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

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# **Final Audit Report**

**AUDIT OF THE FEDERAL EMPLOYEES HEALTH  
BENEFITS PROGRAM OPERATIONS AT  
KAISER FOUNDATION HEALTH  
PLAN OF GEORGIA, INC.**

**Report Number 1C-F8-00-19-039  
July 27, 2020**

# EXECUTIVE SUMMARY

## *Audit of the Federal Employees Health Benefits Program Operations at Kaiser Foundation Health Plan of Georgia, Inc.*

Report No. 1C-F8-00-19-039

July 27, 2020

### **Why Did We Conduct The Audit?**

The primary objective of the audit was to determine if Kaiser Foundation Health Plan of Georgia, Inc. (Plan) complied 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).

Due to changes to our audit procedures resulting from OPM's implementation of its MLR methodology, we cannot express an opinion on the fairness of the premium paid for benefits received. Our audit process was limited to an assessment of the Plan's MLR, which is representative of the Plan's cost of doing business with the FEHBP. In our opinion, the MLR calculation is neither transparent nor a fair assessment of the FEHBP rates, concerns that we are addressing with OPM through other channels.

### **What Did We Audit?**

Under Contract CS 2163, the Office of the Inspector General (OIG) completed a performance audit of the FEHBP MLR submissions to OPM for contract years 2014 through 2015. We conducted our audit fieldwork from January 27, 2020, through June 24, 2020, at the Plan's offices in Portland, Oregon and Oakland, California and in our OIG offices.

### **What Did We Find?**

We determined that the Plan's 2014 and 2015 FEHBP MLR submissions were accurate, complete, and current, and were developed in accordance with the laws and regulations governing the FEHBP. Consequently, a draft report was not issued and corrective actions are not recommended.



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*Assistant Inspector General  
for Audits*

# ABBREVIATIONS

<b>CFR</b>	<b>Code of Federal Regulations</b>
<b>Contract</b>	<b>Contract CS 2163</b>
<b>FEHBP</b>	<b>Federal Employees Health Benefits Program</b>
<b>MLR</b>	<b>Medical Loss Ratio</b>
<b>OIG</b>	<b>Office of the Inspector General</b>
<b>OPM</b>	<b>U.S. Office of Personnel Management</b>
<b>Plan</b>	<b>Kaiser Foundation Health Plan of Georgia, Inc.</b>
<b>SSSG</b>	<b>Similarly-Sized Subscriber Group</b>
<b>U.S.C.</b>	<b>United States Code</b>

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# I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at Kaiser Foundation Health Plan of Georgia, Inc. (Plan). The audit was conducted pursuant to the provisions of Contract CS 2163 (Contract); 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 2014 through 2015, and was conducted at the Plan's offices in Portland, Oregon and Oakland, 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 Federal Register 19522). The MLR is the proportion of FEHBP premiums collected by a carrier that is spent on clinical services and quality health improvements.

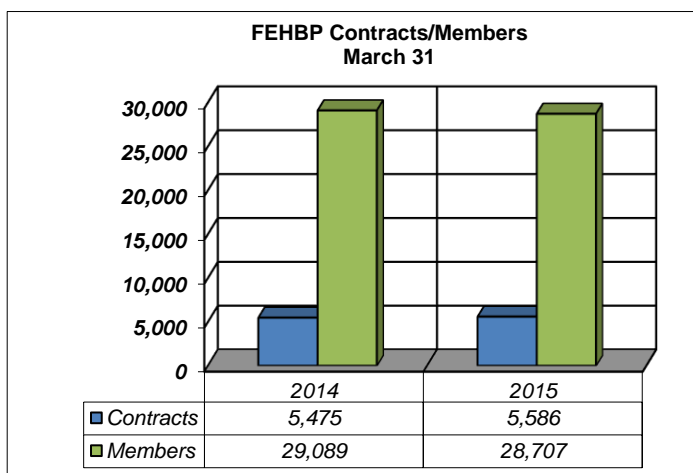
The MLR was established to ensure that health plans are meeting specified thresholds for spending on medical care and health care quality improvement measures, and thus limiting spending on administrative costs, such as executive salaries, overhead, and marketing of the health plan. However, in our opinion the FEHBP MLR is not as transparent as intended and does not provide an assessment of the fairness of the premium paid for benefits received. As this continues to be a significant Program concern for us, we are addressing this issue with OPM through other channels.

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. However, beginning in 2013, 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 1987 and provides health benefits to FEHBP members in the Atlanta, Georgia metropolitan area, as well as the Athens,

Columbus, Macon, and Savannah service areas. A prior FEHBP audit of the Plan covered contract years 2011 and 2012. The audit did not identify any findings or questioned costs, and no corrective action was necessary.

The preliminary results of this audit were discussed with Plan officials at an exit conference and in subsequent correspondence. Since this audit concluded that the Plan's 2014 and 2015 FEHBP MLR submissions were developed in accordance with applicable laws, regulations, and OPM rate instructions, a draft report was not issued.

## II. OBJECTIVES, SCOPE, AND METHODOLOGY

### **OBJECTIVES**

The primary objective of this performance audit was to determine whether the Plan complied with the provisions of its Contract and the laws and regulations governing the FEHBP. Specifically, we verified whether the Plan met the MLR requirements and thresholds established by OPM and paid the correct amount to the Subsidization Penalty Account, if applicable.

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 frequently not available for audit, and the fairness of the FEHBP premium rates cannot be evaluated. As this continues to be a significant Program concern for us, we are addressing this issue with OPM through other channels.

### **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 2014 through 2015. For these years, the FEHBP paid approximately \$286.4 million in premiums to the Plan.

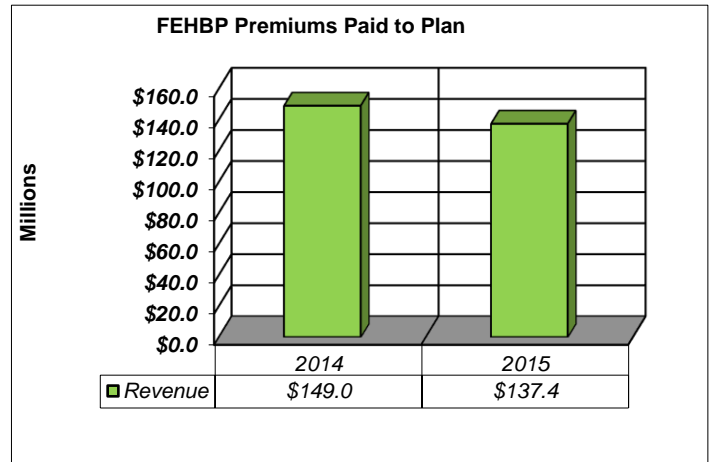
The Office of the Inspector General's (OIG) audits of community-rated carriers are designed to test carrier compliance with the FEHBP contract, applicable laws and regulations, and the rate instructions. These audits are also designed to provide reasonable assurance of detecting errors, irregularities, 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;
- medical claims were processed accurately;
- appropriate allocation methods were used; and
- 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.

We conducted our audit fieldwork from January 27, 2020, through June 24, 2020, at the Plan's offices in Portland, Oregon and Oakland, California, as well as in our offices in Cranberry Township, Pennsylvania; Jacksonville, Florida; 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 medical claim payments, quality health expenses, taxes and regulatory fees, premium income, and any other applicable costs to verify that the cost data used to develop the MLR was accurate, complete, and valid. Finally, we used the Contract, the OPM rate instructions, and applicable Federal regulations to determine the propriety of the Plan's MLR calculations.

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

The tests performed for medical claims, along with the methodology, are detailed in Exhibit A at the end of this report. Due to current contract limitations, our review of the Pharmacy claims was limited to the Plan's policies and procedures and did not include an evaluation of the contract pricing of pharmacy claims or benefits received.

# III. AUDIT RESULTS

## A. MEDICAL LOSS RATIO REVIEW

We determined that the Plan's 2014 and 2015 FEHBP MLR submissions were filed with OPM in accordance with applicable laws, regulations, and the U.S. Office of Personal Management's Rate Instructions to Community-Rated Carriers for the years audited.

During our review of the Affordable Care Act fees, the Plan brought to our attention that there was a misclassification of a department code. In 2014, the department code was inadvertently classified to medical claims when it should have been classified to taxes. In 2015, the department code was misclassified to both medical claims and taxes. The misclassification issue occurred because of a mapping error, which was not discovered until our audit. The Plan noted in 2014 and 2015 that each individual rating region under Kaiser Permanente was responsible for its statutory statement account mapping. Per the MLR instructions, taxes should be excluded from the premium (denominator) and not the incurred claims (numerator). We noted that the overall impact of the mapping error on the 2014 and 2015 MLR ratios was immaterial. We also confirmed that the mapping issue only impacted the Georgia region. Although this is noteworthy, we do not have a recommendation because the issue was corrected in 2017 when the department code stopped being used. Also in 2017, the Plan's national reporting team undertook building consistent report mapping across all regions for statutory reporting to discover this type of issue.

## B. QUALITY HEALTH IMPROVEMENT EXPENSES

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

## C. FEDERAL AND STATE TAXES AND LICENSING OR REGULATORY FEES

Our review determined that the amounts reported in Section 3 "Federal and State Taxes and Licensing or Regulatory Fees" on the Plan's MLR filing are supported, allowable and consistently allocated based on the principles and methods described in the Public Health Service Act section and the Federal Register.

#### **D. MEDICAL CLAIMS DATA**

Our review of 75 medical claims determined that the Plan's fee-for-service and internal encounter medical claims were allowable, accurately priced, and processed correctly.

# EXHIBIT A

## Claims Sample Selection Criteria/Methodology

### Medical Claims Sample

Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Medical claims incurred from 1/1/2015 through 12/31/2015	520,3113 claims	\$122,435,484	Utilized RAT-STATS <sup>1</sup> (90% Confidence Level 50% Anticipated Rate of Occurrence and 20% Desired Precision Range), which generated a sample size of 75. Then utilized SAS <sup>2</sup> to randomly select 75 incurred, unadjusted medical claims.	Statistical	No

<sup>1</sup> RAT-STATS is a statistical software designed by the U.S. Department of Health and Human Services OIG to assist in selecting random samples.

<sup>2</sup> SAS Enterprise Guide is a software used to analyze data allowing users to access and manipulate data quickly.



## **Report Fraud, Waste, and Mismanagement**

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