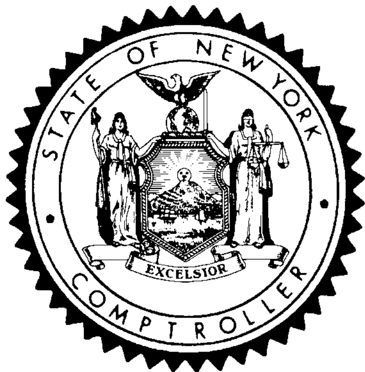
State of New York
Office of the State Comptroller
Division of Management Audit and State Financial Services

DEPARTMENT OF CIVIL SERVICE

NEW YORK STATE HEALTH INSURANCE PROGRAM ADMINISTRATION OF THE EMPIRE PLAN

REPORT 97-S-35



H. Carl McCall

Comptroller

State of New York
Office of the State Comptroller

Division of Management Audit and
State Financial Services

Report 97-S-35

Mr. George C. Sinnott
Commissioner
New York State Department of Civil Service
State Office Building Campus
Albany, NY 12239

Dear Mr. Sinnott:

The following is our report on the New York State Department of Civil Service relating to the administration of the Empire Plan component of the New York State Health Insurance Program.

We performed this audit according to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law. We list major contributors to this report in Appendix A.

Office of the State Comptroller
Division of Management Audit
and State Financial Services

February 8, 2000

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Executive Summary

Department of Civil Service
New York State Health Insurance Program
Administration of the Empire Plan

Scope of Audit

The Department of Civil Service (Department) is responsible for administering the New York State Health Insurance Program (NYSHIP), which provides hospital, medical, mental health/substance abuse and prescription drug coverage for active and retired employees and dependents of the State and local governments that elect to participate in the State program. The Empire Plan is NYSHIP's primary health insurance plan, with more than 800,000 enrollees and annual premiums of $1.7 billion. The Department's responsibilities include executing contracts with insurance companies to provide health insurance coverage, monitoring compliance with contracts, collecting insurance premiums from the State, participating agencies and enrollees, approving payments to the insurance carriers, maintaining enrollment, premium billing and accounting records, and providing health benefit information to enrollees. Within the Department, the Employee Benefits Division (Division) has day-to-day responsibility for NYSHIP.

In 1991, the Department and the Office of the State Comptroller (OSC) entered into an agreement to use dedicated OSC staff to provide comprehensive audit coverage of NYSHIP insurance companies. Under this arrangement, the Department and OSC agreed to coordinate their audit efforts, to ensure comprehensive audit coverage and to optimize savings to employers and enrollees.

Our audit of Department operations addressed the following questions for the period January 1, 1993 through November 13, 1998:

! Has the Division effectively administered the Empire Plan?

! Has the Department been effective in implementing an enrollment management system for the NYSHIP program?

Audit Observations and Conclusions

A longstanding agreement between the Department and OSC pertaining to audits of NYSHIP insurance carriers has not worked as intended. For this and for other reasons, there are significant opportunities to improve the administration of the Empire Plan to adequately protect the interests of the employers and enrollees whose premium payments fund the Empire Plan.

While not required to be bid, the original contracts for the hospitalization and medical services components of the Empire Plan were let without competitive bidding in 1959. The hospitalization contract has been renewed annually since. The medical services contract was renewed annually until

1986 when it was bid and has been renewed annually since. Subsequent to our audit period, the Department issued a Request for Proposals (RFP) for the Empire Plan's hospitalization contract and has begun to develop an RFP for the medical services contract as well. We found that the existing contracts for hospital and medical services themselves inhibit effective program administration, because of language that is unclear, incomplete and ambiguous regarding areas such as performance standards, access to records and conduct of audits of insurance carrier activities. We recommend that the Division bid the insurance contracts as soon as possible. (See pp. 5-7)

Since 1991, OSC has issued 27 audit reports of Empire Plan insurance carriers identifying $51.3 million in overpayments pertaining to insurance claims paid by the carriers. However, according to their reports, the insurance carriers have repaid only $8.5 million of the overpayments as of October 1998. An additional $19.3 million in overpayments is not recoverable. The low rate of recovery of audit findings is attributable to the fact that the existing arrangement between the Department and OSC has not worked as intended. The primary reason is that there has been disagreement and confusion regarding statistical sampling methodologies used by OSC in conducting audits of insurance carriers. Other factors also contributed to the low rate of recovery. Disagreements over audit findings have not been resolved, the Department has not actively pursued recovery of overpayments, and contract language is unclear concerning carrier responsibility for collecting overpayments. To remedy these matters, we recommend that the Department and OSC work together to amend the current agreement between the two agencies as part of a collective effort to improve the working relationship and increase the rate of recovery of overpayments identified by OSC audits. (See pp. 9-11)

There are deficiencies in the Division's own audits of insurance carriers. The Division's audit working papers lack summaries, documentation to support methodologies used, and appropriate cross-referencing. Also, we found that the Division is not issuing audit reports in timely fashion. Of 21 audit reports issued between April 1993 and January 1998, eleven were issued three or more years after the audit period. Further, we identified an instance where the Division did not document its decision to reduce an $8.8 million overpayment identified in an audit of MetLife to $1.3 million. We make recommendations to improve the Division's audit activities. (See pp. 11-15)

Comments of Department Officials

In their response to our draft report, Department officials stated that they agree with each of the recommendations made in the report and will continue to work to implement them. The Department's complete response is included as Appendix B to this report. We have prepared an Appendix C, containing State Comptroller's Notes, which addresses certain comments made by the Department in its response.

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Introduction

Background

The Department of Civil Service (Department) is responsible for managing and administering the New York State Health Insurance Program (NYSHIP). NYSHIP provides hospital, medical, mental health/substance abuse and prescription drug coverage for active and retired State employees and their dependents. In conjunction with the Department, the Governor's Office of Employee Relations negotiates the health benefits covered under NYSHIP with unions representing State employees, and the Division of the Budget approves the annual premium rates the Department pays the insurance companies. NYSHIP also provides health insurance coverage for local government agencies, such as counties, cities and school districts, that elect to participate in the program (participating agencies).
The Department's responsibilities include executing contracts with insurance companies to provide health insurance coverage, monitoring contractor compliance, collecting insurance premiums from the State, participating agencies and enrollees, approving premium payments to the insurance carriers, maintaining enrollment, premium billing and accounting records, and providing benefit information to enrollees. Within the Department, the Employee Benefits Division (Division) has day-to-day responsibility for NYSHIP. At the time of our audit, the Division had 139 staff organized into four units: Contract Management and Audit, Operations, Financial Management and Benefits Management.

The State, participating agencies and enrollees jointly pay the insurance premiums that fund NYSHIP. The Empire Plan is NYSHIP's primary health insurance plan. Active and retired State employees and their dependents may enroll in the Empire Plan or one of 27 Health Maintenance Organizations (HMOs) that are available geographically throughout the State. NYSHIP enrollees covered by local governments must enroll in the Empire Plan because the HMO option is not available for these individuals. Total premiums during calendar year 1997 for all NYSHIP insurance carriers were $2.0 billion, including $1.7 billion for the Empire Plan and $300 million for the HMOs. As of November 1998, total NYSHIP enrollment including spouses and dependents was 1.04 million people, including 845,322 in the Empire Plan and 199,277 in the HMOs.

During calendar year 1997, the Department approved premium payments of over $1.7 billion to the three insurance carriers that comprise the Empire Plan, as follows: Empire Blue Cross Blue Shield (Empire) provides hospitalization coverage, $566 million; Metropolitan Life Insurance Company (MetLife) provides medical and mental health/substance abuse coverage, $854 million; and CIGNA provides prescription drug coverage, $304 million. Subsequent to the completion of our fieldwork for this audit, the Department awarded new mental health and prescription drug contracts that were

effective January 1, 1999. Additionally, on July 29, 1999, subsequent to our audit period, the Department issued a Request for Proposals for the hospitalization contract.

In 1991, the Department and the Office of the State Comptroller (OSC) entered into an agreement to use dedicated OSC staff to provide comprehensive audit coverage of NYSHIP insurance companies. Under this arrangement, the Department and OSC agreed to coordinate their efforts to ensure comprehensive audit coverage and to optimize savings to employers and enrollees. The parties anticipated that with the increased audit resources and an aggressive response by the Department to hold the carriers accountable for properly administering the health insurance program, significant savings to the State would result.

Audit Scope, Objectives and Methodology

We audited the operations of the Department's Employee Benefits Division (Division) for the period January 1, 1993 through November 13, 1998. The objectives of our performance audit were to determine whether the Division is complying with State requirements to solicit competition for contracts, whether the audit arrangement between the Department and OSC has been effective, and whether the Division has been successful in developing and implementing automated systems necessary to properly administer the Empire Plan. To accomplish our objectives, we evaluated the Department's internal control framework, interviewed Department management, and reviewed and analyzed pertinent laws, contracts, records and reports. We also reviewed the Department's efforts to implement an enrollment management system.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess those operations of the Department that are within our audit scope. Further, these standards require that we understand the Department's internal control structure and its compliance with those laws, rules and regulations that are relevant to our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe that our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach when selecting activities to be audited. This approach focuses our audit efforts on those operations that we have identified through a preliminary survey as having the greatest probability of needing improvement. Consequently, by design, we used our finite audit resources to identify where and how improvements can be made. Thus, we devoted little audit effort to reviewing operations that may be relatively efficient and effective. As a result, our reports are prepared on an "exception basis."

This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

Response of Department Officials to Audit

We provided draft copies of this report to Department officials for their review and comment. Their comments have been considered in preparing this report and are included as Appendix B. Appendix C contains State Comptroller's Notes, which address matters contained in the Department's response.

In addition to the matters discussed in this report, we provided Department officials with detailed comments on other matters. Although these matters are of lesser significance, our recommendations relating to these matters should be implemented to improve operations.

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

Contract Administration

Contract premiums for the Empire Plan's hospitalization and medical services insurance contractors total about $1.3 billion annually. In contracting for such services, it is important to seek competition for a number of reasons. Competition is important for contracts of the magnitude of the Empire Plan hospitalization and medical services contracts because it helps to ensure best value for all parties. In addition, periodic solicitation of competition through bidding helps to ensure that contracts protect the interests of all parties and contain clear, complete and unambiguous language to promote administrative efficiency. While not required to obtain bids for these contracts, the original contracts for the hospitalization and medical services components of the Empire Plan were let without competitive bidding in 1959. The hospitalization contract has been renewed annually since 1959. The medical services contract was renewed annually until 1986 when it was bid and has been renewed annually since 1986.

Since 1995 the State Finance Law has required a formal, competitive process for all service contracts that exceed $15,000. As of the time of our audit, the hospitalization contract had not been bid and the medical services contract had not been rebid, although the Division had prepared a bid schedule. In our judgement, bidding these contracts would help to ensure the Empire Plan employers and enrollees are getting the best value for the insurance premiums they pay. Further, bidding the contracts would afford the Division the opportunity to strengthen and enhance language contained in the contracts that has hindered the Division's ability to administer the contracts. On July 29, 1999, subsequent to our audit period, the Department issued a Request for Proposals (RFP) for the Plan's hospitalization contract. The RFP and its model contract contain contractor responsibility, performance standards and audit authority provisions, which should facilitate and improve the Department's administration of the prospective contract.

Solicitation of Competition for Empire Plan Contractors

The Division's Contract Management and Audit Unit is responsible for managing and auditing contracts pertaining to the delivery of health benefits to enrollees. The two largest contracts are for hospitalization and medical services. Empire Blue Cross Blue Shield provides hospitalization coverage, and MetLife is the medical contractor. When originally negotiated in 1959, neither of these contracts was awarded on the basis of competitive bids. Both contracts contain annual renewal provisions. However, the renewals are automatic unless either party requests otherwise. The Empire contract has been renewed annually since 1959. The MetLife contract was renewed annually until 1986 when it was bid; it has been renewed annually since 1986.

Since 1995, Section 163.6 of the State Finance Law (Law) requires a formal, competitive process for all service contracts that exceed $15,000. In conjunction with the Law, the State has issued procurement guidelines, which state that competition in the procurement process serves both State agencies and offerers by:

- ensuring that the procurement process produces an optimal solution at a reasonable price;
- guarding against favoritism, fraud and collusion; and
- allowing qualified vendors an opportunity to obtain State business.

The guidelines use the term "best value" as the basis for awarding all service contracts, the definition of which is the optimizing of quality, cost and efficiency among responsive and responsible offerers. The guidelines also state that the best value basis will be quantifiable, wherever possible.

In October 1993, the Division submitted a schedule to OSC which indicated that the Division would bid its various insurance contracts, including the hospitalization and medical services contracts. The schedule showed that a new medical services contract would be in effect by January 1, 1996 and a new hospitalization contract by January 1, 1998. In March 1994, the Division submitted an amended schedule to OSC showing revised effective dates for the new medical services and hospitalization contracts as January 1, 1998 and January 1, 2000, respectively. As of November 1998 the Division had not yet begun the process of soliciting bids for either of these contracts.

According to Department officials, at the time the 1993 bid schedule was developed, the Department indicated to OSC that changes to the health insurance program resulting from legislation or collective bargaining could require modification to the schedule. Also, according to Department officials, such changes did occur and additional concerns regarding the procurement process, coupled with other procurements, required modification of the schedule.

In our judgement, by soliciting bids for the hospitalization contracts and medical services, the Division would help to ensure that the State, participating agencies and enrollees are receiving the best value for their insurance premiums. Renewing these contracts annually without exploring what competitors can offer may not be in the best interest of the various parties to these contracts. Additionally, because the contracts have been in place so long, certain State administrative requirements have not been followed. For example, State guidelines require a standard "Appendix A" attachment for contracts, which contains provisions requiring contractors to make their

records available for examination to OSC, the State Attorney General (AG) and the agency involved in administering the contract. Neither the medical services nor the hospitalization contract contains the Appendix A attachment and neither contains language giving OSC and the AG access to records. Also, the Empire contract does not contain a provision giving the Department access to the carrier's financial records, despite a recommendation in a 1988 OSC audit of the Department titled Employees Health Insurance Program (Report 88-S-144), with which the Department agreed.

Further, the Empire Blue Cross Blue Shield contract does not contain performance standards. Generally, these standards provide for financial incentives and/or penalties depending on contractor performance levels. Examples of performance standards include claim turnaround time and claim payment accuracy. The 1988 audit report noted above also included a recommendation that the Department amend the Empire contract to include performance standards. While Department officials agreed, they did not implement the recommendation. We note that the MetLife contract contains performance standards.

Recommendation

1. Comply with the State Finance Law and solicit competition for all Empire Plan contracts as soon as is practicable. In carrying out this process, include Appendix A requirements and performance standards in all health insurance contracts negotiated by the Division.

Audits of NYSHIP Activity

In 1991, the Department and OSC entered into an agreement to ensure comprehensive audit coverage of expenses charged to NYSHIP by Empire Plan insurance companies. In accordance with this agreement, OSC auditors routinely conduct independent audits of health insurance claims paid by the Empire Plan to ensure that expenses are appropriate. We determined that the existing agreement between the Department and OSC has not worked as intended. Consequently, the significant savings to the State envisioned by this agreement have not been realized. Division officials need to work with the OSC auditors to address the many unresolved issues that are precluding recovery of overpayments identified by the OSC audits. In addition, the Division conducts its own audits of expenses charged to the Empire Plan. We found that the Division needs to improve its operating practices relating to these audits.

State Comptroller Audits of Empire Plan Activities

The 1991 agreement between the Department and OSC acknowledged that the sheer size and complexity of NYSHIP demanded an aggressive and comprehensive audit plan to ensure contract compliance and maximum cost-effectiveness. The agreement recognized that an increase in audit resources using independent OSC auditors and an aggressive response by the Department could result in significant savings to employers and enrollees. Further, the agreement recognized OSC's ability to conduct audits of insurance company costs using the mainframe computer, and that the Department lacked the resources to carry out this function. In 1994, the Department and OSC also signed a "guiding principles" agreement to clarify the terms and conditions of the 1991 agreement. The guiding principles agreement requires OSC to issue audit reports directly to the Empire Plan's insurance companies, and makes the Department responsible for recovering overpayments.

Since the initiation of the agreement between the Department and OSC in 1991 through October 1998, the OSC audit unit has issued 27 audit reports on the Empire Plan carriers. As shown in Exhibit A, these audits identified $51.3 million in potential overpayments. However, through October 1998, the insurance carriers reported they had repaid only $8.5 million of these overpayments. Further, as detailed in Exhibit A, approximately $19.3 million in potential overpayments identified by OSC is not recoverable, leaving $23.6 million in potential overpayments uncollected as of the end of October 1998. About $2.6 million in overpayments identified in several prescription drug audits is not recoverable because the State's right of recovery for improper prescription drug payments was limited by performance standards contained in the contract. In addition, $16.7 million in overpayments is not recoverable from Medicare because of the Department's participation in 1996 settlement

agreement between the Federal Health Care Financing Administration and Blue Cross.

We identified a number of reasons which contributed to the low recovery of overpayments identified by OSC audits. The primary reason is the audit methodology used by OSC auditors to identify potential overpayments. The 1994 guiding principles agreement between the Department and OSC contains specific language concerning the use of statistical sampling. The agreement states that when it is not possible or practical to identify actual errors, valid statistical sampling methods will be used to project findings or savings. OSC, in its professional judgement, used statistical sampling on most audits of insurance carriers to project the amount of claims in the population which were overpaid. OSC expected that these projected overpayments would be accepted by the carriers and the Department as a basis for recovering overpayments from the carriers.

However, Department officials maintain that the State's contracts with Empire Plan insurers do not provide for the recovery of overpayments based upon projections from statistical samples. Therefore, they contend that they have no legal basis for demanding such recoveries.

In addition, other factors have contributed to the low rate of recovery, as follows:

- Disagreement over OSC audit findings

OSC audits identify overpaid claims processed and paid by the Empire Plan insurance carriers. Pursuant to the guiding principles agreement, OSC issues audit reports to the insurance carriers and discusses matters contained in these reports with the Department. There have been many instances where the insurance companies have disagreed with OSC findings. However, there are no provisions for resolving findings disputed by the carriers.

The Department, as administrator of NYSHIP, is responsible for recovering overpayments identified by OSC audits. However, the Department's involvement in the report process is limited to responding to management letters sent by OSC to the Department relating to NYSHIP audits. The Department is not required to respond to OSC NYSHIP audit reports. For the relationship between the Department and OSC to succeed, there needs to be continual dialogue and a process to resolve issues in dispute.

- The Department does not actively seek recovery of overpayments

As previously stated, the Department is responsible for seeking recovery of audit findings identified by OSC audits. However, to date, as previously stated, minimal recoveries have been facilitated by the Department.

The carriers have raised the concern that overpayments are not always possible or cost effective to recover. However, neither the carriers nor the Department have supported this position with a cost/benefit analysis showing that the cost of insurance company recovery efforts would exceed the overpayments identified by audits. An example which illustrates this deficiency is an OSC audit titled Inadequate Coordination of Benefits Resulted in $2.75 Million in Empire Plan Overpayments (Report 93-S-49), which identified overpaid claims totaling $2.75 million. Department officials agreed with the report's recommendations and stated they were working to recover the overpayments. However, Department officials also stated that the cost to recover overpayments should not be borne solely by the carrier without charge to the Empire Plan. As shown in Exhibit A, the entire $2.75 million overpayment remains outstanding.

In 1997, Empire Plan insurance carriers were paid $127.8 million in administrative cost reimbursements for paying claims. Therefore, any discussion of the cost/benefit of pursuing overpaid claims should consider the fact that the carriers have already been reimbursed to pay the claims correctly.

! Contract language is unclear concerning carrier responsibility to collect overpayments

For overpayments identified by OSC audits, there are no provisions in the contracts which define the process that Empire Plan insurance companies must follow to review claims, assess their collectibility, seek recovery from providers, and take action to prevent the future occurrence of claims processing errors. Absent such language, there has been disagreement between the Department, the insurance carriers and OSC concerning the sufficiency of the carrier's recovery efforts. Consequently, the Empire Plan carriers' processes for recovery vary significantly both in the steps taken and the outcomes.

Division Audits of NYSHIP Activities

Each Empire Plan insurance company submits an annual financial report (settlement report) to the Division. The Division uses the settlement report as the basis for setting the rates that employers and enrollees pay for health insurance coverage in the Empire Plan. Therefore, to protect the interests of the employers and enrollees, it is very important that reported numbers are accurate. The settlement report contains information concerning insurance premium and interest income, and claims and administrative expenses. In 1997, the Empire Plan insurance companies reported total

premium income of $1.7 billion, total claims expenses of $1.5 billion, total administrative expenses of $127.8 million and total interest income of $8.5 million. The Division, through its Audit Unit, which employs 8 auditors, conducts audits of these amounts to determine their accuracy. Our audit shows that the Division needs to improve its audit practices.

! Audit Standards

According to AICPA standards, working papers are the principal support of the auditor's report. They should include documentation showing that the work is adequately planned and supervised, the system of internal control has been evaluated, and the audit evidence obtained, the audit procedures used and the audit tests performed have provided sufficient, competent evidential material to form a reasonable basis for a conclusion. In addition, Generally Accepted Government Auditing Standards (GAGAS) contain standards for audits of government organizations, programs, activities and functions. In a prior OSC audit of the Department's administration of NYSHIP titled Employees Health Insurance Program (Report 88-S-144), we determined that the Division was not complying with AICPA standards concerning audit documentation. We recommended that the Division comply with AICPA standards when it conducts audits of insurance company expenses. In responding to the prior audit report, Department officials stated that they would improve compliance with accepted standards through staff training and a systemic review of working papers. However, during our current audit, we found that the Division is not complying with these standards.

The Division issued 21 audits during our audit scope period. To determine whether the Division is complying with applicable audit standards, we reviewed the working papers for a judgmental sample of three audits. The sample included the only audit of administrative expenses the Division completed during our audit scope period and two audits which focused on claims reimbursed by the insurance carriers. Generally, we found that the working papers did not include a source, purpose or conclusion, evidence of supervisory review, documentation to support the audit sampling method used, or an evaluation of internal controls. In addition, although not specifically required by GAGAS or AICPA standards, the working papers did not include a summary of findings, a cross-referenced audit program or a cross-referenced audit report. We found it difficult to find support for audit conclusions; also, the Division failed to adequately document its reasons for reducing or eliminating audit findings, as we discuss in the next sub-section of this report, Documenting Changes In Audit Findings. Division officials acknowledged these problems in their response to our audit, and indicated that the Audit Unit's working papers have improved with respect to standards and will continue to do so.

In our prior audit, we also recommended that the Division improve the timeliness of issuing audit reports. The prior report cited a Division decision to eliminate an audit finding under the prescription drug contract because the audit was so old that the contract had expired and the company was no longer the administrator. The Department's response to our prior audit indicated that it would develop a new audit plan which would reflect time schedules and man-day allocations to ensure completion of the audits. During our current audit, we again found that the Division is not issuing reports in a timely fashion. Of the 21 audit reports issued during our audit period, eleven were issued three or more years after the audit period. Officials told us that it is their goal to issue audit reports within one year after the audit period. They acknowledged that they are not meeting this goal, but stated that the timeliness of reports is improving. To be effective, the Audit Unit must achieve its stated goals with regards to timeliness.

! Documenting Changes In Audit Findings

In 1995, the Division issued a final audit report titled Division of Employee Benefits Audit of Metropolitan Administrative Expenses 1989 and 1990 (audit 302) concerning administrative expenses that MetLife charged to the Empire Plan. The scope period for this audit was the 1989 and 1990 calendar years. In its preliminary report, the Division questioned $8.8 million in payments; the final report questioned only $1.3 million in payments. Our audit shows that the Division reduced the overpayment amount without adequate support. For example, MetLife's 1989 settlement report included $2.7 million in expenses deferred from 1986. In its preliminary report, the Division questioned this amount, by taking the position that deferred expenses were not allowed without a contract amendment. However, the finding did not appear in the final report. The Division also questioned in its preliminary report MetLife's charging of $400,000 for payroll and benefit administrative expenses and a charge for check-writing that exceeded costs by $1.1 million. These findings were eliminated from the final report, despite the fact that MetLife did not provide sufficient supporting documentation for these charges. Division officials were not able to provide us with sufficient documentation to substantiate their decision to drop these matters.

These findings are similar to those OSC reported in a 1990 audit titled The State's Health Insurance Program is Paying for Significant Undocumented Administrative Expenses (Report 90-S-83) of MetLife's undocumented administrative expenses. In response to that audit, Department officials reported that they had begun issuing guidelines to define administrative expenses and that they would incorporate the guidelines into the MetLife contract, when appropriate. However, officials acknowledged during our current audit that they did not amend the contract and did not issue guidelines to define administrative expenses. For the Empire Plan insurance carriers,

administrative expenses amounted to $127.8 million in 1997 or about 10 percent of total contract costs with the carriers; close attention and scrutiny of these expenditures is warranted because of the high inherent risk associated with these costs.

! Recovering Overpayments From Final Audit Reports

The Division's Audit Unit reported recoveries of $10.8 million from the 21 audit reports issued between April 1993 and January 1998. Division officials provided us with documentation to show that the Empire Plan was credited with $8.4 million of this amount; officials could not provide documentation to support recovery of the remaining $2.4 million. Officials did provide a report that Empire prepared showing the status of its disallowed amounts. However, the Division did not verify the accuracy of this report.

Recommendations

2. Work cooperatively with OSC auditors to amend the current agreement between the two agencies. At the minimum, the revised agreement should:

   ! establish mutually acceptable audit methodologies;

   ! establish a process for resolving disagreements over audit findings;

   ! require the Department to respond in writing to OSC audit reports of Empire Plan insurance carriers;

   ! specify the steps the Department should take to recover overpayments identified by OSC audits;

   ! establish procedures for determining the cost/benefit of insurance company recovery efforts;

   ! require the Department to verify the validity of insurance company reasons for not recovering overpayments identified by audits; and

   ! clarify the insurance companies' expectations and responsibilities for recovery of overpayments.

3. Improve the operations of the Division's Audit Unit. At a minimum, this should include the following actions:

   ! Comply with AICPA audit standards and GAGAS.

   ! Issue audit reports in a timely fashion.

   ! Ensure that decisions to eliminate or reduce audit findings are fully supported and properly documented in the audit working papers.

4. Establish procedures to ensure that reported recoveries of overpayments identified by OSC and Division audits are credited to the Empire Plan.

SUMMARY OF OSC AUDITS OF EMPIRE PLAN INSURANCE CARRIERS

As of October 1998

	HOSPITALIZATION AUDIT RESULTS			MEDICAL SERVICES AUDIT RESULTS			PRESCRIPTION DRUG AUDIT RESULTS			COMBINED TOTALS		
Audit Number	Total Overpayments	Amount Recovered	Amount Outstanding	Total Overpayments	Amount Recovered	Amount Outstanding	Total Overpayments	Amount Recovered	Amount Outstanding	Total Overpayments	Amount Recovered	Amount Outstanding
92-S-84	$945,991	$589,178	$356,813	$958,962	$29,365	$929,597	$278,423	$0	$278,423 (1)	$2,183,376	$618,543	$1,564,833
92-S-105				371,917	0	371,917				371,917	0	371,917
92-S-106							479,466	0	479,466 (1)	479,466	0	479,466
93-S-48							340,943	0	340,943 (1)	340,943	0	340,943
93-S-49				2,753,781	0	2,753,781				2,753,781	0	2,753,781
93-S-77							709,719	0	709,719 (1)	709,719	0	709,719
93-S-80	30,006	28,843	1,163	254,198	78,809	175,389				284,204	107,652	176,552
93-S-81				3,708,177	1,428,706	2,279,471				3,708,177	1,428,706	2,279,471
93-S-88							404,804	0	404,804 (1)	404,804	0	404,804
94-S-10							351,143	0	351,143 (1)	351,143	0	351,143
94-S-26	6,200,000	3,588,278	2,611,722 (2)							6,200,000	3,588,278	2,611,722
94-S-52	0	0	0	0	0	0				0	0	0
94-S-68				1,018,236	12,744	1,005,492				1,018,236	12,744	1,005,492
95-S-23	10,850,000	131,227	10,718,773 (2)	977,236	25,937	951,299				11,827,236	157,164	11,670,072
95-S-87	705,895	25,665	680,230							705,895	25,665	680,230
95-S-88				865,444	0	865,444				865,444	0	865,444
95-S-92	2,500,000	213,641	2,286,359 (2)	672,267	74,000	598,267				3,172,267	287,641	2,884,626
95-S-124	564,576	547,016	17,560							564,576	547,016	17,560
96-S-26	364,549	67,481	297,068 (2)							364,549	67,481	297,068
96-S-27	1,180,000	104,148	1,075,852 (2)	900,000	9,679	890,321				2,080,000	113,827	1,966,173
96-S-56	642,684	612,687	29,997							642,684	612,687	29,997
96-S-62	375,000	55,163	319,837 (2)	364,000	0	364,000				739,000	55,163	683,837
96-S-63				1,726,484	745	1,725,739				1,726,484	745	1,725,739
96-S-64				1,353,968	2,841	1,351,127				1,353,968	2,841	1,351,127
96-S-79				4,712,429	1,674	4,710,755				4,712,429	1,674	4,710,755
97-S-1	510,763	483,726	27,037							510,763	483,726	27,037
97-S-20	1,590,000	261,901	1,328,099	1,650,000	115,102	1,534,898				3,240,000	377,003	2,862,997
	26,459,464	6,708,954	19,750,510	22,287,099	1,779,602	20,507,497	2,564,498	0	2,564,498	51,311,061	8,488,556	42,822,505
Less: Uncollectible Amounts			16,703,922						2,564,498			19,268,420
	$26,459,464	$6,708,954	$3,046,588	$22,287,099	$1,779,602	$20,507,497	$2,564,498	$0	$0	$51,311,061	$8,488,556	$23,554,085

Notes:

1. The overpayments identified by these audits are not recoverable because the State's rights of recovery for improper drug prescription payments was limited by performance standards set out in the contract.
2. Of the $17.3 million of uncollected overpayments identified by these audits, $16.7 million is not recoverable from Medicare because of the Department's participation in the 1996 HCFA/Blue Cross settlement agreement.

Exhibit A

Major Contributors to This Report

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DEPARTMENT OF CIVIL SERVICE
THE STATE CAMPUS
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GEORGE C. SINNOTT
COMMISSIONER

DANIEL E. WALL
EXECUTIVE
DEPUTY COMMISSIONER

January 19, 2000

Mr. Kevin M. McClune
Audit Director
Office of the State Comptroller
Alfred E. Smith Office Building
Albany, NY 12236

Dear Mr. McClune:

Enclosed is the Department's response to your letter dated January 13,2000, concerning the Office of the State Comptroller's audit findings relative to the New York State Health Insurance Program's Administration of the Empire Plan (97-S-35).

Please feel free to contact Ms. Regina DuBois, Director of Internal Audit, if you have any questions.

Sincerely,

George C. Sinnott
Commissioner

Enclosure

cc: Hon. Carole Stone, Division of the Budget
Mr. David English, Division of the Budget
Ms. Andrea Zaretzki, Assembly Committee on Oversight, Analysis & Investigation

DEPARTMENT OF CIVIL SERVICE
RESPONSE TO OSC'S AUDIT REPORT (97-S-35)
NEW YORK STATE HEALTH INSURANCE PROGRAM'S
ADMINISTRATION OF THE EMPIRE PLAN

JANUARY 19, 2000

We agree with each of the recommendations made in the report and will continue our work to implement those recommendations. However, the Department believes the report contains some language that overstates the impact of its findings, makes certain unsupported conclusions regarding the Department's administration of this program.

The report concludes "the Division does not have sufficient assurance that Empire Plan employers and enrollees are getting the best value for the insurance premiums they pay." The report provides no evidence to support this conclusion, which continues to be based solely on the fact that, at the time of the audit, two of the five Empire Plan contracts had not been bid in accordance with the Department's own schedule for conducting competitive reprocurements of all its insurance contracts. The Empire Plan continues to pursue its primary objective of providing its enrollees with exceptional health benefits at the lowest possible price. The best measure of that performance lies in the market. The fact that an increasing number of local governments throughout the state are choosing the Empire Plan over other health plans available to them is a far stronger indication that the plan is indeed the "best value" for its participants.

* **Note 1**

Additionally the report states that the Department has not actively sought recovery of overpayments made by the Empire Plan's insurance carriers that were identified as the result of various audits conducted by the Comptroller's auditors. In fact, the Department has, as acknowledged by the report, collected over $8 million in specific overpayments which it confirmed as a result of OSC audits. The remainder of the potential overpayments is not collectable for the various reasons articulated in the report. Whenever the OSC audits identify specific overpayments that the Department can verify, it is our expectation that the carriers will make recoveries.

* **Note 2**

The report states that the failure of the joint audit effort to work as intended results in "significant opportunities to improve the administration of the Empire Plan." Even if all of the "potential overpayments" identified by the OSC auditors were, in fact, actual overpayments (and they are not) they account for ***less than one half of one percent*** of the Empire Plan's total paid claims for those years. At best, there is potential for some incremental improvement in the accuracy of claims payment, not the "significant improvement in the administration of the program" claimed in the report.

* **Note 3**

Following are our responses to each recommendation in the audit report:

Recommendation 1: *"Comply with the State Finance Law and solicit competition for all Empire Plan contracts as soon as is practicable. In carrying out this process include Appendix A requirements and performance standards in all health insurance contracts negotiated by the Division."*

Response: The Department agrees with the audit recommendation that it rebid both the hospital coverage and medical coverage components of the Empire Plan. The procurement process for the hospital benefit program is well underway; in fact, the RFP was issued.

It is also important to note that in the agreement between the Office of the State Comptroller and the Department these contracts should be rebid on a periodic basis was the result of an overture by the Department's general counsel in 1993, prior to the 1995 revision to State Finance Law. The Department has conducted 13 procurements, including five for components of the Empire Plan, since the 1993 agreement.

*See State Comptroller's Notes, Appendix C

The report also states that the Empire Plan contract should require language guaranteeing access to carrier financial records. We agree and also point out that our access to such records has never been denied.

Recommendation 2: *"Work cooperatively with OSC auditors to amend the current agreement between the two agencies. At the minimum, the revised agreement should:*

- *Establish mutually acceptable audit methodologies;*
- *Establish a process for resolving disagreements over audit findings;*
- *Require the Department to respond in writing to OSC audit reports of Empire Plan insurance carriers;*
- *Specify the steps the Department should take to recover overpayments identified by OSC audits;*
- *Establish procedures for determining the cost/benefit of insurance company recovery efforts;*
- *Require the Department to verify the validity of insurance company reasons for not recovering overpayments identified by audits; and*
- *Clarify the insurance companies' expectations and responsibilities for recovery of overpayments."*

Response: We agree with this recommendation and have to date met three times with OSC staff to discuss specific issues. Additional meetings are scheduled to address various aspects of the inter-agency audit activities. Many of the elements the report identifies as appropriate for inclusion in the agreement are already in place and the Department has no objection to including them in the agreement. We believe that significant progress in understanding the concept of cost-effectiveness in the development of controls on the claims payment process and in the recovery of overpayments has been made. Additionally, a potential opportunity for increasing recoveries of small overpayments has been identified.

Also, the Department's two most recent contracts include the recommended provisions regarding administrative expenses associated with recovery of overpayments. We also believe that these contracts clearly define administrative expenses. The recently executed Prescription Drug contract does, in fact, allow for the use of statistical sampling with respect to measuring compliance with performance guarantees.

Recommendation 3: *"Improve the operations of the Division's Audit Unit. At a minimum, this should include the following actions:*

- *Comply with AICPA audit standards and GAGAS.*
- *Issue audit reports in a timely fashion.*
- *Ensure that decisions to eliminate or reduce audit findings are fully supported and properly documented in the audit working papers."*

Response: The Division's Audit Unit work papers have improved with respect to AICPA standards and will continue to do so despite limited staff resources and an increasing workload. Great strides have been made in automating work papers and much of the pertinent information now resides in the unit's electronic files. While some work papers prior to 1997 may not have complied with all proposed standards, the factual information to prove carrier errors and allow for **recovery of more than $10 million in actual overpayments** is present in all files. We believe the review of 3 audits from the 21 issued is not an adequate sample for measuring the unit's effectiveness, and it fails to accurately reflect the quality and quantity of work performed by audit staff.

* Note 4

*See State Comptroller's Notes, Appendix C

The EBD unit's recoveries to date:

Employee Benefits Division's Audit Unit
COMPLETED AUDITS – 1993 TO DATE

Audit No.	Auditee	Program	Final	Findings Reported	Recovery or Penalty
490-4A	Blue Cross	Hospital	4/25/93	$321,904	$206,799
702	Intracorp – 1991	BMP	8/18/93	$474,176	$474,176
490-1A	Blue Cross	Hospital	12/30/93	$1,336,977	$304,176
490-4B	Blue Cross	Hospital	3/24/94	$199,115	$118,714
703	Intracorp – 1992	BMP	7/29/94	$289,897	$289,897
490-T1S2	Blue Cross – 1990	Hospital	8/22/94	$244,780	$119,425
302	Metropolitan Adm. Exp.	Medical	1/4/95	$2,287,269	$2,287,269
704	Intracorp – 1993	BMP	3/7/95	$317,684	$317,684
391	Metropolitan	Medical	6/22/95	$767,696	$767,696
492-3S2	Blue Cross	Hospital	9/14/95	0	0
491-3S1	Blue Cross	Hospital	10/10/95	$287,806	$255,757
501	ValueRx	Drug	2/14/96	$1,576,568	$1,579,679
492-3S1	Blue Cross	Hospital	2/26/96	$223,054	$109,112
351	MetLife/VBH	MH/SA	5/13/96	$388,298	$294,692
705	Intracorp – 1994	BMP	6/19/96	$295,956	$295,956
392	Metropolitan – 1992	Medical	12/30/96	$1,100,000	$1,100,000
706	Intracorp – 1995	BMP	6/18/97	$152,444	$152,544
495-2*	Blue Cross	Hospital/BMP	6/27/97	$176,226	$176,226
494	Blue Cross	Hospital	8/6/97	$467,879	$391,673
496-2*	Blue Cross	Hospital/BMP	11/25/97	$13,594	$13,594
393	Metropolitan – 1993	Medical	1/12/98	$1,350,000	$1,350,000
Total				$12,271,323	$10,605,069

*These are results of reviews, not formal reports.

- *Issue audit reports in a timely fashion.*

There are a variety of factors that contribute to the length of time required to issue a **thorough** audit report, which identifies actual errors and results in real **recoveries**. Despite this fact, the timeliness of the Division's Audit Unit reports has improved steadily. In 1998, we issued reports for the 1996 Benefits Management Program; dental claims paid in 1996; and prescription drug claims paid in 1996 and 1997.

We have begun work on the 1997 United Health Care Quality Control audit and the 1997 Benefits Management Program performance standards audit. We have performed tests of 1998 Prescription Drug claims which have already resulted in audit credits to the program and we are beginning analysis of 1999 mental health claims processed by GHI ValueOptions.

- *Ensure that decisions to eliminate or reduce audit findings are fully supported and properly documented in the audit working papers.*

Preliminary findings are presented and draft audit reports are issued to elicit additional information and obtain documentation to resolve or confirm audit findings. We thoughtfully consider additional documentation as well as the carriers' responses to preliminary and draft audit reports. In the judgment of Division management, the carrier adequately responded to each of the items, questioned in the audit report this recommendation relates to. Therefore, the findings were not included in the final audit report.

*** Note 5**

*See Sate comptroller's Notes, Appendix C

The best evidence of the successful operation of the Division's audit unit is the results of its audit activity. The Division's audit unit has identified findings of over $12 million, with actual recoveries of over $10 million. In addition to actual monies returned to the Plan, Division audits have identified significant findings that have and will realize future benefits to the Plan.

Recommendation 4: *"Establish procedures to ensure that reported recoveries of overpayments identified by OSC and Division audits are credited to the Empire Plan."*

Response: While we are confident that all recoveries to date have been properly credited to the plan, we will review the structure of carrier financial reports and make the changes necessary to assure that audit credits are both explicitly identified in the reporting and that all audit recoveries are in fact credited.

STATE COMPTROLLER'S NOTES

3. Our report does not conclude that the Division does not have sufficient assurance Empire Plan employers and enrollees are getting the best value for the insurance premiums they pay. Rather, we state that bidding the hospitalization contract and rebidding the medical services contract would help to ensure the Empire Plan employers and enrollees are getting the best value for the insurance premiums they pay. At the time of our audit, the hospitalization contract had not been bid since it was let in 1959 and the medical services contract had not been rebid since 1986. Further, bidding the contracts would afford the Division the opportunity to strengthen and enhance language contained in the contracts that has hindered the Division's ability to administer the contracts. We note that the Department agrees with our recommendation to solicit competition for the hospitalization and medical services contracts as soon as is practicable.

4. The 27 OSC audits of Empire Plan insurance carriers conducted between 1991 and 1998 identified $51 million in potential overpayments. The Department collected $8 million of these overpayments and about $19 million is uncollectible for reasons stated in the report. However, the remaining nearly $24 million in potential overpayments is not uncollectible; it remains to be collected. As noted in its response to recommendation 2, the Department and OSC are engaged in meetings to improve the working arrangement. These meetings include analysis and discussion of uncollected overpayments identified by OSC audits.

5. We believe there are significant opportunities to improve the administration of the Empire Plan. They lie in bidding the insurance contracts, clarifying contract language, improving the working relationship between the Department and OSC, collecting potential overpayments identified by OSC audits and improving the activities of the Division's audit unit.

6. As stated in our report, we reviewed the working papers for three audits to determine whether the Division's audit unit was complying with applicable auditing standards. The purpose of this review was not to assess the effectiveness of the Division's audit unit. We selected the only audit of administrative expenses completed during our audit period and two relatively recent audits of claims payments, which should be reflective of current practices.

7. We recognize that changes occur between draft and final audit reports. However, as stated in our report, the Division was not able to provide us with sufficient documentation to substantiate the decision to make the changes. Hence, we recommended that decisions to eliminate or reduce audit findings be fully supported and documented in the working papers.