



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

Final Audit Report

**AUDIT OF
GROUP HEALTH INCORPORATED
NEW YORK, NEW YORK**

**Report Number 1D-80-00-15-044
June 13, 2016**

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EXECUTIVE SUMMARY

Audit of Group Health Incorporated

Report No. ID-80-00-15-044

June 13, 2016

Why did we conduct the audit?

We conducted this limited scope audit to obtain reasonable assurance that Group Health Incorporated (Plan) is complying with the provisions of the Federal Employees Health Benefits Act and regulations that are included, by reference, in the Federal Employees Health Benefits Program (FEHBP) contract. Specifically, the objectives of our audit were to determine if the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract.

What did we audit?

Our audit covered miscellaneous health benefit payments and credits, administrative expenses, and cash management activities from 2010 through 2014. In addition, we reviewed the Plan's Fraud and Abuse (F&A) Program for 2014 through March 31, 2015. Due to concerns with the Plan's medical drug rebates and working capital funds, we expanded our audit scope for these items to also include January 1, 2015 through September 30, 2015.



Michael R. Esser
*Assistant Inspector General
for Audits*

What did we find?

We questioned \$4,077,394 in health benefit charges, administrative expenses, cash management activities, and lost investment income (LII). We also identified a procedural finding regarding the Plan's F&A Program. The Plan agreed with the questioned amounts and disagreed with the procedural finding regarding the F&A Program. We verified that the Plan has returned all of the questioned amounts to the FEHBP.

Our audit results are summarized as follows:

- Miscellaneous Health Benefit Payments and Credits – We questioned \$230,025 (net) for pharmacy and medical drug rebates and program integrity recoveries that had not been returned to the FEHBP and \$107,847 for LII on health benefit refunds and recoveries, pharmacy and medical drug rebates, and program integrity recoveries that were returned untimely to the FEHBP.
- Administrative Expenses – We questioned \$249,133 for letter of credit account drawdowns in excess of the actual transitional reinsurance and health insurance provider fee amounts and \$3,349 for applicable LII on these excess drawdown amounts.
- Cash Management – We determined that the Plan held an excess working capital deposit of \$3,487,040 in the dedicated FEHBP investment account as of September 30, 2015.
- Fraud and Abuse Program – The Plan is not in compliance with the communication and reporting requirements for fraud and abuse cases that are set forth in FEHBP Carrier Letters 2011-13 and 2014-29.

ABBREVIATIONS

ACA	Affordable Care Act
BMP	Behavioral Management Program
CL	Carrier Letter
CFR	Code of Federal Regulations
Contract	CS 1056
EFTs	Electronic Funds Transfers
FAR	Federal Acquisition Regulations
FEHB	Federal Employees Health Benefits
FEHBAR	Federal Employees Health Benefits Acquisition Regulations
FEHBP	Federal Employees Health Benefits Program
F&A	Fraud and Abuse
FWA	Fraud, Waste, and Abuse
GHI or Plan	Group Health Incorporated
Guidelines	Letter of Credit System Guidelines
HHS	Department of Health and Human Services
HIP	Health Insurance Provider
HMO	Health Maintenance Organization
ICD-10	International Classification of Diseases 10
LOCA	Letter of Credit Account
LII	Lost Investment Income
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
TR	Transitional Reinsurance
WC	Working Capital

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I. BACKGROUND

This final audit report details the findings, conclusions, and recommendations resulting from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at Group Health Incorporated (GHI or Plan). The Plan is located in New York, New York.

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 (FEHB) 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. OPM's Healthcare and Insurance Office has overall responsibility for administration of the FEHBP. The provisions of the FEHB Act are implemented by OPM through regulations, which are codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations (CFR). Health insurance coverage is made available through contracts with various health insurance carriers.

The Plan is an experience-rated health maintenance organization (HMO) that provides health benefits to federal enrollees and their families.¹ Enrollment is open to all federal employees and annuitants that live or work in the Plan's service area, which includes New York and the surrounding counties in Northern New Jersey.

The Plan's contract (CS 1056) with OPM is experience-rated. Therefore, the costs of providing benefits in the prior year, including underwritten gains and losses which have been carried forward, are reflected in current and future years' premium rates. In addition, the contract provides that in the event of termination, unexpended program funds revert to the FEHBP Trust Fund. In recognition of these provisions, the contract requires an accounting of program funds to be submitted at the end of each contract year. The accounting is made on a statement of operations known as the Annual Accounting Statement.

Compliance with laws and regulations applicable to the FEHBP is the responsibility of the Plan's management. Also, management of the Plan is responsible for establishing and maintaining a system of internal controls.

All findings from our prior audit of the Plan (Report No. 1D-80-00-10-046, dated July 27, 2011) for contract years 2004 through 2009 have been satisfactorily resolved.

¹ Members of an experience-rated HMO have the option of using a designated network of providers or using non-network providers. A member's choice in selecting one healthcare provider over another has monetary and medical implications. For example, if a member chooses a non-network provider, the member will pay a substantial portion of the charges and benefits available may be less comprehensive.

The results of this audit were provided to the Plan in written audit inquiries; were discussed with Plan officials throughout the audit and at an exit conference on December 10, 2015; and were presented in a draft report, dated December 22, 2015. The Plan's comments offered in response to the draft report were considered in preparing our final report and are included as an Appendix to this final report. Also, additional documentation provided by the Plan through February 2, 2016 was considered in preparing our final report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The objectives of our audit were to determine whether the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract. Specifically, our objectives were as follows:

Miscellaneous Health Benefit Payments and Credits

- To determine whether miscellaneous payments charged to the FEHBP were in compliance with the terms of the contract.
- To determine whether credits and miscellaneous income relating to FEHBP benefit payments were returned timely to the FEHBP.

Administrative Expenses

- To determine whether administrative expenses charged to the contract were actual, allowable, necessary, and reasonable expenses incurred in accordance with the terms of the contract and applicable regulations.

Cash Management

- To determine whether the Plan handled FEHBP funds in accordance with applicable laws and regulations concerning cash management in the FEHBP.

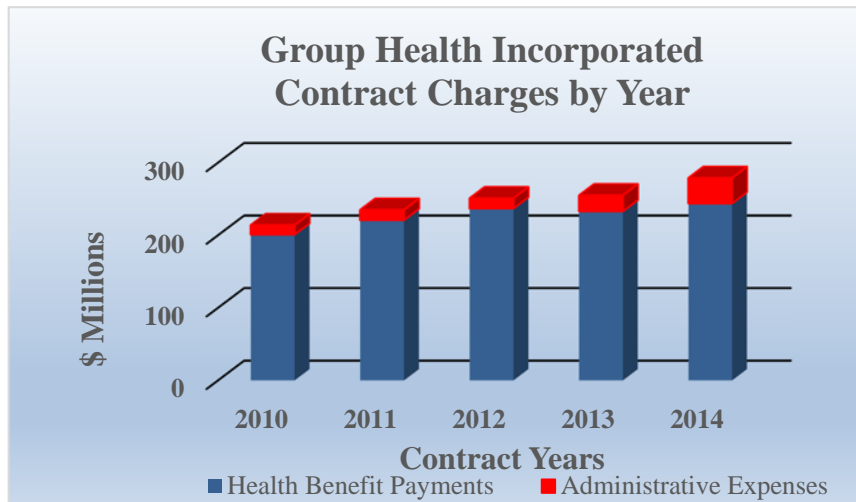
Fraud and Abuse Program

- To determine whether the Plan's communication and reporting of fraud and abuse cases were in compliance with the terms of Contract CS 1056 and the applicable FEHBP Carrier Letters.

SCOPE

We conducted our limited scope performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient and 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.

We reviewed GHI's Annual Accounting Statements pertaining to Plan code 80 for contract years 2010 through 2014. During this period, GHI processed approximately \$1.1 billion in FEHBP health benefit payments and charged the FEHBP \$97 million in administrative expenses for this Plan code.



Specifically, we reviewed miscellaneous health benefit payments and credits (e.g., refunds, subrogation recoveries, pharmacy and medical drug rebates, and program integrity recoveries), administrative expenses, and cash management activities from 2010 through 2014. We also reviewed the Plan's Fraud and Abuse (F&A) Program activities and practices for 2014 through March 31, 2015. Due to concerns with the Plan's medical drug rebates and working capital funds, we expanded our audit scope for these items to also include the period January 1, 2015 through September 30, 2015.

In planning and conducting our audit, we obtained an understanding of the Plan's internal control structure to help determine the nature, timing, and extent of our auditing procedures. This was determined to be the most effective approach to select areas of audit. For those areas selected, we primarily relied on substantive tests of transactions and not tests of controls. Based on our testing, we did not identify any significant matters involving the Plan's internal control structure and its operations. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the Plan had complied with the contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations (FAR) and Federal Employees Health Benefits Acquisition Regulations (FEHBAR), as appropriate), and the laws and regulations governing the FEHBP. The results of our tests indicate that, with respect to the items tested, the Plan did not comply with all provisions of the contract and federal procurement

regulations. Exceptions noted in the areas reviewed are set forth in detail in the "Audit Findings and Recommendations" section of this audit report. With respect to the items not tested, nothing came to our attention that caused us to believe that the Plan had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the Plan. Due to time constraints, we did not verify the reliability of the data generated by the various systems involved. However, while utilizing the computer-generated data during our audit, nothing came to our attention to cause us to doubt its reliability. We believe that the data available was sufficient to achieve our audit objectives.

The audit was performed at the Plan's office in New York, New York on various dates from August 3, 2015 through October 22, 2015. Audit fieldwork was also performed at our office in Jacksonville, Florida through December 2015.

METHODOLOGY

We obtained an understanding of the internal controls over the Plan's financial, cost accounting, and cash management systems by inquiry of Plan officials.

We interviewed Plan personnel and reviewed the Plan's policies, procedures, and accounting records during our audit of miscellaneous health benefit payments and credits. For the period 2010 through 2014, we also judgmentally selected and reviewed the following FEHBP items:

- All [REDACTED] pharmacy drug rebate amounts, totaling \$ [REDACTED].
- 50 high dollar provider offsets, totaling \$2,101,530, and 41 high dollar health benefit refund cash receipts, totaling \$1,436,358. We selected these 91 sample items, totaling \$3,537,888, from a universe of [REDACTED] refund cash receipts and provider offsets, totaling \$ [REDACTED]. We judgmentally selected all refund cash receipt and provider offset amounts of \$15,000 or more.
- All [REDACTED] program integrity recovery amounts, totaling \$ [REDACTED].
- 32 subrogation recoveries, totaling \$174,568, from a universe of [REDACTED] subrogation recoveries, totaling \$ [REDACTED]. We selected a statistical sample of subrogation recoveries from a stratification of \$500 or more.
- All [REDACTED] medical drug rebate amounts, totaling \$ [REDACTED].

- All [REDACTED] medical drug settlement amounts, totaling \$ [REDACTED] in net credits.
- All [REDACTED] hospital settlement amounts, totaling \$ [REDACTED] in payments (charges to the FEHBP).

We reviewed these samples to determine if health benefit refunds and recoveries and pharmacy and medical drug rebates were timely returned to the FEHBP and if miscellaneous payments were properly charged to the FEHBP. The results of these samples were not projected to the universe of miscellaneous health benefit payments and credits. Due to concerns with medical drug rebates, we expanded our audit scope and also reviewed all FEHBP medical drug rebate amounts, totaling \$ [REDACTED], that were received by the Plan during the period January 2015 through September 2015.

We judgmentally reviewed administrative expenses charged to the FEHBP for contract years 2010 through 2014. Specifically, we reviewed administrative expenses relating to pension, the Behavioral Management Program (BMP), and the Plan's International Classification of Diseases 10 (ICD-10) implementation phase.² We also reviewed administrative expenses relating to patient protection and the Affordable Care Act that were allocated and charged to the FEHBP (i.e., health insurance provider, transitional reinsurance, and "Patient-Centered Outcomes Research Institute" fees). We used the FEHBP contract, the FAR, the FEHBAR, and the Affordable Care Act (Public Law 111-148) to determine the allowability, allocability, and reasonableness of charges.

We reviewed the Plan's cash management activities and practices to determine whether the Plan handled FEHBP funds in accordance with Contract CS 1056 and applicable laws and regulations. Specifically, we reviewed the Plan's letter of credit account (LOCA) drawdowns and interest income transactions from 2010 through 2014, the Plan's working capital calculations, adjustments and/or balances from 2010 through September 30, 2015, as well as the Plan's dedicated FEHBP investment account activity from 2010 through 2014 and balance as of December 31, 2014.

We also interviewed the Plan's Special Investigations Unit regarding the effectiveness of the F&A Program, as well as reviewed the Plan's communication and reporting of fraud and abuse cases to test compliance with Contract CS 1056 and the applicable FEHBP Carrier Letters.

² We judgmentally selected and reviewed 10 months of BMP fees, totaling \$1,202,312 in charges to the FEHBP (from a universe of 60 months of BMP fees, totaling \$ [REDACTED] in charges to the FEHBP, from 2010 through 2014). For ICD-10 implementation, we judgmentally selected and reviewed a sample of 7 high dollar project cost amounts, totaling \$19,448,485 (from a universe of [REDACTED] project cost amounts, totaling \$ [REDACTED], in 2013 and 2014), that were allocated and charged to all applicable participating groups, including the FEHBP. The results of these samples were not projected to the applicable universes of BMP and ICD-10 charges.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

1. Medical Drug Rebates

\$164,697

Our audit determined that the Plan had not returned medical drug rebates, totaling \$161,176, to the FEHBP. As a result of this audit finding, the Plan returned \$164,697 to the FEHBP, consisting of \$161,176 for the questioned medical drug rebates and \$3,521 for applicable lost investment income (LII).

48 CFR 31.201-5 states, “The applicable portion of any income, rebate, allowance, or other credit relating to any allowable cost and received by or accruing to the contractor shall be credited to the Government either as a cost reduction or by cash refund.”

Contract CS 1056, Part II, Section 2.3 (i) states, “All health benefit refunds and recoveries . . . must be deposited into the working capital or investment account within 30 days and returned to or accounted for in the FEHBP letter of credit account within 60 days after receipt by the Carrier.”

FAR 52.232-17(a) states, “all amounts that become payable by the Contractor . . . shall bear simple interest from the date due . . . The interest rate shall be the interest rate established by the Secretary of the Treasury as provided in 41 U.S.C. 7109, which is applicable to the period in which the amount becomes due, as provided in paragraph (e) of this clause, and then at the rate applicable for each six-month period as fixed by the Secretary until the amount is paid.”

The Plan participates in medical drug rebate programs with various drug manufacturers. The drug rebates are determined based on medical claims for the applicable drugs, which are primarily administered in a physician’s office. These medical drug rebates are received multiple times a year (usually on a monthly basis) by the Plan and credited to the participating groups, including the FEHBP. Prior to November 2013, the medical drug rebates were combined with the pharmacy drug rebates and then allocated and returned to the FEHBP. Starting in November 2013, the Plan separated the invoicing of pharmacy and medical drug rebates. However, the invoices did not include a specific category code for the FEHBP’s share of the medical drug rebates. As a result, we determined that the Plan inadvertently had not allocated medical drug rebates to the FEHBP for the period November 2013 through December 2014.

For this period, the Plan received [REDACTED] medical drug rebate amounts, totaling \$ [REDACTED], for all participating groups. As a result of our audit, the Plan determined that \$90,709 of these medical drug rebate amounts should have been allocated and returned to the FEHBP, but inadvertently had not been. We reviewed and accepted the Plan's analysis for these medical drug rebate amounts for November 2013 through December 2014.

Due to this oversight by the Plan, we expanded our audit scope to also include the medical drug rebates that were received by the Plan during the period January 2015 through September 2015. For this period, the Plan identified [REDACTED] additional medical drug rebate amounts, totaling \$ [REDACTED], that should have been allocated and returned to the FEHBP, but inadvertently had not been (as of November 30, 2015).

Our audit identified unreturned medical drug rebates, totaling \$161,176, which the Plan then returned, along with LII of \$3,521, to the FEHBP.

In total, we are questioning \$161,176 (\$90,709 plus \$70,467) for medical drug rebates that had not been returned to the FEHBP for the period November 2013 through September 2015. We are also questioning \$3,521 for applicable LII calculated on these medical drug rebates that were returned untimely to the FEHBP.

Plan Response:

The Plan agrees with this finding.

OIG Comment:

We verified that the Plan returned \$164,697 to the FEHBP (via multiple LOCA drawdown adjustments in November and December 2015), consisting of \$161,176 for the questioned medical drug rebates and \$3,521 for applicable LII. In additional comments provided by the Plan on February 2, 2016 (via email), the Plan informed us that corrective actions have also been implemented to ensure that medical drug rebates are timely allocated and returned to the FEHBP.

Recommendation 1

We recommend that the contracting officer require the Plan to return \$161,176 to the FEHBP for the questioned medical drug rebates. However, since we verified that the Plan returned \$161,176 to the FEHBP for these questioned medical drug rebates, no further action is required for this amount.

Recommendation 2

We recommend that the contracting officer require the Plan to return \$3,521 to the FEHBP for LII on the questioned medical drug rebates. However, since we verified that the Plan returned the questioned LII to the FEHBP, no further action is required for this LII amount.

2. Program Integrity Recoveries **\$76,502**

Our audit determined the Plan had not returned program integrity recoveries, totaling \$73,613, to the FEHBP as of December 31, 2014. As a result of this audit finding, the Plan returned \$76,502 to the FEHBP on November 30, 2015, consisting of \$73,613 for the questioned program integrity recoveries and \$2,889 for applicable LII on these recoveries.

As previously cited from Contract CS 1056, all health benefit refunds and recoveries must be deposited into the FEHBP investment account within 30 days and returned to the FEHBP within 60 days after receipt by the Carrier.

As previously cited from FAR 52.232-17(a), all amounts that become payable by the Carrier should include simple interest from the date due.

The Plan allocates and returns program integrity recoveries (fraud recoveries) to the FEHBP on a yearly basis. From 2010 through 2014, the Plan received [REDACTED] program integrity recovery amounts, totaling \$ [REDACTED], for all participating groups, including the FEHBP. The Plan allocated \$193,662 of these program integrity recoveries to the FEHBP. We reviewed all of these program integrity recovery amounts for the purpose of determining if the Plan properly allocated and timely returned the applicable recovery amounts to the FEHBP. We verified the Plan returned program integrity recoveries, totaling \$120,049, to the FEHBP for 2010 through 2012. However, as a result of our audit, the Plan self-disclosed that \$73,613 of the program integrity recoveries for 2013 and 2014 had not been returned to the FEHBP.

In total, we are questioning \$73,613 for program integrity recoveries that had not been returned to the FEHBP as of December 31, 2014, as well as \$2,889 for LII calculated on these recoveries that were subsequently returned untimely to the FEHBP.

Plan Response:

The Plan agrees with this finding.

OIG Comment:

We verified that the Plan returned \$76,502 to the FEHBP on November 30, 2015, consisting of \$73,613 for the questioned program integrity recoveries and \$2,889 for applicable LII.

Recommendation 3

We recommend that the contracting officer require the Plan to return \$73,613 to the FEHBP for the questioned program integrity recoveries. However, since we verified that the Plan returned \$73,613 to the FEHBP for these questioned program integrity recoveries, no further action is required for this amount.

Recommendation 4

We recommend that the contracting officer require the Plan to return \$2,889 to the FEHBP for LII on the questioned program integrity recoveries. However, since we verified that the Plan returned the questioned LII to the FEHBP, no further action is required for this LII amount.

3. Health Benefit Refunds and Recoveries \$61,610

During the audit scope, the Plan untimely returned provider offsets of \$2,166,774, health benefit refunds of \$312,539, and subrogation recoveries of \$110,318 to the FEHBP. Since the Plan returned these funds to the FEHBP during the audit scope and prior to receiving our audit notification letter, we did not question these amounts as a monetary finding. However, we are questioning LII of \$61,610 since these funds were returned untimely to the FEHBP. As a result of this finding, the Plan returned this questioned LII to the FEHBP on December 29, 2015.

As previously cited from Contract CS 1056, all health benefit refunds and recoveries must be deposited into the FEHBP investment account within 30 days and returned to the FEHBP within 60 days after receipt by the Carrier.

As previously cited from FAR 52.232-17(a), all amounts that become payable by the Carrier should include simple interest from the date due.

The following summarizes our reviews for health benefit refunds, provider offsets, and subrogation recoveries:

Health Benefit Refunds and Provider Offsets

For the period 2010 through 2014, there were [REDACTED] health benefit refund receipts and provider offsets, totaling \$ [REDACTED], for the FEHBP. From this universe, we selected and reviewed a judgmental sample of 41 health benefit refunds, totaling \$1,436,358, and 50 provider offsets, totaling \$2,101,530, for the purpose of determining if the Plan timely returned or credited these refunds and provider offsets to the FEHBP. Our sample included all health benefit refunds and provider offsets of \$15,000 or more.

Our review determined the following:

- The Plan self-disclosed that \$2,166,774 in provider offsets for 2010 through 2012 were returned untimely to the FEHBP. Since the Plan returned these funds to the FEHBP during the audit scope and prior to receiving our audit notification letter, we did not question this principal amount as a monetary finding. However, the FEHBP is due LII of \$58,574 on these provider offsets since the funds were returned untimely to the FEHBP. As a result of this finding, the Plan returned the questioned LII of \$58,574 to the FEHBP on December 29, 2015.
- The Plan returned health benefit refunds, totaling \$312,539, untimely to the FEHBP during the audit scope. Specifically, we noted that the Plan deposited these refunds into the dedicated FEHBP investment account from 6 to 164 days late. Since the Plan returned these funds to the FEHBP during the audit scope and prior to receiving our audit notification letter, we did not question this principal amount as a monetary finding. However, the FEHBP is due LII of \$2,245 on these refunds since the funds were returned untimely to the FEHBP. As a result of this finding, the Plan returned the questioned LII of \$2,245 to the FEHBP on December 29, 2015.

Subrogation Recoveries

For the period 2010 through 2014, there were [REDACTED] subrogation recoveries, totaling \$ [REDACTED], for the FEHBP. We selected a statistical sample of 32 subrogation recoveries, totaling \$174,568, for the purpose of determining if the Plan timely returned these recoveries to the FEHBP. Our statistical sample included subrogation recoveries from a recovery stratification of \$500 or more.

Based on our review, we determined that the Plan returned 12 subrogation recoveries, totaling \$110,318, untimely to the FEHBP during the audit scope. Specifically, we noted that the Plan deposited these subrogation recoveries into the dedicated FEHBP investment account from 1 to 144 days late. Since the Plan returned these funds to the

FEHBP during the audit scope and prior to receiving our audit notification letter, we did not question this principal amount as a monetary finding. However, the FEHBP is due LII of \$791 on these recoveries since the funds were returned untimely to the FEHBP. As a result of this finding, the Plan returned the questioned LII of \$791 to the FEHBP on December 29, 2015. (Note: Due to the immateriality of the questioned LII for the sample and since there were no questioned principal amounts, we did not project the results and/or potential LII to the universe of subrogation recoveries.)

Summary of Questioned Amounts

In total, we are questioning \$61,610 (\$58,574 plus \$2,245 plus \$791) for applicable LII on the provider offsets, health benefit refunds, and subrogation recoveries that were returned untimely to the FEHBP.

Plan Response:

The Plan agrees with this finding.

OIG Comment:

We verified that the Plan returned \$61,610 to the FEHBP on December 29, 2015 for the questioned LII.

Recommendation 5

We recommend that the contracting officer require the Plan to return \$61,610 to the FEHBP for the questioned LII on provider offsets, health benefit refunds, and subrogation recoveries that were returned untimely to the FEHBP during the audit scope. However, since we verified that the Plan returned the questioned LII to the FEHBP, no further action is required for this LII amount.

4. Pharmacy Drug Rebates \$35,063

Our audit determined that the Plan returned 54 pharmacy drug rebate amounts, totaling \$18,477,391, untimely to the FEHBP during the audit scope. Since the Plan returned these pharmacy drug rebates to the FEHBP during the audit scope and prior to receiving our audit notification letter, we did not question this amount as a monetary finding. However, we are questioning LII of \$39,827 on these pharmacy drug rebates since the funds were returned untimely to the FEHBP. We also determined that the Plan returned an excess amount of pharmacy drug rebates, totaling \$4,764, to the FEHBP during the

audit scope. As a result of this audit finding, the Plan returned the net questioned amount of \$35,063 to the FEHBP on December 29, 2015.

As previously cited from Contract CS 1056, all health benefit refunds and recoveries must be deposited into the FEHBP investment account within 30 days and returned to the FEHBP within 60 days after receipt by the Carrier.

As previously cited from FAR 52.232-17(a), all amounts that become payable by the Carrier should include simple interest from the date due.

The Plan participates in pharmacy drug rebate programs with various drug manufacturers. These drug rebates are usually received on a monthly basis by the Plan and credited to the participating groups, including the FEHBP. From 2010 through 2014, the Plan received [REDACTED] pharmacy drug rebate amounts, totaling \$[REDACTED], for all participating groups. The Plan allocated \$22,190,826 of these pharmacy drug rebate amounts to the FEHBP. We selected and reviewed all of the FEHBP pharmacy drug rebate amounts to specifically determine if the Plan properly allocated and timely returned these rebate amounts to the FEHBP.

We determined that the Plan untimely deposited 54 pharmacy drug rebate amounts, totaling \$18,477,391, into the FEHBP investment account (i.e., from 2 to 329 days late) during the audit scope. Since the Plan returned these pharmacy drug rebates to the FEHBP during the audit scope and prior to receiving our audit notification letter, we did not question this amount as a monetary finding. However, we calculated that the FEHBP is due LII of \$39,827 on these pharmacy drug rebate amounts that were returned untimely to the FEHBP.

For the period 2010 through 2014, we also determined that the Plan inadvertently returned \$22,195,590 to the FEHBP for pharmacy drug rebates instead of \$22,190,826, resulting in an excess amount of \$4,764 (\$22,195,590 minus \$22,190,826) returned to the FEHBP. In total, we are questioning \$35,063 (net) for this audit finding, consisting of \$39,827 for LII on pharmacy drug rebates returned untimely to the FEHBP minus \$4,764 for the excess pharmacy drug rebate amount returned to the FEHBP.

Plan Response:

The Plan agrees with this finding.

OIG Comment:

We verified that the Plan returned \$35,063 (net) to the FEHBP on December 29, 2015, consisting of \$39,827 for the questioned LII on pharmacy drug rebates returned untimely to the FEHBP minus \$4,764 for the excess pharmacy drug rebate amount inadvertently returned to the FEHBP.

Recommendation 6

We recommend that the contracting officer require the Plan to return \$39,827 to the FEHBP for the questioned LII on pharmacy drug rebates that were returned untimely to the FEHBP during the audit scope. However, since we verified that the Plan returned the questioned LII to the FEHBP, no further action is required for this LII amount.

Recommendation 7

We recommend that the contracting officer allow the Plan to recover \$4,764 from the LOCA for an excess pharmacy drug rebate amount inadvertently returned to the FEHBP. However, since we verified that the Plan already recovered this excess amount from the LOCA, no further action is required for this amount.

B. ADMINISTRATIVE EXPENSES

1. Affordable Care Act Fees - Excess Drawdowns \$252,482

Our audit determined the Plan withdrew \$249,133 from LOCA in excess of the FEHBP's actual amounts for the transitional reinsurance (TR) and health insurance provider (HIP) fees in 2014. As a result of this finding, the Plan returned \$252,482 to the FEHBP, consisting of \$249,133 for the excess drawdown amounts and \$3,349 for applicable LII.

Contract CS 1056, Part III, section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable."

As previously cited from FAR 52.232-17(a), all amounts that become payable by the Carrier should include simple interest from the date due.

Transitional Reinsurance Fee

Section 1341 of the Affordable Care Act (ACA) provides for a transitional reinsurance program in each State from 2014 through 2016. The reinsurance program imposes an

annual fee on health insurers designed to reduce the costs of high-risk enrollees and reduce premiums for enrollees in the individual market. This yearly fee is based on each health insurer's enrollment count. Starting in 2014, the Department of Health and Human Services (HHS) collects these contributions annually from all health insurance issuers and self-insured group health plans. The ACA required a collection of reinsurance contributions of \$12 billion for 2014. Emblem Health's (GHI's parent company) share of this TR fee totaled \$28,624,575 for 2014. Of this TR fee amount, the Plan allocated \$1,974,910 to the FEHBP.

In 2014, the Plan overcharged the FEHBP \$130,643 for the ACA transitional reinsurance fee.

We determined that the Plan calculated the FEHBP's share of this fee correctly by multiplying the FEHB plan's annualized average enrollment from January 2014 through September 2014 by the national contribution rate of \$63 (as established by HHS). However, we also determined that the Plan inadvertently withdrew \$2,105,553 from the LOCA for the TR fee amount, instead of the FEHBP's actual allocation amount of \$1,974,910, resulting in an overcharge of \$130,643 (\$2,105,553 minus \$1,974,910) to the FEHBP.

Health Insurance Provider Fee

Section 9010 of the ACA imposes an annual fee on health insurers for the purpose of funding the health insurance exchange subsidies. This yearly fee is based on each health insurer's share of net premiums written. The Internal Revenue Service calculates the health insurer fee based on a ratio of the health insurer's net premiums written to the total net premiums written by all health insurance providers (i.e., industry premiums). The ACA required all health insurance providers to collectively contribute \$8 billion in HIP fees for 2014. Emblem Health's share of these HIP fees totaled \$ [REDACTED] for 2014. The Plan allocated \$4,736,468 of this amount to the FEHBP.

In 2014, the Plan overcharged the FEHBP \$118,490 for the ACA health insurance provider fee.

We determined that the Plan calculated the FEHBP's share of this fee correctly by multiplying the FEHB plan's net premium income by the Plan's gross fee percentage. However, we also determined that the Plan inadvertently withdrew \$4,854,958 from the LOCA for the HIP fee amount, instead of the FEHBP's actual allocation amount of \$4,736,468, resulting in an overcharge of \$118,490 (\$4,854,958 minus \$4,736,468) to the FEHBP.

Summary of Questioned Amounts

In total, we are questioning \$252,482, consisting of \$249,133 for excess LOCA drawdowns (overcharges of \$130,643 for the TR fee and \$118,490 for the HIP fee) and \$3,349 for applicable LII calculated on these excess drawdowns.

Plan Response:

The Plan agrees with this finding.

OIG Comment:

We verified that the Plan returned \$252,482 to the FEHBP on November 30, 2015, consisting of \$249,133 (\$130,643 plus \$118,490) for the TR and HIP fee overcharges and \$3,349 for applicable LII.

Recommendation 8

We recommend that the contracting officer require the Plan to return \$249,133 to the FEHBP for the questioned TR and HIP fee overcharges. However, since we verified that the Plan returned \$249,133 to the FEHBP for these overcharges, no further action is required for this questioned amount.

Recommendation 9

We recommend that the contracting officer require the Plan to return \$3,349 to the FEHBP for LII on the questioned TR and HIP fee overcharges. However, since we verified that the Plan returned the questioned LII to the FEHBP, no further action is required for this LII amount.

C. CASH MANAGEMENT

1. Excess Working Capital Deposit **\$3,487,040**

As of September 30, 2015, the Plan held a working capital (WC) deposit of \$3,487,040 over the amount needed to meet the Plan's daily cash needs for FEHBP claim payments. As a result of our audit, the Plan returned \$3,487,040 to the FEHBP for the excess WC deposit.

OPM’s “Letter of Credit System Guidelines” (Guidelines), dated May 2009, state: “Carriers should maintain a working capital balance equivalent to an average of 2 days of paid claims. The working capital fund should be established using federal funds. Carriers are required to monitor their working capital funds on a monthly basis and adjust if necessary on a quarterly basis. The interest earned on the working capital funds must be credited to the FEHBP at least on a monthly basis. The working capital is not required but strongly recommended.” Also, based on the Guidelines, the Carrier’s WC calculation must exclude electronic fund transfers (EFTs).

The regulations governing the financing of Federal programs by the letter of credit method, as established in 31 CFR 205 (Treasury Department Circular No. 10750), also state that EFTs should not be included in the WC calculation. These instructions are established under the provisions of Treasury Department Circular No. 1083 (Regulations Governing the Utilization of the U.S. TFCS), 5 CFR Part 890, and 48 CFR Chapter 16.

Based on industry practice (e.g., other FEHBP experience-rated Carriers), the WC deposit should be recalculated on a regular basis to determine if the amount currently maintained is adequate to meet the Plan’s daily cash needs for FEHBP claim payments. If the WC deposit is not adequate (either over or underfunded), the Plan should make an appropriate adjustment.

The Plan reviewed the WC deposit on a regular basis (usually monthly) during the period January 2010 through September 2015.³ We noted that the Plan increased the WC deposit amount in March 2011 after receiving approval from OPM’s contracting officer. When reviewing the Plan’s WC calculation, we determined that the Plan inappropriately included EFTs in the calculation. As of September 30, 2015, the Plan held a WC deposit amount of \$ [REDACTED] in the dedicated FEHBP investment account.

The Plan held an excess WC deposit of \$3,487,040 in the dedicated FEHBP investment account as of September 30, 2015.

To determine if the Plan maintained an appropriate WC deposit amount, we recalculated what the Plan’s WC deposit should be and determined that, as of September 30, 2015, the Plan should have only maintained a WC deposit of \$ [REDACTED]. Our calculation excluded EFTs. Therefore, we determined that, as of September 30, 2015, the Plan held a WC deposit with \$3,487,040 (\$ [REDACTED] minus \$ [REDACTED]) over the amount actually needed to meet the Plan’s daily cash needs for FEHBP claim payments. Since the Plan maintained these excess WC funds in the dedicated FEHBP investment account, LII is not applicable for this finding.

³ Although the scope for the Plan’s cash management activities and practices initially only included 2010 through 2014, we expanded the scope for the WC deposit to also include the period January 2015 through September 2015.

Plan Response:

The Plan agrees with this finding.

OIG Comment:

We verified that the Plan returned the excess WC deposit of \$3,487,040 to the FEHBP in November 2015.

Recommendation 10

We recommend that the contracting officer require the Plan to return \$3,487,040 to the FEHBP for the excess WC deposit. However, since we verified that the Plan returned \$3,487,040 to the FEHBP for the excess WC deposit, no further action is required for this questioned amount.

Recommendation 11

We recommend that the Plan implement corrective actions to ensure that the WC deposit is properly calculated in accordance with the Guidelines and applicable regulations. The Plan should monitor and recalculate the WC deposit on a monthly basis and adjust at least on a quarterly basis (if necessary).

Recommendation 12

We recommend that the contracting officer update the Annual Accounting Statement for the experience-rated HMO's and Employee Organization plans to include a specific worksheet for the WC balances and adjustments.

D. FRAUD AND ABUSE PROGRAM

1. Special Investigations Unit

Procedural

The Plan is not in compliance with the communication and reporting requirements for fraud and abuse cases that are set forth in the FEHBP Carrier Letter (CL) 2011-13 and CL 2014-29. Specifically, the Plan did not report, or did not timely report, all fraud and abuse cases to the OIG. Without awareness of these existing potential fraud and abuse issues, the OIG cannot investigate the broader impact of these potential issues on the FEHBP as a whole.

CL 2011-13 (Mandatory Information Sharing via Written Case Notifications to OPM’s Office of the Inspector General), dated June 17, 2011, states that all FEHBP Carriers “are required to submit a written notification to the OPM OIG ... within 30 working days of becoming aware of a fraud, waste or abuse issue where there is a reasonable suspicion that a fraud has occurred or is occurring against the Federal Employees Health Benefits (FEHB) Program.” There is no dollar threshold for this requirement.

CL 2014-29 (Federal Employees Health Benefits Fraud, Waste and Abuse), dated December 19, 2014, states that all FEHBP Carriers “are required to submit a written notification to OPM-OIG within 30 working days when there is a potential reportable FWA that has occurred against the FEHB Program. OPM-OIG considers a potential reportable FWA to have occurred when, after a preliminary review of the complaint, the carrier takes an affirmative step to investigate the complaint. . . . There is no financial threshold for these case notifications.”⁴

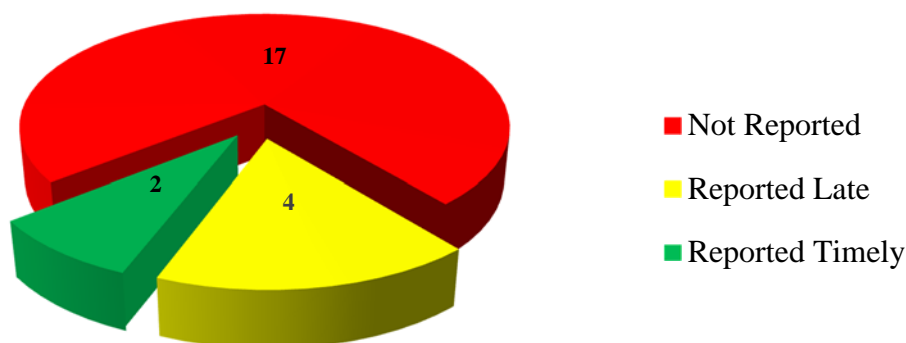
During the period January 1, 2014 through March 31, 2015, the Plan opened [REDACTED] fraud and abuse cases. Of these, the Plan identified 23 cases with potential FEHBP exposure. We reviewed these 23 cases with FEHBP exposure to determine if the cases were reported to the OIG as required by CLs 2011-13 and 2014-29. Based on our review, we determined that notifications for only 6 of these 23 fraud and abuse cases with FEHBP exposure were sent to the OIG. Because all of these cases have FEHBP exposure, and there is no financial threshold for reporting suspected fraud against the FEHBP, all of these 23 cases should have been reported to the OIG as required by CLs 2011-13 and 2014-29.

CLs 2011-13 and 2014-29 require the Plan to submit written notification to the OIG within 30 days of relevant FEHBP fraud activity. However, of the 23 cases with FEHBP exposure during the period January 1, 2014 through March 31, 2015, we determined that 2 cases (9 percent) were reported timely to the OIG, 4 cases (17 percent) were reported untimely to the OIG, and 17 cases (74 percent) were not reported to the OIG. We noted that the 17 cases not reported to the OIG were all opened by the Plan in 2014; whereas, the 6 cases reported to the OIG were all opened by the Plan during the period January 1, 2015 through March 31, 2015.

The Plan did not report, or did not timely report, all fraud and abuse cases to the OIG.

⁴ CL 2014-29 consolidates and updates the information from CLs 2003-23, 2003-25, 2007-12, and 2011-13, which are superseded by this guidance. CL 2014-29 also supplements guidance from the contract (Section 1.9 – Plan Performance).

Cases Opened with FEHBP Exposure (as Identified by the Plan)



Ultimately, the Plan’s untimely communicating or not reporting of potential FEHBP cases to the OIG has resulted in a failure to meet the communication and reporting requirements that are set forth in CLs 2011-13 and 2014-29. The lack of notifications and/or untimely case notifications did not allow the OIG to investigate whether other FEHBP Carriers are exposed to the identified provider committing fraud against the FEHBP. This also does not allow the OIG’s Administrative Sanctions Group to be notified timely. As a result, this non-compliance by the Plan may result in additional improper payments being made by other FEHBP Carriers.

Plan Response:

In the draft report response, the Plan did not address this procedural finding beyond stating their disagreement.

In additional comments provided by the Plan on February 2, 2016 (via email), the Plan disagreed with this finding and stated that the SIU “did not fail the 2014 reporting requirements as per the guidance instructions that were in force at the time the cases were opened. . . . Until December 19, 2014, we had determined that none of the cases opened in 2014 met the reporting guidelines of CL 2011-13 . . . Additionally, there were no instructions given to amend the prior reports in CL 2014-29. In 2015, the SIU has taken corrective measures to ensure that SIU is in compliance with the requirements of CL 2014-29. We have educated the investigative staff and amended our case set-up protocols.”

OIG Comment:

Of the 17 cases opened by the Plan in 2014 with potential FEHBP exposure, we noted that none were reported to the OIG. Since there is no financial threshold for reporting suspected fraud against the FEHBP, all of these cases should have been reported to the OIG as required by CL 2011-13. Of the six cases opened by the Plan from January 2015 through March 2015 with potential FEHBP exposure, we noted that four of these cases were not reported timely to the OIG as required by CL 2014-29. Therefore, the Plan did not comply with the communication and reporting requirements for fraud and abuse cases that are contained in CLs 2011-13 and 2014-29.

Recommendation 13

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation ensuring that the Plan has implemented the necessary procedural changes to meet the communication and reporting requirements of fraud and abuse cases that are contained in CL 2014-29.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

██████████, Auditor-In-Charge

██████████, Auditor

██████████, Auditor

██████████, Auditor

██████████, Chief ██████████

██████████, Senior Team Leader

V. SCHEDULE A

GROUP HEALTH INCORPORATED
 PLAN CODE 80
 NEW YORK, NEW YORK
 QUESTIONED CHARGES

AUDIT FINDINGS	2010	2011	2012	2013	2014	2015	TOTAL
A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS							
1. Medical Drug Rebates*	\$0	\$0	\$0	\$1,563	\$91,965	\$71,169	\$164,697
2. Program Integrity Recoveries*	0	0	0	35,501	41,001	0	76,502
3. Health Benefit Refunds and Recoveries*	26,363	28,066	7,181	0	0	0	61,610
4. Pharmacy Drug Rebates*	14,204	13,120	7,274	1,001	(536)	0	35,063
TOTAL MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS	\$40,567	\$41,186	\$14,455	\$38,065	\$132,430	\$71,169	\$337,872
B. ADMINISTRATIVE EXPENSES							
1. Affordable Care Act Fees - Excess Drawdowns*	\$0	\$0	\$0	\$0	\$252,482	\$0	\$252,482
TOTAL ADMINISTRATIVE EXPENSES	\$0	\$0	\$0	\$0	\$252,482	\$0	\$252,482
C. CASH MANAGEMENT							
1. Excess Working Capital Deposit	\$0	\$0	\$0	\$0	\$0	\$3,487,040	\$3,487,040
TOTAL CASH MANAGEMENT	\$0	\$0	\$0	\$0	\$0	\$3,487,040	\$3,487,040
D. FRAUD AND ABUSE PROGRAM							
1. Special Investigations Unit (Procedural)	\$0	\$0	\$0	\$0	\$0	\$0	\$0
TOTAL FRAUD AND ABUSE PROGRAM	\$0	\$0	\$0	\$0	\$0	\$0	\$0
TOTAL QUESTIONED CHARGES	\$40,567	\$41,186	\$14,455	\$38,065	\$384,912	\$3,558,209	\$4,077,394

* We included lost investment income (LII) within audit findings A1 (\$3,521), A2 (\$2,889), A3 (\$61,610), A4 (\$39,827), and B1 (\$3,349). Therefore, no additional LII is applicable for these findings.



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

February 1, 2016

[REDACTED]
Group Chief, Experience-Rated Audit Group
Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, Room 6400
Washington, DC 20415-1100

Re: Response to Report 1D-80-00-15-044

Dear [REDACTED]:

Enclosed is Group Health Incorporated's ("The Plan") response to the Draft Audit Report that was released on December 22, 2015. The report contains eight findings and or recommendations including one procedural finding. We have responded to each finding.

With respect to the \$4,077,394 in charges to the Plan as identified in the audit report, the following is a summary of the findings and our response.

1. The Plan agrees with the finding that \$161,176 of medical drug rebates were not returned to FEHBP as of September 30, 2015. The audit scope was expanded to September 30, 2015 to include medical drug rebates that were received by the Plan from January 2015 through September 2015. The Plan returned the \$90,709 on November 30, 2015, including \$3,002 of lost investment income, and \$70,467 including \$519 of lost investment income on December 18, 2015. The total amount of the finding was \$164,697.
2. The Plan agrees with the finding that \$73,512 of program integrity credits (fraud recoveries) were not returned to FEHBP as of December 31, 2014. The Plan returned the funds on November 30, 2015, including lost investment income of \$2,889.
3. The Plan agrees with the finding that \$61,610 of lost investment income is due to FEHBP for years 2010-2014 relating to Health Benefit Refunds and Recoveries. Provider offsets of \$2,166,774 for year 2010-2012 were not returned timely, and health benefit cash refunds totaling \$312,539 and 12 subrogation recoveries totaling \$110,318 were not deposited timely to the dedicated FEHBP investment account. The Plan returned the funds on December 28, 2015.

4. The Plan agrees with the finding that \$39,827 of lost investment income is due to FEHBP for years 2010-2014. A total of \$18,477,391 of pharmacy drug rebates were not deposited timely into the dedicated FEHBP investment account. Excess pharmacy rebate amounts totaling \$4,764 previously returned to FEHBP were credited to the Plan resulting in a net balance due FEHBP. The Plan returned the funds on December 28, 2015.
5. The Plan agrees with the finding that withdrawals of \$130,643 from the LOCA were made in excess of the Transitional Reinsurance Fee amount for 2014. The Plan subsequently returned the funds plus lost investment income of \$1,756, on November 30, 2015.
6. The Plan agrees with the finding that withdrawals of \$118,490 from the LOCA were made in excess of the Health Insurance Providers Fee amount for 2014. The Plan subsequently returned the funds plus lost investment income of \$1,593 on November 30, 2015.
7. The Plan agrees with the finding that there were \$3,487,040 in excess funds deposited into the Working Capital Account. The excess funds were returned to FEHBP through several LOCA adjustments from November 10, 2015 through November 12, 2015. Since the funds were held in an interest bearing account and the interest earned was returned to FEHBP, no lost investment income is due.
8. The final item is a procedural finding relating to the Special Investigations Unit. The Plan disagrees with this finding.

As part of the attachments to this response you will find the backup to support the return of these funds to the LOCA. In addition, we have enclosed the bank statements for the WC account to confirm the money was moved to the LOCA.

It is our goal to be in compliance with the FEHBP contract at all times. Should you have any questions regarding this response to your audit report, please feel free to contact me or [REDACTED].

Sincerely,

George Babitsch
Senior Vice President, Underwriting and Account Management

cc: [REDACTED]



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