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 GlobalHealth, Inc.

Report Number 2022-CRAG-005
December 13, 2022

Executive Summary

Audit of the Federal Employees Health Benefits Program Operations at GlobalHealth, Inc.

Report No. 2022-CRAG-005 **December 13, 2022**

Why Did We Conduct the Audit?

The primary objective of the audit was to determine whether GlobalHealth, Inc. 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 FEHBP premium rates were developed in accordance with contract regulations and rating instructions established by the U.S. Office of Personnel Management (OPM).

What Did We Audit?

Under Contract CS 2893, the Office of the Inspector General completed a performance audit of the FEHBP premium rate developments for contract years 2019 through 2021. We conducted our audit fieldwork remotely from January 24, 2022, through August 16, 2022.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

We found that GlobalHealth, Inc.'s FEHBP rates for plan code IM were developed in accordance with applicable laws, regulations, and the Office of Personnel Management's rules and regulations in contract years 2019 through 2021.

We also reviewed the Plan's medical and pharmacy claims data submitted to OPM to reconcile the claims totals to the FEHBP's rate development for contract year 2021. We determined that the Plan did not provide the full data for both years of the FEHBP's experience period.

Lastly, we reviewed the Plan's enrollment process to verify the reliability of the enrollment reports used in FEHBP rate developments for all years of the audit scope. We determined that the Plan was not timely in terminating coverage for dependent children, as required by the FEHBP Handbook. We also concluded that the Plan did not provide written notification during its process for verifying or removing FEHBP members as specified in Carrier Letters 2020-16 and 2021-06.

Abbreviations

ACR	**Adjusted Community Rating**
CFR	**Code of Federal Regulations**
Contract	**OPM Contract CS 2893**
FEHBP	**Federal Employees Health Benefits Program**
MLR	**Medical Loss Ratio**
NFR	**Notice of Findings and Recommendations**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**GlobalHealth, Inc.**

Table of Contents

I. Background

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at GlobalHealth, Inc. (Plan), plan code IM. The audit was conducted pursuant to the provisions of Contract CS 2893 (Contract); 5 United States Code Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract years 2019 through 2021 and was conducted remotely by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG) staff.

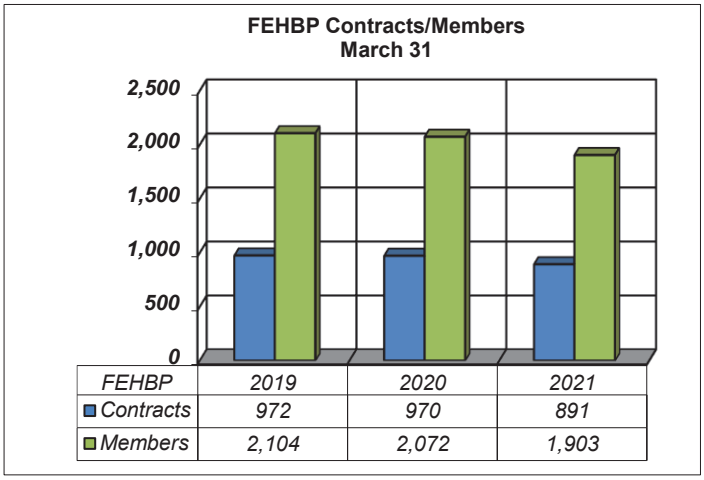
The FEHBP was established by the Federal Employees Health Benefits Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for Federal employees, annuitants, and dependents, and is administered by the OPM Healthcare and Insurance Office. The 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 comparison requirement for most community-rated FEHBP carriers (77 Federal Register 19522). 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. 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.

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

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



FEHBP	2019	2020	2021
Contracts	972	970	891
Members	2,104	2,072	1,903

The Plan has participated in the FEHBP since 2005 and provides health benefits to FEHBP members in the State of Oklahoma.

The last full scope audit of the Plan conducted by our office covered contract years 2011 and 2012. The prior audit identified inappropriate health benefit charges to the FEHBP in 2011. The Plan agreed with the findings and all issues were resolved. This is a limited scope, close-out audit because the Plan no longer provides benefits to FEHBP members as the Plan dropped from the program, effective January 1, 2022. We performed a close-out audit limiting our review to the Plan's premium rate developments and related policies and procedures.

The preliminary results of this audit were communicated to Plan officials during the Notice of Finding and Recommendations (NFR) process as well as the draft report. The Plan's comments, if any, to both the NFR's and draft report were considered in preparation of this report and are included, as appropriate, in the report. Additionally, we discussed the issues outlined in this report with Plan officials during the Exit Conference.

II. Objectives, Scope, and Methodology

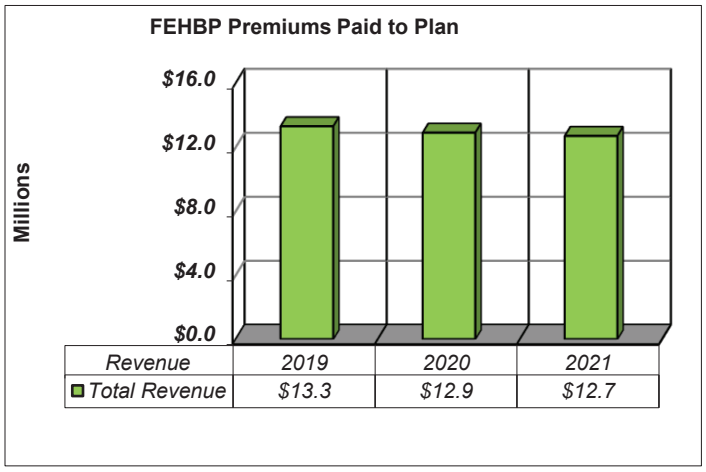
Objectives

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

Scope

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

This performance audit covered contract years 2019 through 2021. For these years, the FEHBP paid approximately $38.9 million in premiums to the Plan.



The OIG's audits of community-rated carriers are designed to test carrier compliance with the FEHBP contract, applicable laws and regulations, and 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 premium rate calculations were accurate, complete, and valid;
- appropriate allocation methods were used; and
- any other costs associated with its premium rate 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 remotely conducted our audit fieldwork from January 24, 2022, through August 16, 2022.

Methodology

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

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

III. Audit Findings and Recommendations

A. Premium Rate Review

Our audit showed that the premium rating of the FEHBP for GlobalHealth, Inc., plan code IM, was in accordance with applicable laws, regulations, and the rate instructions for contract years 2019 through 2021. Consequently, the audit did not identify any questioned costs and no corrective action is necessary. As noted in the Background section above, the Plan dropped from the FEHBP for the 2022 contract year. Any recommendations made below are contingent upon the Plan returning to the FEHBP.

B. Contract Compliance

1. ACR Claims Compliance: Procedural

The Plan did not provide the full 2021 Adjusted Community Rating (ACR) claims data to OPM.

Per OPM Carrier Letter 2020-09, large carriers using an ACR methodology were required to submit the FEHBP rate development claims data to OPM for contract year 2021. Small carriers, such as the Plan, were encouraged but not required to submit this data. The Plan chose to submit its 2021 ACR claims data to OPM; however, we determined that the claims data was incomplete.

The Plan provided incomplete ACR claims data to OPM for contract year 2021.

The Plan's experience period consisted of the 2018 and 2019 calendar years in its 2021 ACR rating. The Plan only provided the claims data for the 2019 calendar year experience. The Plan stated that it misinterpreted Carrier Letter 2020-09 and provided the 2018 experience claims with the 2020 ACR claims data. However, the Plan did not submit its 2020 ACR claims data to the OPM OIG prior to the audit. As a result, we were unable to review the raw claims data for both experience years used to rate the FEHBP for 2021.

Recommendation 1:

If the Plan returns to the FEHBP and elects to submit its ACR experience claims data, we recommend that the Plan submit its full ACR experience claims data to OPM for each contract year in accordance with OPM Carrier Letter 2020-09.

Plan's Response:

The Plan agreed in its response to the OIG's Notification of Finding and Recommendation that that the 2018 experience claims were not included with the

original 2021 ACR data submission. However, the Plan reiterated that it was not required to provide the claims detail due to its size. The Plan also stated that the 2018 ACR claims detail can be provided if requested. The Plan did not submit an additional response to the draft report.

OIG Comment:

As stated above, since the Plan elected to submit its 2021 ACR data, it should have included the full 2018 and 2019 experience claims data. While we appreciated the Plan's willingness to provide the data if requested, we did not request the data from the Plan as it was not necessary to meet the audit objectives in this instance.

2. Member Eligibility: Procedural

Per the FEHBP Handbook, carriers are required to provide coverage for dependent children for an additional 31 days after their 26th birthday. Additionally, carriers are required to provide written notification to FEHBP members when verifying family member eligibility or removing ineligible family members per OPM Carrier Letters 2020-16 and 2021-06, respectively. We determined that the Plan was not timely in terminating coverage for dependent children and that the Plan did not provide written notification during its process for verifying or removing FEHBP members.

The Plan did not follow the applicable criteria for timely termination of dependent coverage or for verifying member eligibility or removing ineligible family members.

a. Untimely Dependent Terminations

The Plan did not appropriately terminate coverage for dependent members who became ineligible for coverage during contract years 2019 through 2021. Per the Plan's enrollment process, coverage for a child dependent is terminated on the last calendar day of the month of the dependent's 26th birthday. However, the FEHBP Handbook states that a dependent is covered until their 26th birthday, unless they are incapable of self-support, with an additional 31 days of extended coverage. The extended coverage begins when a family member is no longer eligible, which in this case, begins the day of their 26th birthday. Based on the erroneous termination process, we concluded the timing discrepancy resulted in early dependent terminations for any eligible FEHBP members who turned 26 during the scope of the audit.

b. Notification of Family Member Eligibility

The Plan did not provide written notification to FEHBP members when it verified family member eligibility or removed ineligible family members. OPM Carrier Letters 2020-16 and 2021-06 provide instructions for carriers regarding the verification of family member eligibility and the removal of ineligible family members, respectively. Both Carrier Letters require the Plan to notify the FEHBP members in writing. While the Plan implemented steps to address the Carrier Letter's instructions, the Plan did not provide written notification to the members throughout its processes. This oversight could have resulted in miscommunication with FEHBP members and confusion around the eligibility of family members.

Recommendation 2:

If the Plan returns to the FEHBP, we recommend that the Plan take the necessary corrective action to accurately terminate overage FEHBP dependents in accordance with the guidance in the FEHBP Handbook.

Recommendation 3:

If the Plan returns to the FEHBP, we recommend that the Plan provide the required written notifications to FEHBP members, as stated in OPM's Carrier Letters, regarding the verification of family member eligibility and the removal of ineligible family members.

Plan's Response:

The Plan agreed with the finding.

Appendix

GlobalHealth, Inc. Response to Draft Audit Report Number 2022-CRAG-005
Received via e-mail on September 14, 2022

From: **Deleted by the OIG – Not Relevant to the Final**
Sent: Wednesday, September 14, 2022 10:33 AM
To: **Deleted by the OIG – Not Relevant to the Final**
Subject: RE: Draft Audit Report No. 2022-CRAG-005

Good morning **Deleted by the OIG – Not Relevant to the Final**,

We do not have any questions or comments on the report.

Thank you,

Deleted by the OIG – Not Relevant to the Final
GlobalHealth Holdings, LLC
Deleted by the OIG – Not Relevant to the Final

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