Department and eServices. Many of the specific possible causes and situations that allowed the ineligible claim payments noted above were discussed with the Plan Administrator and the Comptroller's Payroll Department during the course of this audit. As such, we have been informed that each is working to incorporate procedures to further reduce ineligible claims.

We Recommend the Plan Administrator performs the following:

A) Analyzes the ineligible claims and specific data issues related to the claims and works with the Comptroller's Office to take the appropriate steps to reduce the ineligible claim payments; and,

B) Continues to work with UHC to identify and reprocess all claims paid within 60 days of a Retroactive Eligibility Termination. Further, the Plan Administrator should work with the Comptroller's Office to ensure a process is in place to verify refunded claims were credited to the County's bank account.

Management's Response:

Concur.

A) The County will work with the Comptroller's Office Payroll Department to streamline the leave without pay (LOA) and COBRA process to ensure that employees are paying the proper premium amounts for those opting to continue coverage and that eligibility files are updated to reflect those who have no coverage during these periods of time.

B) In early 2011, the County put into effect an automatic reprocessing procedure of all claims related to retroactive terminations affecting members' eligibility for coverage. In addition, the County centralized the Human Resources function in FY2012 and this will allow us to streamline the termination paperwork.

Human Resources will work with the Comptroller's Office to verify refunded claims and ensure that they are properly credited to the County's account.

5. The Plan Administrator Should Work To Reduce Inconsistencies Between Eligible Medical Conditions and Treatments and Plan Documentation

As noted in the background section of the report, the overriding plan document governing the plan is referred to as Medical Benefits Booklet (formerly called the Employee Benefits Booklet). The Medical Benefits Booklet (MBB) is prepared each year by UHC and the County and available for review by all plan participants. Among other items, the MBB defines what are covered and non-covered health services. During the claims audits for the 2008 through 2011 Plan years, we noted UHC processed claims related to health services that were listed as not covered services or were specifically listed as excluded services in the MBB. These claims involved payments related to dermatology procedures, acupuncture, dental services, eye services, foot care, etc. In addition, in some instances the member was charged an incorrect copayment or received treatments in excess of number of calendar year treatments allowed. Additionally, paid claims were noted in the pharmaceutical claims audit for prescriptions that were not allowed under the Express Scripts Summary Plan Description based on the documentation provided.

A breakout of the claims paid that were not in accordance with the MBB for the plan years reviewed are as follows:

Claim Payment Errors and Related Claims Category	2008-2010 Claims Audit	2011 Claims Audit
UHC Agreed to Errors	$ 19,750	$ 5,563
Related to Agreed to Errors*	$ 14,200	$ 666
Non-Covered Health Services and Conditions per MBB language	$176,601	$81,850
Non-Covered Pharmaceutical Drugs	$141,187	$ 0
Total	$351,738	$88,079

*These are additional claim errors for the same individual and condition noted

During our review, we discussed the specifics of the non-covered claim payments with representatives from UHC and the County[1]. We were informed by the Plan Administrator that many of the non-covered health services noted were for services the Plan Administrator understood were covered and in the circumstances noted, should be covered by the plan. However, as noted above, the claim payments were not in compliance with the Plan document.

During the 2011 plan year, the Plan Administrator addressed many of the inconsistencies in covered health services noted during the 2008 through 2010 claims audit by modifying the MBB to reflect that the services noted in our review are covered. Not all of the inconsistencies noted were modified, and based on discussions, additional changes to the MBB may be warranted. Conversely, the Plan Administrator may decide to continue to exclude some health services from coverage under the Plan. All covered and excluded health services should be addressed in the MBB. Further, the Plan Administrator should review the claim payments not in accordance with the MBB noted during the claims review and request reimbursement for claims paid for non-covered health services as appropriate.

[1] The specific data related to the medical procedures performed is protected personal health information (PHI) under HIPAA, exempt from disclosure under Florida Public Records law, and not included in this document.

We Recommend the Plan Administrator reviews the claims paid for health services not in compliance with the MBB and request reimbursement from UHC or modifies the MBB, as appropriate.

Management's Response:

Concur. The County will work to develop additional reporting and review procedures to ensure claims are paid in compliance with the MBB. Further, the County is currently reviewing the language in the MBB document and we will be making appropriate changes to resolve inconsistencies between sections of that document and the UHC formal appeals process. On rare occasions, procedures have been approved through the appeals process because of medical necessity that would appear to be in conflict with the exclusions in the MBB. The County will also develop a process so that we can review all claims that were paid after being appealed. In regard to the "UHC Agreed to Errors" and "Related to Agreed to Errors," the County has requested reimbursement from UHC for these amounts.

Appendix – Management's Supplemental Response

HUMAN RESOURCES DIVISION
J. RICARDO DAYE, *Director*
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June 18, 2013

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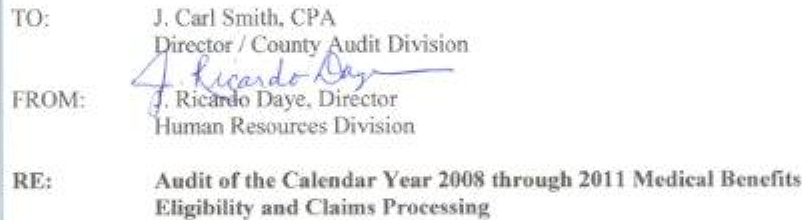

TO: J. Carl Smith, CPA
Director / County Audit Division

FROM: J. Ricardo Daye, Director
Human Resources Division

RE: **Audit of the Calendar Year 2008 through 2011 Medical Benefits Eligibility and Claims Processing**

I have carefully reviewed your *Audit of Orange County's Self-Funded Employee Medical Benefits Insurance Program* for Calendar 2008 through 2011 medical benefits eligibility and claims processing. This is the second audit of the Medical Plan since it became self-funded in 2007 and United Healthcare's role changed to an Administrative Services Only (ASO).

We appreciate your assistance in conducting this audit of our Administrative Services Only contracts for group medical and pharmacy plan services. We were also pleased that this audit concluded that both United Healthcare and Express Scripts are materially complying with the contractual terms of their agreements. Please find attached our response to the above referenced audit's *Recommendations*.

Let us know if there are any questions or concerns.

Attachment

C: Eric Gassman, Chief Accountability Officer

RD/pp