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 NEW YORK

Report Number 1C-51-00-16-057
December 13, 2017

EXECUTIVE SUMMARY

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

Report No. 1C-51-00-16-057 **December 13, 2017**

Why Did We Conduct The Audit?

The primary objectives of this performance audit were to determine whether Health Insurance Plan of New York (Plan) developed the Federal Employees Health Benefits Program (FEHBP) premium rates using complete, accurate and current data, and that the rates are equivalent to the Plan's Similarly-Sized Subscriber Groups, as provided in the Federal Employees Health Benefits Acquisition Regulations 1652.216-70(a). Additional tests were performed to determine if 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 (OIG) completed a performance audit of the FEHBP's rates offered for contract years 2015 and 2016. Our audit fieldwork was conducted from August 8, 2016, through June 22, 2017, at the Plan's office in New York, New York, and in our OIG offices.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

This report questions $1,579,859 for inappropriate health benefit charges to the FEHBP in contract years 2015 and 2016. Specifically, our audit identified the following:

- In contract years 2015 and 2016, we found that the FEHBP's rates were developed with an incorrect children's loading, an incorrect copay value for dialysis, and an inappropriate loading for preventative dental. We also determined that the FEHBP Medicare loading calculation contained errors relating to incorrect benefit loadings, a misstatement of FEHBP Medicare enrollment, and unsupported Medicare Advantage rates. Finally, we determined that an unsupported and inconsistently applied regional adjustment factor was applied to the FEHBP. Due to these errors, we found the FEHBP was overcharged $1,132,938 and $371,707 in 2015 and 2016, respectively.

- The FEHBP is due $75,214 for lost investment income on the defective pricing overcharges calculated through November 30, 2017.

ABBREVIATIONS

COB	**Coordination of Benefit**
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**
PCP	**Primary Care Provider**
Plan	**Health Insurance Plan of New York**
SSSG	**Similarly Sized Subscriber Group**
U.S.C.	**United States Code**

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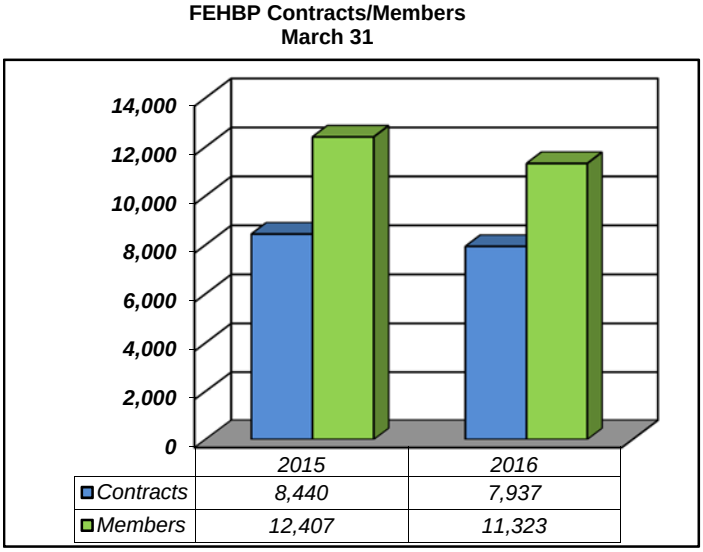
I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at the Health Insurance Plan of New York (Plan). 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 who 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. In addition, participation in the FEHBP subjects the carriers to the Federal Employees Health Benefits Act and implementing regulations promulgated by OPM.

For 2015, the FEHBP should pay a premium rate that is equivalent to the best rate given to either of the two groups closest in subscriber size to the FEHBP. However, starting in 2016, this premium comparison was limited to one similarly-sized subscriber group (SSSG). 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 area. The last audit of the Plan was conducted in 2014 and covered contract years 2013 and 2014. All findings associated with the prior audit have been 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 response was considered in preparation of this report and is included, as appropriate, as the Appendix to the report.

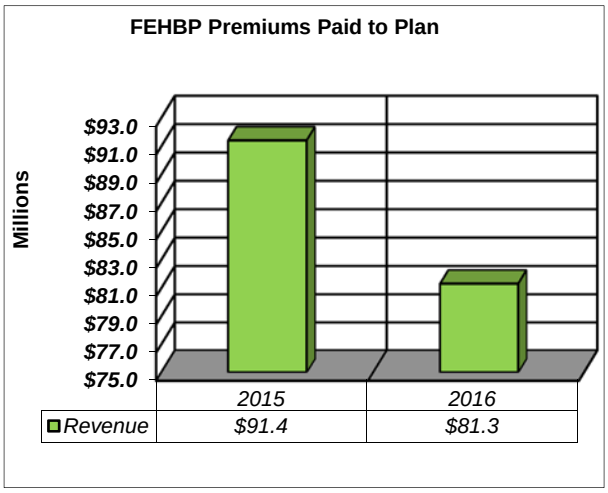
II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The primary objectives of the audit were to determine if the FEHBP premium rates were developed using complete, accurate and current data, and were equivalent to the Plan's SSSG, as provided in Federal Employees Health Benefits Acquisition Regulation (FEHBAR) 1652.216-70(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 2015 and 2016. For these years, the FEHBP paid approximately $172.7 million in premiums to the Plan.

OIG audits of community-rated carriers are designed to test carrier compliance with the FEHBP contract, applicable laws and regulations, and the 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 had 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, nothing came to our attention during our audit utilizing the computer-generated data to cause us to doubt its reliability. We believe that the available data was sufficient to achieve our audit objectives. 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 August 8, 2016, through June 22, 2017, at the Plan's office in New York, New York. Additional audit work was completed at our Cranberry Township, Pennsylvania; Jacksonville, Florida; and Washington, D.C. offices.

METHODOLOGY

We examined the Plan's Federal rate submission and related documents as a basis for validating its 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.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. DEFECTIVE PRICING $1,504,645

The Certificates of Accurate Pricing Health Insurance Plan signed for contract years 2015 and 2016 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 totaling $1,504,645 (see Exhibit A).

FEHBAR 1652.216-70 provides that carriers proposing rates to OPM are required to submit a Certificate of Accurate Pricing certifying that the proposed subscription rates, subject to adjustments recognized by OPM, are market price rates. OPM regulations refer to a market price rate in conjunction with the rates offered to an SSSG. For 2015, the SSSGs are the Plan's two employer groups closest in subscriber size to the FEHBP. For 2016 and forward, however, the SSSGs are limited to the single employer group closest in size to the FEHBP. If it is found that the FEHBP was charged higher than the market price rate (i.e., best rate offered to an SSSG), a condition of defective pricing exists, requiring a downward adjustment of the FEHBP premiums to the equivalent market price rate.

1. 2015

We found that the Plan overcharged the FEHBP $1,132,938 in contract year 2015. The Plan selected [redacted] and [redacted] as the SSGs for contract year 2015. We agree with its selections. Our analysis of the rates charged shows that [redacted] and [redacted] did not receive a discount.

The Plan did not follow the regulations and rating instructions in developing the FEHBP's 2015 rates, resulting in Program overcharges of $1,132,938.

Our audit showed that the Plan inappropriately charged the FEHBP [redacted] percent for coverage of dependent children to age 26. The state approved filed rate for this benefit is [redacted] percent for all groups, and was consistently applied to [redacted] and [redacted]. To account for the additional 31 days of coverage for FEHBP dependents turning 26, OPM's rating instructions allow Traditional Community Rated plans to include a [redacted] percent extension of coverage loading, which the Plan applied to the FEHBP's rates. However, the Plan also added the additional [redacted] percent to the FEHBP's children's loading, essentially double charging the FEHBP for this 31 day extension of coverage. Consequently, we applied the [redacted] percent children's loading and the [redacted] percent extension of

coverage loading to the audited FEHBP rates to account for the dependent coverage to age 26 plus the 31 day extension of coverage.

Additionally, the Plan incorrectly adjusted the 2015 rates for a $20 primary care provider (PCP) dialysis benefit. The FEHBP purchased a $20 PCP / $40 Specialist dialysis benefit, as supported by the FEHBP brochure. Also, the Plan charged the FEHBP for a preventative dental benefit, even though this particular benefit is listed as a non-FEHBP benefit that is not part of the FEHBP contract or premium. Per Section 1.13(a) of the 2015 contract between OPM and the Plan, "The Carrier [Plan] bears full responsibility for the accuracy of its FEHBP brochure." Also, Section 2.2(a) states, "The Carrier shall provide the Benefits as described in the agreed upon brochure text … ." Based on the contract specifications and the benefits outlined in the FEHBP brochure, we adjusted the FEHBP's audited rates to account for the actual dialysis benefit and removed the loading for the preventative dental benefit.

Moreover, we analyzed the FEHBP's 2015 Medicare loading and found the following issues:

- The Plan credited the FEHBP Medicare members for a $45 eyeglass hardware benefit. However, the $45 eyeglass hardware benefit is a non-FEHBP benefit that is not part of the FEHBP contract or premium. Therefore, the FEHBP should receive no adjustment for this benefit.

- The Plan utilized an unsupported Medicare advantage base rate of $[redacted] for all FEHBP Medicare advantage members in all areas (New York City, Queens, Nassau, and Suffolk and Westchester). Utilizing the $[redacted] as the medical rate for the Medicare advantage product netted the credit/loading for the FEHBP Medicare advantage members to [redacted] percent. However, by utilizing the Medicare advantage rates published in the Plan's Medicare advantage brochures and adjusting those rates to account for the special benefits offered to Medicare advantage members in the FEHBP brochure, we determined that the Medicare advantage medical rates are $[redacted] for FEHBP members living in New York City and Queens, $[redacted] for those living in Nassau, and $[redacted] for those living in Suffolk and Westchester. The overall impact was an [redacted] percent reduction in cost for those FEHBP members receiving the Medicare advantage plan.

- The Plan incorrectly categorized 28 FEHBP Medicare members as having "No Medicare" coverage. However, of these 28 members we found that 15 have

Medicare Part A, 4 have Medicare Part B, and 9 have Medicare Part A and B. We adjusted the FEHBP Medicare enrollment to account for these changes.

Finally, the Plan applied a regional adjustment factor to the FEHBP's rates that was based on unsupported membership. The total FEHBP regional membership varied [redacted] percent from the total FEHBP membership reported to OPM for that same time period. Without accurate membership data by region, the regional adjustment factor can be manipulated to increase or decrease group rates. Furthermore, the rate development for the other SSSG, [redacted], did not include a regional adjustment factor. Since the Plan provided regional enrollment files that were incomplete and inaccurate, and the regional adjustment factor was not consistently applied to all SSSGs, we removed this factor from the FEHBP's rates.

A comparison of our audited rates to the Plan's reconciled rates shows that the FEHBP was overcharged $1,132,938 in contract year 2015 (see Exhibit B).

2. <u>2016</u>

We found that the Plan overcharged the FEHBP $371,707 in contract year 2016. The Plan selected [redacted] as the SSSG for contract year 2016. We agree with the Plan's selection. Our analysis of the rates charged shows that [redacted] did not receive a discount.

The Plan did not follow the regulations and rating instructions in developing the FEHBP's 2016 rates, resulting in Program overcharges of $371,707.

We determined that the Plan inappropriately charged the FEHBP [redacted] percent for coverage of dependent children to age 26. The state approved filed rate for this benefit is [redacted] percent for all groups, and was consistently applied to [redacted]. To account for the additional 31 days of coverage for FEHBP dependents turning 26, OPM's rating instructions allow Traditional Community Rated plans to include a [redacted] percent extension of coverage loading, which the Plan applied to the FEHBP's rates. However, the Plan also added the additional [redacted] percent to the FEHBP's children's loading, essentially double charging the FEHBP for this 31 day extension of coverage. Consequently, we applied the [redacted] percent children's loading and the [redacted] percent extension of coverage loading to the audited FEHBP rates to account for the dependent coverage to age 26 plus the 31 day extension of coverage.

Additionally, the Plan incorrectly adjusted the 2016 rates for a $30 PCP dialysis benefit. The FEHBP purchased a $30 PCP / $50 Specialist dialysis benefit, as supported by the FEHBP brochure. Also, the Plan charged the FEHBP for a preventative dental benefit, even though this particular benefit is listed as a non-FEHBP benefit that is not part of the FEHBP contract or premium. Per Section 1.13(a) of the 2016 contract between OPM and the Plan, "The Carrier [Plan] bears full responsibility for the accuracy of its FEHBP brochure." Also Section 2.2(a) states, "The Carrier shall provide the Benefits as described in the agreed upon brochure text … ." Based on the contract specifications and the benefits outlined in the FEHBP brochure, we adjusted the FEHBP's audited rates to account for the actual dialysis benefit and removed the loading for the preventative dental benefit.

Moreover, we analyzed the FEHBP's 2016 Medicare loading and found the following issues:

- The Plan charged the FEHBP Medicare members for a $40 outpatient physical therapy benefit. Per the FEHBP brochure, the outpatient physical therapy benefit is covered under a $50 copay. Therefore, we credited the FEHBP Medicare benefits for the higher $50 copay.

- The Plan did not adjust for the FEHBP Medicare members benefit increase to a maximum out-of-pocket benefit of $6,850. To account for this benefit, we applied the filed credit.

- The Plan credited the FEHBP Medicare members for a $45 eyeglass hardware benefit. However, the $45 eyeglass hardware benefit is a non-FEHBP benefit that is not part of the FEHBP contract or premium. Therefore, we removed the credit from the FEHBP Medicare benefits.

- The Plan utilized an unsupported Medicare advantage base rate of $[redacted] for all FEHBP Medicare advantage members in all areas (Brooklyn, New York, Queens, Nassau, Suffolk, and Westchester). However, by utilizing the Medicare advantage rates published in the Plan's Medicare advantage brochures and adjusting those rates to account for the special benefits offered to Medicare advantage members in the FEHBP brochure, we determined that the Medicare advantage medical rates are $[redacted] for FEHBP members living in Brooklyn; $[redacted] for those living in New York, Queens, and Nassau; and $[redacted] for those living in Suffolk and Westchester. We updated these rates in the audited FEHBP

Medicare loading calculation and found the FEHBP Medicare members should receive an [redacted] percent reduction instead of the [redacted] percent applied by the Plan.

- Even though the Plan submitted the FEHBP Coordination of Benefit (COB) Medicare enrollment in the 2016 reconciliation, the Plan did not utilize that data in the 2016 FEHBP Medicare loading. Furthermore in the COB enrollment data, the Plan incorrectly categorized 157 FEHBP Medicare members as having "No Medicare" and "Medicare Risk" coverage. However, of these 157 members we found that 67 have Medicare Part A, 2 have Medicare Part B, and 88 have Medicare Part A and B. We adjusted the FEHBP Medicare enrollment to account for these changes and applied the revised enrollment amounts to the FEHBP Medicare loading calculation.

Finally, the Plan applied a regional adjustment factor to the FEHBP's rates that was based on unsupported membership. The total FEHBP regional membership varied more than [redacted] percent from the total FEHBP membership reported to OPM for that same time period. Without accurate membership data by region, the regional adjustment factor can be manipulated to increase or decrease a group's rate. Since the Plan provided regional enrollment files that were incomplete and inaccurate, we removed the factor from the FEHBP's rates.

A comparison of our audited rates to the Plan's reconciled rates shows that the FEHBP was overcharged $371,707 in contract year 2016 (see Exhibit B).

Plan Response:

Except as discussed below, the Plan agreed with all of the defective pricing findings questioned in 2015 and 2016.

The Plan does not agree with the high option member premiums that were derived and used by the OIG for the Medicare load for 2015 and 2016. It expressed that the full benefit package for the FEHBP population in the Medicare Advantage must be used, not just the difference between the High Option benefit and the active benefit. It asserted that the blended rates it used in the development of the High Option premiums are reasonable and should not be adjusted.

Additionally, the Plan stated that it does not agree with the OIG's reclassification of FEHBP Medicare members as having "No Medicare" coverage in 2015 and 2016. It

explained that there was an indicator in its data that showed these members have Medicare as secondary coverage; therefore, its original calculation should be used.

OIG Comment:

We recognize the Plan's response regarding the high option member premiums for the Medicare load for 2015 and 2016. However, according to Section 1.13(a) of the 2015 and 2016 contracts between OPM and the Plan, "The Carrier [Plan] bears full responsibility for the accuracy of its FEHBP brochure." The Plan's brochures specified Medicare Advantage base rates along with adjustments to those rates to account for the special benefits offered to Medicare Advantage members, which is the information we used to calculate the high option member premiums.

Additionally, while the Plan states that the FEHBP Medicare members had Medicare as secondary coverage, it does not change our position that the Plan incorrectly categorized the members as having "No Medicare" coverage. In determining our audited FEHBP Medicare enrollment we reviewed the data provided by the Plan line by line to verify the coverage of each member. Consequently, we maintain that our adjusted FEHBP Medicare enrollment amounts are correct for both years.

Recommendation 1

We recommend that the contracting officer require the Plan to return $1,132,938 to the FEHBP for defective pricing in contract year 2015.

Recommendation 2

We recommend that the contracting officer require the Plan to return $371,707 to the FEHBP for defective pricing in contract year 2016.

B. LOST INVESTMENT INCOME $75,214

The Plan owes the FEHBP $75,214 in lost investment income on Plan overcharges for contract years 2015 and 2016.

We found that the FEHBP is due $75,214 for lost investment income on the defective pricing overcharges, calculated through November 30, 2017.

In accordance with the 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 2015 and 2016. We determined that the FEHBP is due $75,214 for lost investment income, calculated through November 30, 2017 (see Exhibit C). In addition, the FEHBP is entitled to lost investment income for the period beginning December 1, 2017, until all defective pricing finding 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.

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

Plan Response:

The Plan did not address this finding within its response to the draft report.

Recommendation 3

We recommend that the contracting officer require the Plan to return $75,214 to the FEHBP for lost investment income, calculated through November 30, 2017. We also recommend that the contracting officer recover lost investment income on amounts due for the period beginning December 1, 2017, until all defective pricing finding amounts have been returned to the FEHBP.

EXHIBIT A

Health Insurance Plan of New York
Summary of Questioned Costs

Defective Pricing Questioned Costs		
Contract Year 2015	$1,132,938	
Contract Year 2016	$371,707	
Total Defective Pricing Questioned Costs		$1,504,645
Lost Investment Income		$75,214
Total Questioned Costs		**$1,579,859**

EXHIBIT B

Health Insurance Plan of New York
Defective Pricing Questioned Costs

Contract Year 2015

	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, 2015 enrollment	[redacted]	[redacted]
Pay Periods	26	26
Subtotal	$611,155	$521,783

Total Defective Pricing Questioned Costs - 2015 $1,132,938

Contract Year 2016

	Self	Self + 1	Family
FEHBP Line 5 - Reconciled Rate	$ [redacted]	$ [redacted]	$ [redacted]
FEHBP Line 5 - Audited Rate	$ [redacted]	$ [redacted]	$ [redacted]
Bi-weekly Overcharge	[redacted]	$ [redacted]	$ [redacted]
To Annualize Overcharge:			
March 31, 2016 enrollment	[redacted]	[redacted]	[redacted]
Pay Periods	26	26	26
Subtotal	$200,647	$33,682	$137,378

Total Defective Pricing Questioned Costs - 2016 $371,707

Grand Total Defective Pricing Questioned Costs **$1,504,645**

EXHIBIT C

Health Insurance Plan of New York
Lost Investment Income

Year Audit Findings:	2015	2016	30-Nov-17	Total
1. Defective Pricing	$1,132,938	$371,707	$0	$1,504,645
Totals (per year):	$1,132,938	$371,707	$0	$1,504,645
Cumulative Totals:	$1,132,938	$1,504,645	$1,504,645	$1,504,645
Avg. Interest Rate (per year):	2.2500%	2.1875%	2.4375%	
Interest on Prior Years Findings:	$0	$24,783	$33,619	$58,402
Current Years Interest:	$12,746	$4,066	$0	$16,812
Total Cumulative Interest Calculated Through November 30, 2017:	$12,746	$28,849	$33,619	**$75,214**

APPENDIX

EmblemHealth®

55 Water Street, New York, New York 10041-8190

August 31, 2017

[redacted]
Chief, Community-Rated
Audits Group
Office of Personnel Management
1900 "E" Street, N.W. Room
Washington, DC 20414

Re: HIP HMO (Plan Code 51)
Audit #1C-51-00-16-057

Dear [redacted]

On behalf of the HIP HMO FEHB program, enclosed are the Plan's responses to the 2015 – 2016 Audit #1C-51-00-16-057 findings.

After you have had an opportunity to review the information provided, please do not hesitate to contact me or [redacted] with any questions or if any supplemental data is needed to support our responses. You can reach me at [redacted]@EmblemHealth.com or [redacted]

Sincerely,

[redacted]
Director Account Management

CC: [redacted], Sr. Director
[redacted], Sr. Account Executive

2015

We found that the Plan overcharged the FEHBP $1,132,938 in contract year 2015. The Plan selected [redacted] and [redacted] as the SSSGs for contract year 2015. We agree with the Plan's selections. Our analysis of the rates charged show that [redacted] and [redacted] did not receive a discount.

Our audit showed that the Plan inappropriately charged the FEHBP [redacted] percent for coverage of dependent children to age 26. The state approved filed rate for this benefit is [redacted] percent for all groups, and was consistently applied to [redacted] and [redacted]. To account for the additional 31 days of coverage for FEHBP dependents turning 26, OPM's rating instructions allow Traditional Community Rated (TCR) plans to include a [redacted] percent extension of coverage loading, which the Plan applied to the FEHBP's rates. However, the Plan also added the additional [redacted] percent to the FEHBP's children's loading, essentially double charging the FEHBP for this 31 day extension of coverage. Consequently, we applied the [redacted] percent children's loading and the [redacted] percent extension of coverage loading to the audited FEHBP rates to account for the dependent coverage to age 26 plus the 31 day extension of coverage.

The Plan agrees with this finding

Additionally, the Plan incorrectly adjusted the 2015 rates for a $20 primary care provider (PCP) dialysis benefit. The FEHBP purchased a $20 PCP / $40 Specialist (SPC) dialysis benefit, as supported by the FEHBP brochure. Also, the Plan charged the FEHBP for a preventative dental benefit, even though this particular benefit is listed as a non-FEHBP benefit that is not part of the FEHBP contract or premium. Per Section 1.13(a) of the 2015 contract between OPM and the Plan, "the Carrier [Plan] bears full responsibility for the accuracy of its FEHBP brochure." Also, Section 2.2(a) states, "The Carrier shall provide the Benefits as described in the agreed upon brochure text…" Based on the contract specifications and the benefits outlined in the FEHBP brochure, we adjusted the FEHBP's audited rates to account for the actual dialysis benefit and removed the loading for the preventative dental benefit.

The Plan agrees with this finding

Moreover, we analyzed the FEHBP's 2015 Medicare loading and found the following issues:

- The Plan credited the FEHBP Medicare members for a $45 eyeglass hardware benefit. However, the $45 eyeglass hardware benefit is a non-FEHBP benefit that is not part of the FEHBP contract or premium. Therefore, the FEHBP should receive no adjustment for this benefit.

The Plan agrees with this finding.

- The Plan utilized an unsupported Medicare advantage base rate of $[redacted] for all FEHBP Medicare advantage members in all areas (New York City, Queens, Nassau, and Suffolk and Westchester). Utilizing the $[redacted] as the medical rate for the Medicare advantage product netted the credit/loading for the FEHBP Medicare advantage members to [redacted] percent. However, by utilizing the Medicare advantage rates published in the Plan's Medicare advantage brochures and adjusting those rates to account for the special benefits offered to Medicare advantage members in the FEHBP brochure, we determined that the Medicare advantage medical rates are $[redacted] for FEHBP members living in New York City and Queens, $[redacted] for those living in Nassau, and $[redacted] for those living in Suffolk and Westchester. The overall impact was an [redacted] percent reduction in cost for those FEHBP members receiving the Medicare advantage plan.

Deleted by OIG - Not Relevant to the Final Report

- The Plan incorrectly categorized 28 FEHBP Medicare members as having "No Medicare" coverage. However, of these 28 members we found that 15 have Medicare Part A, 4 have Medicare Part B, and 9 have Medicare Part A and B. We adjusted the FFEHBP Medicare enrollment to account for these changes.

  The Plan does not agree with this finding

  We see where these numbers are being generated on the COB file. The indicators in columns AO and AP of the COB file tab 'No Medicare' are the reason for the inclusion. Status 'I' indicates Medicare inactive in column AO. Otherinsind 'S' in column AO, indicates Medicare secondary. The load for these members therefore should be greater. The numbers should be kept as they were in the original load.

- Finally, the Plan applied a regional adjustment factor to the FEHBP's rates that was based on unsupported membership. The total FEHBP regional membership varied [redacted] percent from the total FEHBP membership reported to OPM for that same time period. Without accurate membership data by region, the regional adjustment factor can be manipulated to increase or decrease group rates. Furthermore, the rate development for the other SSSG, [redacted], did not include a regional adjustment factor. Since the Plan provided regional enrollment files that were incomplete and inaccurate, and the regional adjustment factor was not consistently applied to all SSSGs, we removed this factor from the FEHBP's rates.

A comparison of our audited rates to the Plan's reconciled rates shows that the FEHBP was overcharged $1,132,938 in contract year 2015 (see Exhibit B).

2016

We found that the Plan overcharged the FEHBP $371,707 in contract year 2016. The Plan selected [redacted] as the SSSG for contract year 2016. We agree with the Plan's selection. Our analysis of the rates charged show that [redacted] did not receive a discount.

We determined that the Plan inappropriately charged the FEHBP [redacted] percent for coverage of dependent children to age 26. The state approved filed rate for this benefit is [redacted] percent for all groups, and was consistently applied to [redacted]. To account for the additional 31 days of coverage for FEHBP dependents turning 26, OPM's rating instructions allow Traditional Community Rated (TCR) plans to include a [redacted] percent extension of coverage loading, which the Plan applied to the FEHBP's rates. However, the Plan also added the additional [redacted] percent to the FEHBP's children's loading, essentially double charging the FEHBP for this 31 day extension of coverage. Consequently, we applied the [redacted] percent children's loading and the [redacted] percent extension of coverage loading to the audited FEHBP rates to account for the dependent coverage to age 26 plus the 31 day extension of coverage.

The Plan agrees with this finding

Additionally, the Plan incorrectly adjusted the 2016 rates for a $30 primary care provider (PCP) dialysis benefit. The FEHBP purchased a $30 PCP / $50 Specialist (SPC) dialysis benefit, as supported by the FEHBP brochure. Also, the Plan charged the FEHBP for a preventative dental benefit, even though this particular benefit is listed as a non-FEHBP benefit that is not part of the FEHBP contract or premium. Per Section 1.13(a) of the 2016 contract between OPM and the Plan, "the Carrier [Plan] bears full responsibility for the accuracy of its FEHBP brochure." Also Section 2.2(a) states, "The Carrier shall provide the Benefits as described in the agreed upon brochure text…" Based on the contract specifications and the benefits outlined in the FEHBP brochure, we adjusted the FEHBP's audited rates to account for the actual dialysis benefit and removed the loading for the preventative dental benefit.

The Plan agrees with this finding

Moreover, we analyzed the FEHBP's 2016 Medicare loading and found the following issues:

- The Plan charged the FEHBP Medicare members for a $40 outpatient physical therapy benefit. Per the FEHBP brochure, the outpatient physical therapy benefit is covered under a $50 copay. Therefore, we credited the FEHBP Medicare benefits for the $50 copay.

  The plan agrees that $50 is the correct benefit

- The Plan did not adjust for the FEHBP Medicare members benefit increase to a maximum out-of-pocket benefit of $6,850. To account for this benefit, we applied the filed credit.

  The plan agrees that $6,850 is the correct benefit

- The Plan credited the FEHBP Medicare members for a $45 eyeglass hardware benefit. However, the $45 eyeglass hardware benefit is a non-FEHBP benefit that is not part of the FEHBP contract or premium. Therefore, we removed the credit from the FEHBP Medicare benefits.

  The Plan agrees with this finding

- The Plan utilized an unsupported Medicare advantage base rate of $[redacted] for all FEHBP Medicare advantage members in all areas (Brooklyn, New York, Queens, Nassau, Suffolk and Westchester).

However, by utilizing the Medicare advantage rates published in the Plan's Medicare advantage brochures and adjusting those rates to account for the special benefits offered to Medicare advantage members in the FEHBP brochure, we determined that the Medicare advantage medical rates are $[redacted] for FEHBP members living in Brooklyn, $[redacted] for those living in New York and Queens and Nassau, and $[redacted] for those living in Suffolk and Westchester. We updated these rates in the audited FEHBP Medicare loading calculation and found the FEHBP Medicare members should receive an [redacted] percent reduction instead of the [redacted] percent applied by the Plan.

Deleted by OIG - Not Relevant to the Final Report

- Even though the Plan submitted the FEHBP Coordination of Benefit (COB) Medicare enrollment in the 2016 reconciliation, the Plan did not utilize that data in the 2016 FEHBP Medicare loading. Furthermore in the COB enrollment data, the Plan incorrectly categorized 157 FEHBP Medicare members as having "No Medicare" and "Medicare Risk" coverage. However, of these 157 members we found that 67 have Medicare Part A, 2 have Medicare Part B, and 88 have Medicare Part A and B. We adjusted the FEHBP Medicare enrollment to account for these changes and applied the revised enrollment amounts to the FEHBP Medicare loading calculation.

  The Plan agrees that there were duplicate members in the "No Medicare" tab. The plan believes, similar to 2015, however, that members with Status 'I' or Otherinsind 'S' belong in this tab

Finally, the Plan applied a regional adjustment factor to the FEHBP's rates that was based on unsupported membership. The total FEHBP regional membership varied more than [redacted] percent from the total FEHBP membership reported to OPM for that same time period. Without accurate membership data by region, the regional adjustment factor can be manipulated to increase or decrease a group's rate. Since the Plan provided regional enrollment files that were incomplete and inaccurate, we removed the factor from the FEHBP's rates.

A comparison of our audited rates to the Plan's reconciled rates shows that the FEHBP was overcharged $371,707 in contract year 2016 (see Exhibit B).

Plan Response – October 2017

Membership

The plan would like to review the members no longer deemed "No Medicare". The plan still believes that members with Status 'I' or Otherinsind 'S' belong in this tab and should be included in the Medicare load.

High Option Rates

The plan does not agree with the high option member premiums derived and used for the Medicare load for 2015 or 2016. The Medicare Risk portion of the Medicare load compares the FEHBP active life cost to the high option benefit package offered to the FEHBP population under Medicare Advantage.

The rates developed by OPM are not comparable. To develop a rate using the methodology in the audited "STL MR Benefit" tabs, the full benefit package for the FEHBP population in Medicare Advantage must be used, and not simply the difference between the High Option Medicare Advantage benefit and the active benefit. The HIP COB responsibility for the High Option Medicare Advantage members is based on the benefits those members have.

The plan feels that the blended rates used in the development of the High Option premium are reasonable and should not be adjusted.

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