Preventing Inappropriate and Excessive Costs in the New York State Health Insurance Program

A Summary of Audits Identifying Out-of-Network Providers Engaged in Routine Waiving

OFFICE OF THE NEW YORK STATE COMPTROLLER

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2016-D-1 | MAY 2018

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Executive Summary

The New York State Health Insurance Program (NYSHIP), administered by the State Department of Civil Service (Civil Service), is one of the nation's largest public sector health insurance programs. NYSHIP covers over 1.2 million active and retired State, local government and school district employees, and their dependents. In 2017, NYSHIP cost the State, other government employers, and NYSHIP members $9.2 billion.

Members of NYSHIP have the opportunity to select various plans for coverage. The Empire Plan is by far the most popular plan, covering 1.1 million people, or 89 percent of NYSHIP's members, at an annual cost of $8.4 billion. Civil Service contracts with UnitedHealthcare (United) to administer the medical/surgical portion of the Empire Plan. United processes and pays medical and surgical claims submitted by health care providers on behalf of Empire Plan members. United contracts with a large network of health care providers who agree to be reimbursed at rates established by United. Members also pay a nominal co-payment to the in-network provider.

Empire Plan members may also choose to receive medical and surgical services from out-of-network providers. United's reimbursements for out-of-network services are usually higher than reimbursements for the same services provided in-network. Also, when Empire Plan members elect to use an out-of-network provider, they are required to pay higher out-of-pocket costs (deductibles and co-insurance). After members reach their annual deductible, United will generally reimburse the member 80 percent of the 'reasonable and customary' charge for the out-of-network service. The member remits United's payment to the provider, and is responsible for paying the remaining 20 percent.

In 2017, United processed claim payments totaling almost $2.9 billion. Of that amount, $1 billion (37 percent) was for out-of-network services.

Starting in 2007, the Office of the New York State Comptroller (OSC) conducted a series of audits to determine whether out-of-network providers routinely waived (did not collect) members' out-of-pocket costs. OSC found that this practice caused United to make overpayments on claims for out-of-network services.

Between 2007 and 2017, OSC completed 35 audits and found that 32 of 35 out-of-network providers routinely waived Empire Plan members' out-of-pocket costs, which caused $22.8 million in overpayments. Because a claim should reflect the provider's actual charge (the amount the provider intended to accept as payment-in-full) for the service, if an out-of-network provider waives a member's out-of-pocket costs, the provider should reduce its claim to United by the waived amount. Failing to do so can result in United paying 80 percent of an inflated charge.

To illustrate, a provider who charges $1,000 for a service and collects $800 in payments by United should collect $200 from the Empire Plan member. In the event that the provider does not collect (waives) the member's out-of-pocket

cost of $200, it has actually provided a medical service for $800, not $1,000, and United should have paid only $640 (80 percent of $800) of that cost, resulting in an overpayment of $160 ($800 - $640).

The submission of an insurance claim with false information, such as inaccurate service charges, may constitute insurance fraud pursuant to State Law. The State Insurance Department (now the New York State Department of Financial Services) has concluded that it may be a fraudulent billing practice and violation of the State Insurance Law when a provider routinely waives out-of-pocket cost obligations and accepts amounts from the insurer as payment-in-full. In November 2016, the Department of Health and Department of Financial Services sent a joint letter to New York State physicians reminding them that, by regulations, they must charge all patients the same price for the same service.

As a result of OSC's audits, the New York State Insurance Department conducted its own investigation into the issues identified by OSC, and in 2010 reported that New York State recouped over $11.5 million in restitution from 13 providers found to be routinely waiving members' out-of-pocket costs. In addition, some providers agreed to discontinue the practice of waiving and join the Empire Plan network, which has led to significant additional savings over the years subsequent to the audits. Between November 2016 and March 2017, OSC referred three audit reports to the Department of Financial Services to determine whether routine waiving would violate insurance law.

OSC's follow-up reviews of seven providers who joined the Empire Plan network as a result of the audits identified over $70 million in subsequent NYSHIP savings due to United paying the providers at in-network rates as opposed to higher out-of-network rates.

Recent trends show that the cost of providing out-of-network services under the Empire Plan is growing at a faster rate than in-network services: from 2012 to 2017, total annual out-of-network costs grew at a higher rate (38.9 percent) than in-network costs (26.4 percent), and average claim costs grew at a higher rate out-of-network (44.5 percent) than in-network (18.3 percent). Out-of-network providers who do not collect members' out-of-pocket costs negate Empire Plan members' financial incentive (lower out-of-pocket costs) to use in-network providers. Given that out-of-network services cost more compared to the same services provided in-network, waiving undermines the State's health insurance program and drives up health care costs for New York State taxpayers.

Based on our audit findings, we determined significant cost savings to NYSHIP would occur if more out-of-network providers who improperly waive members' out-of-pocket costs discontinued this practice and joined the Empire Plan network. Additionally, out-of-network providers who join the Empire Plan benefit plan members by expanding the number of in-network providers from which members can choose. We recommend that a course of action be taken to recover overpayments and prevent out-of-network providers from improperly waiving members' out-of-pocket costs.

Introduction

The Office of the New York State Comptroller (OSC) conducted a series of 35 audits from 2007 to 2017 that examined payments made by UnitedHealthcare (United) on behalf of the State for services provided by non-participating (out-of-network) medical providers to members of the Empire Plan of the New York State Health Insurance Program (NYSHIP). OSC's audits found out-of-network health care providers who routinely failed to collect ("waived") members' out-of-pocket costs, and OSC identified $22.8 million in overpayments for services rendered by 32 out-of-network providers as a result of this practice.

Additionally, OSC audits reported that out-of-network services are significantly more expensive compared to providing the same services in-network. Waiving cost-sharing obligations negates a member's incentive to use lower-cost in-network providers, which results in additional costs to the State. This practice drives up the cost of health care, risking higher premiums for members, while increasing costs for taxpayers who support these benefits. In fact, trends over the past several years (2012–2017) show that both total Empire Plan costs and average claim costs are growing at a faster rate for out-of-network services than for in-network services.

OSC determined significant savings can be achieved when providers who routinely waive members' out-of-pocket costs stop improper waiving and join the Empire Plan network. In the past, State insurance regulators examined providers engaged in routine waiving, and negotiated settlements in which providers agreed to refund overpayments and stop improper waiving. In addition, many providers subsequently joined the Empire Plan's participating (in-network) provider network.

Background

The New York State Health Insurance Program

NYSHIP was established in 1957 under the provisions of Chapter 461 of the Laws of 1956, which added Article 7 (renumbered Article 11) to the Civil Service Law. Outside of the federal government, NYSHIP is one of the largest public sector health insurance programs in the nation, covering over 1.2 million active and retired State, local government and school district employees, and their dependents. The New York State Department of Civil Service (Civil Service) is the State agency responsible for administering NYSHIP.

In 2017, NYSHIP cost the State, other government employers, and NYSHIP-covered members $9.2 billion. The Empire Plan, the primary health plan option in NYSHIP, accounted for $8.4 billion of this cost, and several health maintenance organization (HMO) options accounted for the remaining costs at $823 million. For the Empire Plan, the State's share of these costs was $4.3 billion and other government employers' share was about $4.1 billion.

Currently, New York State government employers pay a share of members' health insurance premiums, and members pay the balance. For example, for many employees, the State pays 84 percent of the cost of their coverage and 69 percent of the cost of their dependents' coverage.[1]

The Empire Plan

As of December 2017, the Empire Plan covered 1.1 million members, or 89 percent of NYSHIP's members, including about 281,000 active employees, about 224,000 retirees, and about 551,000 dependents. The remaining 11 percent of NYSHIP members were covered through various HMOs.

The Empire Plan provides its members with four types of health insurance coverage: medical/surgical, hospital, prescription drugs, and mental health and substance abuse. To administer the Empire Plan, Civil Service contracts with four vendors, one for each type of coverage. Each vendor is responsible for establishing a network of participating providers, establishing reimbursement rates, processing and paying claims from both participating and non-participating providers, and ensuring compliance with the requirements of the Empire Plan. Under the Empire Plan, each vendor is reimbursed by Civil Service for the claims they process and pay. Additionally, Civil Service pays each vendor an administrative fee.

1 The Public Employees Federation, AFL-CIO and the State of New York Professional, Scientific and Technical Services Unit, 2011-2015 Agreement, Article 9 (Health Insurance), 9.2 (h).

Civil Service contracts with United to administer the medical/surgical portion of the Empire Plan. Medical/surgical benefits cover a range of services including, but not limited to: office visits, surgery, diagnostic testing, physical therapy, chiropractic services, home care services, and durable medical equipment. United processes and pays claims for these services to, or on behalf of, Empire Plan members. In 2017, United made Empire Plan claim payments totaling almost $2.9 billion. Within United's Empire Plan participating provider network, members have access to a wide choice of health care professionals in various specialties. United contracts with in-network health care providers who agree to accept payments at rates established by United to furnish medical services to Empire Plan members. United remits payments directly to in-network providers based on claims submitted for services provided. Members pay a nominal co-payment amount to the in-network provider for the services rendered.

Empire Plan members may also choose to receive services from out-of-network providers. United's payments for out-of-network provider services are generally higher than the rates in-network providers agree to accept for the same services. If a member decides to select an out-of-network provider, the member is required to pay significantly higher out-of-pocket costs (deductibles and co-insurance). This cost-sharing arrangement is designed to serve as a disincentive for selecting out-of-network providers. Once members reach their annual deductible amount, United will generally reimburse the member 80 percent of the claim, and the patient is responsible for paying the provider for the service, including any out-of-pocket costs owed. In 2017, United paid $1 billion (37 percent of United's total payments) for out-of-network services.

United bases its payments of out-of-network provider claims on the reasonable and customary charge (R&C) for the service. The R&C charge is the lowest of the provider's actual charge for the service, the provider's usual charge for the same or similar service, or the usual charge of other providers in the same or similar geographic area for the same or similar service.

How Does Waiving Work?

In accordance with the Empire Plan's requirements, when United processes claims for services by an out-of-network provider, it is with the understanding that members are liable for a portion of the claimed amount, representing the members' out-of-pocket cost obligations. Waiving occurs when an out-of-network provider fails to collect or pursue collection of a member's out-of-pocket costs—such as deductibles and co-insurance.

An out-of-network provider's claim to United should reflect the provider's actual charge for the service (the amount the provider intends to accept as payment-in-full). After the member meets his or her annual deductible, United pays 80 percent of the R&C charge. However, if a provider waives the member's portion of the charge and accepts United's payment as payment-in-full, and the claim to United does not reflect the provider's actual (reduced) charge for the service, United is at risk for making an overpayment based on an inflated charge stated on the claim.

To illustrate, an out-of-network provider submits a claim to United, charges $1,000 for a service, collects $800 in payments by United (or 80 percent of $1,000), and should collect $200 from the Empire Plan member as the member's out-of-pocket co-insurance. However, if the provider waives the member's out-of-pocket cost of $200 and accepts United's $800 payment as payment-in-full, the provider's actual charge is $800, not $1,000, and United should only pay $640 of that charge (or 80 percent of $800). In this example, United would have made an overpayment on the claim of $160 ($800 - $640).

A 2016 OSC audit of an orthopedic provider (2015-S-29) illustrates an actual instance of waiving identified by OSC auditors:

> *The provider charged $19,289 on a claim, which United used as the basis for allowing $8,665 as the reasonable and customary rate for the service. As a result, United paid $6,932 (80 percent of $8,665) on the claim and the member's out-of-pocket portion of the claim should have been $1,733 (20 percent of $8,665). However, the provider accepted the $6,932 as payment-in-full and waived the $1,733 due from the member. The provider wrote off the $1,733 as an "Insurance Adjustment." Because the provider accepted $6,932 as the full payment, United should have only paid $5,546 (80 percent of $6,932) on the claim. This resulted in an overpayment by United of $1,386 ($6,932 - $5,546).*

The following scenario demonstrates waiving from the perspective of an Empire Plan member:

An Example of Out-of-Network Waiving

Bob, a 45-year-old man enrolled in the Empire Plan, needs a common knee surgery.

Bob goes to a local orthopedic surgeon for the operation.

Bob has his knee surgery. His surgeon is an out-of-network provider.

Bob's doctor's office submits a claim to United for $10,000. United processes and pays the claim on behalf of the Empire Plan member.

United processes the claim, allowing $10,000 for the procedure. After applying Bob's required 20% co-insurance, United issues a check to Bob for $8,000 as reimbursement for the cost of the operation.

Bob gets United's $8,000 check in the mail.

Waiving

Bob remits the $8,000 payment from United to his surgeon. The surgeon waives Bob's required $2,000 out-of-pocket co-insurance.

The surgeon credits Bob's account for $8,000.

The surgeon does not collect Bob's out-of-pocket-costs ($2,000).

No further billing activity occurs.

Had the provider submitted a claim to United for its actual charge of $8,000, United would have paid $6,400 (80% of $8,000) instead of $8,000 (80% of $10,000) and avoided an overpayment of $1,600.

Non-Waiving

Bob remits the $8,000 payment from United to his surgeon. Bob uses his personal funds to pay the remaining $2,000 out-of-pocket costs (his co-insurance) to his surgeon.

The doctor credits Bob's account for $10,000.

No further billing activity occurs.

Note: The In-Network Alternative

Had Bob gone to a surgeon who was in the Empire Plan's network, United would have paid a lower rate ($3,000 for example, as opposed to $8,000) and Bob's out-of-pocket costs (co-payment) would have been $20.

Results from OSC Audits

Pursuant to the State Comptroller's authority under Article V, Section I of the State Constitution and Article II, Section 8 of the State Finance Law, OSC regularly conducts audits on all aspects of NYSHIP, including claim payments made under the Empire Plan. In 2009, two out-of-network health care providers challenged the Comptroller's authority to examine their billing records in connection with the Comptroller's audits of United's payments for services provided to Empire Plan members. During several years of litigation, OSC suspended its audits of United's payments for out-of-network services. However, in May 2014, the New York State Court of Appeals affirmed the Comptroller's authority to examine the billing records of out-of-network providers, and OSC resumed its audits.[2]

1. Audits Found Providers Routinely Waived Empire Plan Members' Out-of-Pocket Costs

Between 2007 and 2017, OSC conducted a series of 35 audits of United's payments for out-of-network services to determine whether out-of-network providers routinely waived Empire Plan members' out-of-pocket costs, resulting in excess payments for claims. These audits found out-of-network providers have systemically waived members' out-of-pocket cost-sharing obligations: 32 of the 35 providers routinely waived Empire Plan members' cost-sharing obligations. See Appendix A for a complete list of OSC waiving audits and findings.

2. Audits Identified Substantial Overpayments

Between 2007 and 2017, OSC's audits have found $22,796,368 in overpayments on out-of-network providers' claims.

To determine the amount of overpayments, auditors reviewed claims for out-of-network services. Auditors selected random samples of claims, reviewed the providers' financial records for those claims, and determined if the providers waived all or a portion of the Empire Plan members' out-of-pocket costs.

Auditors then analyzed the overpaid claims in more detail. In some cases, providers wrote off the outstanding balances (i.e., members' out-of-pocket cost obligations) from the patients' accounts. In other cases, providers' patient account records indicated the members had an outstanding balance due, but upon closer examination auditors found that many of the balances had been outstanding for several years. Furthermore, the providers' financial records did not note attempts to collect the outstanding balances on these claims, indicating the providers likely intended to accept the amounts already paid by United as payment-in-full, and effectively waive the outstanding balances.

2 *Handler, M.D., P.C. v. DiNapoli,* 23 N.Y.3d 239 (2014).

A 2016 audit of an orthopedic provider (2015-S-29) illustrates this issue. OSC auditors found the provider waived the members' out-of-pocket costs on 176 of 215 (82 percent) of the sampled claims. For 130 of the 176 claims (74 percent), the provider wrote off the members' out-of-pocket costs. For the remaining 46 overpaid claims, the provider's patient account records indicated the members had an outstanding balance due. However, auditors determined 83 percent (38 of 46) of the claims in question had been outstanding for a year or more. Auditors' review of the provider's financial records found no attempt to collect the outstanding balances, indicating that the provider likely intended to accept the amounts already paid as payment-in-full, and effectively waive the outstanding balances for the 46 claims. See Table 1.

TABLE 1

Breakdown of Outstanding Balances in OSC Audit: 2015-S-29		
Length of Time That Balance Was Outstanding From Date of Service Until Audit	**Number of Claims**	**Percentage of Claims**
Less than one year	8	17%
Between one and two years	23	50%
Between two and three years	12	26%
More than three years	3	7%
Total Number of Sampled Claims With Outstanding Balances	**46**	**100%**

3. Audit Concludes Out-of-Network Services Are Significantly More Expensive

New York State has seen significant increases in the cost of providing health care for government employees under the Empire Plan, with increases of over $1.8 billion from 2010 through 2016 according to the Empire Plan's Annual Financial Settlement Reports. It's apparent that out-of-network costs are contributing to this significant increase more than in-network costs. A 2009 OSC audit, *Cost of Out-of-Network Benefits* (2009-S-34), determined that out-of-network services generally cost more than in-network services. As shown in Table 2, out-of-network services continue to be more costly than in-network services. As the table shows, United's average payment for out-of-network services was nearly three times the average payment for in-network services in 2017.

TABLE 2

Comparison of United's In-Network and Out-of-Network Payments for 2017			
	In-Network	**Out-of-Network**	**Total**
Number of Claims Submitted to United	19,342,288	3,828,659	23,170,947
Total Amount Paid	$1,803,782,356	$1,058,053,342	$2,861,835,698
Average Amount Paid	$93	$276	$124

In addition, audit 2009-S-34 also found that the costs of out-of-network services were increasing at a faster rate than those of in-network services. For example, the audit found that the average cost of an out-of-network procedure increased from $49 to $89 from 2001 to 2008 compared to an increase of $36 to $42 for the average cost of an in-network procedure for the same time period.

OSC's subsequent analysis of United's aggregate spending shows that this trend has continued. From 2012 to 2017, the annual costs of out-of-network services grew at a higher rate (38.9 percent) than in-network costs (26.4 percent), and average claim costs grew at a higher rate out-of-network (44.5 percent) than in-network (18.3 percent).

Auditors found that a primary factor that contributed to this significant cost differential is the manner in which out-of-network providers are reimbursed for their services. Under the Empire Plan, when a member chooses to use an in-network provider, United pays providers at contracted rates set by United. When a member chooses an out-of-network provider, United bases the reimbursement for services upon R&C rates. Because R&C rates are often significantly higher than the rates United pays to in-network providers, out-of-network services are more costly for the State. Taken from 2009-S-34, Table 3 illustrates in-network and out-of-network payment disparities and subsequent costs to the State.

TABLE 3

Higher Costs of Out-of-Network Procedures According to 2009 OSC Audit			
Procedure	**Out-of-Network Payment**	**Amount that Would Have Been Paid In-Network**	**Additional Cost for Using Out-of-Network Providers**
Procedure A	$34,244,806	$9,378,257	$24,866,549
Procedure B	$6,214,917	$2,021,191	$4,193,726
Procedure C	$6,594,639	$2,490,442	$4,104,197
Procedure D	$7,483,563	$3,934,019	$3,549,544
Procedure E	$6,183,474	$2,776,697	$3,406,777
Procedure F	$3,982,245	$596,463	$3,385,782

The audit found that savings could be achieved by taking steps to reduce the Empire Plan's out-of-network utilization. Elective non-emergency services by out-of-network providers represented over 92 percent of out-of-network expenditures. However, the audit also found there was virtually no shortage of in-network providers. Had the out-of-network services been delivered by in-network providers, costs could have been reduced by approximately $212 million (based on 100 percent in-network utilization). However, it is unrealistic to expect that all of these procedures would have been done with in-network providers. In 2009, the utilization rate of out-of-network services by Empire Plan members was 7.7 percent. We determined that some of United's other (non-NYSHIP) plans were able to keep their out-of-network utilization for these procedures as low as 3.2 percent. We therefore estimated annual cost savings of about $124 million if the rate of members' out-of-network utilization was reduced to 3.2 percent for the medical/surgical component of the Empire Plan.

Impact of OSC Audits

1. Routine Waiving Circumvents a Key Cost Control and Increases Health Care Costs

OSC's audits concluded that waiving members' out-of-pocket costs and accepting reimbursement amounts from the insurer as payment-in-full allows out-of-network providers to increase revenues significantly by negating Empire Plan members' financial incentive (i.e., lower out-of-pocket costs) to use in-network providers. This practice undermines the State's health insurance program and drives up health care costs for Empire Plan members and taxpayers.

To illustrate, for a common chest surgical procedure in 2017, United's average in-network reimbursement amount was $1,381, and members were responsible for a nominal co-payment, generally $20. In contrast, for the same procedure performed by an out-of-network provider, United's average reimbursement amount was $15,593 (over 11 times United's in-network payment), and members' average out-of-pocket costs were $1,062. If an out-of-network provider waives a member's out-of-pocket costs, the member's incentive to use an in-network provider is negated. Additionally, if the submitted claim is inflated by failing to show the waived out-of-pocket costs, the costs for NYSHIP, which are ultimately borne by taxpayers, are increased.

2. Significant Savings Result When Providers Join the Network

OSC's audits found the State achieves significant savings when out-of-network providers stop improper waiving and join the Empire Plan network. In 2010, OSC conducted follow-up reviews of five audits in which providers were found to be routinely waiving—four audits were issued in December 2007 and one was issued in February 2008. All five providers agreed to pay restitution and subsequently joined the Empire Plan network in 2008. OSC auditors estimated the Empire Plan realized recurring annual cost savings of $5.6 million as a result of the five providers joining the network, with cumulative cost savings of $53.5 million through the end of 2017.[3] See Table 4 for a summary of these five audits.

3 These savings were achieved due to United reimbursing providers at the lower in-network reimbursement rates. To estimate these savings, we calculated the difference between each provider's average claim cost in the year prior to joining the Empire Plan network and in the year after joining the network, and then multiplied each provider's average cost by their number of claims in the year after joining. This analysis was conducted between 2007 and 2015.

TABLE 4

Summary of Five OSC Audits and Analysis of Savings After Out-of-Network Providers Joined the Empire Plan				
Audit Report	**Audit Overpayment**	**Restitution Paid**	**Estimated Annual Savings After Provider Joined the Network**	**Estimated Cumulative Savings Through 12/2017**
2007-S-72, 2010-F-6	$2,412,416	$2,225,015	$1,478,084	$14,288,145
2007-S-87, 2010-F-7	$1,456,947	$1,332,120	$677,760	$6,438,720
2007-S-120, 2010-F-8	$1,461,856	$1,162,232	$362,917	$3,447,712
2007-S-86, 2010-F-9	$1,413,548	$1,165,000	$2,096,823	$19,570,348
2007-S-73, 2010-F-10	$2,686,856	$3,135,834	$996,272	$9,713,652
Total annual savings			**$5,611,856**	
Total cumulative savings				**$53,458,577**

In addition to the five providers, thirteen other providers joined the Empire Plan network (for a total of 18 of 32 providers which OSC found to be improperly waiving Empire Plan members' out-of-pocket costs). Our review of two providers who joined the Empire Plan network in 2017 found that this will result in an estimated $18.2 million in savings for NYSHIP over the following five-year period. We believe that additional savings—likely in the tens of millions of dollars—has occurred as a result of the remaining eleven other providers who joined the network, but which were not included in a follow-up analysis.

3. Routine Waiving May Violate State Insurance Law

OSC's audits concluded that providers who routinely waive out-of-pocket costs and inflate their billed amounts submitted to United by the amount of the waived member out-of-pocket costs, causes United to make excessive payments on these claims. The submission of an insurance claim with false information, such as inflated billed amounts, may constitute insurance fraud and violate the State Insurance Law.

In 2005, the Office of General Counsel of the New York State Insurance Department (currently the Department of Financial Services) issued an opinion stating that if a health care provider made waiving a common business practice, the health care provider may be guilty of insurance fraud.[4] In 2008, the Office of General Counsel issued an additional opinion stating that, depending on the circumstances, the waiver of otherwise applicable co-payments could constitute insurance fraud.[5]

In its 2009 annual report, the State Insurance Department strongly supported OSC's audits and the State Insurance Department conducted its own investigation into the issues identified by OSC.[6] As a result, New York State recouped $11,546,457 in restitution from 13 providers found to be routinely waiving and imposed $124,000 in fines through stipulations the State Insurance Department negotiated with these providers, as reported in the 2009 annual report. In addition, the providers agreed to discontinue the practice of waiving. Moreover, the State Insurance Department's support helped United bring many of the providers into the Empire Plan's participating provider network.

OSC suspended waiving audits in 2009 after litigation challenged the Comptroller's authority to examine out-of-network providers' billing records. Likewise, the State Insurance Department did not reach stipulations with any additional providers found to be routinely waiving by OSC audits. In May 2014, the New York State Court of Appeals affirmed the Comptroller's audit authority, and OSC has resumed its audits.

Between November 2016 and March 2017, OSC referred three audit reports to the Department of Financial Services to investigate the commission of fraudulent insurance activity and, if warranted, to take appropriate action to recoup overpayments. A renewed effort by the Department of Financial Services to seek additional recoveries and compel out-of-network providers to cease improper waiving and join the Empire Plan network could result in significant savings.

In November 2016, the Department of Financial Services and the Department of Health issued a joint letter to New York State physicians. The letter reminded physicians of the rules related to billing for patient co-insurance, and noted that routinely waiving co-insurance may be considered insurance fraud. Moreover, billing a patient's insurer for waived co-insurance is considered to be a fraudulent practice (see Appendix B).

4 New York State Insurance Department, Office of General Counsel, Opinions, Re: Co-Payment and Deductible, Waivers, April 8, 2005 at http://www.dfs.ny.gov/insurance/ogco2005/rg050407.htm.

5 New York State Insurance Department, Office of General Counsel, Re: Health Insurance, Waiver of Deductibles and Co-Insurance at http://www.dfs.ny.gov/insurance/ogco2008/rg080404.htm.

6 The Annual Report of the Superintendent of Insurance on the Activities of the Insurance Department to Investigate and Combat Health Insurance Fraud, 2009 Report, Section V, The Year in Review, Part B. Waiver of Co-Insurance, page 13 at http://www.dfs.ny.gov/reportpub/fraud/fd09hlthrp.pdf.

Tables 5 summarizes OSC's audit findings and the results of the State Insurance Department's investigation as of 2010:

TABLE 5

Summary of OSC Audit Findings and the State Insurance Department's Investigation							
Litigation Status	**Year Audit Report Issued**	**OSC Audits Issued**	**Total Overpayments**	**Providers Found Routinely Waiving**	**Providers Who Paid Restitution**	**Overpayments Recovered (Restitution)**	**Providers Who Joined the Empire Plan Network**
Pre-Litigation	2007	4	$7,969,767	4	4	$7,857,969	4
	2008	19	$5,828,284	17	8	$3,557,843	9
	2009	4	$2,423,669	4	1	$130,645	1
	2010	1	$0	0	0	$0	0
Totals		**28**	**$16,221,720**	**25**	**13**	**$11,546,457**	**14**

During 2016–2017, OSC issued seven audit reports that identified overpayments totaling $6,574,648. All seven providers were found to be improperly waiving out-of-pocket costs. As of December 2017, four of those providers have joined the Empire Plan network. See Appendix A for a complete list of waiving audits and a summary of key audit findings.

Conclusion

The cost of health care is a national concern. According to the National Conference of State Legislatures (NCSL), U.S. health care spending reached $3 trillion in 2014, accounting for 17.5 percent of the nation's gross domestic product.[7] Furthermore, the NCSL found health care spending is projected to grow faster than average economic growth for the period from 2013 through 2023, with the health care share of the gross domestic product expected to rise to 19.3 percent in 2023.

It is critical that New York State pursue all avenues to mitigate health care costs and lower Empire Plan premiums. Waiving, however, drives up costs, which can lead to higher premiums. Recent OSC audits found that out-of-network providers continue to routinely waive members' out-of-pocket costs, submitting inflated claims and causing overpayments. With health care costs on the rise, should waiving continue unabated, its impact will continue to add to rising costs for the State and local governments, their employees, and, ultimately, New York's taxpayers. Waiving also impacts consumer choice. When more out-of-network providers join the Empire Plan network, members have a greater number of in-network providers from which to choose.

The State Insurance Department examined providers based on prior OSC audits, and was successful in reaching settlement agreements with providers. As a result, overpayments were recovered, providers agreed to stop improper waiving, and several providers joined the Empire Plan's network of participating providers. In 2016 and 2017, OSC issued seven additional audits of United's payments for out-of-network services which identified about $6.6 million in overpayments.

OSC is moving to coordinate efforts with other oversight agencies and address the problem of improper waiving. OSC offers the following recommendations for consideration.

7 Health Finances Issues 12/2/2015 at http://www.ncsl.org/research/health/health-finance-issues.aspx.

Recommendations

To the New York State Department of Financial Services:

Continue efforts to help recover overpayments identified in OSC waiving audits and compel out-of-network providers to discontinue the practice of improperly waiving Empire Plan members' out-of-pocket costs.

To UnitedHealthcare:

Recover overpayments from providers found through OSC audits to be improperly waiving and refund the State accordingly.

Work with the Department of Civil Service to pursue an appropriate course of action designed to prevent out-of-network providers from improperly waiving Empire Plan members' out-of-pocket costs. This may include, but not be limited to: monitoring out-of-network providers' billing practices, educating providers about the consequences of improper waiving, recovering overpayments as appropriate, and taking steps to bring out-of-network providers into the Empire Plan's participating provider network.

Appendix A: Summary of OSC Audits from 2007 to 2017 in Descending Order by Overpayment

Report #	Date Issued	OSC Overpayment	Joined Network	Date Joined
2007-S-73	12/3/2007	$2,686,856	Yes	4/1/2008
2007-S-72	12/3/2007	$2,412,416	Yes	5/1/2008
2007-S-120	2/8/2008	$1,461,856	Yes	7/1/2008
2007-S-87	12/3/2007	$1,456,947	Yes	7/1/2008
2007-S-86	12/3/2007	$1,413,548	Yes	9/4/2008
2015-S-53[1]	5/5/2016	$1,378,178	Yes	2/2/2017
2014-S-70	5/5/2016	$1,258,855	No	N/A
2015-S-54	5/5/2016	$1,100,655	No	N/A
2008-S-11	4/24/2008	$1,004,415	Yes	2/1/2009
2009-S-23	11/19/2009	$903,563	No	N/A
2015-S-28	5/5/2016	$890,931	Yes	6/1/2017
2015-S-29[2]	5/5/2016	$872,373	Yes	5/1/2015
2008-S-173	5/5/2009	$787,134	No	N/A
2008-S-43	9/30/2008	$744,055	No	N/A
2008-S-28	9/30/2008	$624,278	Yes	12/1/2008
2016-S-17[3]	9/8/2016	$566,126	No	N/A
2009-S-24	11/19/2009	$542,317	Yes	3/1/2006
2008-S-44	9/30/2008	$507,786	Yes	2/1/2009
2016-S-8	3/1/2017	$507,530	Yes	11/1/2017
2008-S-33	9/30/2008	$214,520	Yes	6/1/2011
2008-S-32	9/30/2008	$200,216	No	N/A
2009-S-22	11/19/2009	$190,655	No	N/A
2008-S-34	9/30/2008	$178,633	No	N/A
2008-S-41	9/30/2008	$177,610	No	N/A
2008-S-35	9/30/2008	$140,656	Yes	5/1/2010
2008-S-39	9/30/2008	$117,451	No	N/A
2008-S-42	9/30/2008	$117,160	No	N/A
2008-S-30	9/30/2008	$104,202	Yes	1/1/2010
2008-S-36	9/30/2008	$98,418	Yes	5/1/2010
2008-S-40	9/30/2008	$77,946	No	N/A
2008-S-37	9/30/2008	$48,213	No	N/A
2008-S-10	9/30/2008	$10,869	No	N/A
2008-S-29	9/30/2008	$0	No	N/A
2008-S-31	9/30/2008	$0	Yes	4/1/2012
2009-S-98	2/10/2010	$0	No	N/A
2010-F-6	4/19/2010			
2010-F-7	4/19/2010			
2010-F-8	4/19/2010			
2010-F-9	4/19/2010			
2010-F-10	4/19/2010			
Totals		**$22,796,368**	**18**	

Referred to the New York State Department of Financial Services on [1] December 23, 2016; [2] March 1, 2017; and [3] November 28, 2016.

Appendix B: Department of Health and Department of Financial Services Letter to Physicians

NEW YORK STATE | Department of Health | Department of Financial Services

Howard A. Zucker, MD, JD
Commissioner

Maria T. Vullo
Superintendent

November 9, 2016

Dear New York State Physicians:

The Department of Financial Services (DFS) and New York State Department of Health (Department) have worked with all stakeholders – consumers, insurers, health care providers and practitioners – to ensure that New York's health insurance market is among the most robust in the nation.

Part of maintaining a robust market is making sure that all participants are playing by the same set of rules. We send this notice to remind all physicians of the rules related to billing for patient co-payment or co-insurance.

Providers are required by financial services regulations to charge all patients the same price for the same services, including the patient's co-payment or co-insurance. In some instances a provider may, due to unique circumstances, decide to waive a co-payment or co-insurance.

A physician may understandably and rightly occasionally waive a co-payment or co-insurance for an indigent patient, for example, or decide that prosecuting a patient for a co-payment or co-insurance is not cost effective. Routinely waiving co-payments or co-insurance, depending upon all of the facts and circumstances, may be considered insurance fraud. Furthermore, billing a patient's insurer for a waived co-payment or co-insurance is also considered to be fraudulent practice. Any physician who is determined to have engaged in fraudulent practice may be subject to professional misconduct penalties, including, but not limited to, revocation of his/her medical license. A patient misrepresenting a claim submitted for a co-payment or co-insurance that has been waived, is similarly at risk of committing insurance fraud.

DFS and the Department strongly encourage all physicians to review their current policies and practices related to patient co-payment and co-insurance and to ensure compliance with laws, regulations, and rules.

Sally R. Dreslin, M.S., R.N.
Executive Deputy Commissioner
New York State Department of Health

Scott D. Fischer
Executive Deputy Superintendent for Insurance
New York State Department of Financial Services

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Prepared by the Division of State Government Accountability

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