



**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 ALLIANCE PLAN**

Report Number 1C-52-00-17-031

May 10, 2018

EXECUTIVE SUMMARY

Audit of the Federal Employees Health Benefits Program Operations at Health Alliance Plan

Report No. 1C-52-00-17-031

May 10, 2018

Why Did We Conduct the Audit?

The primary objective of the audit was to determine if Health Alliance Plan (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 Program, 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 1092, the Office of the Inspector General (OIG) completed a performance audit of the FEHBP MLR submissions to OPM for contract years 2013 and 2014. Our audit fieldwork was conducted from May 15, 2017, through October 4, 2017, at the Plan's office in Southfield, Michigan and in our OIG Offices.



Michael R. Esser
*Assistant Inspector General
for Audits*

What Did We Find?

This report identified overstated OPM MLR credits totaling \$1,215,409 for contract years 2013 and 2014. Specifically, these overstated credits were derived due to the following identified errors:

- The Plan used inconsistent membership timeframes to calculate the quality health improvement and tax allocation expenses for 2013.
- The Plan included claims for unsupported disabled and ineligible overage dependents in their 2013 and 2014 claims data.

We corrected the above errors in our audited MLR calculations for each year. Consequently, this audit shows that the Plan overstated its reported 2013 and 2014 MLR credits by \$437,844 and \$777,565, respectively.

Our audit did not disclose any findings related to the Plan's procedures for fraud and abuse, debarment, and off-shore contracting. Additionally, our audit did not disclose any findings related to our claim reviews for coordination of benefits, deceased members, high dollar scripts, member eligibility, or non-covered benefits.

ABBREVIATIONS

CFR	Code of Federal Regulations
FEHBAR	Federal Employees Health Benefits Acquisition Regulations
FEHBP	Federal Employees Health Benefits Program
MLR	Medical Loss Ratio
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
Plan	Health Alliance Plan
QHI	Quality Healthcare Improvement
QI	Quality Improvement
SSSG	Similarly Sized Subscriber Group
U.S.C.	United States Code

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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 Health Alliance Plan (Plan). The audit was conducted pursuant to the provisions of Contract CS 1092; 5 United States Code (U.S.C.) Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract years 2013 and 2014, and was conducted at the Plan's office in Southfield, Michigan.

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-

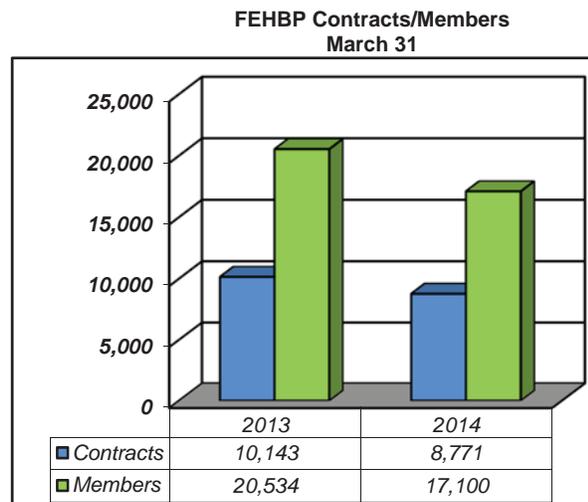
mandated to use traditional community rating. State-mandated traditional community-rated carriers continue to be subject to the SSSG comparison rating methodology.

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 on the right.

The Plan has participated in the FEHBP since 1962 and provides health benefits to FEHBP members in the Detroit and Southeastern Michigan areas.



There were no previous MLR audits of the Plan. However, a prior audit of the Plan covered contract years 2009 through 2011. The audit found that the FEHBP premium rates were developed in accordance with the Office of Personnel Management's rules and regulations for the years audited.

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 fraud and abuse, debarment, 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, 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.

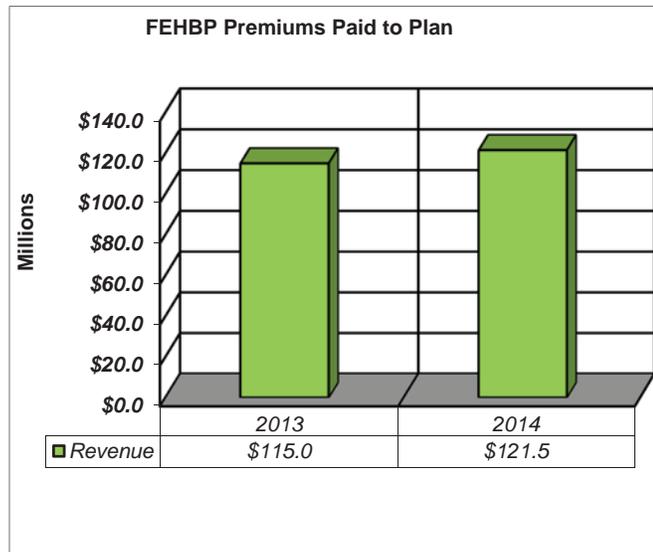
Although the FEHBP premiums used in the MLR calculation are ultimately determined by the premium rates proposed by the Plan and certified and paid by OPM, the OPM rating instructions no longer provide sufficient criteria to evaluate the fairness of those rates against the standard market value of similarly-sized 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 and 2014. For these years, the FEHBP paid approximately \$236.5 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.



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 May 15, 2017, through October 4, 2017, at the Plan's office in Southfield, Michigan and in our offices in Jacksonville, Florida; 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 calculation.

To gain an understanding of the internal controls in the Plan's claims processing system, we reviewed the Plan's claims processing policies and procedures and interviewed appropriate Plan officials regarding the controls in place to ensure that claims were processed accurately. Other auditing procedures were performed as necessary to meet our audit objectives.

Additionally, we interviewed Plan officials and reviewed the Plan's policies and procedures associated with its internal controls over the fraud and abuse, debarment, and offshore contracting programs.

The tests performed for the medical and pharmacy claims, along with the methodology, are detailed in the Exhibits D and 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

1. Overstated Medical Loss Ratio Credit \$1,215,409

In order to assess the appropriateness of the Plan's premium rates in 2013 and 2014, the Plan was required to file an MLR calculation under OPM's MLR program. The MLR program replaced SSSG requirements with an MLR threshold. Simply stated, the MLR is the ratio of the FEHBP's incurred claims (including expenses for quality healthcare improvements (QHI)) to total premium revenue determined by OPM.

For contract years 2013 and 2014, OPM established an MLR threshold of 85 percent and created an MLR corridor. This threshold requires carriers to spend 85 cents of every health care premium dollar on health care expenses. If a carrier's MLR falls between 85 and 89 percent, no penalty is due. If a carrier's MLR is less than 85 percent, the carrier will owe a subsidization penalty equal to the difference between the threshold and the carrier's actual MLR, multiplied by the denominator of the MLR. If the MLR is over 89 percent, the carrier receives a credit equal to the difference between the carrier's reported MLR and 89 percent, multiplied by the denominator of the MLR. For contract year 2013, this credit can be used to offset any future MLR penalty and is available until it is used up by the Plan or the Plan exits the FEHBP. For contract year 2014, the credit can be used to offset any future MLR penalties for a period of five years.

The Plan calculated an MLR of 93.92 percent for contract year 2013 and 91.61 percent for contract year 2014. Since these ratios exceeded the OPM established threshold of 89 percent, the Plan received an MLR credit of \$5,647,791 for 2013 and \$3,120,141 for 2014. However, during our review of the Plan's MLR submission, we identified issues that resulted in an audited MLR that was lower than that calculated by the Plan for both years. As a result, we determined that the Plan's MLR credit should be reduced by \$437,844 and \$777,565 in contract years 2013 and 2014, respectively. The specific issues that led to the credit adjustments were the following.

a. QHI and Tax Allocation

The Plan used a member-based methodology to calculate the FEHBP's QHI and tax allocation expenses for contract year 2013. Specifically, the Plan calculated a membership ratio using the large group membership as of March 31, 2014, and the FEHBP membership as of December 31, 2013. While we are not opposed to the use

of a membership ratio to allocate expenses, it is our position that the large group and FEHBP membership used by the Plan should be consistent and capture the same timeframes. Section 3.3(a)(4) of the Plan's contract with OPM states that participating carriers cannot submit or keep in their files data or information of any description that is not complete, accurate, and current, as support for the FEHBP rate. Additionally, the Plan did not maintain written policies and procedures for calculating the allocation of their QHI and tax expenses to the FEHBP. Therefore, some of the Plan's calculations could not be traced or recalculated using supporting documentation. Consequently, we recalculated the FEHBP's expenses using the December 31, 2013, large group and FEHBP membership totals that were supportable.

The Plan's QHI expense totaled \$514,112 and the tax expense totaled \$278,193 for 2013. However, our audited calculations resulted in a total QHI and tax expense amount of \$510,026 and \$327,150, respectively. A comparison of the Plan's total expense to our audited expense resulted in a QHI expense variance of \$4,086 and a tax expense variance of \$48,957. We used our audited QHI and tax expense amounts in our audited 2013 MLR calculation.

Plan Response:

HAP used the 3/31/14 MLR filing as a basis for their membership, the support of which comes from the annual filing information prepared in February for the State on the Supplemental Healthcare Exhibit. The effective date of the membership that is included in the State's filing is 12/31/13. Additionally, HAP's member months totaling 224,378 was only 2 member months off of the OIG's total member months of 224,376. HAP is not sure how the OIG derived their member month amount, but the difference changed the expense allocation by \$4,085, which reduced the credit by the same amount. Furthermore, the taxes and fees percentage allocated by the OIG increased their amount by \$48,957. In doing so, the OIG actually increased the credit by \$43,952.

"In summary, the net of these two items increased the credit by [\$]39,487. The two figures [\$]4,085 and [\$]43,952 do not net to the difference, since it is a formula and one effects the numerator and one effects the denominator." The main reason for the decrease in the credit amount comes from the changes to the adjusted incurred claims.

OIG Comment:

Our audited QHI and tax calculations include the December 31, 2013, large group membership of 3,301,364 that tied to the Supplemental Healthcare Exhibit and the MLR filing. The Plan's calculation included 3,275,157 membership for the large group. Their membership tied to the March 31, 2014, HHS filing. The total FEHBP membership of 244,376 derived from the Plan's enrollment support provided for 2013.

We determined the percentage of taxes allocated to HAP by using their Quality Improvements (QI) workbook, which was consistent with the methodology used in the 2014 tax allocation calculation. The Plan allocated 83.96 percent of their taxes to HAP, however, the QI workbook shows that 83.1 percent of their taxes should have been allocated.

We calculated our audited rates using the revised tax allocation percentage and the December 31, 2013, large group and FEHBP membership data.

The Plan did not provide any written policies and procedures in response to the draft report. Our position has remained unchanged for this finding.

b. MLR Claims Data

i. Disabled Dependents

The Plan does not maintain adequate supporting documentation for disabled dependents and was unable to retrieve documentation to support their eligibility prior to January 1, 2011. The FEHBP Handbook states that it is the responsibility of the subscriber's enrollment office to provide documentation for disabled dependents. However, the Plan is responsible for maintaining this documentation per OPM Contract 1092 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 claims for possible ineligible 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." By not maintaining eligibility documentation, which is necessary to ensure that the Plan is properly including claims for eligible disabled dependents in its incurred claims amounts, the Plan is not only potentially overstating its MLR, but it is also not in compliance with contractual and regulatory requirements for the maintenance of records.

To test the impact that this lack of supporting documentation had on the claims universe, we reviewed five medical members and two pharmacy members, identified as disabled dependents, as part of our overage dependent claims review. We found that the Plan did not maintain appropriate documentation to support the eligibility for all seven disabled dependents. Consequently, we expanded our review to query all 2013 and 2014 medical and pharmacy claims for disabled dependents. Once these members were identified, we used SAS to query all 2013 and 2014 claims incurred for these members. The claims identified from this query were removed from the numerator of our audited 2013 and 2014 MLR calculations. Specifically, we removed 753 medical claims totaling \$241,843 and 1,250 pharmacy claims totaling \$163,055 from the numerator of the 2013 MLR calculation. Similarly, we removed 857 medical claims totaling \$211,145 and 1,161 pharmacy claims totaling \$135,501 from the numerator of the 2014 MLR calculation.

ii. Late Terminations

The Plan did not terminate coverage for ineligible overage dependents until the end of the calendar year. During our audit we met with Plan personnel to discuss their dependent termination policies and procedures. Per the Plan, they do not terminate dependent coverage for overage dependents until either contacted by OPM or on their failsafe date of December 31st. However, according to the FEHBP benefit brochures, 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.

The Plan's 2013 and 2014 MLRs included improperly paid claims for dependents over the age of 26.

Our sample of late terminations included 20 medical members and 22 pharmacy members. During our review, we found that the Plan did not properly terminate dependent coverage for all 42 members 31 days after their 26th birthday. Due to

the systematic late terminations in our 2014 medical and pharmacy overage dependent samples, we queried all medical and pharmacy claims for members over age 26 that were not identified as subscribers, spouses, or disabled for contract years 2013 and 2014. We also queried members from the Plan's disabled member lists for both years. Once we identified our target universe for testing, we queried any claims that were processed for these members after the extension of coverage date (31 days after the member's 26th birthday). The claims identified as being improperly paid were removed from the numerator of our audited MLR calculations for 2013 and 2014. We removed 252 medical claims totaling \$63,343 and 214 pharmacy claims totaling \$9,089 from the numerator of the 2013 MLR calculation. Similarly, we removed 777 medical claims totaling \$382,754 and 665 pharmacy claims totaling \$48,165 from the numerator of the 2014 MLR calculation.

iii. Coordination of Benefits

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

iv. Deceased Members

Based on our review, we concluded that the Plan did not pay any medical or pharmacy claims for deceased members.

v. High Dollar Pharmacy Scripts

Based on our review, we concluded that the Plan supported all high dollar claims with an original script.

vi. 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.

vii. Non-Covered Benefits

Based on our review, we concluded that the Plan did not pay for benefits not covered in the FEHBP Plan brochure.

Plan Response:

“The sample size audited was for members in 2013 [and] 2014. These were not new disabled dependents to HAP and were coded in our system prior to these dates. Unfortunately, any documentation received from the payroll offices for the sample members are in an offsite storage as these members were coded as permanently disabled prior to 2011. ... HAP maintains all documentation it receives for FEHB members. As of August 2016, that documentation is now scanned into a workflow system and is readily available for review. ... If HAP does not receive proper documentation from a payroll office for a disabled dependent – our enrollment specialist will reach out to the payroll office [three] times to obtain this approval documentation. These attempts will be documented in our workflow system for reference. Unfortunately, it is very difficult to work with many of the payroll offices when we need additional information. We use the contacts in the CLER system but have been unsuccessful in attempts to solidify membership details. ... The workflow system houses all information and documentation for FEHB membership and will be readily available and not sent to storage.”

“Prior to April 2017, our system was programmed to terminate any 26 year old nondisabled dependent at the end of the calendar year unless we received an EDI transaction for termination or notification from the family or payroll office. ... After April 2017, our system is now programmed to terminate 26 year old nondisabled dependents as of the dependents date of birth. We have submitted a request to have the system changed to 31 days after the dependents 26th birthday. This request will be prioritized in 2018.”

OIG Comment:

We acknowledge the Plan’s claim that they have implemented a system to make the documentation for disabled dependents available onsite after August 2016. However, the necessary documentation for disabled dependents was not available for our audit. We also acknowledge that the Plan is in the process of updating their system to terminate ineligible overage dependents per OPM’s guidelines in 2018. However, ineligible overage dependents were not terminated timely during our audit scope. The Plan did not provide any written policies and procedures in response to the draft report. Therefore, our position has remained unchanged for this finding.

Conclusion

We corrected the 2013 and 2014 MLR calculations for the errors identified above. A comparison of our audited 2013 and 2014 MLR calculations to the 2013 and 2014 MLR calculations included in the Plan's submissions to OPM showed overstated credit amounts in both years. Specifically, we identified overstated MLR credits of \$437,844 for 2013 and \$777,565 for 2014.

Recommendation 1

We recommend that the contracting officer instruct OPM's Office of the Actuary to decrease the Plan's MLR credit by \$437,844 for 2013.

Recommendation 2

We recommend that the contracting officer instruct OPM's Office of the Actuary to decrease the Plan's MLR credit by \$777,565 for 2014.

Recommendation 3

We recommend that the Plan develop written policies and procedures to document their FEHBP QHI and tax allocation expense calculations.

Recommendation 4

We recommend that the Plan maintain adequate documentation from the responsible payroll offices for designated FEHBP disabled dependents.

Recommendation 5

We recommend that the Plan establish policies and procedures for terminating non-disabled FEHBP dependents 31 days after their 26th birthday.

B. Fraud and Abuse Review

Based on our review, we concluded that the Plan has adequate procedures in place to provide reasonable assurance of detecting fraud and abuse and other illegal acts.

C. Debarment Review

Based on our review, we concluded the Plan has procedures in place to identify providers debarred or suspended from participation in the FEHBP. Also, we determined the Plan has procedures in place to notify both the provider and the subscriber and to stop payment to debarred or suspended providers.

D. Offshore Contracting Review

Based on our review, we concluded that the Plan has adequate procedures to ensure oversight of their offshore activities.

EXHIBIT A

Health Alliance Plan Summary of MLR Credit Adjustment

2013 Overstated MLR Credit	(\$437,844)
2014 Overstated MLR Credit	(\$777,565)
Total Overstated MLR Credit	<u>(\$1,215,409)</u>

EXHIBIT B

Health Alliance Plan 2013 MLR Credit Adjustment

	Plan	Audited
Adjusted Incurred Claims	\$107,239,111	\$106,761,781
Quality Health Improvement Expenses	<u>\$514,112</u>	<u>\$510,026</u>
MLR Numerator	\$107,753,223	\$107,271,807
Premium Income	\$115,003,397	\$115,003,397
Federal and State Taxes and Licensing or Regulatory Fees	\$278,193	\$327,150
MLR Denominator (a)	\$114,725,204	\$114,676,247
FEHBP Medical Loss Ratio (b)	93.92%	93.54%
2013 FEHBP MLR Lower Corridor (c)	85.00%	85.00%
2013 FEHBP MLR Upper Corridor (d)	89.00%	89.00%
Penalty Calculation (If (b) is less than (c), ((c-b)*a)	\$0	\$0
Credit Calculation (If (b) is greater than (c), ((b-d)*a)	\$5,647,791	\$5,209,947
Credit Adjustment Due To OPM		(\$437,844)

EXHIBIT C

Health Alliance Plan 2014 MLR Credit Adjustment

	Plan	Audited
Adjusted Incurred Claims	\$108,724,647	\$107,947,082
Quality Health Improvement Expenses	<u>\$882,243</u>	<u>\$882,243</u>
MLR Numerator	\$109,606,890	\$108,829,325
Premium Income	\$122,566,963	\$122,566,963
Federal and State Taxes and Licensing or Regulatory Fees	\$2,918,930	\$2,918,930
MLR Denominator (a)	\$119,648,033	\$119,648,033
FEHBP Medical Loss Ratio (b)	91.61%	90.96%
2014 FEHBP MLR Lower Corridor (c)	85.00%	85.00%
2014 FEHBP MLR Upper Corridor (d)	89.00%	89.00%
Penalty Calculation (If (b) is less than (c), ((c-b)*a)	\$0	\$0
Credit Calculation (If (b) is greater than (c), ((b-d)*a)	\$3,120,141	\$2,342,576
Credit Adjustment Due To OPM		(\$777,565)

EXHIBIT D

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 w/Medicare – High Dollar 2014	Members greater than or equal to age 65.	82,180 claims	\$17,681,167	15 claims with the highest amount paid totaling \$1,577,988.	Judgmental	No
Coordination of Benefits w/Medicare – Random 2014	Members greater than or equal to age 65.	82,180 claims	\$17,681,167	Used SAS to randomly select 15 claims totaling \$4,566.	Random	No
Dependent Eligibility 2014	Medical claims for dependents greater than or equal to age 26.	170 members	N/A	Used SAS to randomly select 25 members from the universe after removing duplicate members.	Random	No
Deceased Member 2014	Members greater than or equal to age 90.	64 members	N/A	Used SAS to randomly select 25 members from the universe after removing duplicate members.	Random	No
Member Eligibility 2014	Members with at least one medical claim in CY 2014	17,204 members	N/A	Used SAS to randomly select 25 members from the universe.	Random	No

EXHIBIT E

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?
High Dollar Scripts 2014	Pharmacy claims greater than or equal to \$15,000.	18 claims	\$399,503	All 18 pharmacy claims in the universe totaling \$399,503.	N/A	N/A
Dependent Eligibility 2014	Pharmacy claims for dependents greater than or equal to age 26.	176 members	N/A	Used SAS to randomly select 24 members from the universe after removing duplicate members and any members selected in the Medical Dependent Eligibility review.	Random	No
Deceased Member 2014	Members greater than or equal to age 90.	63 members	N/A	Used SAS to randomly select 14 members from the universe after removing duplicate members and any members already selected in the Medical Deceased Member review.	Random	No

APPENDIX

January 12, 2018

[REDACTED]
Chief, Community – Rated Audit Groups
United States Office of Personnel Management
Washington, DC 20415

Dear [REDACTED],

Our responses to the findings and recommendations of the draft audit report detailing the FEHBP operations at Health Alliance Plan, plan codes 52 and Y for contract years 2013 and 2014 are incorporated below:

Deleted by OIG – Not Relevant to the Final Report

Section 1a QHI and Tax Allocation – 2013

- 1) They indicated that we used HAP large group membership as of 3/31/14. In my explanation to them I indicated that I use the 3/31/14 MLR filing that we do for HAP as a basis for HAP's membership, but it comes from the annual filing information we had done in February for the State on the Supplemental Healthcare Exhibit. This filing with the State is the information as of 12/31/13. In any event the member months I used was 224,378 and the figure they have in their spreadsheet is 224,376. A difference of 2 member months. I am not sure where they obtained the 224,376 or is what a typo, but this changed the Quality Improvements expense allocation by \$4,085, which reduced the credit by the same amount.
- 2) I am not exactly sure where they obtained the taxes and fees percentage to allocated these expenses to their plan, but in doing so they increased their amount by 48,957. This was from my original amount of 278,193 to 327,150. In doing so they actually increased our credit by 43,952, which they can surely do.
- 3) In summary, the net of these two items increased the credit by 39,487. The two figures 4,085 and 43,952 do not net to the difference, since it is a formula and one effects the numerator and one effects the denominator. It is close but off by 379.

Since these two items actually increase the credit for 2013 the decrease in the credit comes mainly from the adjusted incurred claim amount of 477k. The reason for this is indicated in the report for a few different findings. This net with the credit increase on the admin and taxes provides the net decrease in the credit of 438k that they are indicating.

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Section A i. - Disabled Dependents, page 3

- 1) The sample size audited was for members in 2013 & 2014. These were not new disabled dependents to HAP and were coded in our system prior to these dates. Unfortunately, any documentation received from the payroll offices for the sample members are in an offsite storage as these members were coded as permanently disabled prior to 2011.
- 2) HAP maintains all documentation it receives for FEHB members. As of August 2016, that documentation is now scanned into a workflow system and is readily available for review. Searchable fields include by member name, date of birth, SSN, or HAP member id.
- 3) If HAP does not receive proper documentation from a payroll office for a disabled dependent – our enrollment specialist will reach out to the payroll office 3 times to obtain this approval documentation. These attempts will be documented in our workflow system for reference. Unfortunately, it is very difficult to work with many of the payroll offices when we need additional information. We use the contacts in the CLER system but have been unsuccessful in attempts to solidify membership details.
- 4) The workflow system houses all information and documentation for EHB membership and will be readily available and not sent to storage. Again, this workflow system was implemented in August 2016.

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Section A ii. - Late Terminations, page 4

- 1) Prior to April 2017, our system was programmed to terminate any 26 year old nondisabled dependent at the end of the calendar year unless we received a EDI transaction for termination or notification from the family or payroll office.
- 2) After April 2017, our system is now programmed to terminate 26 year old nondisabled dependents as of the dependents date of birth. We have submitted a request to have the system changed to 31 days after the dependents 26th birthday. This request will be prioritized in 2018.

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Conclusion

We corrected the 2013 and 2014 MLR calculations for the errors identified above. A comparison of our audited 2013 and 2014 MLR calculations to the 2013 and 2014 MLR calculations included in the Plan's submissions to OPM showed overstated credit amounts in both years. Specifically, we identified overstated MLR credits of \$437,842 for 2013 and \$777,566 for 2014.

Recommendation 1

We recommend that the contracting officer instruct OPM's Office of the Actuary to decrease the Plan's MLR credit by \$437,842 for 2013.

Recommendation 2

We recommend that the contracting officer instruct OPM's Office of the Actuary to decrease the Plan's MLR credit by \$777,566 for 2014.

Recommendation 3

We recommend that the Plan develop written policies and procedures to document their EHBP QHI and tax allocation expense calculations.

OPM recommends that we develop written policies and procedures to document their administrative and tax expense calculations and we will do this. In fact, in 2014 the explanation is provided in the far right on how the allocation is done as our reference/procedure, so we may already be meeting this request. We have already completed the 2015 and 2016 OPM MLR filings, which have both provided additional credits to HAP. Each line is exactly referenced as to how the amounts are allocated to OPM and we continue to do this in the years after 2014.

Recommendation 4

We recommend that the Plan maintain adequate documentation from the responsible payroll offices for designated FEHBP disabled dependents.

- 1) The sample size audited was for members in 2013 & 2014. These were not new disabled dependents to HAP and were coded in our system prior to these dates. Unfortunately, any documentation received from the payroll offices for the sample members are in an offsite storage as these members were coded as permanently disabled prior to 2011.
- 2) HAP maintains all documentation it receives for FEHB members. As of August 2016, that documentation is now scanned into a workflow system and is readily available for review. Searchable fields include by member name, date of birth, SSN, or HAP member id.

- 3) If HAP does not receive proper documentation from a payroll office for a disabled dependent – our enrollment specialist will reach out to the payroll office 3 times to obtain this approval documentation. These attempts will be documented in our workflow system for reference. Unfortunately, it is very difficult to work with many of the payroll offices when we need additional information. We use the contacts in the CLER system but have been unsuccessful in attempts to solidify membership details.
- 4) The workflow system houses all information and documentation for FEHB membership and will be readily available and not sent to storage. Again, this workflow system was implemented in August 2016.

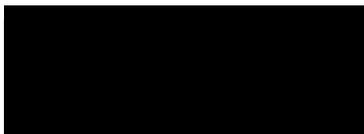
Recommendation 5

We recommend that the Plan establish policies and procedures for terminating nondisabled EHBP dependents 31 days after their 26th birthday.

- 1) Prior to April 2017, our system was programmed to terminate any 26 year old nondisabled dependent at the end of the calendar year unless we received a EDI transaction for termination or notification from the family or payroll office.
- 2) After April 2017, our system is now programmed to terminate 26 year old nondisabled dependents as of the dependents date of birth. We have submitted a request to have the system changed to 31 days after the dependents 26th birthday. This request will be prioritized in 2018.

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Sincerely,



Director, Auditing Services and MAR Compliance



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