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 UNITEDHEALTHCARE OF CALIFORNIA

Report Number 1C-CY-00-17-047

October 9, 2018

EXECUTIVE SUMMARY

Audit of the Federal Employees Health Benefits Program
Operations at UnitedHealthcare of California

Report No. 1C-CY-00-17-047 **October 9, 2018**

Why Did We Conduct the Audit?

The primary objective of the audit was to determine if UnitedHealthcare of California (Plan) was in compliance with the provisions of its contract and the laws and regulations governing the Federal Employees Health Benefits Program (FEHBP). To accomplish this objective, we verified whether the Plan met the Medical Loss Ratio (MLR) requirements and thresholds established by the U.S. Office of Personnel Management (OPM).

Because of Program changes resulting from OPM's roll-out of its MLR methodology, we are no longer performing a review of the FEHBP's rates. Consequently, this change to our audit process only allows us to verify whether the calculated percentage of the premium paid is spent on patient related health care expenses. It does not allow us to assess the fairness of the premium paid for benefits received.

What Did We Audit?

Under Contract CS 1937, the Office of the Inspector General (OIG) completed a performance audit of the FEHBP MLR submissions to OPM for contract years 2013 through 2015. Our audit fieldwork was conducted from November 13, 2017, through May 4, 2018, at the Plan's offices in Minnetonka, Minnesota and Cypress, California, and in our OIG offices.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

The Certificates of Accurate MLR signed by the Plan in 2013 through 2015 were defective, resulting in an overstated OPM MLR credit of [redacted] in contract year 2013, and understated OPM MLR credits of [redacted], and [redacted] for contract years 2014 and 2015, respectively. Specifically, our audit identified the following:

- The Plan included claims for unsupported and ineligible disabled dependents in its 2013 through 2015 claims data.
- The Plan included medical claims for non-covered services in its 2013 incurred claims total.
- The Plan did not maintain supporting documentation for the capitation benefit adjustment factors for contract years 2013 through 2015.

Our audit did not disclose any findings related to the Plan's procedures for premium income; quality health improvements; taxes; fraud, waste, and abuse; debarment; audited financial statements; off-shore contracting; and its hold harmless language. Additionally, our audit did not disclose any findings related to our coordination of benefits and member eligibility claim reviews.

ABBREVIATIONS

CFR	**Code of Federal Regulations**
Contract	**OPM Contract CS-1937**
FEHBAR	**Federal Employees Health Benefits Acquisition Regulations**
FEHBP	**Federal Employees Health Benefits Program**
FWA	**Fraud, Waste, and Abuse**
MLR	**Medical Loss Ratio**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**UnitedHealthcare of California**
SSSG	**Similarly-Sized Subscriber Group**

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REPORT FRAUD, WASTE, AND MISMANAGEMENT

I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at UnitedHealthcare of California (Plan). The audit was conducted pursuant to the provisions of Contract CS 1937 (Contract); 5 United States Code Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract years 2013 through 2015, and was conducted at the Plan's offices in Minnetonka, Minnesota and Cypress, California.

The FEHBP was established by the Federal Employees Health Benefits Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for Federal employees, annuitants, and dependents, and is administered by the U.S. Office of Personnel Management's (OPM) Healthcare and Insurance Office. The provisions of the Federal Employees Health Benefits Act are implemented by OPM through regulations codified in 5 CFR Chapter 1, Part 890. Health insurance coverage is provided through contracts with health insurance carriers who provide service benefits, indemnity benefits, or comprehensive medical services.

In April 2012, OPM issued a final rule establishing an FEHBP-specific Medical Loss Ratio (MLR) requirement to replace the similarly-sized subscriber group (SSSG) comparison requirement for most community-rated FEHBP carriers (77 FR 19522). MLR is the proportion of FEHBP premiums collected by a carrier that is spent on clinical services and quality health improvements. The MLR for each carrier is calculated by dividing the amount of dollars spent for FEHBP members on clinical services and health care quality improvements by the total amount of FEHBP premiums collected in a calendar year.

The MLR was established to ensure that health plans are meeting specified thresholds for spending on medical care and health care quality improvement measures, and thus limiting spending on administrative costs, such as executive salaries, overhead, and marketing. For example, the threshold of 85 percent requires carriers to spend 85 cents of every premium dollar on patient care and limits the amount that can go to administrative expenses and profit to 15 cents of every dollar. However, the MLR does not provide an assessment of the fairness of the premium paid for benefits received, only that the calculated percentage of the premium paid is spent on patient related health care expenses.

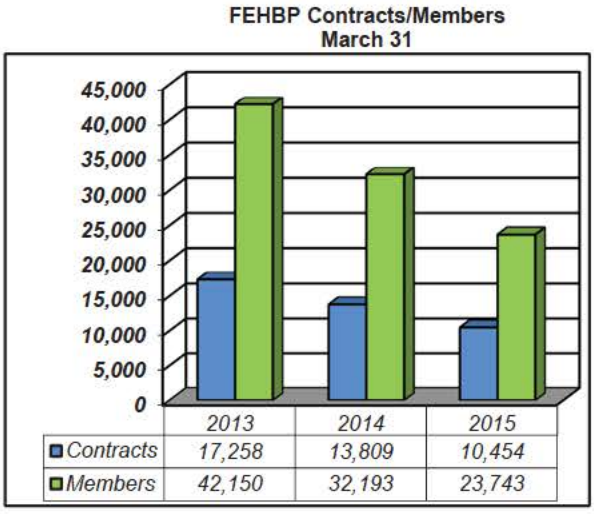
The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act (P.L. 111-148) and defined by the U.S. Department of Health and Human Services in 45 CFR Part 158. In 2012, community-rated FEHBP carriers could elect to follow the FEHBP-specific MLR requirements, instead of the SSSG requirements. Beginning in 2013, however, the

MLR methodology was required for all community-rated carriers, except those that are state-mandated to use traditional community rating. State-mandated traditional community-rated carriers continue to be subject to the SSSG comparison rating methodology.

Starting with the pilot program in 2012 and for all non-traditional community-rated FEHBP carriers in 2013, OPM required the carriers to submit an FEHBP-specific MLR. This FEHBP-specific MLR calculation required carriers to report information related to earned premiums and expenditures in various categories, including reimbursement for clinical services provided to enrollees, activities that improve health care quality, and all other non-claims costs. If a carrier fails to meet the FEHBP-specific MLR threshold, it must make a subsidization penalty payment to OPM within 60 days of notification of amounts due.

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

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



The Plan has participated in the FEHBP since 2004 and provides health benefits to FEHBP members in the southern and central California areas.

There were no previous MLR audits of the Plan. However, a prior SSSG audit of the Plan covered contract years 2010 through 2012. The audit found that the Plan applied an inappropriate benefit loading to the FEHBP rates in all contract years, and paid for non-covered benefits during contract year 2012. The audit report did not result in questioned costs, but recommended that the Contracting Officer require the Plan to remove the inappropriate benefit loading in the FEHBP rate development going forward and that the Contracting Officer require the Plan to effectively monitor all FEHBP claims to identify non-covered benefits. The Plan made the necessary corrections to its system and the audit was closed.

The preliminary results of this audit were discussed with Plan officials at an exit conference and

in subsequent correspondence. A draft report was also provided to the Plan for review and comment. The Plan's comments were considered in preparation of this report and are included, as appropriate, as an Appendix to the report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The primary objective of this performance audit was to determine whether the Plan was in compliance with the provisions of its Contract and the laws and regulations governing the FEHBP. Specifically, we verified whether the Plan met the MLR requirements and thresholds established by OPM and paid the correct amount to the Subsidization Penalty Account, if applicable. Additional tests were also performed to determine whether the Plan was in compliance with the provisions of other applicable laws and regulations. Further, we reviewed the Plan's internal controls; compliance with fraud, waste, and abuse (FWA) requirements; debarment from the FEHBP; and offshore contracting program areas to ensure that the Plan had adequate policies and procedures covering these areas.

Our audits of the MLR submission filed with OPM are completed in accordance with the criteria expressed in OPM's rating instructions. The MLR audit evaluation includes an assessment of key components of the MLR calculation, including allowable claims, capitations, health care expenses, and quality health improvements (numerator), and the premium received, excluding applicable tax expenses (denominator). The result of the MLR calculation must meet OPM's prescribed thresholds. If the calculation falls below the threshold, the health plan must pay a penalty determined by the variance between the actual MLR ratio and the established threshold.

Although the FEHBP premiums used in the MLR calculation are ultimately determined by the premium rates proposed by the Plan and certified and paid by OPM, the OPM rating instructions no longer provide sufficient criteria to evaluate the fairness of those rates against the standard market value of similarly-sized groups. Furthermore, per the OPM rating instructions, health plans can utilize OPM's total reported premium, as the denominator in the MLR calculation, which when utilized is not subject to audit. Since the majority of health plans choose this option, the premiums utilized in the MLR calculation are very frequently not available for audit and the fairness of the FEHBP premium rates cannot be evaluated.

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 2013 through 2015. For these years, the FEHBP paid approximately [redacted] million in premiums to the Plan.

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

[redacted]

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 FEHBP MLR calculations were accurate, complete, and valid; claims were processed accurately; appropriate allocation methods were used; and, that any other costs associated with its MLR calculations were appropriate.

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

The audit fieldwork was performed from November 13, 2017, through May 4, 2018, at the Plan's offices in Minnetonka, Minnesota and Cypress, California, as well as in our offices in Cranberry Township, Pennsylvania and Washington, D.C.

METHODOLOGY

We examined the Plan's MLR calculations and related documents as a basis for validating the MLR. Further, we examined claim payments, quality health expenses, taxes and regulatory fees,

and any other applicable costs to verify that the cost data used to develop the MLR was accurate, complete, and valid. We also examined the methodology used by the Plan in determining the premium in the MLR calculations. Finally, we used the Contract, the Federal Employees Health Benefits Acquisition Regulations (FEHBAR), and the rate instructions to determine the propriety of the Plan's MLR calculations.

To gain an understanding of the internal controls over the Plan's MLR process, we reviewed the Plan's MLR policies and procedures and interviewed appropriate Plan officials regarding the controls in place to ensure that MLR calculations were completed accurately and appropriately. Other auditing procedures were performed as necessary to meet our audit objectives.

We also interviewed Plan officials and reviewed the Plan's policies and procedures associated with its internal controls over the claims processing system, FWA, debarment, and offshore contracting programs.

We determined whether the Plan has adequate hold harmless language in its provider contracts to ensure that the subscribers are not liable for payment obligations in the event of Plan insolvency.

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

Finally, we examined the Plan's financial information and evaluated the Plan's financial condition and ability to continue operations as a viable ongoing business concern.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. Medical Loss Ratio Review

In accordance with Federal regulations and the U.S. Office of Personnel Management's (OPM) Community Rating Guidelines, our audit identified the following issues:

1. Overstated Medical Loss Ratio Credit [redacted]

For contract year 2013, the Plan calculated an MLR of [redacted] percent. Since this ratio exceeded the OPM established threshold of 89 percent, the Plan received an OPM MLR credit of [redacted]. However, during our review of the Plan's MLR submission, we identified issues that resulted in an audited MLR percentage that was lower than that calculated by the Plan (see MLR Claims Data [page 8] and Defective Certificate of Accurate MLR [page 12] below). As a result, we determined that the Plan's OPM MLR credit should be reduced by [redacted] for contract year 2013.

Plan Response:

The Plan agrees with the adjustment to the credit balance for contract year 2013. The Plan discovered that the detailed supporting documentation provided during the audit did not match the OPM MLR form information that was submitted on September 30th. [redacted] ***The Plan submitted a revised MLR Form to the OIG auditors, which calculated a lower credit amount for 2013. The*** [redacted] ***issue has been corrected and there is now a process in place to ensure that all changes are reviewed and incorporated into the reporting for the OPM MLR Form.***

2. Understated Medical Loss Ratio Credit [redacted]

The Plan calculated an OPM MLR of [redacted] percent for contract year 2014, and [redacted] percent for contract year 2015. Since the ratio for contract year 2014 exceeded the OPM established threshold of 89 percent, the Plan received an OPM MLR credit of [redacted]. The Plan did not receive a credit or pay a penalty during contract year 2015 since its ratio fell between 85 and 89 percent. However, during our review of the Plan's OPM MLR submissions for both years, we identified issues that resulted in audited MLR percentages that were higher than those calculated by the Plan (see MLR Claims Data [page 8] and Defective Certificate of Accurate MLR [page 12] below). As a result, we determined that the Plan's OPM MLR credits should be increased by [redacted] and [redacted] in contract years 2014 and 2015, respectively.

Plan Response:

The Plan agrees with the adjustments to the credit balances for contract years 2014 and 2015. The Plan discovered that the detailed supporting documentation provided during the audit did not match the OPM MLR forms' information that was submitted on September 30th of the respective years. [redacted] ***The Plan submitted revised MLR Forms to the OIG auditors, which calculated an increased credit for 2014 and 2015. The*** [redacted] ***issue has been corrected and there is now a process in place to ensure that all changes are reviewed and incorporated into the reporting for the OPM MLR Form.***

3. MLR Claims Data

a. Claims Paid for Ineligible Dependents

We reviewed a random sample of [redacted] members who were age 26 or older in contract year 2013. Based on our review, we determined that claims were paid for members whose (i) dependent eligibility status could not be supported, and (ii) coverage was not terminated timely, which inflated the claims costs used in the Plan's OPM MLR submissions.

i. Unsupported Dependent Eligibility

The Plan did not maintain supporting documentation for disabled dependents and was unable to retrieve documentation to support their eligibility due to time restrictions within its systems.

According to the FEHBP benefit brochure, dependents are only eligible to be covered after age 26 if the dependent is disabled or incapable of self-support. In these cases, the FEHBP Handbook indicates that the subscriber's employment office will provide the insurance carrier with its decision about the dependent's eligibility and notes that the carrier may extend coverage for these members if appropriate medical documentation or certification is provided. The Plan is responsible for maintaining this documentation per its OPM Contract at Section 1.11(b), which requires insurance carriers to maintain all records relating to the contract and to make these records available for a period of time specified by FEHBAR 1652.204-70.

A lack of supporting documentation resulted in the payment of [redacted] claims, totaling [redacted] for unsupported dependent members.

Additionally, FEHBAR 1652.204-70 is incorporated into the contracts at Section 3.4, which requires the carrier to maintain individual enrollee and/or patient claim records "for six years after the end of the contract term to which the claim records relate."

We determined that the Plan did not maintain appropriate documentation to support the eligibility of [redacted] dependents in contract year 2013. Consequently, we expanded our review to query all 2013 through 2015 medical and pharmacy claims data for the [redacted] dependents. The claims identified from this query were removed from the numerator of our audited MLR calculations because we cannot verify that the claims paid were allowable. Specifically, we removed the following amounts from the numerator of the MLR calculations:

Unsupported Dependent Eligibility						
Contract Years	**Medical Claims**	**Medical Dollars**	**Pharmacy Claims**	**Pharmacy Dollars**	**Total Claims**	**Total Dollars**
2013	[redacted]					
2014						
2015						
Total						

Because the Plan did not maintain supporting documentation for disabled dependents and was unable to retrieve documentation to support the dependents' eligibility due to system timing restrictions, it is not in compliance with its contractual and regulatory requirements and may be overstating its MLR.

Plan Response:

The Plan asserts that the OPM electronic data transfer is sufficient support for the ongoing coverage of these dependents. The Plan attempted to follow up with the relevant agencies for [redacted] the disabled dependents but no response was received from the agencies. The Plan requested the original data for [redacted] disabled dependents but the employing agencies indicated their records were not available for the historical period requested. For [redacted] the disabled dependents, the Plan provided support for a different time period where the dependent disability was documented prior to reaching the overage limit. For [redacted] the disabled dependents, the Plan previously provided an internal system report based on the electronic data received from OPM at the time of the enrollment. The Plan maintains these

dependents were eligible for coverage during 2013 through 2015 and therefore no adjustments should be made to the medical or pharmacy claims for these disabled dependents.

OIG Comment:

We acknowledge that the Plan contacted various employing agencies and did not receive responses or supporting documentation. However, we reiterate that the Plan is responsible for maintaining all original determination documentation (i.e., approval letters, OPM correspondence, etc.) for dependents that are incapable of self-support. Additionally, the FEHBP Handbook specifies that the Plan may approve disabled dependent coverage in certain cases. In instances such as these, we expect the Plan to provide sufficient documentation to support the disabled dependent determination.

ii. Untimely Termination of Dependent Coverage

The Plan did not timely terminate coverage for dependent members who had become ineligible for coverage in contract years 2013 through 2015.

As mentioned previously, the FEHBP's benefit brochure states that dependent coverage ends once dependents turn 26 years of age, unless they are incapable of self-support. It should also be noted that dependents have coverage for an additional 31 days after their 26th birthday.

Use of a manual enrollment process puts the FEHBP at risk for improper claim payments for ineligible members.

For contract year 2013, we determined that the Plan did not properly terminate coverage for [redacted] dependents within 31 days after the dependent's 26th birthday. This error resulted from the Plan's use of a manual enrollment process that terminates overage dependents at 32 or 33 days from their 26th birthday instead of 31 days. Consequently, there is a risk that the Plan could improperly pay claims for members who were not eligible for coverage, which would inflate the claims used in the Plan's FEHBP MLR submissions; potentially skewing the ratio. However, it was determined that no claims were paid for these members during the dependents' ineligible timeframes.

Plan Response:

The Plan disagrees that it did not timely terminate coverage for these dependent members and stated that it used the method prescribed by OPM to calculate the appropriate termination dates. The Plan reviewed OPM's Handbook for the requirements for termination which states in part, "Coverage terminates at midnight on the date of terminating event - not at the end of a pay period" and "Days- Whenever, in this Handbook, a period of time is stated as a number of days, or as a number of days from an event, the period is computed in calendar days, excluding the day of the event." The Plan reviewed the [redacted] specific members identified by the OIG and determined that they were terminated in compliance with OPM's methodology. The Plan disagrees with the calculation of the number of days that the auditors used stating it does not appear to conform to OPM's definition/method.

OIG Comment:

During the review, we calculated the dependents' 26th birthday plus 31 days of extended coverage granted to the dependents per OPM's guidelines. Therefore, we maintain that our termination date calculation is correct for the ineligible dependents.

b. Non-Covered Benefits

We identified [redacted] claims that were paid for non-covered benefits, specifically elective abortions, during contract year 2013.

OPM's Contract Section 2.2(a) states that, "The Carrier shall provide the Benefits as described in the agreed upon brochure text … ." The FEHBP Benefits Brochure, Section 6, General Exclusions, notes that any costs related to abortions are not covered except when the life of the mother would be endangered if the fetus were carried to term or in cases of rape or incest.

The Plan acknowledged that these [redacted] claims were paid incorrectly and stated that the claims contained an alert for review. However, the claims adjuster did not review the alert or validate the services against the member's evidence of coverage.

We verified that the claims did have suspend messages in the Plan's system and that training provided to adjusters instructs them to review and fully process all claims that contain a suspend code. Although the Plan had both system and procedural controls in place to process only those benefits allowed per the contract and benefit brochure, the

claims adjuster's failure to follow the existing controls is an operational control deficiency. We removed the [redacted] claims, totaling [redacted], from the MLR numerator in contract year 2013.

Plan Response:

The Plan acknowledges that the non-covered benefits claims were paid in error. The Plan re-trained the claims processor involved in the error. The Plan believes that the issue was appropriately corrected and no further action is needed.

c. Coordination of Benefits

Based on our review, we concluded that the Plan correctly coordinated claims for members over age 65.

d. Member Eligibility

Based on our review, we concluded that the Plan did not pay any medical benefits for members, other than those identified above, after they were terminated by the Plan, dropped coverage, or during a gap in coverage.

4. Defective Certificate of Accurate MLR

The Certificates of Accurate MLR that the Plan signed for contract years 2013 through 2015 were defective because the Plan submitted MLR calculations to OPM that were inaccurate. The Certificate of Accurate MLR states that the FEHBP-specific MLR is accurate, complete, and consistent with the methodology in 5 CFR Sec. 1615.402(c)(3)(ii).

As stated above, the Plan submitted inaccurate MLR calculations to OPM due to a mapping issue in its financial reporting area. Therefore, it was unable to provide sufficient documentation to support its incurred claims amounts for contract years 2013 through 2015. This resulted in significant variances in each year's MLR calculation, which were identified once revised FEHBP-specific MLR forms and supporting documentation were provided during our audit. We used the revised MLR forms and supporting documentation to calculate our audited MLR calculations.

The Plan's inability to support its MLR calculations resulted in variances of [redacted] in 2013; [redacted] in 2014; and [redacted] in 2015.

In calculating our audited MLRs in each year, we identified the following discrepancies between the Plan's numbers used in its original FEHBP-specific MLR that was filed with OPM and its revised submission, provided during the audit. Specifically, for contract year 2013, the pharmacy and capitation claims were overstated by [redacted] and [redacted] respectively, and the intersegment and vision claims were understated by [redacted] and [redacted], respectively. The Plan was also unable to support its original Line 2.1(b) claims amount, which reduced our audited claims by [redacted]. In contract year 2014, the pharmacy, vision, and dental claims were understated by [redacted], [redacted], and [redacted], respectively, and the Plan was unable to support its original Line 2.1(b) claims amount, which reduced our audited claims by [redacted]. Finally, in contract year 2015, the vision and dental claims were understated by [redacted], and [redacted], respectively. The Plan's Line 2.1(b) claims amount was also understated by [redacted].

Plan Response:

The Plan acknowledges an issue which required the re-filing of the OPM MLR submission and agrees with the revised credit amounts outlined.

Conclusion

We recalculated the Plan's 2013 through 2015 OPM MLRs, incorporating the above mentioned adjustments. A comparison of our audited MLR calculations to those submitted by the Plan showed an overstated OPM MLR credit amount of [redacted] for 2013 and understated MLR credit amounts of [redacted] and [redacted] for 2014 and 2015, respectively (see Exhibits B, C, and D).

Recommendation 1

We recommend that the contracting officer instruct OPM's Office of the Actuary to reduce the Plan's 2013 credit by [redacted].

Recommendation 2

We recommend that the contracting officer instruct OPM's Office of the Actuary to increase the Plan's 2014 credit by [redacted].

Recommendation 3

We recommend that the contracting officer instruct OPM's Office of the Actuary to increase the Plan's 2015 credit by [redacted].

Recommendation 4

We recommend that the Plan maintain supporting documentation for designated FEHBP disabled dependents.

Recommendation 5

We recommend that the Plan incorporate system edits to terminate non-disabled dependents 31 days after their 26th birthday.

Recommendation 6

We recommend that the Plan establish periodic training courses to refresh its employees on the policies and procedures to prevent the payment of non-covered benefits.

Recommendation 7

We recommend that the Plan ensure that the data used in the creation of the OPM MLR form, which is submitted to OPM, is accurate, complete, and consistent with the methodology stated in 5 CFR Sec. 1615.402(c)(3)(ii) and can be produced upon request during future audits.

B. Internal Controls Review

The Plan did not have adequate written policies and procedures to govern the MLR process and was unable to provide all of the necessary supporting documentation during the audit, including its capitation benefit factor adjustments for contract years 2013 through 2015. In addition to not being in compliance with the Contract's records retention requirements, this lack of internal controls over the MLR process resulted in significant discrepancies in the MLRs that were filed with OPM in each year and required material changes in the credit amounts claimed as discussed above.

A lack of sufficient policies and procedures over the MLR process resulted in significant discrepancies to the FEHBP-specific MLR forms filed with OPM.

Section 5.64(c)(2)(ii)(A) of the Contract states that the Contractor's internal control system will at a minimum provide for "Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the … internal control system." The Contract further states at Section 5.64(c)(2)(ii)(C)(1), (2) and (3) that the Contractor's internal control system should provide "Periodic reviews of company business practices, procedures, policies, and internal

controls for compliance with … the special requirements of Government contracting, including--

(1) Monitoring and auditing to detect criminal conduct;

(2) Periodic evaluation of the effectiveness of the … internal control system, especially if criminal conduct has been detected; and

(3) Periodic assessment of the risk of criminal conduct, with appropriate steps to design, implement, or modify … the internal control system as necessary to reduce the risk of criminal conduct identified through this process."

Additionally, OPM's Contract Section 1.11(b) requires insurance carriers to maintain all records relating to the contract and to make these records available for a period of time specified by FEHBAR 1652.204-70. The referenced clause is incorporated into the contracts at Section 3.4, which requires the carrier to maintain "all records applicable to a contract term ... for a period of six years after the end of the contract term to which the claim records relate."

During our review of capitated claims, we determined that the benefit factors used in the calculation of the 2013 through 2015 capitated rates varied from the supporting rate workbooks provided by the Plan. The Plan explained that the supporting rate workbooks were periodically adjusted. Therefore, the discrepancies identified were caused by changes between the rates used during the audit scope and the rates that are currently being used. The Plan was unable to provide a copy of the workbooks that would support the benefit factor adjustments during 2013 through 2015.

We determined that the impact of the benefit factor variance on the overall capitated rate was immaterial. However, the Plan is not in compliance with its contractual and regulatory requirements for the maintenance of records since it did not maintain the historical records used to support the benefit factor adjustments.

Finally, as mentioned previously, due to a lack of adequate written policies and procedures over the MLR process, we were unable to determine if the Plan had sufficient oversight over its MLR calculation for our audit scope and were unable to obtain supporting documentation for various pieces of the MLR calculation in each year.

Plan Response:

The Plan stated that it does have standard policies and procedures to govern the MLR process and has implemented a process to ensure the issue that occurred in the calculations during the

audit scope does not occur in the future. The Plan maintains that it is in compliance with the record retention requirements of its contract and stated it will continue to ensure compliance in the future.

OIG Comment:

We maintain that the Plan's written policies and procedures were not adequate, which resulted in OPM MLR calculation discrepancies for all years of the audit scope. Furthermore, we disagree that the Plan was in compliance of its record retention requirements due to the lack of accurate supporting documentation for its capitation benefit factors used in the OPM MLR calculation for each year of the audit.

Recommendation 8

We recommend that the Plan develop adequate written, standardized policies and procedures over its MLR calculation and reporting process.

Recommendation 9

We recommend that the Plan comply with the record retention requirements of its contract.

C. Premium Review

The Plan opted to use OPM's subscription income in its FEHBP MLR calculations. We confirmed that the Plan accurately reported OPM's subscription income in its FEHBP MLR submissions. Consequently, no further reviews were necessary.

D. Quality Health Improvements Review

Our review determined that the Plan's quality health improvements included in its MLR filing were allowable and equitably allocated to the FEHBP-specific MLR using a reasonable allocation method.

E. Tax Review

Our review determined that the Plan's Federal and state taxes and licensing or regulatory fees included in its MLR filing were allowable and consistently allocated based on the principles and methods described in the Public Health Service Act section and the Federal Register.

F. Fraud, Waste, and Abuse Review

Our review determined that the Plan had adequate procedures in place to provide reasonable assurance of detecting fraud, waste, and abuse and other illegal acts.

G. Debarment Review

Our review determined that the Plan had procedures in place to identify providers debarred or suspended from participation in the FEHBP. Additionally, the Plan had procedures in place to notify both the provider and the subscriber and to stop payment to debarred or suspended providers.

H. Financial Statement Review

Our limited review of the Plan's audited financial statements found that the Plan maintained sufficient financial resources to be compliant with its OPM contract.

I. Offshore Contracting Review

Our review determined that the Plan had processes and procedures in place to ensure oversight of its offshore activities.

J. Hold Harmless Review

Our review determined that the Plan has sufficient hold harmless language in its provider contracts to certify that the member will not be held liable for payments in the case of Plan insolvency.

EXHIBIT A

UnitedHealthcare of California
Summary of MLR Credit Adjustments

2013 Overstated MLR Credit	[redacted]
2014 Understated MLR Credit	[redacted]
2015 Understated MLR Credit	[redacted]

EXHIBIT B

UnitedHealthcare of California
2013 MLR Credit Adjustment

	Plan	Audited
2013 FEHBP MLR Lower Corridor (a)	85%	85%
2013 FEHBP MLR Upper Corridor (b)	89%	89%
Claims Expense		
Incurred Claims (Medical and Pharmacy)	[redacted]	[redacted]
Less: Unsupported Line 2.1(b) Claims	$0	[redacted]
Less: Dependent Eligibility Claims – Unsupported	$0	[redacted]
Less: Dependent Eligibility Claims – Untimely Terminations	$0	$0
Less: Non-Covered Services Claims	$0	[redacted]
Less: Overstated Pharmacy Claims	$0	[redacted]
Less: Overstated Capitation Claims	$0	[redacted]
Plus: Understated Intersegment Claims	$0	[redacted]
Plus: Understated Vision Claims	$0	[redacted]
Adjusted Incurred Claims	[redacted]	[redacted]
Less: Healthcare Receivables	[redacted]	[redacted]
Plus: Allowable Fraud Reduction Expense	[redacted]	[redacted]
Plus: Expenses to Improve Health Care Quality	[redacted]	[redacted]
Total MLR Numerator	[redacted]	[redacted]
Premium Expense		
Premium Income	[redacted]	[redacted]
Less: Federal and State Taxes and Licensing or Regulatory Fees	[redacted]	[redacted]
Total MLR Denominator (c)	[redacted]	[redacted]
FEHBP MLR Calculation (d)	[redacted]	[redacted]
Penalty Calculation (If (d) is less than (a), ((a-d)*c)	$0	$0
Credit Calculation (If (d) is greater than (b), ((d-b)*c)	[redacted]	[redacted]
Credit Adjustment Due To OPM		[redacted]

EXHIBIT C

UnitedHealthcare of California
2014 MLR Credit Adjustment

	Plan	Audited
2014 FEHBP MLR Lower Corridor (a)	85%	85%
2014 FEHBP MLR Upper Corridor (b)	89%	89%
Claims Expense		
Incurred Claims (Medical and Pharmacy)	[redacted]	[redacted]
Less: Unsupported Line 2.1(b) Claims	$0	[redacted]
Less: Dependent Eligibility Claims – Unsupported	$0	[redacted]
Less: Dependent Eligibility Claims – Untimely Terminations	$0	$0
Less: Non-Covered Services Claims	$0	$0
Plus: Understated Pharmacy Claims	$0	[redacted]
Plus: Understated Vision Claims	$0	[redacted]
Plus: Understated Dental Claims	$0	[redacted]
Adjusted Incurred Claims	[redacted]	[redacted]
Less: Healthcare Receivables	[redacted]	[redacted]
Plus: Allowable Fraud Reduction Expense	[redacted]	[redacted]
Plus: Expenses to Improve Health Care Quality	[redacted]	[redacted]
Total MLR Numerator	[redacted]	[redacted]
Premium Expense		
Premium Income	[redacted]	[redacted]
Less: Federal and State Taxes and Licensing or Regulatory Fees	[redacted]	[redacted]
Total MLR Denominator (c)	[redacted]	[redacted]
FEHBP Medical Loss Ratio (d)	[redacted]	[redacted]
Penalty Calculation (If (d) is less than (a), ((a-d)*c)	$0	$0
Credit Calculation (If (d) is greater than (b), ((d-b)*c)	[redacted]	[redacted]
Credit Adjustment Due To Plan		[redacted]

EXHIBIT D

UnitedHealthcare of California
2015 MLR Credit Adjustment

	Plan	Audited
2015 FEHBP MLR Lower Corridor (a)	85.00%	85.00%
2015 FEHBP MLR Upper Corridor (b)	89.00%	89.00%
Claims Expense		
Incurred Claims (Medical and Pharmacy)	[redacted]	[redacted]
Plus: Understated Line 2.1(b) Claims	$0	[redacted]
Less: Dependent Eligibility Claims – Unsupported	$0	
Less: Dependent Eligibility Claims – Untimely Terminations	$0	$0
Less: Non-Covered Services Claims	$0	$0
Plus: Understated Vision Claims	$0	[redacted]
Plus: Understated Dental Claims	$0	
	[redacted]	[redacted]
Less: Healthcare Receivables	[redacted]	[redacted]
Plus: Allowable Fraud Reduction Expense		
Plus: Quality Health Improvement Expenses		
Total MLR Numerator	[redacted]	[redacted]
Premium Expense		
Premium Income	[redacted]	[redacted]
Less: Federal and State Taxes and Licensing or Regulatory Fees	[redacted]	[redacted]
Total MLR Denominator (c)	[redacted]	[redacted]
FEHBP Medical Loss Ratio (d)	[redacted]	[redacted]
Penalty Calculation (If (d) is less than (a), ((a-d)*c)	$0	$0
Credit Calculation (If (d) is greater than (b), ((d-b)*c)	$0	[redacted]
Credit Adjustment Due To Plan		[redacted]

EXHIBIT E

Medical Claims Sample Selection Criteria/Methodology

Medical Claims Review Area	Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Coordination of Benefits with Medicare 2013	Queried high dollar medical claims for members greater than or equal to age 65	[redacted] claims	[redacted]	Judgmentally selected [redacted] claims greater than or equal to $50,000 totaling [redacted] for [redacted] members	Judgmental	No
Member Eligibility 2013	Queried members with at least one medical claim during FY 2013.	[redacted] members	N/A	Randomly selected [redacted] members from the universe using SAS EG	Random	No
Dependent Eligibility 2013	Queried members greater than or equal to age 26 designated as dependent	[redacted] members	N/A	Randomly selected [redacted] members from the universe [redacted]	Random	No
Non-Covered Benefits 2013	Queried medical claims with procedure codes 59821, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 59866 with amount paid greater than zero	[redacted] claims	[redacted]	Selected the full universe of [redacted] claims, totaling [redacted]	N/A	N/A

Pharmacy Claims Sample Selection Criteria/Methodology

Pharmacy Claims Review Area	Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Dependent Eligibility 2013	Queried members greater than or equal to age 26 designated as dependent	139 members	N/A	Randomly selected 25 members from the universe using SAS EG after removing members selected in the Medical Dependent Eligibility review	Random	No

APPENDIX

July 20, 2018

[redacted]
U.S. Office of Personnel Management
Office of the Inspector General
1900 E Street, N.W.
Room 64
Washington, DC 20415

**RE: Comments to the Draft Audit Report on UHC of California,
Plan Code CY, Report No. 1C-CY-00-17-047**

Dear [redacted]:

On May 18, 2018, the United States Office of Personnel Management, Office of the Inspector General ("OPM/OIG") submitted to UHC of California ("the Plan") a "Draft Report" (1C-CY-00-17-047) ("Draft Report"), detailing the results of its audit of the Federal Employees Health Benefits Program ("FEHBP") operations of the UHC of California ("the Plan"), rate code CY, for contract years 2013 – 2015. Upon submission, OPM/OIG requested the Plan provide comments to the Draft Report.

The Plan appreciates the opportunity to respond to this Draft Report and the willingness of OPM to help resolve the outstanding issues in this audit. The Plan has used its best efforts to obtain all relevant information to respond to the Draft Report's findings and recommendations. This Response will address each issue presented in the Draft Report.

Deleted by the OIG – Not Relevant to the Final Report

Overstated/Understated MLR Credit Carryforward

The Auditors state *"The Plan submitted inaccurate MLR calculations to OPM and was unable to provide sufficient documentation to support its incurred claims amounts for contract years 2013 through 2015. This resulted in significant variances in each year's MLR calculation, which were identified once revised FEHBP-specific MLR forms and supporting documentation were provided during our audit. We used the revised MLR forms and supporting documentation to calculate our audited MLR calculations."*

The Plan discovered that the detail support gathered to confirm the information provided on the MLR Form submitted on September 30 of each year did not match exactly to the numbers reported on the MLR Form. This was due to change in the account mapping within the financial reporting area. As a result the Plan submitted revised MLR Forms (which resulted in the overstated and understated MLR Credit Carryforward numbers mentioned in the Draft Report) to the OIG Auditors. The revised numbers did not result in a change to the position of the Plan relative to a rebate or carryforward stance. The Plan remained in a credit carryforward position for all three years within the scope of the audit, the amount of the credit carryforward decreased in 2013 and increased in 2014 and 2015. The account mapping has been corrected and going forward there is a process to insure that all changes are reviewed and incorporated into the reporting used as the basis for completing the FEHBP-specific MLR Form submitted to OPM September 30 of each year.

Claims Paid for Ineligible Dependents

The auditors state *"Based on our review, we determined that claims were paid for members whose (i) dependent eligibility status could not be supported, and (ii) coverage was not terminated timely, which inflated the claims costs used in the Plan's Federal Employees Health Benefits Program (FEHBP) MLR submissions."*

The Plan has reviewed the specific dependents identified in the workpapers and has determined the following:

Medical & Prescription Drug Claims Paid

Of the 15 dependents identified as disabled by the Plan and questioned for Medical and Prescription Drug claims by the OIG Auditors:

5 dependents – The Plan followed up with requests to the relevant agency and no response was received from the agency,

2 dependents – The Plan requested the original data and the agency indicated their records were not available for the historical period requested,

6 dependents - The Plan provided documentation for a different time period where the dependent disability was documented and by the age logic implemented on the program would be eligible and,

2 dependents - The Plan previously provided MB1000 (internal system) report based on the EDI received from OPM at the time of the enrollment.

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Based on the Plan's review of the relevant information, the Plan maintains these dependents were eligible for benefits during the review period within the scope of the audit and therefore no adjustments to the medical or prescription drug claims should be made for these eligible disabled dependents.

Termination of Coverage

The Auditors state *"…The Plan did not timely terminate coverage for dependent members who had become ineligible for coverage in contract years 2013 through 2015."* The Auditors conclude *"…However, it was determined that no claims were paid for these members during the dependents' ineligible timeframes."*

The Plan reviewed the requirements for termination based on OPM's Handbook which states in part *"…Coverage terminates at midnight on the date of terminating event - not at the end of a pay period" and "Days-Whenever, in this Handbook, a period of time is stated as a number of days, or as a number of days from an event, the period is computed in calendar days, excluding the day of the event."*

The Plan has reviewed the specific members identified by the OIG auditors and has determined that all 5 members identified were terminated in compliance with OPM's methodology as stated in the handbook referenced above (and can also be found at the following address -- https://www.opm.gov/healthcare-insurance/healthcare/reference-materials/reference/glossary/)

Therefore the Plan does not believe any adjustment to claims is necessary (as the Auditors acknowledge there were not claims questioned as a result of the termination dates). Further, the Plan disagrees with the calculation of the number of days that the Auditors used as it does not appear to conform to OPM's definition/method outlined in their own handbook. The Plan does not believe the methodology that is utilized by the Plan requires any adjustment.

Non-Covered Benefits

In the Draft Report, the Auditors state: "We identified two claims that were paid for non-covered benefits, specifically elective abortions, during contract year 2013."

The Plan acknowledges (as also stated in the Draft Report) that the claims were paid in error. Further, the Plan implemented a re-training process for the claims processor involved in the error. The Auditors acknowledge *"….the Plan had both system and procedural controls in place"*….and*…."We verified the claims did have suspend messages in the Plan's system and that training provided to adjusters instructs them to review and fully process all claims that contain a suspend code."*

The Plan believes the issue was addressed appropriately and no further action is required as the Auditors did remove the $3,144 from the MLR numerator in contract year 2013.

Deleted by the OIG – Not Relevant to the Final Report

Conclusion

Each of the recommendations made in the Draft Report are addressed by the Plan as follows:

Recommendation 1 – 3 – MLR Credit Carry Forward Adjustments

The Plan agrees with Recommendations 1 through 3 regarding the adjustments necessary to the credit carry forward balances for contract years 2013 through 2015.

Recommendation 4 – Supporting Documentation – Disabled Dependents

The Plan agrees that supporting documentation is required for designated FEHBP disabled dependents. However, the Plan does assert that the information supplied by OPM through electronic data transfer is sufficient to support the ongoing designation of these dependents.

Recommendation 5 – System Edits 31 day termination

The Plan has used the method prescribed by OPM to calculate the appropriate termination date for non-disabled dependents and therefore does not believe any action is required with respect to this recommendation.

Recommendation 6 – Strengthen Policies and Procedures – Non-Covered Benefits

The Plan agrees that is important to assure non-covered benefits are not paid. With respect to the recommendation the Plan has reiterated the policy and will monitor the process going forward to insure non-covered benefits are not paid.

Recommendation 7 – MLR accuracy

The Plan acknowledges there was an issue requiring re-filing of the MLR submission to the auditors and agrees that the revised credit carry forward amounts outlined in the Draft Report are accurate.

Recommendation 8 – MLR Policies and Procedures

The Plan does have standard policies and procedures and has implemented a process to ensure the error that occurred in the calculation of MLR does not occur in the future.

Recommendation 9 – Record Retention

The Plan believes it is in compliance with the record retention requirements of its contract and will continue to ensure compliance with the contract in the future.

The Plan appreciates the opportunity to respond to the Draft Audit Report. Once you have had an opportunity to review the information contained in this response, please contact me if you have any questions or require additional information.

Thank you for your assistance in resolving the issues identified in the Draft Report.

Respectfully,

[redacted]

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Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, NW
Room 6400
Washington, DC 20415-1100

Report No. 1C-CY-00-17-047