Office of the New York State Comptroller

Division of State Government Accountability

Department of Civil Service

Cost of Out-of-Network Benefits

2009-S-34

Thomas P. DiNapoli

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State of New York
Office of the State Comptroller

Division of State Government Accountability

September 2, 2010

Nancy G. Groenwegen
Commissioner
Department of Civil Service
A. E. Smith Building
Albany, New York 12234

Dear Commissioner Groenwegen:

The Office of the State Comptroller is committed to helping State agencies, public authorities and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit addressing the *Cost of Out-of-Network Benefits*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

EXECUTIVE SUMMARY

Audit Objective

Our objective was to determine the extent of savings that could be achieved by reducing the cost of out-of-network benefits under the medical/surgical and major medical portion of the Empire Plan.

Audit Results - Summary

The Empire Plan (Plan) is the primary health insurance program in the New York State Health Insurance Program (NYSHIP), covering nearly 1.1 million State and local government employees, retirees and their dependents at a cost of more than $5.1 billion a year. This cost is borne by the State and local government employers and employees and retirees that participate in the Empire Plan. The employers pay monthly premiums based on the Empire Plan's estimated costs for the year. The Department of Civil Service (Department) collects the payments and remits them to the insurance carriers providing coverage under the Empire Plan.

The Department contracts with United HealthCare Company of New York (United) to administer the medical/surgical and major medical portion of the Empire Plan. Within the network of providers for the Empire Plan, United offers a wide choice of health care professionals in all specialties. However, United also pays for services members receive from out-of-network providers. United's reimbursements for the out-of-network services are generally higher, and often significantly higher, than reimbursements for the same services provided in-network.

Nationally health care spending continues to rise at an alarming rate. Over the last decade, health insurance premiums increased by 131 percent. During this period, the cost of family coverage rose from $5,791 in 1999 to $13,375 in 2009. If this trend continues, the average cost of family coverage will be nearly $31,000 in 2019. New York has seen significant increases in the cost of providing health care coverage for its government employees. One factor that has contributed to these increases is the high cost associated with providing coverage for out-of-network services for medical/surgical services administered by United. From 2001 to 2008, the cost of out-of-network services increased by 151 percent, from $240 million in 2001 to $603 million in 2008. Although some of this increase is attributable to a growth in enrollment in the Empire Plan and the corollary increase in the number of out-of-network procedures, a primary factor for these rising costs is the increase in the per procedure cost of out-of-network services. From 2001 to 2008, the average cost of an out-of-network procedure increased from $49 to $89. Over this same time period the average cost of an in-network procedure experienced a modest increase, from $36 to $42. In light of these

ever increasing costs, action needs to be taken to minimize the impact that the cost of providing out-of-network services has on providing coverage.

We analyzed the cost of elective non-emergency services provided by out-of-network providers. We found that out-of-network services are significantly more costly than in-network services. In total, we determined that if the services provided by out-of-network providers were provided in network, the cost of these services could have been reduced by approximately $212 million. In 2008, the elective non-emergency services provided by out-of-network providers represented 7.7 percent of the total elective non-emergency procedures under the Plan. Other plans administered by United were able to keep out-of-network utilization for these procedures as low as 3.2 percent. We recognize that it is unrealistic to expect that all of these elective non-emergency procedures could have been done with in-network providers. However, there is no shortage of in-network providers. We base this on United's determination that the approximately 85 percent of the 1.1 million elective out-of-network procedures, which accounted for over 92 percent of the out-of-network expenditures, could have been provided in-network because there was an adequate number of in-network providers in the region where the services were provided. As such, if steps are taken to reduce the Empire Plan's out-of-network utilization rate to 3.2 percent, we estimate recurring annual savings of approximately $124 million can be realized.

The Plan already has disincentives to the high usage of costly out-of-network services. For example, Plan members are responsible for paying a greater percentage of the cost when they utilize the services of an out-of-network provider. Also, there are annual deductibles that must be met as well as co-insurance requirements when using an out-network provider. These higher out-of-pocket costs are designed to encourage members to utilize in-network providers. However our audit work in this area over the last two years has shown that this cost sharing methodology is not always followed. We have issued 23 audit reports focusing on payments by United to out-of-network providers and related billing practices. We found that 21 of the 23 out-of-network providers routinely waived members' out-of-pocket costs, and accepted United's payment as payment in full. Since reimbursement for out-of-network services are based on charges that are generally much higher than the in-network reimbursement rate, this practice results in overpayments because United is unaware that part of the charge has been waived. The total overpayment for these 21 out-of-network providers totaled nearly $14.6 million.

In addition, other plans within United's book of business shift more of the out-of-network costs to the member by having higher levels of co-insurance, higher deductibles, and higher total out-of-pocket cost limits than exist in the Plan. As a result, other plans administered by United have achieved higher in-network utilization rates compared to the Empire Plan. In addition, by increasing these requirements, it could create a situation where out-of-network providers would be less willing to waive the deductible and co-insurance requirements, a practice that we have exposed in several of our prior audits. Finally, although deductible, co-insurance and total out of pocket requirements for Plan members have increased every year since 2003, New York's out-of-pocket requirements are considerably lower that those in effect for Federal government employees and the employees of several other states.

(In their response to our draft audit report, Department officials agreed with the report's conclusions and recommendations and they indicated the steps they plan to take to better analyze program costs and develop strategies to mitigate cost increases.)

This report, dated September 2, 2010, is available on our website at: http://www.osc.state.ny.us. Add or update your mailing list address by contacting us at: (518) 474-3271 or

Office of the State Comptroller
Division of State Government Accountability
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Introduction

Background

The New York State Department of Civil Service (Department) is responsible for administering the New York State Health Insurance Program (NYSHIP). NYSHIP provides health insurance coverage to State and local government employees, retirees and their dependents. NYSHIP includes several health plan options, of which the Empire Plan is by far the largest. Nearly 1.1 million of the more than 1.2 million individuals covered by NYSHIP are members of the Empire Plan.

While the Empire Plan is a State program, it is also open to other public employers in New York State. If a public authority, local government agency or school district elects to participate in the Empire Plan, it signs a participation agreement with the State. Currently a total of 98 public authorities and more than 800 local government units participate in the Empire Plan.

In the Empire Plan, the Department contracts with insurance carriers to provide four types of health insurance coverage: medical/surgical coverage; hospitalization coverage; prescription drug coverage; and mental health and substance abuse related coverage. Each carrier is responsible for establishing a network of in-network providers in its area of coverage, establishing the reimbursement rates for these providers, and processing payment claims from all providers serving Empire Plan members.

United, pursuant to its administration of the medical/surgical portion of the Empire Plan, contracts with a wide variety of medical providers across virtually all specialty areas. These providers are considered in-network, and agree to accept a contracted rate plus a nominal payment from the Plan member as payment in full for their services. United sends payment for in-network services directly to the providers.

United also pays for services members receive from out-of-network providers. However, to encourage members to use in-network providers, the Empire Plan requires members to pay higher out-of-pocket costs when they use out-of-network providers. The member is responsible for paying an annual deductible, after which United reimburses the member 80 percent of the reasonable and customary (R&C) charge for that service. The member is responsible for paying the remaining 20 percent as co-insurance. The R&C charge is the lowest of the provider's actual charge, 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.

R&C charges are generally higher, and often significantly higher, than the rates paid to in-network providers. Therefore, services provided by out-of-network providers are more costly to the State. For example in 2008, United paid about 43 million charges totaling over $1.8 billion for the Empire Plan, including about $1.2 billion to in-network providers and over $600 million for services provided by out-of-network providers. Seventy-eight percent of the charges, but only 67 percent of the dollars, were paid to in-network providers. In contrast, charges for services provided by out-of-network providers accounted for only 22 percent of the total charges, but constituted about 33 percent of United's total payments. This contrast is directly attributable to the higher cost for services provided by out-of-network providers.

While the Department is responsible for the administration of the Empire Plan, a Council on Employee Health Insurance was created to supervise the administration of changes to the health insurance plan and to provide continuing policy direction to insurance plans administered by the State. The council consists of the Commissioner of Department of Civil Service, the Director of the Division of Budget and the Director of Employee Relations.

Audit Scope and Methodology

The objective of our audit was to determine the extent of savings that could be achieved by reducing the cost of out-of-network benefits under the medical/surgical and major medical portion of the Empire Plan. To determine the extent of savings, our audit work focused on the cost differential of payments made by United for services provided by out-of-network providers versus payments for similar services by in-network providers for the period January 1, 2008 to December 31, 2008. To accomplish our objective, we interviewed officials at the Department and United, and we reviewed relevant documents and records maintained by the Department and United. We also reviewed relevant laws, rules and regulations. In addition, to illustrate the cost differential between services provided by in-network and out-of-network providers, we used data analysis techniques to identify payments made for services provided during 2008 that were both elective and non-emergency in nature (both in-network and out-of-network), and where the basis for reimbursement of the out-of-network claims was the R&C charge for that service.

For this analysis we eliminated emergency type services (emergency room visits, ambulance, etc.), services where members may not have chosen the provider (inpatient or outpatient hospital based radiology, anesthesia, and pathology), and services where the reimbursement is not based on the R&C charge (home health services, physical medicine and rehabilitation, acupuncture, etc). In addition, charges in which the Empire Plan paid

secondary to another insurer were eliminated because the reimbursement for these charges is not based on the R&C charge. In total, we identified nearly 15 million charges totaling over $1.2 billion. Of these, 1.1 million charges totaling over $340 million were provided by out-of-network providers. To put this in perspective, approximately eight percent of the charges accounted for more than 27 percent of the cost. Finally, we obtained and analyzed information regarding the benefit limits of employer sponsored health insurance plans available to government employees in the Federal government and several states (Florida, Georgia, Maine, Michigan, New Jersey, North Carolina, Rhode Island, South Dakota and Vermont).

We conducted our performance 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 objective.

In performing the audit, an understanding of the internal control over United's payment process was obtained and it was determined to be suitably designed and implemented within the context of the audit objective. There were no deficiencies identified during the audit within the context of the audit's objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and comment. Their comments were considered in preparing this report. Department officials agreed with our conclusions and recommendations. Officials identified the measures they have taken or plan to take to control

the costs of out-of-network services. The Department's comments are included in their entirety at the end of this report.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Civil Service shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

Contributors to the Report

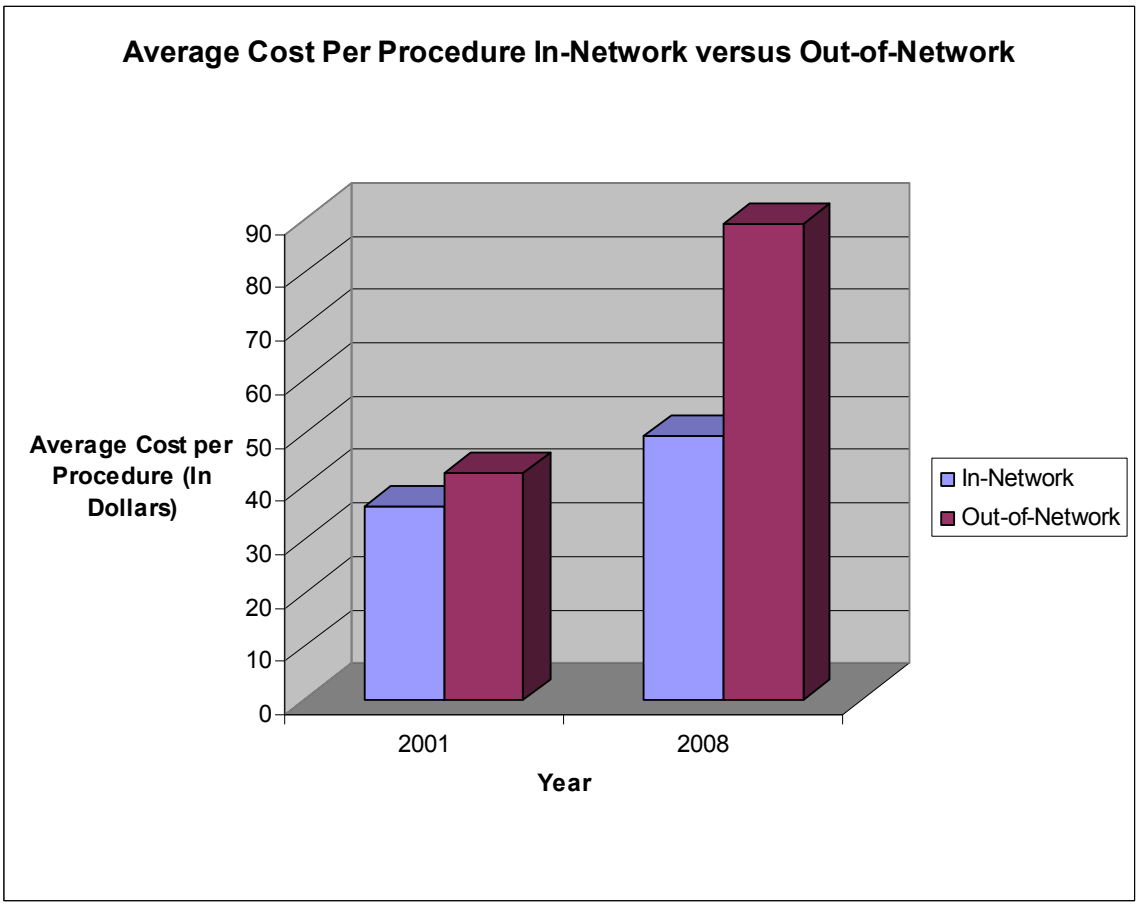
Major contributors to this report include Steven Sossei, Brian Mason, Ed Durocher, David Fleming, Laura Brown, Jessica Turner, Anthony Calabrese and Michael Sulem.

Audit Findings and Recommendations

Growth of Costs

Health care spending continues to rise at an alarming rate. According to national statistics, over the last decade employer sponsored health insurance premiums have increased by 131 percent. During this period, the average health insurance premium for family coverage rose from $5,791 in 1999 to $13,375 in 2009. To put this in perspective, the cumulative increase in employer sponsored health insurance premiums rose at four times the rate of inflation during the last decade. If the growth in premium increases average what they did over the last five years (approximately 6.1 percent per year), the average cost for family coverage in 2019 will be $24,180. However, if the average increase approximates what the trend has been over the last decade (approximately 8.7 percent per year) the average cost for family coverage in 2019 will be $30,803.

New York has seen increases in the cost of providing health care coverage under the Empire Plan. One factor that has contributed to these increases is the high cost associated with providing coverage for out-of-network services for medical/surgical services administered by United. From 2001 to 2008, the costs associated with out-of-network services increased by 151 percent, from $240 million in 2001 to $603 million in 2008. While some of the increase is attributable to a growth in enrollment in the Empire Plan as well as an increase in the number of out-of-network procedures paid for under the plan, the primary reason for these rising costs is the increase in the per procedure cost of out-of-network services. In 2001 the average cost for an out-of-network procedure was $49; by 2008 the average payment had risen to $89 (an 82 percent increase). In contrast, United's average payment for an in-network procedure increased modestly from $36 in 2001 to $42 in 2008 (an increase of 17 percent). Significant cost saving opportunities are available by taking steps to encourage the use of in-network providers while discouraging the use of out-of-network providers. The following chart illustrates this difference:



One of the primary factors 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 out-of-network provider, United bases the reimbursement for services upon the reasonable and customary (R&C) charge. The R&C charge is the lowest of the provider's actual charge, 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.

To arrive at R&C, charges are accumulated by procedure and geographic region and sorted in descending order. The Department contracts with United, to reimburse services provided by out-of-network providers, at the 90th percentile of R&C (the charge that is greater than or equal to 90 percent of the charges for that procedure and region). The member is responsible for paying an annual deductible, after which United will reimburse 80 percent of the R&C charge. The remaining 20 percent is the responsibility

of the member as co-insurance. This payment structure was designed to encourage members to use in-network providers. Also, once members reach a certain out-of-pocket limit (total deductible and co-insurance), United will reimburse 100 percent of the R&C charge. In addition to the deductible and co-insurance, the member is responsible for paying any charges exceeding the R&C charge.

United's reimbursements for out-of-network services are generally higher, and often significantly higher, than reimbursements for the same services provided in-network. Consequently, when a patient chooses to use an out-of-network provider it increases the cost of providing coverage because the R&C charge is significantly higher than United's reimbursement for the same service rendered by an in-network provider. In addition, members' costs are increased because of deductible and co-insurance requirements.

Department officials acknowledge that the cost of providing coverage under the medical/surgical component of the Empire Plan for out-of-network services is increasing at a faster rate than that of in-network services. Officials further stated that steps need to be taken to minimize this effect on the cost of providing coverage. As demonstrated above, the cost of providing health care coverage has increased dramatically and future increases could conceivably approach levels that are unsustainable. Therefore, we recommend that the Department work with the Health Insurance Council to assess alternatives for increasing reliance on Empire Plan in-network services and decreasing reliance on Empire Plan out-of-network services.

The following section of our report discusses our analysis of the growth of the Empire Plan's out-of-network costs and the factors that are contributing to this growth.

Analysis of Out-of-Network Costs

To determine what effect the use of out-of-network providers had on the overall cost of providing health care coverage, we identified all 2008 elective non-emergency procedures that are reimbursed based on the R&C charge when performed by an out-of-network provider. In total, we identified over $1.2 billion in payments made by United for these procedures. Of this amount, $900 million was paid to in-network providers for over 13 million procedures at an average cost of $66 per procedure. In contrast, there is an alarming difference in the rates paid for services performed by out-of-network providers for the same procedures. In 2008, we identified $340 million in out-of-network payments for over 1.1 million procedures, which translates to an average cost of $301 per procedure (356 percent higher than the average in-network cost per procedure). If these out-of-network services were provided in-network, it would have cost approximately $212 million less than the $340 million paid to provide these procedures out-of-network.

The following table illustrates the additional costs that were incurred by members who chose to utilize the services of an out-of-network provider for several types of common services. We cannot disclose the specific procedures associated with these payments or the number of instances associated with each type of payment because by doing so we would be disclosing information that is competitive and proprietary to United. Nevertheless, the table clearly shows how much more expensive it is to utilize the services of an out of network provider.

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

It is unrealistic to expect that all of these elective non-emergency services could have been provided by in-network providers. However, there is a significant difference between the Empire Plan's in-network utilization rate compared to other plans administered by United. In 2008, the $340 million United paid for elective non-emergency out-of-network procedures represented 7.7 percent of the total elective non-emergency procedures we analyzed for this audit. Other plans administered by United were able to keep out-of-network utilization as low as 3.2 percent. If the Empire Plan's out-of-network utilization rate for elective non-emergency procedures was reduced to 3.2 percent, we estimate recurring annual savings of $124 million. Based on the rapid growth in out-of-network costs over the past several years, it is likely these annual savings will be even greater in the future. There are a number of factors that contribute to the Empire Plan's low rate of in-network utilization. These factors have contributed to the Empire Plan's higher utilization of more costly out-of-network providers, each of which we explain later in this report.

The Empire Plan contains certain features designed to enable members to maximize the use of in-network providers at the most reasonable cost. A key feature is a comprehensive network of in-network providers to give members sufficient access to in-network providers within a reasonable distance of their home. We reviewed information on the levels of in-network providers across the State by field of practice to determine if there is adequate in-network provider availability to avoid the unnecessary use of out-of-network providers. United's contract does not contain specific terms and conditions

to evaluate the level of provider availability. However, United applies certain standards to gauge provider availability. These standards vary by type of practitioner and type of area (urban, rural, and suburban). According to United, there is widespread availability of in-network providers. Over 1 million of the Empire Plan's 1.1 million members have adequate in-network provider access. Only 31,000 or 3 percent of Empire Plan members do not have adequate in-network provider access. This includes Empire Plan members that may live in states such as Alaska, Nevada and Ohio, where United does not typically recruit providers to join the network.

We asked United to review the 1.1 million procedures paid in 2008 for elective non-emergency out-of-network procedures. United determined that approximately 85 percent of the 1.1 million procedures, which constituted over 92 percent of the out-of-network expenditures, could have been provided in-network because there was an adequate number of in-network providers in the region. Based on this analysis, the high use of out-of-network providers is not due to a lack of in-network provider availability. Consequently, the personal choices made by members have increased the cost of the Empire Plan. This cost is borne by New York State, local government agencies that participate in the NYSHIP program, government employees who pay a share of their health care premiums, and New York State taxpayers.

Factors that Contributed to the High Usage of Out-of-Network Benefits

The medical/surgical and major medical contract is an agreement between United and the Department. The agreement addresses many items such as co-payment amounts, deductible amounts, co-insurance requirements, out-of pocket limits, and the R&C percentile. All these have an impact on the cost of providing medical coverage to Empire Plan members.

When a member utilizes in-network providers, United pays these providers directly based on a pre-determined fee schedule and the member is responsible for paying a nominal co-payment. In contrast, when a member chooses to utilize out-of-network providers, the Empire Plan requires the member to pay higher out-of-pocket costs. First, there are annual deductibles that must be met. Once the deductible is satisfied, United will reimburse 80 percent of the R&C charge. The member is responsible for paying the remaining 20 percent of these charges, known as co-insurance, and any balance exceeding the R&C charge. Once members reach a certain out-of-pocket cost limit, United reimburses up to 100 percent of the R&C charge. This fee sharing structure was designed to encourage members to utilize in-network providers to minimize their out-of-pocket expenses.

When United processes claims for an out-of-network provider, it does so with the understanding that members are responsible for a portion of the charge which represents their out-of-pocket costs. However our audit

work in this area over the last two years would indicate that this payment methodology is not always followed. We have issued 23 audit reports focusing on payments by United to out-of-network providers and related billing practices. We found that 21 of the 23 out-of-network providers routinely waived members' out-of-pocket costs, and accepted United's payment as payment in full. This practice results in overpayments because United bases their reimbursement on the total charge, unaware that part of the charge has been waived. The total overpayment for these 21 out-of-network providers totaled nearly $14.6 million. Five providers accounted for $9.5 million of the overpayments (65 percent) of the overpayments:

Provider Name	**Overpayment**
Endoscopy Center of Long Island	$2.7 million
Capital Region Ambulatory Surgery Center	$2.4 million
Digestive Health Center of Huntington	$1.5 million
DayOp of North Nassau	$1.5 million
DayOp Center of Long Island	$1.4 million

According to United officials, $9.8 million has been recovered from eight providers and United is nearing agreement with one additional provider for an additional $624,000. In addition, seven of the 23 out-of-network providers have since joined the Empire Plan as a result of our audits, including the five providers mentioned above. United estimates that this will result in additional savings of more that $4 million annually.

Nevertheless, providers who routinely waive members' out-of-pocket costs negate the disincentive from using more costly out-of-network providers. When this occurs, out-of-network providers in effect simulate in-network providers by rendering services at a nominal cost to the member, but they receive a much higher reimbursement from United because they have overridden the cost controls built into the Empire Plan. We have no reason to believe that this practice is limited to the 21 providers where we identified this problem. Further this practice inflates the R&C charges because these charges are based on the total provider charges, including the amount that the provider waived. These practices drive up the cost of the Empire Plan to taxpayers and in addition, submitting insurance claims with false information may constitute insurance fraud.

In addition to the waiving of members' out-of-pocket costs, the high cost of out-of-network services is primarily attributable to the fact that R&C charges are much higher than the rates paid to in-network providers. This is compounded by the fact that the Empire Plan reimburses out-of-network providers based on the 90th percentile of the R&C charge. According to

United, other plans they administer use a lower percentile of R&C. In fact, most other plans use the 80th percentile of R&C, and many plans are moving towards the 70th percentile of R&C. By doing this, it lowers reimbursements to out-of-network providers.

Other plans within United's book of business shift more of the out-of-network costs to the member by having higher levels of co-insurance, higher deductibles, and higher total out-of-pocket cost limits. As previously indicated, United offers a wide choice of health care professionals in all specialties that accept the Empire Plan in-network reimbursement rates as payment in full. By having higher deductibles and higher co-insurance requirements, the member would be responsible for greater percentage of the costs associated with their health care. Other plans within United's book of business that are set up with these higher deductible and co-insurance requirements have a higher in-network utilization rate compared to the Empire Plan. In addition, by increasing these requirements, it could create a situation where out-of-network providers would be less willing to waive the deductible and co-insurance requirements, a practice that we have exposed in several of our prior audits.

Deductibles, co-insurance amounts and total out-of-pocket requirements for Plan members have increased every year since 2003. For 2009, the total out-of-pocket requirement for plan members in one of the State's largest unions was $4,089, up from $2,211 that was in effect in 2003. However, New York's total out-of-pocket requirements are considerably lower than those that are in effect for government employees in the Federal government and several other states. In New York, the maximum deductible limits under a family plan are $1,089 and the maximum co-insurance requirements are $3,000 for a total of $4,089. These limits pale in comparison to the plan limits that are in effect for government employees in Vermont. For Vermont employees the deductible limits under a family plan are $1,000 but the co-insurance requirements for out-of-network services is $12,000 for a family. Obviously requirements of this magnitude would in all likelihood compel the member to find suitable in-network providers for their medical care. While the Vermont example is one of the more stark contrasts we could show, as the following table shows we also found that government employees with family coverage in the Federal government and the states of Florida, Georgia, New Jersey, North Carolina, Rhode Island and South Dakota all have higher out-of-pocket requirements that government employees do in New York.

	Maximum Deductible	Co-Insurance Percentage	Total Out-of-Pocket Maximum
New York	$1,089	20	$4,089
Federal Government	600	30	7,000
Florida	5,000	40	15,000
Georgia	4,600	40	7,000
Maine	400	36	4,000
Michigan	1,200	10	4,000
New Jersey	250	30	5,000
North Carolina	4,800	50	19,500
Rhode Island	0	20	9,000
South Dakota	4,000	35	12,000
Vermont	1,000	40	12,000

New York is facing unprecedented budget deficits in the coming fiscal years. In light of these deficits, the Department and the State need to take action to lower the cost of providing health care coverage to State and local government employees, retirees, and their dependents. The cost of providing coverage for out-of-network services is increasing and steps need to be taken to minimize its effect on the cost of providing coverage.

Recommendation

Work with the Health Insurance Council to assess alternatives for increasing reliance on Empire Plan in-network services and decreasing reliance on Empire Plan out-of-network services.

Agency Comments

DAVID A. PATERSON
GOVERNOR

STATE OF NEW YORK
DEPARTMENT OF CIVIL SERVICE
ALFRED E. SMITH STATE OFFICE BUILDING
ALBANY, NEW YORK 12239
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NANCY G. GROENWEGEN
COMMISSIONER

January 7, 2010

Mr. Edward Durocher
Audit Manager
Division of State Government
Accountability
Office of the State Comptroller
110 State Street -11th Floor
Albany, New York 12236

Dear Mr. Durocher:

Thank you for the opportunity to respond to the draft audit report entitled "Cost of Out-of-Network Benefits" (2009-S-34). The Department of Civil Service (the Department) agrees with the draft report's conclusions and recommendations. The cost of providing coverage under the medical component of the Empire Plan for out-of-network services is increasing at a rate faster than that of in-network services and steps need to be taken to minimize this effect on the cost of providing coverage.

Because the report's recommendations involve the Council on Employee Health Insurance, which is composed of the Director of the Division of the Budget and the Director of the Governor's Office of Employee Relations as well as the President of the Civil Service Commission, we shared the report with staff of each of those offices and have incorporated their comments in preparing this response.

While approximately 70% of the dollars paid out on an annual basis for Empire Plan medical claims are for services received from participating providers, we agree that increasing the use of participating providers will result in additional cost savings to the Plan.

As the report acknowledges, the Empire Plan benefit design is collectively bargained. As a result, any changes in the design of the Plan, including those related to increases in deductible, co-insurance or a different basis for calculating reimbursement for non-network charges, must be agreed to by the unions representing the State workforce.

The Council on Employee Health Insurance has consistently encouraged the use of participating providers as a tool for controlling health insurance costs. In developing the State's collective bargaining demands for benefit plan modifications intended to generate cost savings, the Council identified the need for increases in deductibles and out-of-pocket maximums and

changes in the way the enrollee's coinsurance obligation was determined. The Council's strategy has been successful in that each successive round of negotiations has resulted in deductible and out-of-pocket maximum increases tied to increases in the Consumer Price Index for Urban Wage Earners or of a fixed dollar amount.

During the last round of collective bargaining, the State proposed a change in the methodology for determining the coinsurance required when an enrollee receives treatment by an out-of-network provider. This proposal would have based the Plan's reimbursement for out-of-network services on a percentage of the Medicare fee schedule rather than provider-driven reasonable and customary (R&C) charges. Because Medicare fees are based in federal law, reimbursement costs under that program have grown at a slower rate than provider charges which drive R&C amounts. While this plan design change was ultimately not negotiated, the State and the unions agreed to expansion of the Empire Plan Centers of Excellence Program to include bariatric surgery, one of the most costly procedures frequently performed as an out-of-network service. This program identifies medical procedures which have a high risk of complications, recruits providers with high levels of experience and superior outcomes, and through benefit design, encourages enrollees to use these participating providers who have agreed to reduced fees. This program saves program costs through reduced fees and by improving outcomes avoids costs associated with avoidable complications.

In addition, the Department has sought to control the high costs of out-of-network services by working with your office and the Insurance Department to enforce the coinsurance feature of the Empire Plan benefit design. As mentioned in the preliminary findings, OSC identified certain providers routinely waiving co-insurance and deductible. We applaud these efforts, and given that the Department has no contractual right to audit providers who do not participate in the Plan, we urge your office to continue these audits to identify other abuses by non-participating providers.

We concur with the recommendation that the Department work with the other members of the Council on Employee Health Insurance to formally assess the potential cost savings available from some redesign of the Empire Plan benefits. Based on the resulting assessment, we will work with the Council in presenting these cost saving features to the unions during the next round of collective bargaining.

To position itself to better quantify potential cost savings, the Department is developing a request for proposals for a decision support system which will allow it to better analyze program costs and develop strategies to mitigate cost increases. We expect to issue this RFP in early 2010. Additionally, the Department, on behalf of the Council on Employee Health Insurance, recently completed a procurement to select a consulting firm to conduct a study of NYSHIP. One of the deliverables required by this contract is the development of recommendations for future cost savings. We expect these will include recommendations regarding the out-of-network benefit design.

Again, thank you for providing the Department with the opportunity to comment on the audit's preliminary findings. We remain committed to continuing to work with the other members of the Council on Employee Health Insurance and the Office of the State Comptroller to manage the Empire Plan in the most cost effective manner possible.

Sincerely,

Nancy G. Groenwegen

Nancy G. Groenwegen
Commissioner