U.S. Office of Personnel Management
Office of the Inspector General
Office of Audits

Final Audit Report

Audit of the Federal Employee Health Benefit Operations at Health Insurance Plan of New York

Report Number 1C-51-00-21-024
June 23, 2022

– Caution –

Executive Summary

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

Report No. 1C-51-00-21-024 **June 23, 2022**

Why Did We Conduct the Audit?

The primary objective of the audit was to determine if Health Insurance Plan of New York (Plan), plan codes 51 and YL, complied with the provisions of its contract and the laws and regulations governing the Federal Employees Health Benefits Program (FEHBP). To accomplish this objective, we verified whether the FEHBP premium rates were developed in accordance with contract regulations and rating instructions established by the U.S. Office of Personnel Management (OPM), as well as in a manner consistent with the Plan's rating of the similarly-sized subscriber group (SSSG).

What Did We Audit?

Under Contract CS 1040, the Office of the Inspector General (OIG) completed a performance audit of the FEHBP premium rate developments and FEHBP member claims for contract years 2018 through 2020. We conducted our audit fieldwork remotely from July 26, 2021, through January 10, 2022, in our OIG offices.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

We determined that the Plan did not comply with the provisions of its contract and the laws and regulations governing the FEHBP for contract years 2018 through 2020 for plan codes 51 and YL. All of the issues we identified in our audit are designated as procedural in this report.

The Plan did not maintain adequate documentation to support aspects of its FEHBP premium rate development or the Similarly-Sized Subscriber Group (SSSG) premium rate development; nor did it have adequate internal controls over its process for the Medicare loading calculation. The Plan also calculated the Medicare loading using a richer benefit than that listed in the FEHBP benefit brochure.

We determined the Plan incorrectly administered its 2019 laboratory and diagnostic benefits for the standard option, plan code YL. We also could not verify that the members were properly reimbursed for the error in accordance with the directives from OPM.

Additionally, the Plan did not provide sufficient support documentation to verify the accurate pricing of claims, nor did it report security data breaches affecting FEHBP members timely.

Lastly, our review of a random sample of medical claims showed that the Plan's claim system was not properly configured to price and pay claims in accordance with provider contracts, its explanation of benefits did not clearly disclose the member responsibility for claims where Medicare paid primary and the Plan paid as secondary, and it passed an unallowable surcharge to its FEHBP members through cost sharing.

Abbreviations

CFR	**Code of Federal Regulations**
Contract	**Contract CS 1040**
DOH	**Department of Health**
EOB	**Explanation of Benefits**
FEHBAR	**Federal Employee Health Benefits Acquisition Regulation**
FEHBP	**Federal Employees Health Benefits Program**
NYHCRA	**New York Health Care Reform Act**
NYS	**New York State**
NYSHIP	**New York State Health Insurance Program**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**Health Insurance Plan of New York**
SSSG	**Similarly-Sized Subscriber Group**
TCR	**Traditional Community Rated**

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I. Background

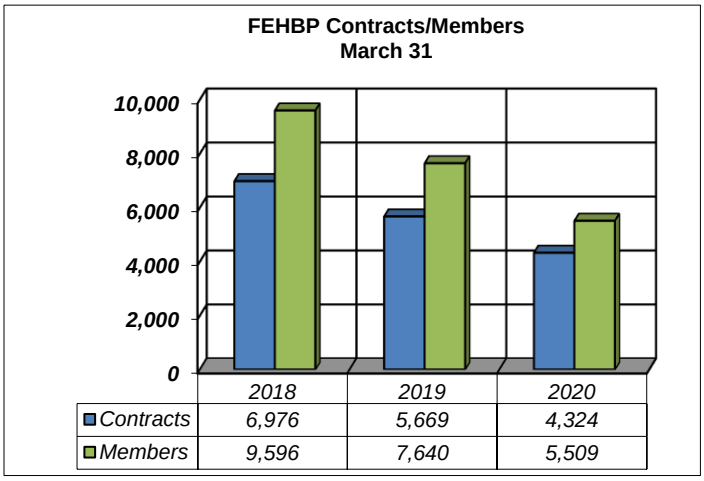
This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at Health Insurance Plan of New York (Plan), plan codes 51 and YL. The audit was conducted pursuant to the provisions of Contract CS 1040 (Contract); 5 United States Code Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract years 2018 through 2020 and was conducted remotely by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG) staff.

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 the OPM Healthcare and Insurance Office. The provisions of the Federal Employees Health Benefits Act are implemented by OPM through regulations codified in 5 CFR Chapter 1, Part 890. Health insurance coverage is provided through contracts with health insurance carriers who provide service benefits, indemnity benefits, or comprehensive medical services.

Beginning in 2012, OPM issued a final rule establishing an FEHBP-specific Medical Loss Ratio requirement for most community-rated FEHBP carriers. However, OPM allowed state-mandated traditional community rated (TCR) carriers to continue to operate under the similarly-sized subscriber group (SSSG) methodology. The Plan was audited under the applicable SSSG criteria since the State of New York mandates Health Maintenance Organizations products be TCR. Per the SSSG instructions, the FEHBP should pay a market price rate, which is defined as the best rate offered to the groups closest in size to the FEHBP. In contracting with traditional 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.

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.

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



	2018	2019	2020
Contracts	6,976	5,669	4,324
Members	9,596	7,640	5,509

The Plan has participated in the FEHBP since 1960 and provides health benefits to FEHBP members in the greater New York City area. A previous OPM OIG premium rate audit of contract years 2015 and 2016 identified that the FEHBP's rates were overstated in both years. The audit determined the rates were developed with incorrect loadings,

including the FEHBP Medicare loading; and determined that an unsupported and inconsistently applied regional adjustment factor was applied to the FEHBP. The final audit report was issued in December of 2017, and all issues were resolved by OPM. These issues were considered in the planning and completion of this audit.

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 an Appendix to the report.

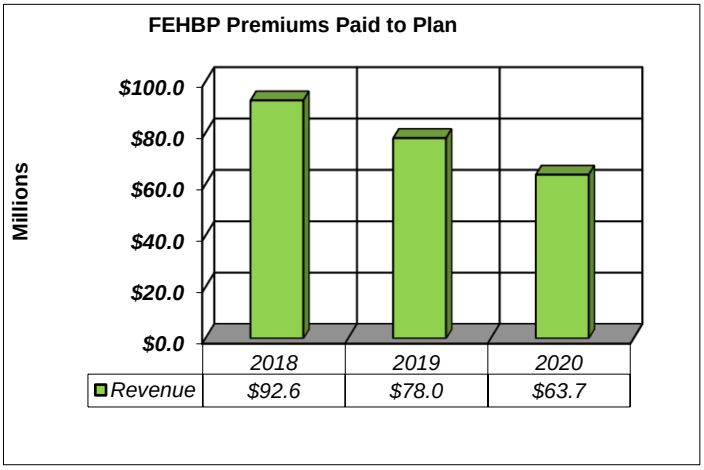
II. Objectives, Scope, and Methodology

Objectives

The primary objective of this performance audit was to determine whether the Plan complied with the provisions of its Contract and the laws and regulations governing the FEHBP. Specifically, we verified whether the FEHBP premium rates were developed using complete, accurate, and current data, and were equivalent to the Plan's rating of the SSSG. We performed additional tests to determine whether the Plan followed the provisions of the laws and regulations governing the FEHBP as well as rating instructions established by OPM.

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 2018 through 2020. For these years, the FEHBP paid approximately $234.3 million in premiums to the Plan.

The OIG's 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. Our review of internal controls was limited to the procedures the Plan has in place to ensure that:

- the appropriate SSSG was selected;
- the rates charged the FEHBP were market price rates (i.e., equivalent to the best rates offered to the SSSG);
- the loadings to the FEHBP were reasonable and equitable;
- medical claims were processed accurately; and
- data breaches were appropriately reported to OPM in a timely manner.

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.

We conducted our audit fieldwork remotely from July 26, 2021, through January 10, 2022.

Methodology

We examined the Plan's federal rate submissions and related documents as a basis for validating the market price rates, which included reviewing the rate development documentation and billings to the SSSG to determine if the market price was charged to the FEHBP. We used the Contract, the Federal Employees Health Benefits Acquisition Regulations (FEHBAR), the OPM rate instructions, and applicable Federal regulations to determine the propriety of the Plan's premium rate calculations.

We reviewed the applicable criteria, as well as the Plan's own internal policies and procedures, to determine if it was appropriately reporting data security breaches to OPM in a timely manner.

To gain an understanding of the internal controls over the Plan's premium rate processes as well as its claims processing system, we reviewed the Plan's premium rate and claims policies and procedures. We also interviewed appropriate Plan officials regarding the controls in place to ensure that the premium rate calculations and claims pricing were completed accurately and appropriately. Other auditing procedures were performed as necessary to meet our audit objectives.

The tests performed for medical claims, along with the methodology, are detailed in Exhibit A at the end of this report.

III. Audit Findings and Recommendations

A. Premium Rate Review

Carriers proposing rates to OPM are required to submit a Certificate of Accurate Pricing certifying that the cost or pricing data submitted in support of the FEHBP rates were developed in accordance with the requirements of 48 CFR, Chapter 16 and the Contract. We verified that the FEHBP premium rates were developed using complete, accurate, and current data, and were equivalent to the Plan's rating of the SSSG, except as noted below. Furthermore, we determined that the Plan did not comply with the provisions of its contract and the laws and regulations governing the FEHBP for contract years 2018 through 2020 for plan codes 51 and YL. The issues are designated as procedural in this report.

1. Document Retention

The Plan did not maintain documentation for several components of the FEHBP and SSSG premium rate developments.

a. Membership Support

As part of its premium rate development, the Plan calculated a regional adjustment based on the membership data for the respective plan code. The regional adjustment is based on membership numbers and specific regional factors that are filed and approved by the New York State (NYS) Department of Finanacial Services. For 2018 and 2019, the Plan was unable to provide support for the FEHBP or SSSG regional membership numbers used in the calculations.

The Plan did not maintain documentation for the FEHBP or SSSG regional membership or the FEHBP membership support by tiers for the Medicare loading.

Additionally, the Plan's Medicare loading is calculated using membership by contract tiers for each FEHBP option. For 2018 and 2019, the Plan was unable to provide FEHBP membership support by tiers that was used in the FEHBP Medicare loading for the standard and high options.

OPM's Contract Section 1.11(b) requires insurance carriers to maintain all records relating to the contract and to make these records available for a period specified by FEHBAR, 48 CFR 1652.204-70. The referenced clause is incorporated into the contracts at Section 3.4, which requires the carrier to maintain "all records applicable to a contract term ... for a period of six years after the end of the contract term to which the claim records relate." In addition, Carrier Letters 2017-05 and 2018-06 require all carriers to maintain documentation to support all calculations and

statements pertaining to the reconciliation. They specifically note that "For TCR rated plans, this includes documentation supporting the SSSG rates … ."

The Plan stated it was unable to provide the 2018 and 2019 FEHBP regional and tier membership files because the tool for the process used at the time no longer existed and it did not save a database export file from the system. It also could not recreate the New York State Health Insurance Program (NYSHIP) regional membership numbers due to a transition in staff. This lack of internal controls over the Plan's retention of membership data in 2018 and 2019 led to membership numbers used in the FEHBP and NYSHIP rates that could not be verified. As a result, the Plan was not in compliance with the Contract or Carrier Letters 2017-05 and 2018-06.

The Plan noted that beginning with the 2020 renewal, supporting documentation for the SSSG membership was retained.

b. Similarly-Sized Subscriber Group Support

The Plan was unable to support the pricing for the "other" component of the Medicare Risk without pharmacy benefits, which is part of the selected 2018 SSSG's rate development.

OPM's Contract Section 1.11(b) requires insurance carriers to maintain all records relating to the contract and to make these records available for a period specified by FEHBAR, 48 CFR 1652.204-70. The referenced clause is incorporated into the contracts at Section 3.4, which requires the carrier to maintain "all records applicable to a contract term ... for a period of six years after the end of the contract term to which the claim records relate." In addition, Carrier Letter 2017-05 requires all carriers to maintain documentation to support all calculations and statements pertaining to the reconciliation. It specifically notes that, "For TCR rated plans, this includes documentation supporting the SSSG rates … ."

The Plan noted that due to a transition in staff, support for the "other" component of the 2018 NYSHIP rate calculation was not available. As a result, the Plan was not in compliance with the Contract or Carrier Letter 2017-05.

Recommendation 1:

We recommend that the Plan strengthen its internal controls to ensure it maintains documentation to support all aspects of the FEHBP rate reconciliations and SSSG premium rate developments, as required by the Contract and applicable OPM carrier letters.

Plan's Response:

The Plan agreed with the recommendation. The Plan noted its "improved processes include management review of all aspects of the rate development, as well as a requirement to save all work files on the appropriate shared drive." It also noted that its current processes support "appropriate maintenance of documentation" for the FEHBP rate reconciliations and the SSSG premium rate development. It noted its ability to support the FEHBP and SSSG tier membership data used in its 2020 premium rate reconciliations, as well as its ability to support the "other" Medicare Risk without pharmacy benefits for 2019 and 2020 as evidence of its improved processes.

OIG Comment:

We acknowledge the Plan's response and agree that it was able to support the regional and tier memberships used in its 2020 FEHBP and SSSG rate developments. However, we encourage the Plan to continue to evaluate its data retention controls to ensure it complies with all aspects of its Contract and OPM Carrier Letters. A full review of the Plan's improved document retention process will be evaluated during a future audit.

2. Medicare Membership Controls

The Plan lacked adequate internal controls over its process for pulling the membership data used in the FEHBP Medicare load calculations for 2018 through 2020.

The Plan used a manual process for determining its FEHBP Medicare load calculations.

Per Contract Section 5.64, "(c) … The Contractor shall establish the following within 90 days after the contract award. … (2) An internal controls system. (i) The Contractor's internal control system shall--(A) Establish standards and procedures to facilitate timely discovery of improper conduct in connection with Government contracts; and (B) Ensure corrective measures are promptly instituted and carried out. (ii) At a minimum, the Contractor's internal control system shall provide for … (A) Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the business ethics awareness and compliance program and internal control system."

During the scope of the audit, the Plan's process for pulling the membership totals for members over age 65, which was used in its FEHBP Medicare load calculation, was highly manual. It included running reports from its system and manually summing member data to determine the member's Medicare status, if any. Then, the Plan's Coordination of Benefits team manually reviewed a subset of members that lacked a specific identifier to categorize a Medicare status. The updated file was then provided to an actuary who pulled the Medicare risk membership and summarized the data for use in

the reconciliations. Although the actuary compared the current year Medicare category membership totals to the prior year to explain any variances, the Plan's process did not include any additional review of the data compiled by the actuary. Additionally, the Plan noted that in 2018, OPM discovered an error where the Plan inadvertently excluded Medicare Secondary members in the report and had to update the reconciliations accordingly.

The accurate designation of these members is crucial because the cost to cover a member varies greatly based on Medicare type. The incorrect categorization of members could result in a significantly misstated FEHBP Medicare loading within its premium rate.

Recommendation 2:

We recommend that the Plan establish internal controls, including policies and procedures, over its process for compiling the FEHBP Medicare membership data to ensure the accuracy of the totals used to calculate the Medicare load within its FEHBP rate reconciliations.

Recommendation 3:

We recommend that the Plan develop automated processes that minimize manual review and data entry in the compilation of the FEHBP Medicare membership data.

Plan's Response:

The Plan agreed with the recommendations. The Plan noted its process for gathering the FEHBP Medicare membership data has been revised to be more automated and it has also revised its "policies and procedures" document to include additional checks and controls.

OIG Comment:

The policy updates submitted by the Plan appear to address the issues identified in the finding and recommendations, however we are unable to comment on the effectiveness of the policy updates and will evaluate during future audits.

3. Incorrect FEHBP Benefit Loading

The Plan calculated its 2018 Medicare loading for members 65 and older, excluding the Plan's Medicare Advantage product, using an eyeglass benefit loading that was richer than the benefit listed in the Plan's 2018 FEHBP benefit brochure. The eyeglass benefit, listed in the FEHBP benefit brochure under the non-FEHBP benefits available to Plan members section, offers members a complete pair of eye glasses for a $45 copay every 24 months.

The Plan calculated its 2018 Medicare loading using an eyeglass benefit loading that was richer than the benefit listed in the Plan's 2018 FEHBP benefit brochure.

OPM Contract Section 2.2(a) requires the Plan to provide benefits defined in the FEHBP benefit brochure. Furthermore, the non-FEHBP benefits available to Plan members section in the FEHBP benefit brochure explicity states that the benefits are not part of the contract or premium.

The Plan stated that it was unsure why there was a discrepancy between the copay listed in the FEHBP benefits brochure and the benefit used in the Medicare loading calculation for FEHBP members who were 65 or older without the Medicare Advantage product. The Plan's lack of internal controls over the benefits used in the FEHBP premium rate reconciliation development could result in an overstated premium rate in future years.

Recommendation 4:

We recommend that the Plan strengthen controls over its FEHBP premium rate development to ensure the FEHBP rate is loaded for benefits that are in accordance with the FEHBP benefit brochure.

Plan's Response:

The Plan agreed with the recommendation. It stated that its current process over the premium rate development includes appropriate controls. It referred to the correct benefit loadings included in the 2019 and 2020 rate calculations as support for its statement. Furthermore, it explained that it has improved its process to include "management review of all aspects of the rate development, as well as a requirement to save all work files on the appropriate shared drives."

OIG Comment:

We agree that the Plan used correct benefit loadings for both the 2019 and 2020 FEHBP premium rate reconciliations. We will evaluate the effectiveness of the process controls during a future audit.

B. Laboratory and Diagnostic Benefit Review

In early 2019, an OPM Health Insurance Specialist identified that certain benefits in the FEHBP benefit brochure for the Plan differed from the benefits agreed to by OPM. The laboratory and diagnostic benefits were identified as incorrect on the standard option, plan code YL, which was a new plan code for contract year 2019. Specifically, the copay for the laboratory and diagnostic benefits copay was shown as zero dollars in the FEHBP benefit brochure, although the copay was listed as $75 in the 2019 Close Out Letter and was set at $75 within the Plan's claims system.

As a corrective action, OPM amended the 2019 Standard Option Close Out Letter to reflect the zero-dollar cost share. It also instructed the Plan to honor the zero-dollar copay benefit that was communicated to the members via the FEHBP benefit brochure and was incorporated into its Contract with OPM. The Plan agreed that it was given guidance by OPM to provide the laboratory and diagnostic service to the standard option members at no cost to the member. As a result, the Plan should have reimbursed any cost share paid by standard option members for these services.

The Plan erroneously charged standard option members a cost share for lab and diagnostic benefits.

In its response to our Standard Information Request, which was sent at the beginning of the audit, the Plan stated that "On March 15, 2019, the system copay for laboratory and diagnostic service was changed from $75 to $0. Claims that were processed with the higher copay were reprocessed at the $0 copay. Reimbursement checks were mailed to those who had paid a copay." The Plan provided a contradictory response during the audit fieldwork stating, "the system was unable to be operationalized to make the system fix in 2019. Therefore, members who incurred the incorrect copayment were reimbursed manually in two cycles." Additionally, the Plan stated that standard option members were issued manual checks for the cost share amounts applied.

However, we determined that the Plan failed to fully reimburse all of the FEHBP standard option members for the benefits administration error that resulted in the collection of member cost share on lab and diagnostic procedures. Our review of the Plan's reimbursement process for those procedures identified that its process was ineffective and inefficient.

1. Reimbursement Files

The Plan identified affected members and captured them in three separate reimbursement files. Our review of the process determined the Plan's methodology for identifying the impacted member claims was flawed in the ways discussed below.

a. Inclusion of High Option Member Claims

The Plan used the group ID, which identified FEHBP members in both the standard option (plan code YL) and high option (plan code 51). By not applying a filter for the Plan code option, the Plan inappropriately included high option members in its reimbursement files. The high option members were not impacted by the issue.

The Plan's copay benefit reimbursement process was ineffective and inefficient.

b. Incorrect Date Range

The Plan's query that was used to pull the claims for reimbursement inappropriately included claims with dates of service from 2018. Specifically, the query pulled claims from March 15, 2018, through December 31, 2019. However, the claims impacted by the issue were only related to the standard option, which did not exist until January 1, 2019.

c. Incomplete Range of Procedure Codes

The Plan used an incomplete procedure code range to identify claims for reimbursement. The Plan queried procedure codes 70999 through 79999 and 80999 through 89999. It should have used procedure codes 70000 through 79999 and 80000 through 89999, as these procedure codes include laboratory and diagnostic procedures that should have been reimbursed per the directive from OPM. The Plan agreed that these excluded codes should have been included but noted the code range was incorrectly communicated to its coding team. During a meeting with Plan personnel, it was noted by the Plan that an additional procedure code, 36415, which was related to laboratory services, had also been excluded from the query.

d. Omitted Reimbursement File

The Plan provided a third reimbursement file, although it was not submitted in the Plan's response to our initial information request. The third reimbursement file was run on January 13, 2020, for dates of service from June 1, 2019, through December 31, 2019. As a result, any claims from the covered period that finalized after the query run on January 13th were not attempted to be reimbursed.

2. Samples from the Reimbursement Files

We selected a random sample of members from the first two reimbursement files to determine if the Plan correctly reimbursed the standard option members' cost share for laboratory and diagnostic benefits. To test the sampled members, we requested check remittances to validate that the cost share on the members' claims with a procedure code in the range of 70999 through 79999 and 80999 through 89999 was reimbursed appropriately. Our review of the sampled members' claims identified the issues below.

a. Reimbursement File Not Processed

The Plan discovered that the second reimbursement file, totaling approximately $41,562 in member cost share, was not reimbursed due to an oversight. Consequently, these members were not properly reimbursed.

b. Missed Claims

The Plan only captured finalized claims within its reimbursement file queries. It identified that claims with dates of service from one period's reimbursement run that had finalized after the previous run's query date were not captured in the files because the claims were queried based on the claim date of service. For example, if a claim with a date of service prior to June 1st was finalized in the Plan's system on June 3rd but the reimbursement file query took place on June 2nd for the period of January 1st through May 31st, that claim that processed on June 3rd would not be captured in a reimbursement file.

c. Reimbursement of Procedure Codes Outside of Range

The Plan reimbursed claims for a specific member that were *outside* of the 70999 through 79999 and 80999 through 89999 range, which totaled $3,852. The Plan explained that based on its Account Management review, cost share was incorrectly taken for other claims as well. The Plan did not include any further documentation on the additional claims that also erroneously collected copays. Therefore, we were unable to determine if other members were impacted by this issue. Furthermore, the Plan provided to us a reimbursement check for this member in the amount of $2,137 to confirm the member was reimbursed for the procedures within the code ranges of 70999 through 79999 and 80999 through 89999. To further demonstrate the inconsistent documentation surrounding this issue, the reimbursement file for that member listed the total cost share reimbursement at $3,889.

d. Claims in Reimbursement File Were Not in the Universe

The Plan's reimbursement file included several claims that were not included in the universe of claims, which was also provided by the Plan. It did not provide an explanation as to why those claims appeared in the reimbursement file but not in the universe of claims.

Based on the errors noted in B.1 and B.2 above, we determined that the Plan's process for identifying and reimbursing the incorrect member cost share for the lab and diagnostic procedures was ineffective and inefficient. Furthermore, we determined the Plan did not reimburse all the affected standard option members. Due to the number of issues noted, including the late identification of the third reimbursement file, we were unable to determine what number of member claims were or were not appropriately reimbursed.

The potential member overpayment on the lab and diagnostic cost share totaled a minimum of $112,792 for 311 members.

Based on the 2019 universe of claims provided by the Plan, we determined the potential member overpayment on the lab and diagnostic cost share totaled at least $112,792 for 1,108 claims for 311 standard option members. However, as noted in B.2.d above, there were claims in the reimbursement file that did not appear in the claims universe. As a result, we concluded that we do not have the full universe of claims from 2019 and the actual impact cannot be calculated.

Recommendation 5:

We recommend that the Plan perform a detailed review of those members who were impacted by the 2019 copay error and ensure the members are appropriately reimbursed for any cost share applied in error.

Plan's Response:

The Plan agreed with the recommendation. The Plan stated that "only the standard option plan was used as part of the member reimbursement process for 2019." It also noted it is "in the process of determining the FEHBP members who were not fully reimbursed for the amount due related to the cost share error. Once the reconciliation is completed, we will have identified the members who were already reimbursed, partially reimbursed, or not reimbursed and will take action to make the appropriate reimbursements. Additionally, action will be taken to enhance controls over the reimbursement project process, including but not limited to confirming the criteria for pulling the data, thoroughly testing the results, and confirming that the reimbursement file has been processed and checks issued. The target date for completion is April 30, 2022."

OIG Comment:

We cannot confirm that the Plan only included standard option claims in its reimbursement process since, as discussed in the finding, we were unable to validate which member claims were reimbursed.

Recommendation 6:

We recommend that the Plan ensure the FEHBP benefits are administered correctly in accordance with its FEHBP benefit brochure, Contract with OPM, as well as the directive from OPM on this specific issue.

Plan's Response:

The Plan disagreed with the recommendation. It stated that it administered the benefits discussed above in accordance with the original brochure. It noted that "the plan was instructed not to make any systemic adjustments, but to issue reimbursement checks in alignment with the revised brochures."

OIG Comment:

We acknowledge and disagree with the Plan's assertion that it administered benefits in accordance with the 2019 FEHBP benefit brochure for the standard option, as discussed in the finding above. Rather, the Plan administered the benefits that OPM had agreed to through the Close Out Letter. Because the Plan's FEHBP benefit brochure misstated the benefits related to the laboratory and diagnostic cost share, OPM required the Plan to honor the brochure language and to reimburse the impacted members. As a result, we continue to recommend that the Plan ensure it is administering FEHBP benefits in accordance with the FEHBP benefit brochure, its Contract with OPM, and any additional directives from OPM.

C. Internal Controls Review

Per Contract Section 5.64, Contractor Code of Business Ethics and Conduct, "(c) … The Contractor shall establish the following within 90 days after the contract award. … (2) An internal controls system. (i) The Contractor's internal control system shall--(A) Establish standards and procedures to facilitate timely discovery of improper conduct in connection with Government contracts; and (B) Ensure corrective measures are promptly instituted and carried out. (ii) At a minimum, the Contractor's internal control system shall provide for … (A) Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the business ethics awareness and compliance program and internal control system."

We determined that the Plan's internal control system did not sufficiently meet the contractual criteria.

1. Medical Claims Support

The Plan did not provide sufficient support documentation for seven claims that were selected for review.

The Plan did not provide sufficient support documentation to reprice 7 of the 75 FEHBP member claims that were sampled for review.

OPM's Contract Section 1.11(b) requires insurance carriers to maintain all records relating to the contract and to make these records available for a period specified by FEHBAR, 48 CFR 1652.204-70. The referenced clause is incorporated into the contracts at Section 3.4, which requires the

carrier to maintain "all records applicable to a contract term … for a period of six years after the end of the contract term to which the claim records relate."

The missing support documentation included a provider contract; various pricing information; why procedures that were covered under the FEHBP benefits brochure were not paid by the Plan; and explanations of why copays were not applicable to certain procedures. As a result, we determined the Plan lacked adequate internal controls to ensure support documentation was maintained.

Recommendation 7:

We recommend that the Plan strengthen its internal controls to ensure it maintains documentation to support all aspects of FEHBP member claims, as required by the Contract.

Plan's Response:

The Plan agreed with the recommendation. The Plan disagreed with the medical claims support retention issue and provided additional support documentation for seven claims in response to the draft report.

OIG Comment:

We reviewed the additional sample documentation provided by the Plan. The documentation provided by the Plan contained information for four samples that were not part of the claims' documentation issue noted above. Our review of the additional documentation resulted in the conclusion that seven claims from our sample could not be repriced.

2. Late Reporting of Data Security Breaches

During the scope of our audit, three of the Plan's third-party vendors had data security breaches involving FEHBP members that were reported to OPM. In two of the incidents, the Plan did not report the breaches to OPM until five to seven days after it was determined the incidents likely affected FEHBP members.

The Plan did not report security breaches affecting FEHBP members to OPM timely.

Carrier Letter 2017-14 states, "Incidents and data breaches affecting subcontractors must be reported to OPM by the Carrier no later than the calendar day following notice to the Carrier." In addition, the Plan's own internal Mitigation Operational Process requires immediate notification to OPM if it is suspected that a breach has occurred. The process further refers to the FEHBP Carrier Letter 2017-14 for more detail.

The Plan stated that it conducted additional analysis on the data files received by the third-party vendors to provide OPM with a more thorough and complete notice, which resulted in the late reporting of the incidents to OPM. As a result, the Plan was not in compliance with OPM Carrier Letter 2017-14 or its own Mitigation Operational Process requirements.

The Plan has stated that it has identified additional opportunities to streamline its process to ensure timely reporting of data breaches in accordance with OPM Carrier Letter requirements.

Recommendation 8:

We recommend that the Plan ensure sufficient controls exist to ensure data security breaches are reported to OPM timely, in accordance with OPM Carrier Letter 2017-14, as well as the Plan's own internal process.

Plan's Response:

The Plan agreed with the finding and noted that it "implemented sufficient controls to ensure data security breaches are reported to OPM timely, in accordance with the Plan's own internal process and OPM Carrier Letter 2017-14."

OIG Comment:

We will evaluate the effectiveness of the process improvements during a future audit.

D. Medical Claims Review

We reviewed a random sample of 75 medical claims from 2019 to determine if the Plan priced and paid its high and standard option claims for eligible members in accordance with the applicable criteria. Based on our review, we identified several issues, which are noted below. None of the errors had a material impact on the member cost share, except for the laboratory and diagnostic benefit issue discussed in section B of this report. However, if the Plan does not address the deficiencies that led to the issues noted below, the issues may result in material errors in future years.

1. Claims System Configuration

Our review of the sampled claims identified that the Plan did not properly configure its claims system to price and pay member claims based on the terms within its provider contracts and fee schedules.

The Plan's claims system was not configured to price and pay member claims based on the terms in its provider contracts and fee schedules.

The Plan did not update its system timely to reflect an amended provider fee schedule for 2019. Also, it did not reprocess claims that were priced after the fee schedule effective date but were processed before the claims system was updated. As a result, these claims were priced using an outdated fee schedule. Also, the Plan did not properly designate certain in-network providers as participating under the established contract. Consequently, the claims were incorrectly priced as out-of-network. Moreover, the Plan did not configure its system to price the procedure code 36415 for one of its providers in accordance with the terms in its contract with that provider. This caused claims with the procedure code for that specific provider to be incorrectly priced. Finally, the Plan paid another provider for procedure code A9053 at a lesser rate than the terms of its contract with that provider. An explanation of why the procedure code was reimbursed at a lesser amount was not provided to us. Thus, the provider was reimbursed incorrectly for the covered service.

Per Contract Section 5.64, Contractor Code of Business Ethics and Conduct, "(c) … The Contractor shall establish the following within 90 days after the contract award. … (2) An internal controls system. (i) The Contractor's internal control system shall--(A) Establish standards and procedures to facilitate timely discovery of improper conduct in connection with Government contracts; and (B) Ensure corrective measures are promptly instituted and carried out. (ii) At a minimum, the Contractor's internal control system shall provide for … (A) Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the business ethics awareness and compliance program and internal control system."

Based on our review, we concluded that the Plan did not have adequate system and procedural controls in place to ensure amended provider contracts and fee schedules were updated in the claims system timely, nor did it have adequate system and procedural controls in place to ensure claims affected by a retroactively updated provider fee schedule or contract were reprocessed. As a result, the Plan priced and paid FEHBP member claims based on rates that were not in accordance with the terms of its contracts with its providers, which could impact member cost share.

Recommendation 9:

We recommend that the Plan ensure appropriate procedures and controls are in place to update its claims processing systems to reflect the most current provider pricing agreements.

Recommendation 10:

We recommend that the Plan establish controls to ensure any affected member claims are reprocessed when the Plan updates its pricing retroactively.

Plan's Response:

The Plan agreed with recommendation 9 but disagreed with recommendation 10.

In response to recommendation 9, the Plan stated that it revamped its quality assurance process and implemented monthly monitoring. The Plan has seen an improvement in its accuracy audits based on the monitoring. The Plan disagreed that it paid a provider at a lesser rate than the terms of its contract with that provider and cited a correct payment of a claim sample in accordance with the provider contract.

In response to recommendation 10, the Plan asserted that it "has controls in place as part of its normal process. When an error is identified, the remediation takes place immediately and includes a recycle of all affected claims."

OIG Comment:

We acknowledge that the Plan stated it updated it assurance process and monitoring procedures and we will evaluate the effectiveness of these during a future audit.

The specific sample that resulted in recommendation 9 contradicts the Plan's assertion. During the audit, the Plan explained that the sampled claim, incurred on February 14, 2019, was paid using a 2018 fee schedule, which was confirmed through our audited pricing review. The Plan noted that the 2019 fee schedule amendment, which was effective January 1, 2019, was signed on January 23, 2019, and that the system updates do take some time due to quality assurance review. Therefore, its system was updated after the claim was received. However, when we requested support to show the claim was subsequently corrected for the updated fee schedule pricing, the Plan stated the claim was not adjusted. Therefore, if the Plan had controls in place during 2019, the controls failed to ensure the claim was reprocessed after the retroactive pricing update. We continue to recommend that the Plan establish or enhance its controls to ensure any affected member claims are reprocessed when the Plan updates its pricing retroactively.

2. Explanation of Benefits

The Plan did not clearly define the amount due for benefits within the explanation of benefits (EOB) forms that were sent to its members or providers for claims that were coordinated between Medicare, primary payor, and the Plan, secondary payor.

OPM Carrier Letter 2000-17 directs Carriers to review its plan's consumer information, including explanation of benefit forms, to ensure consistent use of plain language. Plain language is defined as "language that is clear and easy to understand … ."

The Plan's EOBs that were sent to providers and members did not clearly state the amount due from the member.

For each sampled claim that was coordinated with Medicare paying primary, we received an EOB that was sent to either the provider or the member. We noted the EOBs that were sent to the provider listed the member responsibility at zero dollars for claims where the member did have either a copay or deductible responsibility. Conversely, EOBs that were sent to the member listed the potential member responsibility at the full Plan allowed amount of the claim, which did not account for the portion paid by Medicare. Although the Plan stated the member knows their responsibility based on the Medicare EOB, it is unclear whether the member and/or provider would know the actual amount due from the member based on the EOBs from the Plan.

Recommendation 11:

We recommend that the Plan ensure the member cost share responsibility is clearly communicated on the EOBs to FEHBP members and providers in accordance with OPM Carrier Letter 2000-17.

Plan's Response:

The Plan agreed with the recommendation and noted it is "currently researching our system capabilities to make cost share clearer on the EOBs."

3. NYHCRA Surcharge

The Plan is passing New York Health Care Reform Act (NYHCRA) surcharge expenses to its FEHBP members through the calculation of copays and coinsurance.

The Plan is passing New York Health Care Reform Act surcharge expenses to its FEHBP members through the calculation of copay and coinsurance.

The Plan stated that the NYHCRA is "calculated according to published guidelines" and further referred the auditors to the NYS Department of Health (DOH) billing examples for calculating the expense. The examples show the member responsibility is determined after adding the surcharge to the billed amount.

However, the NYS DOH specifically addresses the topic of member responsibility on NYHCRA surcharge claims for benefit plans covered under the Federal Employee Health Benefits Act in its question-and-answer section. It specifically states that "the payments by both the insured (patient coinsurance, copays/deductible amounts) and … federal government plans are exempt from the surcharges … for covered services." Further, OPM Carrier Letter 2018-06, states that "OPM will not accept any surcharge."

By calculating the member cost share based on claim costs including the NYHCRA surcharge, the Plan is inflating the FEHBP member responsibility for an expense that is neither applicable to the FEHBP nor the FEHBP members.

Recommendation 12:

We recommend that the Plan update its claims system to calculate member responsibility on FEHBP member claims without applying the NYHCRA surcharge as required by OPM Carrier Letter 2018-06 and the NYS DOH.

Plan's Response:

The Plan disagreed with the recommendation. It alleged that the surcharge expense was not passed on to FEHBP members through the calculation of cost share. It also stated that the FEHBP is a known surcharge exclusion.

OIG Comment:

We cannot validate the Plan's stance that the surcharge is not passed to the member through the calculation of the cost share. The Plan's method, as presented during the audit, is to calculate member cost share after the calculation of the claim allowed amount. As a result, the potential for FEHBP members to pay toward the annual deductible on an allowed amount that includes the NYHCRA surcharge does exist. In our claim samples that were reviewed, we only had one standard option claim that applied the NYHCRA surcharge where the member deductible had not been met. The amount owed was for a greater amount than the outstanding deductible owed by the member. Therefore, we were unable to definitively state what amount, if any, went toward the NYHCRA surcharge. However, we can confirm that the claim allowed amount in the claims data provided by the Plan does include the NYHCRA surcharge. At a minimum, the Plan should ensure claims for FEHBP members do not contain the NYHCRA surcharge as the information provided to the OIG during the audit was not consistent with the assertion in the Plan's response to this recommendation.

Exhibit A

Health Insurance Plan of New York

Medical Claims Sample Selection Criteria and Methodology

Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Medical claims incurred from 1/1/2019 through 12/31/2019[1]	80,740 Claims	$36,029,842	Utilized RAT-STATS[2] (90% Confidence Level/50% Anticipated Rate of Occurrence/20% Desired Precision Range), which generated a sample size of 75. Then utilized SAS[3] to randomly select 75 incurred, unadjusted medical claims.	Random	No

[1] The information presented here is based on the 2019 claims data provided to the OPM OIG by the Plan, which, as noted in finding B.2.d. above, did not contain all FEHBP member claims.
[2] RAT-STATS is a statistical software designed by the U.S. Department of Health and Human Services OIG to assist in selecting random samples.
[3] SAS Enterprise Guide is a software used to analyze data allowing users to access and manipulate data quickly.

Appendix

OPM OIG Draft Audit Report (1C-51-00-21-024) Response
Received February 11, 2022

A. Laboratory & Diagnostic Benefit Review

Deleted by the OIG – Not Relevant to the Final Report

1. Reimbursement Files

Deleted by the OIG – Not Relevant to the Final Report

a. Inclusion of High Option Member Claims

Deleted by the OIG – Not Relevant to the Final Report

Plan Response:

Deleted by the OIG – Not Relevant to the Final Report Only the standard option plan was used as part of the member reimbursement process for 2019.

b. Incorrect Date Range

Deleted by the OIG – Not Relevant to the Final Report

c. Incomplete Range of Procedure Codes

Deleted by the OIG – Not Relevant to the Final Report

d. Omitted Reimbursement File

Deleted by the OIG – Not Relevant to the Final Report

2. Samples from the Reimbursement Files

Deleted by the OIG – Not Relevant to the Final Report

a. Reimbursement File Not Processed

Deleted by the OIG – Not Relevant to the Final Report

b. Missed Claims

Deleted by the OIG – Not Relevant to the Final Report

c. Reimbursement of Procedure Codes Outside of Range

Deleted by the OIG – Not Relevant to the Final Report

d. Claims in Reimbursement File Were Not in the Universe

Deleted by the OIG – Not Relevant to the Final Report

Plan Response:

Deleted by the OIG – Not Relevant to the Final Report The plan did administer benefits in accordance with the 2019 FEHBP benefit brochure for the standard option.

Deleted by the OIG – Not Relevant to the Final Report

Plan Response:

We agree with the recommendation. The criteria for identifying the full scope of impacted members was vetted and we are in the process of determining the FEHBP members who were not fully reimbursed for the amount due related to the cost share error. Once the reconciliation is completed, we will have identified the members who were already reimbursed, partially reimbursed, or not reimbursed and will take action to make the appropriate reimbursements. Additionally, action will be taken to enhance controls over the reimbursement project process, including but not limited to confirming the criteria for pulling the data, thoroughly testing the results, and confirming that the reimbursement file has been processed and checks issued. The target date for completion is April 30, 2022.

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Plan Response:

We disagree with the recommendation. The plan does administer the benefits in accordance to the benefit brochure provided by OPM and were consistent with the information provided. The plan was instructed not to make any systemic adjustments, but to issue reimbursement checks in alignment with the revised brochures.

B. Internal Controls Review

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1. Document Retention

Deleted by the OIG – Not Relevant to the Final Report

a. Membership Support

Deleted by the OIG – Not Relevant to the Final Report

b. Similarly-Sized Subscriber Group Support

Deleted by the OIG – Not Relevant to the Final Report

c. Medical Claims Support

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Plan Response:

We disagree with this finding. Included with this response is documentation that supports the pricing for 7 of the claims in question. We were not able to identify an 8th sample pertaining to this finding.

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Plan Response:

We agree with this recommendation. Our current processes support appropriate maintenance of documentation related to all aspects of the FEHBP rate reconciliation and SSSG premium rate development.

Regarding item B1a, these improved processes were evidenced by our ability to provide membership support for 2020, including the FEHBP and SSSG regional membership numbers and membership by tiers used in the 2020 calculations.

Regarding item B1b, these improved processes were evidenced by our ability to provide the pricing for the "other" component of the Medicare Risk without pharmacy benefits for both 2019 and 2020. The improved processes include management review of all aspects of the rate development, as well as a requirement to save all work files on the appropriate shared drives.

2. Medicare Membership Controls

Deleted by the OIG – Not Relevant to the Final Report

Plan Response:

We agree with recommendation #4 and recommendation #5 by OPM. The Plan has revised its process for compiling FEHBP Medicare membership data to be more automated, as well as revised its "policies and procedures" document. Additional controls/checks have been added as well. All of this is reflected in the policy and procedures document which will be available for OPM's review.

3. Late Reporting of Data Security Breaches

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Plan Response:

We agree with the finding and have implemented sufficient controls to ensure data security breaches are reported to OPM timely, in accordance with the Plan's own internal process and OPM Carrier Letter 2017-14.

4. Incorrect FEHBP Benefit Loading

Deleted by the OIG – Not Relevant to the Final Report

Plan Response:

We agree with this recommendation. Our current processes include appropriate controls over premium rate development. These improved processes were evidenced by correct benefit loadings included in both 2019 and 2020 rate calculations. The improved processes include management review of all aspects of the rate development, as well as a requirement to save all work files on the appropriate shared drives.

C. 2019 Medical Claims Review

Deleted by the OIG – Not Relevant to the Final Report

1. Claims System Configuration

Deleted by the OIG – Not Relevant to the Final Report

Plan Response:

We disagree with the finding. Based on our review of Sample **Deleted by the OIG – Not Relevant to the Final Report**, the Plan paid a provider at a lesser rate than the terms of its contract with that provider. The claim paid at 80% of the Medicare prevailing rate, as indicated in the contract.

Deleted by the OIG – Not Relevant to the Final Report

Plan Response:

We agree with the recommendation. The Plan has revamped the quality assurance process as part of its procedures and controls and implemented monthly monitoring.

Based on the monthly monitoring, the Plan has seen an improvement in its accuracy audits.

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Plan Response:

We disagree with the recommendation. The Plan has controls in place as part of its normal process. When an error is identified, the remediation takes place immediately and includes a recycle of all affected claims.

2. Coordination of Benefits with Medicare

Deleted by the OIG – Not Relevant to the Final Report

Plan Response:

We agree with the recommendation. The Plan is currently researching our system capabilities to make cost share clearer on the EOBs.

3. NYHCRA Surcharge

Deleted by the OIG – Not Relevant to the Final Report

Plan Response:

We disagree with the recommendation. The surcharge expense for FEHBP members was not passed onto them through the calculation of cost share. FEHBP is a known surcharge exclusion.

Roberto Hormazabal Date: February 10, 2022

AVP, Labor Sales

Labor & Gov't Account Management

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–Caution–

Report No. 1C-51-00-21-024