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

Final Audit Report

AUDIT OF THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM OPERATIONS AT HEALTH NET OF CALIFORNIA, INC. – NORTHERN AND SOUTHERN REGIONS

Report Number 2023-CRAG-023
January 13, 2025

EXECUTIVE SUMMARY

Audit of the Federal Employees Health Benefits Program Operations at Health Net of California, Inc. – Northern and Southern Regions

Report No. 2023-CRAG-023 **January 13, 2025**

Why Did We Conduct the Audit?

The primary objective of the audit was to determine if Health Net of California, Inc (Plan) – Northern and Southern Regions complied with the provisions of its contracts and the laws and regulations governing the Federal Employees Health Benefits Program (FEHBP). To accomplish this objective, we verified whether the FEHBP premium rates were developed in accordance with contract regulations and rating instructions established by the U.S. Office of Personnel Management (OPM).

What Did We Audit?

Under Contracts CS 2002 and CS 2956, the Office of the Inspector General completed a performance audit of the FEHBP premium rate developments for contract years 2021 and 2022. We conducted our audit fieldwork remotely from February 12, 2024, through September 5, 2024.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

We determined that the Plan's FEHBP premium rates for Northern California, plan codes LB and T4, and Southern California, plan codes LP and P6, were developed in accordance with applicable laws, regulations, and OPM's rating instructions for contract years 2021 and 2022. However, the Plan did not adhere to OPM's guidance provided in the Benefits Administration Letters and the stipulations in the Code of Federal Regulations when it terminated the standard option in the Southern California and Northern California regions in contract years 2020 and 2021, respectively.

ABBREVIATIONS

BAL	**Benefits Administration Letter**
CFR	**Code of Federal Regulations**
Contract	**OPM Contract CS 2002 and CS 2956**
FEHBP	**Federal Employees Health Benefits Program**
HDHP	**High Deductible Health Plan**
MLR	**Medical Loss Ratio**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**Health Net of California, Inc. – Northern and Southern Regions**

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I. BACKGROUND

This final report details the results of the Federal Employees Health Benefits Program (FEHBP) operations at Health Net of California, Inc. (Plan) – Northern and Southern regions, plan codes LB, LP, P6, and T4. The audit was conducted pursuant to the provisions of Contracts CS 2002 and CS 2956 (Contract); 5 United States Code Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract years 2021 and 2022 and was conducted remotely by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG) staff.

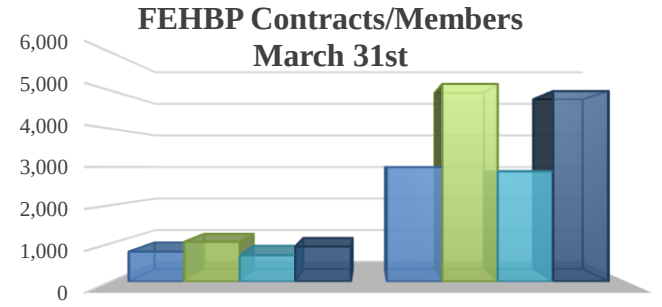
The FEHBP was established by the Federal Employees Health Benefits Act (Public Law 86-382) enacted on September 28, 1959. The Act authorized OPM to implement contracts with private insurance carriers to administer service benefits, indemnity benefits, or comprehensive medical services. The FEHBP is the largest employer-sponsored group health insurance program in the world, covering over 8 million federal employees, retirees, former employees, family members, and former spouses.

In April 2012, OPM issued a final rule establishing an FEHBP-specific Medical Loss Ratio (MLR) requirement for most community-rated FEHBP carriers (77 Federal Register 19522). The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act (Public Law 111-148) and defined by the U.S. Department of Health and Human Services in 45 CFR Part 158. The MLR is a financial metric that measures the percentage of premium dollars that a health plan spends on medical claims and quality improvements. The remaining percentage should be used to cover the health plan's administrative costs, such as executive salaries, overhead, and marketing. The MLR is important because it requires health insurers to provide its enrollees with value for their premium payments.

The premium rates charged to the FEHBP under the MLR methodology should be developed in accordance with OPM Rules and Regulations and the Plan's state-filed standard rating methodology (or if the rating method does not require state filing, the Plan's documented and established rating methodology). All FEHBP pricing data are to be supported by accurate, complete, and current documentation. A rating methodology is defined as a series of well-defined procedures a carrier follows to determine the rates it will charge to its subscriber groups. Further, an independent professional must be able to follow the carriers' procedures and reach the same conclusion. OPM negotiates benefits and rates with each plan annually and all rate agreements between OPM and the carrier are subject to audit by the OPM OIG. The results of such audits may require modifications to previous agreements and subsequent rate adjustments.

Community-rated carriers participating in the FEHBP are subject to various federal, state, and local laws, regulations, and ordinances. In addition, participation in the FEHBP subjects the carriers to the Federal Employees Health Benefits Act and implementing regulations published by OPM.

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



	North (Plan codes: LB, T4)	South (Plan Codes: LP, P6)
2021 Contracts	784	2,998
2021 Members	1,040	5,173
2022 Contracts	690	2,883
2022 Members	917	4,986

The Plan received certification as a Federally Qualified Health Maintenance Organization in 1979 and was licensed by the California Department of Corporations in 1991. Health benefits are provided to FEHBP members in the Plan's Northern and Southern California service areas.

The last full scope audit of the Plan conducted by our office covered the MLR and premium rate calculations for contract years 2012 and 2013. During that audit, we found that the FEHBP premium rates were developed in accordance with the applicable laws, regulations, and OPM's rate instructions. However, we identified procedural issues with the 2012 MLR tax expense calculation. We also found that the 2013 MLR was overstated due to an improper tax expenses calculation and the inclusion of unallowable medical and pharmacy claims, which resulted in an MLR penalty of $47,528 and $137,197 for Northern and Southern California, respectively. All findings and recommendations related to these audits are now closed.

The preliminary results of this audit were communicated to Plan officials during the Notice of Finding and Recommendations process and during an exit conference. The Plan's comments were considered in the preparation of this report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

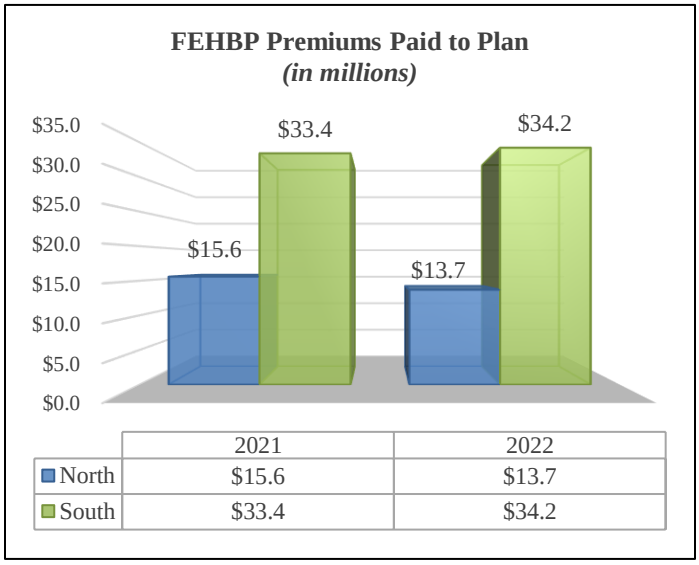
The primary objective of this performance audit was to determine whether the Plan complied with the provisions of its Contract and the laws and regulations governing the FEHBP. Specifically, we verified whether the Plan developed its FEHBP premium rates in accordance with the applicable regulations and rating instructions established by OPM.

SCOPE

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

This performance audit covered contract years 2021 and 2022. For these years, the FEHBP paid approximately $96.9 million in premiums to the Plan.

The OIG's audits of community-rated carriers are designed to test carrier compliance with the FEHBP contract, applicable laws and regulations, and OPM's rate instructions. These audits are also designed to provide reasonable assurance of detecting errors, irregularities, and illegal acts.



We obtained an understanding of the Plan's internal control structure, but we did not use this information to determine the nature, timing, and extent of our audit procedures. Our review of internal controls was limited to the procedures the Plan has in place to ensure that:

- the premium rate calculations were accurate, complete, and valid;
- appropriate allocation methods were used;
- any other costs associated with its premium rate calculations were appropriate;
- FEHBP medical claims were processed accurately; and

- FEHBP members received the 31-day extension of coverage when coverage was lost, as applicable.

In conducting the audit, we relied to varying degrees on computer-generated billing, enrollment, and claims data provided by the Plan. We did not verify the reliability of the data generated by the various information systems involved. However, nothing came to our attention during our audit utilizing the computer-generated data to cause us to doubt its reliability. We believe that the available data was sufficient to achieve our audit objectives. Except as noted above, the audit was conducted in accordance with generally accepted government auditing standards, issued by the Comptroller General of the United States.

We remotely conducted our audit fieldwork from February 12, 2024, through September 5, 2024.

METHODOLOGY

We examined the Plan's premium rate calculations and related documents as a basis for validating the premium rates. Further, we examined medical claim payments, pharmacy rebates, completion factors, benefit factors, trends, administrative expenses, and any other applicable expenses considered in the calculation of the premium rates to verify that the cost data used was accurate, complete, and valid. Finally, we used the Contract, the Federal Employees Health Benefits Acquisition Regulations, the OPM rate instructions, and applicable Federal regulations to determine the appropriateness of the Plan's premium rate calculations.

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

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

III. AUDIT FINDINGS AND RECOMMENDATION

1. Premium Rate Review

Our audit showed that the Plan's rating of the FEHBP was in accordance with applicable laws, regulations, and the rate instructions for contract years 2021 and 2022. Consequently, the audit did not identify any questioned costs, and no corrective action is necessary.

2. Standard Option Termination

We determined that the Plan did not adhere to the guidance provided in OPM's Benefits Administration Letters (BAL) and the stipulations in the Code of Federal Regulations (CFR) when the Plan terminated its standard option in the Southern California and Northern California regions in contract years 2020 and 2021, respectively.

5 CFR 890.301(i)(4)(iii) states that "[i]f one or more options of a plan are discontinued, an employee who does not change the enrollment will be enrolled in the remaining option of the plan, or in the case of a plan with two or more options remaining, the lowest-cost remaining option that is not a High Deductible Health Plan (HDHP)." Furthermore, the Plan was instructed per OPM's BAL 20-403 and BAL 21-403 "to notify the enrollees that their current plan option is being discontinued and that if they do not change to another plan during Open Season, they will be switched automatically" into the Plan's Basic Option for years 2021 and 2022, respectively.

The Plan's controls surrounding the FEHBP option termination process were insufficient to adequately meet the CFR or OPM's requirements. As a result, the enrollees from the standard option were not enrolled in a health plan of their choice during Open Season nor automatically enrolled in the Plan's basic option. Furthermore, the Plan continued to pay standard option network claims for the FEHBP members even though the terminated standard option provider network varied from the basic option provider network and premiums were not paid to the Plan for those members.

Recommendation 1

We recommend that the Plan strengthen its internal controls, including written policies and procedures, to ensure the Plan's FEHBP option termination processes follow the requirements of 5 CFR 890.301(i)(4) (iii) and OPM's Benefits Administration Letters.

Plan Response:

The Plan agrees with the finding. Additionally, the Plan stated that "[t]he Health Net Account Management team will work with the Eligibility and Accounting teams to expand our written policies and procedures as well as all related internal controls to ensure Health Net's FEHBP option termination processes follow the requirements of 5 CFR 890.301(i)(4)(iii) and OPM's Benefits Administration Letters. Upon completion of the updated policies and controls we will provide the updated policies to OPM's audit team as well as to our Contract Benefit Specialist."

EXHIBIT A

Health Net of California, Inc. – Northern and Southern Regions
Medical Claims Sample Selection Criteria and Methodology

Universe Criteria	Medical claims incurred from the claims experience period of 3/1/2019 through 2/28/2020 for premium rating of contract years 2021 and 2022.
Universe of Unique Claims (Number)	7,798 Claims
Universe (Dollars)	$13,819,857
Sample Criteria and Size	Judgmental and random – utilized SAS EG[1] to select a random sample of 10 inpatient claims greater than $30,000 for #LP and $50,000 for #LB; 10 outpatient claims greater than $20,000 for #LP and $40,000 for #LB; and 10 professional claims greater than $2,500 for #LP and $9,000 for #LB
Sample Number	30
Sample Dollars	$2,185,107
Results Projected to the Universe?	N**o**

[1] SAS Enterprise Guide is a Windows.NET application used to analyze data.

APPENDIX

21281 Burbank Blvd.
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October 13, 2024

Lindsay Haber
Acting Chief, Community-Rated Audits Group
U.S. Office of Personnel Management
Office of the Inspector General

Dear Lindsay Haber:

Thank you for the opportunity to review and respond to the draft audit report results of the Federal Employees Health Benefits Program operations at Health Net of California, Inc. – Northern and Southern Regions, plan codes LB, T4, LP and P6. The audit covered contract years 2021 and 2022.

Health Net has reviewed the draft report and does not have any comments, edits or redaction requests as it relates to the draft report.

The Health Net Account Management team will work with the Eligibility and Accounting teams to expand our written policies and procedures as well as all related internal controls to ensure Health Net's FEHBP option termination processes follow the requirements of 5 CFR 890.301(i)(4) (iii) and OPM's Benefits Administration Letters. Upon completion of the updated policies and controls we will provide the updated policies to OPM's audit team as well as to our Contract Benefit Specialist.

We look forward to receiving the final report.

Sincerely,

Tamara Maxson
CA License #0C62851
Senior Consultant
Health Net of California

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Room 6400
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