U.S. OFFICE OF PERSONNEL MANAGEMENT
OFFICE OF THE INSPECTOR GENERAL
OFFICE OF AUDITS

Final Audit Report

AUDIT OF THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM OPERATIONS AT HEALTH INSURANCE PLAN OF GREATER NEW YORK

Report Number 1C-51-00-14-066
August 31, 2015

-- CAUTION --

EXECUTIVE SUMMARY

Audit of the Federal Employees Health Benefits Program Operations at Health Insurance Plan of Greater New York

Report No. 1C-51-00-14-066 **August 31, 2015**

Why Did We Conduct the Audit?

The primary objectives of the audit were to determine if Health Insurance Plan of Greater New York (Plan) offered the Federal Employees Health Benefits Program (FEHBP) premium rates using complete, accurate and current data, and that the rates were equivalent to the Plan's Similarly Sized Subscriber Groups, as provided in Federal Employees Health Benefits Acquisition Regulation 1652.215-70(a). Additional tests were performed to determine whether the Plan was in compliance with the provisions of the laws and regulations governing the FEHBP.

What Did We Audit?

Under contract CS 1040, the Office of the Inspector General completed a performance audit of the FEHBP's rates offered for contract years 2013 and 2014. Our audit fieldwork was conducted from September 8, 2014 through September 19, 2014 at the Plan's office in New York, New York.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

This report questions $17,191,178 for inappropriate health benefit charges to the FEHBP in contract years 2013 and 2014. The questioned amount includes $16,633,324 for defective pricing and $557,854 due the FEHBP for lost investment income, calculated through July 31, 2015.

Additionally, the Plan does not have adequate rating system controls to assure that past audit findings are not repeated in future FEHBP rates and that the FEHBP Medicare loading is developed using reliable data.

ABBREVIATIONS

CMS	**Centers for Medicare and Medicaid Services**
COB	**Coordination of Benefits**
[redacted]	[redacted]
FEHBAR	**Federal Employees Health Benefits Acquisition Regulations**
FEHBP	**Federal Employees Health Benefits Program**
[redacted]	[redacted]
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**Health Insurance Plan of Greater New York**
SSSG	**Similarly Sized Subscriber Group**
TCR	**Traditional Community Rating**
U.S.C.	**United States Code**

TABLE OF CONTENTS

Page

EXECUTIVE SUMMARY i

ABBREVIATIONS ii

I. **BACKGROUND** 1

II. **OBJECTIVES, SCOPE, AND METHODOLOGY** 3

III. **AUDIT FINDINGS AND RECOMMENDATIONS** 5

Premium Rate Review 5

1. Defective Pricing 5

2. Lost Investment Income 12

3. Rating System Controls 13

IV. **MAJOR CONTRIBUTORS TO THIS REPORT** 15

Exhibit A (Summary of Questioned Costs)

Exhibit B (Defective Pricing Questioned Costs)

Exhibit C (Lost Investment Income)

Appendix (Health Insurance Plan's March 31, 2015 response to the draft report)

REPORT FRAUD, WASTE, AND MISMANAGEMENT

I. BACKGROUND

This final report details the findings, conclusions, and recommendations resulting from our audit of the Federal Employees Health Benefits Program (FEHBP) operations at Health Insurance Plan of Greater New York (Plan). The audit covered contract years 2013 and 2014, and was conducted at the Plan's office in New York, New York.

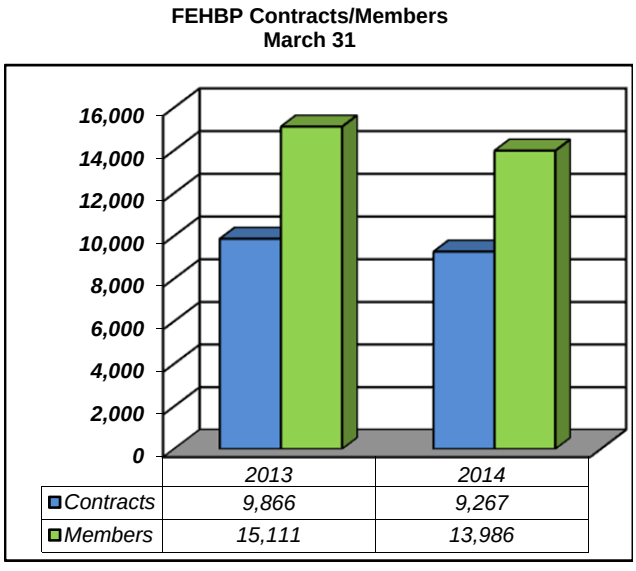
The audit was conducted pursuant to FEHBP contract CS 1040; 5 United States Code (U.S.C.) Chapter 89; and 5 Code of Federal Regulations Chapter 1, Part 890. The audit was performed by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

The FEHBP was established by the Federal Employees Health Benefits Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for Federal employees, annuitants, and dependents, and is administered by OPM's Healthcare and Insurance Office. Health insurance coverage is provided through contracts with health insurance carriers that provide service benefits, indemnity benefits, or comprehensive medical services.

Community-rated carriers participating in the FEHBP are subject to various Federal, state and local laws, regulations, and ordinances. While most carriers are subject to state jurisdiction, many are further subject to the Health Maintenance Organization Act of 1973 (Public Law 93-222), as amended (i.e., many community-rated carriers are Federally qualified). In addition, participation in the FEHBP subjects the carriers to the Federal Employees Health Benefits Act and implementing regulations promulgated by OPM.

The FEHBP should pay a premium rate that is equivalent to the best rate given to either of the two groups closest in size to the FEHBP. In contracting with community-rated carriers, OPM relies on carrier compliance with appropriate laws and regulations and, consequently, does not negotiate base rates. OPM negotiations relate primarily to the level of coverage and other unique features of the FEHBP.

The chart to the right shows the number of FEHBP contracts and members reported by the Plan as of March 31 for each contract year audited.



The Plan has participated in the FEHBP since 1960 and provides health benefits to FEHBP members in the Greater New York City area. The last audit conducted by our office was a rate reconciliation audit and covered contract year 2012. That audit identified inappropriate health benefit charges to the FEHBP contract, which were generated by errors in the FEHBP Medicare loading. All issues identified were resolved.

The preliminary results of this audit were discussed with Plan officials at an exit conference and in subsequent correspondence. A draft report was also provided to the Plan for review and comment. The Plan's comments were considered in preparation of this report and are included, as appropriate, as the Appendix to the report.

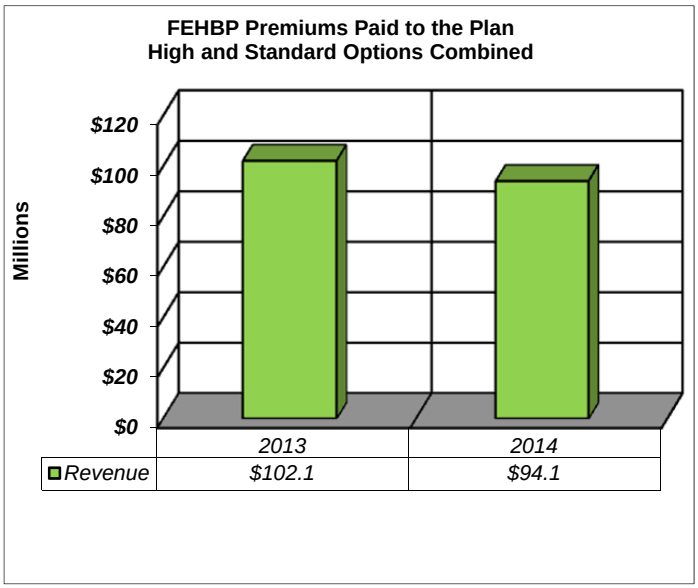
II. OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The primary objectives of this performance audit were to determine if the FEHBP premium rates were developed using complete, accurate and current data, and were equivalent to the Plan's Similarly Sized Subscriber Groups (SSSGs), as provided in Federal Employees Health Benefits Acquisition Regulation (FEHBAR) 1652.215-70(a). Additional tests were performed to determine whether the Plan was in compliance with the provisions of the laws and regulations governing the FEHBP.

Scope

We conducted this 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 objectives.



This performance audit covered contract years 2013 and 2014. For these years, the FEHBP paid approximately $196.2 million in premiums to the Plan. The premiums paid for each contract year are shown on the chart above.

OIG audits of community-rated carriers are designed to test carrier compliance with the FEHBP contract, applicable laws and regulations, and the Rate Instructions to Community-Rated Carriers (rate instructions). These audits are also designed to provide reasonable assurance of detecting errors, irregularities, and illegal acts.

We obtained an understanding of the Plan's internal control structure, but we did not use this information to determine the nature, timing, and extent of our audit procedures. However, the audit included such tests of the Plan's rating system and such other auditing procedures considered necessary under the circumstances. Our review of internal controls was limited to the procedures the Plan has in place to ensure that:

- The appropriate SSSGs were selected;

- the rates charged to the FEHBP were developed using complete, accurate and current data and were equivalent to the best rate given to the SSSGs; and

- the loadings to the FEHBP rates were reasonable and equitable.

In conducting the audit, we relied to varying degrees on computer-generated billing, enrollment, and claims data provided by the Plan. We did not verify the reliability of the data generated by the various information systems involved. However, we did find inconsistencies between two sets of Medicare enrollment data generated from the Plan's information systems. We reported the variances and determined that one set of the data was unreliable. Except as noted above, the audit was conducted in accordance with generally accepted government auditing standards, issued by the Comptroller General of the United States.

The audit fieldwork was performed from September 8, 2014 through September 19, 2014 at the Plan's office in New York, New York. Additional audit work was completed at our office in Cranberry Township, Pennsylvania.

Methodology

We examined the Plan's Federal rate submission and related documents as a basis for validating the Plan's Certificates of Accurate Pricing. In addition, we examined the rate development documentation and billings to other groups, such as the SSSGs, to determine if the FEHBP rates were reasonable and equitable. Finally, we used the contract, the FEHBAR, and the rate instructions to determine the propriety of the FEHBP premiums and the reasonableness and acceptability of the Plan's rating system.

To gain an understanding of the internal controls in the Plan's rating system, we reviewed the Plan's rating system policies and procedures, interviewed appropriate Plan officials, and performed other auditing procedures necessary to meet our audit objectives.

To test whether the Medicare status of the Plan's FEHBP annuitants was accurate, we randomly selected a sample of 25 FEHBP annuitants out of 1,144 annuitants from the Plan's 2013 Medicare Match report. Based on this sample, we found that 18 of the 25 FEHBP annuitants reviewed had "no Medicare" in the Plan's enrollment files, but had some part of Medicare coverage as found in the Plan's coordination of benefits (COB) files. We interviewed appropriate Plan officials and determined that the Plan's COB files were used to coordinate claim payments with Medicare and were accurate and reliable. We then instructed the Plan to re-run its 2013 and 2014 Medicare Match reports and add the annuitant information from its Medicare COB files. The detailed results of these new reports were used in our audited Medicare Loading for 2013 and 2014. Our sample was not statistically based. Consequently, the results could not be projected to the universe since it is unlikely that the results are representative of the universe as a whole.

III. AUDIT FINDINGS AND RECOMMENDATIONS

Premium Rate Review

1. Defective Pricing **$16,633,324**

The Certificates of Accurate Pricing the Plan signed for contract years 2013 and 2014 were defective. In accordance with Federal regulations, the FEHBP is therefore due a rate reduction for these years. Application of the defective pricing remedy shows that the FEHBP is due a premium adjustment of $16,633,324 (see Exhibit A).

The FEHBP is due a rate reduction of $16,633,324 for defective pricing in contract years 2013 and 2014.

FEHBAR 1652.215-70 provides that carriers proposing rates to OPM are required to submit a Certificate of Accurate Pricing certifying that the proposed subscription rates are complete, accurate and current. Furthermore, FEHBAR 1652.216-70 states that the subscription rates agreed to in the contract shall be equivalent to the subscription rates given to the community-rated carrier's SSSGs, as defined in FEHBAR 1602.170-13. SSSGs are the Plan's two employer groups closest in subscriber size to the FEHBP. If it is found that the FEHBP rates were increased because of defective pricing or defective cost or pricing data, then the rates shall be reduced in the amount by which the price was increased because of the defective data or information.

2013

We agree with the Plan's selection of [redacted] ([redacted]) and [redacted] as SSSGs for contract year 2013. The FEHBP, [redacted] and [redacted] were all rated using a Traditional Community Rating (TCR) methodology. The Plan did not apply a discount to the FEHBP rates. Our analysis of the rates charged to the SSSGs shows that [redacted] and [redacted] also did not receive a discount.

During our review of the FEHBP rates, we determined that the Plan's Medicare loading was based on incomplete, inaccurate, and noncurrent Medicare enrollment data. Failure to maintain and use complete, accurate, and current Medicare enrollment data may cause significant overcharges to the FEHBP's Medicare loading. As Medicare loading support, the Plan provided coverage information maintained in its enrollment files. However, these files did not match the information the Plan used in its COB with Medicare. In comparison, there were significant differences between the Plan's enrollment files and its COB files, even though both files were derived from the Plan's [redacted] system.

We were unable to validate the accuracy of the Plan's enrollment files; however, we determined that the Plan's COB files contain complete and current pricing data for the payment of Medicare claims. As a result, we relied on the Medicare COB file data provided by the Plan to determine the FEHBP Medicare enrollment used in our audited FEHBP Medicare loading.

In addition, we determined the Plan applied incorrect copay level values in the Medicare loading calculation, as follows:

	High Option	Standard Option
Primary Care/Specialty Care Copays – Used by Plan	[redacted]	[redacted]
Primary Care/Specialty Care Copays – Actual	$20/$40	$20/$50
Prescription Drug Copay – Used by Plan	[redacted]	[redacted]
Prescription Drug Copay – Actual	$20/$30/$50	$20/$30/$50

The Plan also inappropriately included a cost value for Medicare Part D coverage in its Medicare loading calculation. A 2012 audit, conducted by our office, reported a similar finding of incorrect copay levels being used by the Plan in its Medicare loading calculation. The Plan corrected the 2012 rates, but did not take the steps necessary to ensure that future Medicare loading calculations were correct.

We recalculated the FEHBP Medicare loading by using the COB file enrollment to determine the FEHBP Medicare enrollees. Additionally, we calculated the 2013 FEHBP Medicare loading based on the benefit design supported by the benefits listed in the 2013 FEHBP brochure. A comparison of our audited line 5 rates to the Plan's reconciled line 5 rates shows that the FEHBP was overcharged by $8,704,019 and $565,529, for the high and standard options, respectively (see Exhibit B).

Plan's Response:

Medicare Load (Enrollment Data): The Plan agrees that the COB file contains more accurate and current Medicare status and pricing data and will use the COB file exclusively for the development of the Medicare load for the FEHBP.

Incorrect Copay Levels (Medicare Loading): The Plan agrees that it used the incorrect copay levels for 2013 which need to be corrected. However, the Plan also responded that they had neglected to update the spreadsheet used to price the benefit difference and that there are other benefit differences other than primary care, specialty care and prescription drug copays. In response to this finding, the Plan believes the entire FEHBP benefit design should be used

to determine the cost associated with the FEHBP Medicare population. The Plan submitted revised calculations to support its changed pricing methodology.

2013 Questioned Costs: The Plan disagrees with the questioned costs in 2013. Based on their position, the Plan states that they owe the FEHBP $1,187,002 and $73,719 for the high and standard options respectively, in contract year 2013. These questioned costs are due specifically to the overstatement of the Medicare load.

OIG Comment:

Medicare Load (Enrollment Data): We determined that the Plan's 2013 FEHBP Medicare population submitted in its response to the draft report was not accurate or complete. The FEHBP Medicare population we used in our audited Medicare loading was based on the detailed COB file previously provided by the Plan during our audit which was determined to be accurate and complete. A comparison of the Plan's Medicare numbers submitted in its response to the draft report and our audited Medicare numbers is as shown below.

	Plan's High Option Medicare Enrollment	OIG's High Option Medicare Enrollment	Plan's Standard Option Medicare Enrollment	OIG's Standard Option Medicare Enrollment
Contract Year 2013				
Medicare A&B				
Medicare A Only				
Medicare B Only				
No Medicare				
Medicare Risk				
Total				

Incorrect Copay Levels (Medicare Loading): We accept the Plan's revised FEHBP Medicare benefit design loading methodology and agree to include differences in the entire FEHBP benefit design. However, we reviewed the Plan's revised FEHBP Medicare benefit design that was submitted in its response to the draft report and found errors. Specifically, the Plan did not sufficiently credit the FEHBP Medicare members for outpatient physical therapy and outpatient mental health benefits. The Plan also loaded the FEHBP Medicare members for a Part B drug rider at , which was not the correct benefit level. Finally, the Plan applied a prescription drug rider to the FEHBP Medicare members that was not consistent with similar Part D riders filed with the Centers for Medicare and Medicaid Services (CMS), and used to price the Medicare component of the SSSGs. We corrected these benefit design differences in our audited Medicare Loading.

2013 Questioned Costs: Our 2013 questioned costs were based on the above noted exceptions and are shown on page 6.

2014

We agree with the Plan's selection of [redacted] and [redacted] ([redacted]) as SSSGs for contract year 2014. The FEHBP, [redacted] and [redacted] were all rated using a TCR methodology. The Plan did not apply a discount to the FEHBP rates. Our analysis of the rates charged to the SSSGs shows that [redacted] and [redacted] also did not receive a discount.

Once more, we determined that the Plan's Medicare loading was based on incomplete, inaccurate, and noncurrent Medicare enrollment data. Failure to maintain and use complete, accurate, and current Medicare enrollment data may cause significant overcharges to the FEHBP's Medicare loading. As Medicare loading support, the Plan provided coverage information maintained in its enrollment files. However, these files did not match the information the Plan used in its COB with Medicare. In comparison, there were significant differences between the Plan's enrollment files and its COB files, even though both files were derived from the Plan's [redacted] system.

We were unable to validate the accuracy of the Plan's enrollment files; however, we determined that the Plan's COB files contain complete and current pricing data for the payment of Medicare claims. As a result, we relied on the Medicare COB file data provided by the Plan to determine the FEHBP Medicare enrollment in our audited FEHBP Medicare loading.

Again, we determined the Plan applied incorrect copay level values in the Medicare loading calculation, as follows:

	High Option	Standard Option
Primary Care/Specialty Care Copays – Used by Plan	-	[redacted]
Primary Care/Specialty Care Copays - Actual	-	$30/$50
Prescription Drug Copay – Used by Plan	[redacted]	[redacted]
Prescription Drug Copay – Actual	$15/$35/$75	$15/$35/$75

The Plan also inappropriately included a cost value for Medicare Part D coverage in its Medicare loading calculation. A 2012 audit, conducted by our office, reported a similar finding of incorrect copay levels being used by the Plan in its Medicare loading calculation. The Plan corrected the 2012 rates, but did not take the steps necessary to ensure that future Medicare loading calculations were correct.

Section 1341 of the Affordable Care Act establishes a Transitional Reinsurance Program fee that requires all health insurance issuers to pay a fee under this program to support payments to individual market issuers that cover high-cost individuals. However, fee payments for individuals who are enrolled in any part of Medicare are not required, so long as Medicare is the primary payer of services. In the 2014 reconciliation, the Plan stated that it was aware that the Transitional Reinsurance Program fee was not applicable to Medicare business; however, the FEHBP rates did not reflect a credit to Medicare primary members for this cost. Since we are unable to rely on the Plan's Medicare enrollment data to calculate this credit, we applied a credit based on the entire 2014 FEHBP enrollment.

Finally, the Plan incorrectly adjusted the high and standard option rates for a [redacted] outpatient substance abuse benefit. The FEHBP purchased a $20/$40 (high option) and a $30/$50 (standard option) outpatient substance abuse benefit. We adjusted the FEHBP rates to account for the actual benefit purchased.

We recalculated the FEHBP Medicare loading by using the COB file enrollment to determine the FEHBP Medicare enrollees. Additionally, we calculated the 2014 FEHBP Medicare loading based on the benefit design supported by the benefits listed in the 2014 FEHBP brochure, adjusting for the correct outpatient substance abuse benefit, and applying a credit for the Transitional Reinsurance Program fee in our audited rates. A comparison of our audited line 5 rates to the Plan's reconciled line 5 rates shows that the FEHBP was overcharged by $6,654,758 and $709,018, for the high option and standard option, respectively (see Exhibit B).

Plan's Response:

Medicare Load (Enrollment Data): The Plan agrees that the COB file contains more accurate and current Medicare status and pricing data and will use the COB file exclusively for the development of the Medicare load for the FEHBP.

Incorrect Copay Levels (Medicare Loading): The Plan agrees that it used the incorrect copay levels for 2014; however, the Plan disagrees that the only benefits that should be measured are the primary care, specialty care and prescription drug copays. Instead, the Plan states that the entire FEHBP benefit design should be used to determine the cost associated with the FEHBP Medicare population. The Plan submitted revised calculations to support their position.

Transitional Reinsurance Fee Program: The Plan did not respond to this finding, but included a calculation for the fee in their revised high and standard option reconciliations.

Substance Abuse Benefit: The Plan disagrees with this finding and states that the established benefit is a [redacted] copay for the 2014 high and standard options. The Plan attached the OPM 2014 closeout letter in support of their position.

2014 Questioned Costs: The Plan disagrees with the questioned costs in 2014. Based on their position, the Plan states that they owe the FEHBP $202,516 for the standard option in 2014 and that the FEHBP owes the Plan $33,162 for the high option in 2014. These questioned costs are due specifically to the overstatement of the 2014 Medicare load.

Total Questioned Costs Owed FEHBP: The Plan states that the total owed to the FEHBP for contract years 2013 and 2014 is $1,585,845.04.

OIG Comment:

Medicare Load (Enrollment Data): We determined that the Plan's 2014 FEHBP Medicare population submitted in its response to the draft report was not accurate or complete. The FEHBP Medicare population we used in our audited Medicare loading was based on the detailed COB file previously provided by the Plan during our audit which was determined to be accurate and complete. A comparison of the Plan's Medicare numbers submitted in its response to the draft report and our audited Medicare numbers is as show below.

	Plan's High Option Medicare Enrollment	OIG's High Option Medicare Enrollment	Plan's Standard Option Medicare Enrollment	OIG's Standard Option Medicare Enrollment
Contract Year 2014				
Medicare A&B	[redacted]	[redacted]	[redacted]	[redacted]
Medicare A Only				
Medicare B Only				
No Medicare				
Medicare Risk				
Total				

Incorrect Copay Levels (Medicare Loading): We accept the Plan's revised FEHBP Medicare benefit design loading methodology and agree to include differences in the entire FEHBP benefit design. However, we reviewed the Plan's revised FEHBP Medicare benefit design that was submitted in its response to the draft report and found errors.

Specifically, the Plan did not sufficiently credit the FEHBP Medicare members for specialist care and outpatient mental health benefits (standard option only) and outpatient substance

abuse benefits (high and standard options). The Plan also loaded the FEHBP Medicare members for a Part B drug rider at [redacted], which was not the correct benefit level. Finally, the Plan applied a prescription drug rider to the FEHBP Medicare members that was not consistent with similar Part D riders filed with CMS, and used to price the Medicare component of the SSSGs. We corrected these benefit design differences in our audited Medicare Loading.

Transitional Reinsurance Fee Program: We reviewed the Plan's calculation for the transitional reinsurance fee included in its response. We agree with the calculation; however, due to the differences in the Medicare enrollment numbers, the OIG's audited transitional reinsurance fee credit varies from the Plan's calculated credit.

Substance Abuse Benefit: The information provided by the Plan did not support its position that the established benefit is a [redacted] copay for the 2014 high and standard options. Our position remains that the Plan incorrectly adjusted the high and standard option rates for a [redacted] outpatient substance abuse benefit. The FEHBP actually purchased a $20/$40 (high option) and a $30/$50 (standard option) outpatient substance abuse benefit. We adjusted the FEHBP rates to account for the actual benefit purchased.

2014 Questioned Costs: Our 2014 questioned costs were based on the above noted exceptions and are shown on page 9.

Recommendation 1

We recommend that the contracting officer require the Plan to return $16,633,324 to the FEHBP for defective pricing in contract years 2013 and 2014.

2. Lost Investment Income $557,854

In accordance with FEHBP regulations and the contract between OPM and the Plan, the FEHBP is entitled to recover lost investment income on the defective pricing findings in contract years 2013 and 2014. We determined the FEHBP is due $557,854 for lost investment income, calculated through July 31, 2015 (see Exhibit C). In addition, the FEHBP is entitled to lost investment income for the period beginning August 1, 2015, until all defective pricing amounts have been returned to the FEHBP.

FEHBAR 1652.215-70 provides that, if any rate established in connection with the FEHBP contract was increased because the carrier furnished cost or pricing data that was not complete, accurate, or current as certified in its Certificate of Accurate Pricing, the rate shall be reduced by the amount of the overcharge caused by the defective data. In addition, when the rates are reduced due to defective pricing, the regulation states that the government is entitled to a refund and simple interest on the amount of the overcharge from the date the overcharge was paid to the carrier until the overcharge is liquidated.

The FEHBP is due lost investment income on the defective pricing findings in the amount of $557,854.

Our calculation of lost investment income is based on the United States Department of the Treasury's semiannual cost of capital rates.

Plan's Response:

The Plan agrees that an adjustment to lost investment income should be made based on the adjusted findings; however, the Plan calculated and agreed to $47,340 in lost investment income.

Recommendation 2

We recommend that the contracting officer require the Plan to return $557,854 to the FEHBP for lost investment income, calculated through July 31, 2015. We also recommend that the contracting officer recover lost investment income on amounts due for the period beginning August 1, 2015, until all defective pricing amounts have been returned to the FEHBP.

3. Rating System Controls — Procedural

The Plan does not have adequate rating system controls to assure that prior audit findings are corrected in future rate years and that the Medicare loading applied to the FEHBP rates is developed using consistent, accurate, and current data.

In 2012, we performed an audit that determined the Plan used incorrect prescription benefit levels when developing the Medicare loading charged to the FEHBP. The Plan agreed to the finding and recalculated its Medicare loading. This resulted in a reduction of the FEHBP rates and cost savings of $7,966,352 for contract year 2012. In our current audit, we determined the Plan did not take the necessary steps to ensure that the same, or similar, errors would not occur in the 2013 and 2014 Medicare loading calculations. In fact, as reported above, the errors were repeated in both years and resulted in increased cost to the FEHBP.

The Certificates of Accurate Pricing that the Plan signed in 2013 and 2014 were once again defective.

Furthermore, the Plan does not have sufficient system control checks and balances to identify areas of risk within its [redacted] system. While onsite, we determined that the Plan is tracking inaccurate Medicare status in its [redacted] enrollment files and using this data to load the FEHBP. The Plan is also tracking Medicare status in its [redacted] COB files, which significantly varies from the data tracked in its enrollment files. We found multiple instances of terminated Medicare coverage in the COB files, but continued enrollment/Medicare coverage per the enrollment files. Regardless of the numerous requests we made to the Plan to clarify the Medicare coverage discrepancies, it did not provide any substantial support or explanation to resolve the serious issues we encountered with its system and the Medicare loading calculation.

The issues we encountered over the course of our audit are attributable to the Plan's negligence in correcting past audit findings and a lack of system control checks to validate the data. Failure to correct these issues and adopt adequate rating system controls will result in continued non-compliance with the contract and future defective pricing of the FEHBP rates.

Recommendation 3

We recommend that the contracting officer direct the Plan to take corrective actions so that past audit findings are not repeated in future FEHBP rates.

We also recommend that the contracting officer require the Plan to submit a corrective action plan that addresses the necessary steps to mitigate internal control weaknesses related to its development of the Medicare loading and the FEHBP rating system.

Plan's Response:

The Plan agrees and has submitted a corrective action plan.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

COMMUNITY-RATED AUDITS GROUP

[redacted], Auditor-in-Charge

[redacted], Senior Team Leader

[redacted], Chief

EXHIBIT A

Health Insurance Plan of Greater New York
Summary of Questioned Costs

Defective Pricing Questioned Costs		
Contract Year 2013	$9,269,548	
Contract Year 2014	$7,363,776	
Total Defective Pricing Questioned Costs		$16,633,324
Lost Investment Income		$557,854
Total Questioned Costs		**$17,191,178**

EXHIBIT B

Health Insurance Plan of Greater New York
Defective Pricing Questioned Costs

Contract Year 2013 - High Option

	Self	Family	
FEHBP Line 5 - Reconciled Rate	$ [redacted]	$ [redacted]	
FEHBP Line 5 - Audited Rate	$ [redacted]	$ [redacted]	
Bi-weekly Overcharge	$ [redacted]	$ [redacted]	
To Annualize Overcharge:			
March 31, 2013 enrollment	[redacted]	[redacted]	
Pay Periods	26	26	
Subtotal	[redacted]	$ [redacted]	**$8,704,019**

Contract Year 2013 - Standard Option

	Self	Family	
FEHBP Line 5 - Reconciled Rate	$ [redacted]	$ [redacted]	
FEHBP Line 5 - Audited Rate	$ [redacted]	$ [redacted]	
Bi-weekly Overcharge	$ [redacted]	$ [redacted]	
To Annualize Overcharge:			
March 31, 2013 enrollment	[redacted]	[redacted]	
Pay Periods	26	26	
Subtotal	$ [redacted]	$ [redacted]	**$565,529**

Total Defective Pricing Questions Costs 2013 **$9,269,548**

EXHIBIT B

Health Insurance Plan of Greater New York
Defective Pricing Questioned Costs

Contract Year 2014 - High Option

	Self	Family	
FEHBP Line 5 - Reconciled Rate	$[redacted]	$[redacted]	
FEHBP Line 5 - Audited Rate	$[redacted]	$[redacted]	
Bi-weekly Overcharge	$[redacted]	$[redacted]	
To Annualize Overcharge:			
March 31, 2014 enrollment	[redacted]	[redacted]	
Pay Periods	26	26	
Subtotal	$[redacted]	$[redacted]	**$6,654,758**

Contract Year 2014 - Standard Option

	Self	Family	
FEHBP Line 5 - Reconciled Rate	$[redacted]	$[redacted]	
FEHBP Line 5 - Audited Rate	$[redacted]	$[redacted]	
Bi-weekly Overcharge	$[redacted]	$[redacted]	
To Annualize Overcharge:			
March 31, 2014 enrollment	[redacted]	[redacted]	
Pay Periods	26	26	
Subtotal	[redacted]	$[redacted]	**$709,018**

Total Defective Pricing Questioned Costs - 2014 **$7,363,776**

EXHIBIT C

Health Insurance Plan of Greater New York
Lost Investment Income

Audit Findings: Year	2013	2014	July 31, 2015	Total
1. Defective Pricing	$9,269,548	$7,363,776	$0	$16,633,324
Totals (per year):	$9,269,548	$7,363,776	$0	$16,633,324
Cumulative Totals:	$9,269,548	$16,633,324	$16,633,324	$16,633,324
Avg. Interest Rate (per year):	1.5625%	2.0625%	2.25%	
Interest on Prior Years Findings:	$0	$191,184	$218,313	$409,497
Current Years Interest:	$72,418	$75,939	$0	$148,357
Total Cumulative Interest Calculated Through July 31, 2015:	$72,418	$267,123	$218,313	**$557,854**

APPENDIX

EmblemHealth'

[redacted]
Senior Vice President, Underwriting and Account Management Tel [redacted] Fax [redacted]
[redacted]@emblemhealth.com

55 Water Street, New York, NY 10041-8190 wwwemblemhealth.com

March 31, 2015

[redacted]
Chief, Community-Rated
Audits Group
United States Office of Personnel Management
Office of Inspector General
800 Cranberry Woods Drive - Suite 270
Cranberry Township, Pennsylvania 16066

RE: Response to

Report No. 1C-51-00-14-066

Dear [redacted]:

Enclosed is Health Insurance Plan of Greater New York's (Plan) response to The Draft Audit Report that was released on February 5, 2015. The report contains three findings and three recommendations. We have responded to each finding and provided the Plan's backup. The Plan also has created a corrective action plan to address the procedural fording.

With respect to the $25,635,776 in charges to the plan as identified in the audit report, the following is a summary of the Plan's findings:

1. The Plan disagrees with the defective pricing finding for $25,132,660. The Plan is submitting a revised pricing that indicates a $1,585,845.04 credit is due the FEHBP.

2. The Plan disagrees with the lost investment income finding of $503,116. The Plan has recalculated the lost investment income based on the $1,585,845.04 amount due FEHBP and believes it should be $47,340.08.

3. The Plan agrees with the rating system controls findings and has submitted a corrective action plan in our response.

The Plan asks that you review our responses as well as all supporting documentation before preparing the final report. It is our goal to be in full compliance with the FEHB contract at all times.

Should you have any questions regarding the response to this audit report, please feel free to contact me or [redacted].

[redacted]

Contents

I. Defective Pricing — Audit Finding #1 1
   A. Medicare Load
   B. Incorrect copay levels
   C. Incorrectly adjusting for $25 outpatient substance abuse
II. Lost Investment Income Audit Finding #2 9
III. Rating systems Controls — Audit Finding #3 9

I. Pricing Audit Finding OIG Finding:

The Certificate of Accurate Pricing Health Insurance Plan of Greater New York signed for contract years 2013 and 2014 were defective. Application of the defective pricing remedy shows that the FEHBP is due a premium adjustment of $25,132,660.

A. **Medicare Load -** OIG was unable to validate the accuracy of the Plan's enrollment file or its COB file. As a result, DIG did not rely on the Medicare data provided by the Plan. Due to lack of reliance placed on the Plan's Medicare data, OIG is questioning the validity of the entire Medicare loading for contract year 2013 and 2014
B. **Incorrect Copay Levels —** The Plan applied incorrect copay levels in the Medicare loading calculation
C. **Incorrect Substance Abuse Copay:** The Plan incorrectly adjusted the high and standard option rates for a [redacted] outpatient substance abuse benefit. The FEHBP purchased a $201$40 (high option) and a $30/$50 (Standard option) outpatient substance abuse benefit. We adjusted the FEHBP rates to account for the actual benefit purchased.

Plan Response on Medicare Load:

The Plan disagrees with the removal of the entire Medicare Load. The Medicare Load represents the additional cost taken on by the Plan with respect to the Medicare eligible population. CMG has raised valid concerns about the accuracy of the Plan's enrollment file and the use of this file to establish the Medicare Load for FEHBP. After an internal review of the process of establishing the Medicare Load, the Plan has determined that the use of the enrollment file is not preferred for establishing the Medicare Load because the Plan's enrollment file is only intended as the point-of-entry for new enrollments, age-ins and reporting from CMS and is primarily used for billing purposes.

The Plan also maintains a COB file. This file contains the same data as the enrollment file and is preferred for establishing the Medicare Load because it is also updated with additional information such as, other carrier information. When the Plan's enrollment team receives new Medicare information they update both the enrollment file and COB file. However, when the COB team receives additional information, they update the COB file and not the enrollment file. The COB file, however, is used by the Plan to pay claims because it contains all of the information that is used in processing claims.

The Plan's COB file along with the enrollment file is initially populated with new enrollments. All other insurance information that is reported when members join the Plan is investigated through a questionnaire process. Thereafter on an on-going basis, the COB file is updated with information that we receive through:

- COB Questionnaires
- Other carrier information reported on submitted claims
- Written and phone inquiries from members and providers
- Other carrier data reported by CMS and Medicaid
- Data exchange as part of Section 111 reporting
- Data exchange with other carriers via external vendors

On a daily basis the COB team receives pended claims from the Claim Processing Unit where the presence of other carrier involvement may exist. This could be that the member/provider may have indicated that the patient has other coverage or there may be a prior payment reported on the claim. Claims may also pend to the COB team when information on the claim form doesn't match the information on our COB file. These cases are investigated via telephone calls to the reported primary carrier or with a COB questionnaire sent to the member.

Our Service areas, upon receipt of an inquiry involving COB, will forward these request to the COB team for investigation. Typical request are reports of terminated coverage with the primary carrier or a lead to investigate other carrier liability.

Internally, the COB team will run queries to identify members who are 65 years old or older and Medicare is not indicated as their primary carrier. Investigations are performed to see if these members or their spouses are actively working, their group size, and how recently the Plan updated the COB record.

On a monthly basis, the COB team downloads files available from CMS and Medicaid. These files indicate other commercial coverage that has been reported to their agencies. The Plan investigates and reconciles these reports and updates the COB files as needed.

On a quarterly basis, the Plan provides CMS with our population of working aged members so that they may maintain their COB records. Additionally, the Plan submits a file of members who may be eligible for Medicare based on age and working status parameters. CMS responds by informing the Plan who is enrolled in Medicare. The Plan updates the COB files where applicable.

Finally, on an annual basis, CMS submits a full replacement file to the Plan that contains other insurance information they have on file. The purpose of this file is to ensure that the Plan's records match up to the CMS files. When the Plan receives this file, a systemic query is run to compare other insurance information from CMS against the Plan's COB records.

Matched records are ignored and those that don't match are investigated. Any changes to existing records are communicated back to CMS via the Electronic Correspondence Referral System (ECRS), so that CMS may update their records if needed.

Going forward, the Plan will use the COB file exclusively for the development of the Medicare Load for the FEHBP.

Plan Response on Incorrect Copay Levels:

2013	Incorrect		Correct	
	High Option	Standard Option	High Option	Standard Option
Primary Care/Specialty Care	[redacted]	[redacted]	$20/$40	$20/$50
Prescription Drug Copay	[redacted]	[redacted]	$20/$30/$50	$20/$30/$5

2014	Incorrect		Correct	
	High Option	Standard Option	High Option	Standard Option
Primary Care/Specialty Care	N/A	[redacted]	N/A	$30/$50
Prescription Drug Copay	[redacted]	[redacted]	$15535/575	$15/$35/$75

The Plan has reviewed the copay levels and agrees it used the incorrect levels for 2013 and 2014, however the Plan disagrees that the only benefits that should be measured is copay levels. The Plan has revised the rates using the full benefits available to the member. Below are the factors used in developing the Plan's Medicare loading pricing model.

The Plan's cost is the total estimated cost less the Medicare responsible cost. Medicare being the primary payer once the member signs up for Medicare. The total estimated cost of the FEHBP Medicare population is based on the following:

- The Plan's estimated cost for the Medicare Advantage population
- The additional cost of the FEHBP benefit design, priced off the manual rate sheets

Note the benefit design of the FEHBP population and the Plan's base Medicare plan has greatly varied over the years. Early on in the Load pricing (beginning of Medicare Advantage), the benefits were much more similar. Due to the design of the spreadsheets that the Plan uses, as benefits began to significantly change between the two plans, the spreadsheets were not updated to include pricing for facility copayment differences. Specifically, the Plan has only been pricing the PCP/Specialist copay differences instead of the entire benefit design. As described in the detail below, the pricing is based on the entire benefit design.

The Plan's estimated cost is based on the CMS rate filing for the VIP plan with over [redacted] lives spanning [redacted] service counties. The VIP plan is chosen for the following reasons:

- Largest Direct Pay plan
- Similar provider network as the FEHBP
- Stable non-dual SNP population
- Base plan used when developing the manual rate sheets for which employer group plans are priced off

The entire FEHBP benefit design is used to determine the cost associated with the plan design. Specifically, the individual service category copay is priced off of the manual rate sheets used to price the Plan's employer group Medicare business. The base plan in the manual rate sheet is the VIP plan. So there is a cost associated with cost sharing which is different than the base plan. Since the estimated cost is based on the base plan design, the differential in cost between plan designs needs to be included in the estimated cost of the population.

The CMS rate filing splits cost between Medicare covered (allowed and cost share) and supplemental (non-covered benefits and reduced cost share). The estimated cost share is the Medicare covered cost plus the cost associated with the non-covered benefits plus the cost associated with the FEHBP benefit design. This represents the estimated cost of the FEHBP Medicare population.

The Plan's portion of the cost is the Medicare covered cost sharing, the cost associated with the FEHBP benefit design, and the cost associated with the non-covered benefits. The difference between the estimated cost of the FEHBP Medicare population and the Plan's portion of the cost is the CMS potion of the cost.

Plan Response on Incorrect Substance Abuse Copay:

The Plan disagrees with this finding. The copay level for substance abuse in 2014 was [redacted] not $40. The closeout letter for 2014 is attached for your review.

Repricing Based on Use of COB File and Correct Benefits

The Medicare Load calculation has been revised based on the use of the COB file and correct benefits. The membership has been updated to match the COB files used in paying medical claims. Also, the benefit design has been updated to match the FEHBP benefit design for that given year. The result of this repricing is the Plan overstated the Medicare Load by $1,430,075 for the two plan years 2013 and 2014. The $1,430,075 is broken out as follows:

- 2013 Standard Option: the Plan owes FEHBP $73,719
- 2013 High Option: the Plan owes FEHBP $1,187,002
- 2014 Standard Option: the Plan owes FEHBP $202,516
- 2014 High Option: FEHBP owes the Plan ($33,162)

When the revised Medicare Loads are put into to the rate models (see attached 2013 and 2014 "Rate Reconciliation Files" for rate development), the total amount owed to FEHBP is $1,585,845.04.

Below are the original and revised rate work-ups for 2013 and 2014 that illustrate how the Plan developed the new Medicare Load based on the use of the COB file:

2013 Standard Option

The Plan owes FEHBP: $73,719. The original rate work-up calculated the load dollars as $[redacted]. The current rate work-up with the corrected membership and benefit design calculates the load dollars as $[redacted]. The difference is $73,719.

ORIGINAL RATE WORK-UP

MEDICARE LOADING CALCULATIQN 2013 Medicare lives

Type of Coverage	Number of Members	Community Rate	Loading Factors *	Loading Dollars
A&B	[redacted]	[redacted]	[redacted]	[redacted]
A Only				
B Only				
No Medicare				
Medicare Risk				
Total				

LOADING (LOADING DOLLARS/PROJECTED INCOME) [redacted]**%**

REVISED RATE WORK-UP

MEDICARE LOADING CALCULATION 2013 Medicare lives

Type of Coverage	Number of Members	Community Rate	Loading Factors*	Loading Dollars
A&B				
A Only				
B Only				
No Medicare				
Medicare Risk				
Total				

LOADING (LOADING DOLLARS/PROJECTED INCOME) %

2013 High Option

The Plan owes FEHBP: $1,187,002. The original rate work-up calculated the load dollars as $. The current rate work-up with the corrected membership and benefit design calculates the load dollars as $. The difference is $1,187,002.

ORIGINAL RATE WORK-UP

MEDICARE LOADING CALCULATION 2013 Medicare lives

Type of Coverage	Number of Members	Community Rate	Loading Factors *	Loading Dollars
A&B				
A Only				
B Only				
No Medicare				
Medicare Risk				
Total				

LOADING (LOADING DOLLARS/PROJECTED INCOME) %

REVISED RATE WORK-UP

MEDICARE LOADING CALCULATION 2013 Medicare lives

Type of Coverage	Number of Members	Community Rate	Loading Factors *	Loading Dollars
A&B				
A Only				
B Only				
No Medicare				
Medicare Risk				
Total				

LOADING (LOADING DOLLARS/PROJECTED INCOME) **%**

2014 Standard Option

The Plan owes FEHBP: $202,516. The original rate work-up calculated the load dollars as $. The current rate work-up with the corrected membership and benefit design calculates the load dollars as $. The difference is $202,516.

ORIGINAL RATE WORK-UP

MEDICARE LOADING CALCULATION 2014 Medicare lives

Type of Coverage	Number of Members	Community Rate	Loading Factors *	Loading Dollars
A&B				
A Only				
B Only				
No Medicare				
Medicare Risk				
Total				

LOADING (LOADING DOLLARS/PROJECTED INCOME) **%**

REVISED RATE WORK-UP

MEDICARE LOADING CALCULATION 2014 Medicare lives

Type of Coverage	Number of Members	Community Rate	Loading Factors *	Loading Dollars
A&B	[redacted]	[redacted]	[redacted]	[redacted]
A Only				
B Only				
No Medicare				
Medicare Risk				
Total	[redacted]			[redacted]

LOADING (LOADING DOLLARS/PROJECTED INCOME) [redacted]**%**

2014 High Option

FEHBP owes the Plan: $33,162. The original rate work-up calculated the load dollars as $[redacted]. The current rate work-up with the corrected membership and benefit design calculates the load dollars as $[redacted]. The difference is $33,162.

ORIGINAL RATE WORK-UP

MEDICARE LOADING CALCULATION 2014 Medicare lives

Type of Coverage	Number of Members	Community Rate	Loading Factors	Loading Dollars
A&B	[redacted]	[redacted]	[redacted]	[redacted]
A Only				
B Only				
No Medicare				
Medicare Risk				
Total	[redacted]			[redacted]

LOADING (LOADING DOLLARS/PROJECTED INCOME) [redacted]**%**

REVISED RATE WORK-UP

MEDICARE LOADING CALCULATION 2014 Medicare live

Type of Coverage	Number of Members	Community Rate	Loading Factors *	Loading Dollars
A&B				
A Only				
B Only				
No Medicare				
Medicare Risk				
Total				

LOADING (LOADING DOLLARS/PROJECTED INCOME) **%**

II. Lost Investment Income

OIG Finding:

OIG has determined the FEHBP is due $503,116 for lost investment income, calculated through January 31, 2015. In addition, the FEHBP is entitled to lost investment income for the period beginning February 1, 2015 until the defective pricing amounts have been returned to the FEHBP

Plan Response:

The Plan disagrees with this finding. Based on the new pricing the Plan has recalculated the lost invest income based on OIG's formula and will remit the monies once OIG agrees on the new pricing. The new calculation is $47,340.08. Backup documentation is attached.

III. Rating Systems Controls

OIG Finding:

The Plan does not have adequate rating system controls to assure that prior audit findings are corrected in future years and that the Medicare loading applied to the FEHBP rates is developed using consistent, accurate and current data.

Plan Response:

The Plan agrees with this finding and has submitted a corrective action plan to address the following:

1. Using incorrect benefit levels to rate the FEHBP plans
2. New procedures for rating the Medicare load
3. Eliminating the use of the Medicare enrollment file when rating the FEHBP plans

Report Fraud, Waste, and Mismanagement

Fraud, waste, and mismanagement in Government concerns everyone: Office of the Inspector General staff, agency employees, and the general public. We actively solicit allegations of any inefficient and wasteful practices, fraud, and mismanagement related to OPM programs and operations. You can report allegations to us in several ways:

By Internet: http://www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse

By Phone:

Toll Free Number:	(877) 499-7295
Washington Metro Area:	(202) 606-2423

By Mail:

Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, NW
Room 6400
Washington, DC 20415-1100