



**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 THE
HEALTH PLAN OF THE UPPER OHIO VALLEY, INC.**

**Report Number 1C-U4-00-14-038
February 20, 2015**

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EXECUTIVE SUMMARY

Audit of the Federal Employees Health Benefits Program Operations at The Health Plan of the Upper Ohio Valley, Inc.

Report No. 1C-U4-00-14-038

February 20, 2015

Why Did We Conduct the Audit?

The objectives of our audit were to determine if The Health Plan of the Upper Ohio Valley, Inc. (Plan) offered the Federal Employee Health Benefits Program (FEHBP) market price rates and that the loadings applied to the FEHBP rates were reasonable and equitable. Additional tests were performed to determine whether the Plan was in compliance with the provisions of the laws and regulations governing the FEHBP.

What Did We Audit?

Under contract 2616, the Office of the Inspector General (OIG) completed a performance audit of the FEHBP's rates offered for contract years 2008 through 2010. Our audit was conducted from April 28, 2014 through May 9, 2014 at the Plan's office in St. Clairsville, Ohio.

What Did We Find?

This report questions \$2,144,107 for inappropriate health benefit charges to the FEHBP in contract years 2008 and 2010. The questioned amount includes \$1,940,249 for defective pricing and \$203,858 due the FEHBP for lost investment income, calculated through January 31, 2015. While rating discrepancies were identified in contract year 2009, we found that there was no material cost impact to the FEHBP rates for that year.

Additionally, in contract years 2008 through 2010, we found that the Plan did not maintain original source documentation to support its rate developments of the Similarly Sized Subscriber Groups (SSSGs) as required by Section 3.4 of its FEHBP contract.

Finally, the Plan does not have adequate rating system controls to ensure that the SSSGs and the FEHBP are rated consistently and that the FEHBP receives a market price rate.



Michael R. Esser
*Assistant Inspector General
for Audits*

ABBREVIATIONS

ACR	Adjusted Community Rating
CFR	Code of Federal Regulations
FEHBP	Federal Employees Health Benefits Program
FEHBAR	Federal Employees Health Benefits Acquisition Regulations
FY	Fiscal Year
HMO	Health Maintenance Organization
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
PPO	Preferred Provider Organization
PLAN	The Health Plan of the Upper Ohio Valley, Inc.
SSSG	Similarly Sized Subscriber Group
U.S.C.	United States Code

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I. BACKGROUND

This final report details the findings, conclusions, and recommendations resulting from our audit of the Federal Employees Health Benefits Program (FEHBP) operations at The Health Plan of the Upper Ohio Valley, Inc. (Plan). The audit covered contract years 2008 through 2010, and was conducted at the Plan's office in St. Clairsville, Ohio.

The audit was conducted pursuant to FEHBP contract CS 2616; 5 U.S.C. Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit was performed by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

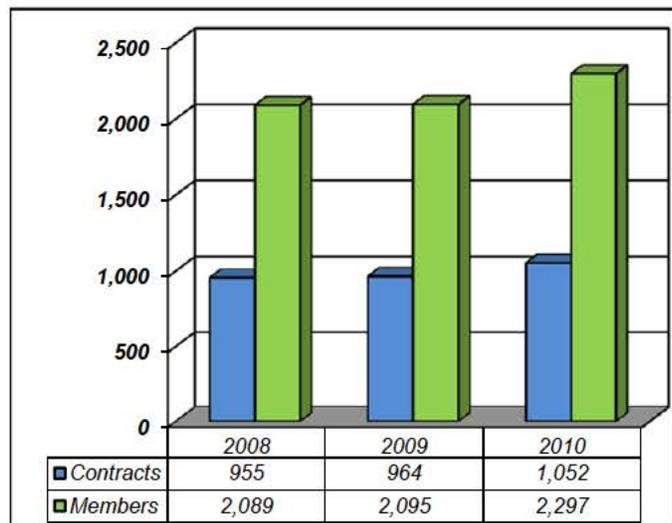
The FEHBP was established by the Federal Employees Health Benefits Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for Federal employees, annuitants, and dependents. The FEHBP is administered by OPM's Healthcare and Insurance Office. Health insurance coverage is provided through contracts with health insurance carriers that provide service benefits, indemnity benefits, or comprehensive medical services.

Community-rated carriers participating in the FEHBP are subject to various Federal, state and local laws, regulations, and ordinances. While most carriers are subject to state jurisdiction, many are further subject to the Health Maintenance Organization Act of 1973 (Public Law 93-222), as amended (i.e., many community-rated carriers are Federally qualified). In addition, participation in the FEHBP subjects the carriers to the Federal Employees Health Benefits Act and implementing regulations promulgated by OPM.

The FEHBP should pay a market price rate, which is defined as the best rate offered to either of the two groups closest in size to the FEHBP. In contracting with community-rated carriers, OPM relies on carrier compliance with appropriate laws and regulations and, consequently, does not negotiate base rates. OPM negotiations relate primarily to the level of coverage and other unique features of the FEHBP.

The chart to the right shows the number of FEHBP contracts and members reported by

FEHBP Contracts/Members
March 31



the Plan as of March 31 for each contract year audited.

The Plan has participated in the FEHBP since 1991 and provides health benefits to FEHBP members in Northeast and Eastern Ohio, and Northern and Central West Virginia. The last audit conducted by our office was a rate reconciliation audit and covered contract year 2011. There were no issues identified during that audit.

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 the Appendix to the report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

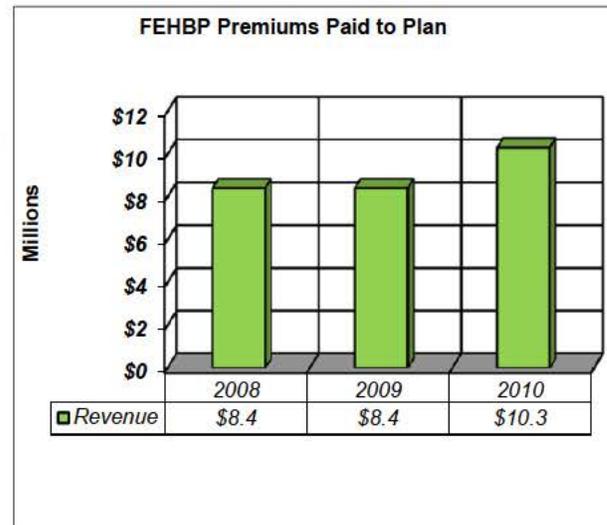
Objective

The primary objectives of the audit were to determine if the Plan offered the FEHBP market price rates and that the loadings to the FEHBP rates were reasonable and equitable. Additional tests were performed to determine whether the Plan was in compliance with the provisions of the laws and regulations governing the FEHBP.

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 2008 through 2010. For these years, the FEHBP paid approximately \$27 million in premiums to the Plan.



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. However, the audit included such tests of the Plan's rating system and such other auditing procedures considered necessary under the circumstances. Our review of internal controls was limited to the procedures the Plan has in place to ensure that:

- The appropriate Similarly Sized Subscriber Groups (SSSG) were selected;
- the rates charged to the FEHBP were the market price rates (i.e., equivalent to the best rate offered to the SSSGs); and

- the loadings to the FEHBP rates were reasonable and equitable.

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 testing 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 at the Plan's office in St. Clairsville, Ohio in April and May 2014.

Methodology

We examined the Plan's Federal rate submission and related documents as a basis for validating the market price rates. In addition, we examined the rate development documentation and billings to other groups, such as the SSSGs, to determine if the market price was actually charged to the FEHBP. Finally, we used the contract, the Federal Employees Health Benefits Acquisition Regulations, and the rate instructions to determine the propriety of the FEHBP premiums and the reasonableness and acceptability of the Plan's rating system.

To gain an understanding of the internal controls in the Plan's rating system, we reviewed the Plan's rating system policies and procedures, interviewed appropriate Plan officials, and performed other auditing procedures necessary to meet our audit objectives.

III. AUDIT FINDINGS AND RECOMMENDATIONS

Premium Rate Review

1. Defective Pricing

\$1,940,249

The Certificates of Accurate Pricing The Health Plan of Upper Ohio Valley, Inc. (Plan) signed for contract years 2008 and 2010 were defective. In accordance with Federal regulations, the FEHBP is therefore due a rate reduction for these years. Application of the defective pricing remedy shows that the FEHBP is due a premium adjustment of \$1,940,249 (see Exhibit A). While rating discrepancies were identified in contract year 2009, we found that there was no material cost impact to the FEHBP rates in that year.

The FEHBP is due a rate reduction of \$1,940,249 for defective pricing in contract years 2008 and 2010.

Federal Employees Health Benefits Acquisition Regulation (FEHBAR) 1652.215-70 provides that carriers proposing rates to OPM are required to submit a Certificate of Accurate Pricing certifying that the proposed subscription rates, subject to adjustments recognized by OPM, are market price rates. OPM regulations refer to a market price rate in conjunction with the rates offered to an SSSG. SSSGs are the Plan's two employer groups closest in subscriber size to the FEHBP. If it is found that the FEHBP was charged higher than the market price rate (i.e., best rate offered to an SSSG), a condition of defective pricing exists, requiring a downward adjustment of the FEHBP premiums to the equivalent market price rate.

2008

We agree with the Plan's selection of [REDACTED] and the [REDACTED] as SSSGs for contract year 2008. The FEHBP and [REDACTED] were rated using an Adjusted Community Rating (ACR) methodology and [REDACTED] was rated using a blended ACR and Community Rating by Class methodology. The Plan did not apply an SSSG discount to the FEHBP rates. Our analysis of the rates charged to the SSSGs shows that the [REDACTED] received a [REDACTED] discount. [REDACTED] did not receive a discount.

The Plan sold the [REDACTED] three benefit options; however, the [REDACTED] rate development did not account for benefit option differences in the claims experience. In addition, each option had a deductible change that was not accounted for in the claims experience. Finally, we found that the [REDACTED] medical claims and enrollment information used in the rate development did not match the supporting documentation. After

adjusting our audited rate development using the supported claims and enrollment numbers and adjusting for the benefit differences, we determined that the [REDACTED] received a [REDACTED] discount.

During our review of the FEHBP rates, we found that the claims and enrollment data used in the Plan's FEHBP rate development did not match the reports generated at the time of rating. In addition, we found that the Plan applied an FEHBP pharmacy trend factor that was lower than the state-filed pharmacy trend factor that was correctly applied to the SSSGs. We updated the claims, enrollment and pharmacy trend factor in our FEHBP audited rates.

We recalculated the FEHBP rates based on the exceptions noted above and applied the SSSG discount of [REDACTED] to our audited rates. A comparison of our audited line 5 rates to the Plan's reconciled line 5 rates shows that the FEHBP was overcharged \$140,296 (see Exhibit B).

Plan's Comments (see Appendix):

[REDACTED] Option Differences

The Plan did not comment on this issue.

[REDACTED] Deductible Change

The Plan agrees that the \$100 deductible benefit should be accounted for in the [REDACTED] [REDACTED] claims experience. However, the Plan believes that the relative change is [REDACTED] [REDACTED] averaged over all of the experience.

[REDACTED] Claims and Enrollment Data

The Plan did not comment on claims and enrollment data variances between their 2008 [REDACTED] [REDACTED] rate development and the source documentation.

FEHBP Claims and Enrollment Data

The Plan did not comment on claims and enrollment data variances between their 2008 FEHBP rate development and the source documentation.

Pharmacy Trend Differences

The Plan agrees that the [REDACTED] Pharmacy trend should be applied consistently to the FEHBP and the [REDACTED] if the auditors are applying a [REDACTED] generated discount to the FEHBP rates.

2008 Questioned Costs

The Plan disagrees with the questioned costs in 2008. Based on their position, the Plan contends that they owe the FEHBP \$18,959 in contract year 2008.

OIG's Response to the Plan's Comments:

██████████ Deductible Change

Prior to the issuance of the draft report, we accounted for the ██████████ experience period deductible change. Per the Plan's rate filing, the applicable benefit change for a \$100 deductible is ██████████, which we applied to the three months of experience when the \$100 deductible was available to ██████████ members. We do not agree with the Plan's calculation of the \$100 deductible adjustment. The Plan did not use the filed benefit change factor of ██████████, instead using an unsupported factor of ██████████. Additionally, the Plan weighted the benefit change over a full year of claims experience, instead of the benefit change being applied to the three months of claims experience when the \$100 deductible was applicable.

Pharmacy Trend Differences

Prior to issuance of the draft report, we applied the ██████████ pharmacy trend to the FEHBP pharmacy rate to be consistent with the Plan's 2008 rating of the ██████████.

2008 Questioned Costs

Our audit documentation accounts for the \$100 deductible change for the ██████████ rate development. Additionally, the application of the ██████████ pharmacy trend factor in the FEHBP and ██████████ rate developments is consistent. The Plan was unable to provide any further evidence that would dismiss our findings in the draft report for contract year 2008. Thus, we continue to question \$140,296 in contract year 2008 (see Exhibit B).

2010

We agree with the Plan's selection of ██████████ and ██████████ ██████████ as SSSGs for contract year 2010. The FEHBP and the SSSGs were rated using ACR. The Plan provided an "other" discount of approximately ██████████ to the proposed 2010 FEHBP rates. The Plan was notified by OPM on July 23, 2009 that they will not be allowed to recoup the "other" discount in the 2010 reconciliation. The Plan did not apply an SSSG discount to the FEHBP rates. Our analysis of the rates charged to the SSSGs shows that ██████████ received a ██████████ discount and ██████████ ██████████ received an ██████████ discount.

The Plan sold ██████████ two products, a Health Maintenance Organization (HMO) and a Preferred Provider Organization (PPO) product. The Plan rated

this group as one product with combined experience, but did not adjust the experience to account for the product benefit differences. In addition, the HMO product had a preventative benefit change that was not accounted for in the experience. To account for the cost of each product, we used the Plan's HMO experience to re-rate the HMO product and the Plan's PPO experience to re-rate the PPO product. We made the adjustment for the preventative benefit change in the HMO experience as outlined by the group's benefit brochure and made the renewal benefit adjustments for each product as outlined by their respective benefit brochures.

In addition, the Plan's catastrophic claims policy is to pool claims and apply a pooling charge to groups with less than 500 covered lives. [REDACTED] had 517 covered lives and did not qualify for pooling; however, the Plan pooled claims for this group and applied a pooling charge. In accordance with the Plan's rating methodology, we removed the catastrophic pooled claims and the pooling charge from our [REDACTED] audited rate development. Additionally, the \$174,883 in claims that the Plan removed from the FEHBP rates due to member termination were added back into the FEHBP rate for consistency.

Finally, the Plan could not support the use of an [REDACTED] medical trend factor used in [REDACTED] rate development. We applied an [REDACTED] trend rate, which was used consistently for the FEHBP and [REDACTED].

We recalculated the FEHBP rates applying the largest SSSG discount of [REDACTED] to our audited rates. A comparison of our audited line 5 rates to the Plan's reconciled line 5 rates shows that the FEHBP was overcharged \$1,799,953 (see Exhibit B).

Plan's Comments (see Appendix):

[REDACTED] SSSG Status

The Plan states that [REDACTED] is not an appropriate SSSG due to the fact that over 50 percent of the covered lives are enrolled in a PPO product which was underwritten by The Health Plan Insurance Company in 2010.

[REDACTED] Product Benefit Differences

The Plan did not comment on this issue.

[REDACTED] HMO Preventative Benefit Change

The Plan agrees that [REDACTED] HMO product should receive an adjustment for the preventative benefit change. However, they contend that the preventative benefit change was accounted for in the 2010 HMO trend factor applied to the group.

████████████████████ Pooling

The Plan agrees that per the underwriting policy, groups with less than 500 covered lives pool their catastrophic claims and in exchange receive a pooling charge. The Plan also states that at their discretion they may pool catastrophic claims and apply a pooling charge to large groups (greater than 500 lives) if the group requests the adjustment.

FEHBP Member Termination

The Plan states that they removed \$174,883 of catastrophic claims from the 2010 FEHBP renewal without a corresponding pooling charge, which represents a discount to the FEHBP rate that was not afforded the SSSGs.

████████████████████ Trend Rates

The Plan disagrees with the use of the ██████████ trend rate applied to ██████████ ██████████ audited rate. Due to the timing of ██████████ rate development, the Plan states that they used an updated rate filing.

████████████████████ Discount

The Plan agrees that they discounted ██████████, but states that the discount was ██████████ effective on the PPO product only.

████████████████████ Discount

The Plan disagrees with the discount calculated on ██████████.

2010 Questioned Costs

The Plan disagrees with the questioned costs in 2010. Based on their position, the Plan contends that they owe the FEHBP \$70,341 in contract year 2010.

OIG's Response to the Plan's Comments:

████████████████████ SSSG Status

The Health Plan Insurance Company does not meet the criteria to be considered a separate line of business. Additionally, the Plan was aware, prior to ██████████ 2010 renewal, that the group met the criteria to be selected as an SSSG and elected them as such in the 2010 Proposal on the Potential SSSG listing, and again in the 2010 Reconciliation. ██████████ qualifies as an SSSG in 2010.

████████████████████ HMO Preventative Benefit Change

The Plan is unable to support that ██████████ HMO preventative benefit change is accounted for in the HMO trend factor.

Pooling

The Plan removed [REDACTED] catastrophic claims and applied a pooling charge at the group's request and at the Plan's discretion. This action was contrary to the Plan's pooling policy. Additionally, the Plan was aware prior to [REDACTED] 2010 renewal that the group met the criteria to be an SSSG and that they should no longer apply pooling to the group. In accordance with the Plan's rating methodology, the catastrophic claims were added back into [REDACTED] rate and the pooling charge was removed, for SSSG discount calculation purposes.

FEHBP Member Termination

To be consistent with [REDACTED] rating, we added the \$174,883 in claims back into the FEHBP rate development. In the 2010 reconciliation, the Plan explained that these claims were related to member termination.

Trend Rates

The Plan was unable to support the [REDACTED] HMO trend and [REDACTED] PPO trend that they blended to arrive at an overall [REDACTED] trend for [REDACTED] 2010 rating. Based on the rate filings we received from the Plan and the OPM rating criteria, we applied the [REDACTED] trend to [REDACTED], as was applied to the FEHBP and [REDACTED].

Discount

We disagree with the Plan's calculation of the [REDACTED] effective discount of [REDACTED]. We maintain that the discount given to [REDACTED] was [REDACTED].

Discount

The Plan was unable to provide any additional documentation to counter the [REDACTED] discount we calculated on the 2010 [REDACTED] rate.

2010 Questioned Costs

We adjusted the audited FEHBP workbook to account for the \$174,883 in claims previously removed by the Plan to account for terminated members. We re-developed the FEHBP's rates by applying the [REDACTED] discount to the line 5 FEHBP rates. We continue to question \$1,799,953 in contract year 2010 (see Exhibit B).

Recommendation 1

We recommend that the contracting officer require the Plan to return \$1,940,249 to the FEHBP for defective pricing in contract years 2008 and 2010.

2. Lost Investment Income

\$203,858

In accordance with FEHBP regulations and the contract between OPM and the Plan, the FEHBP is entitled to recover lost investment income on the defective pricing findings in contract years 2008 and 2010. We determined the FEHBP is due \$203,858 for lost investment income, calculated through January 31, 2015 (see Exhibit C). In addition, the FEHBP is entitled to lost investment income for the period beginning February 1, 2015, until all defective pricing amounts have been returned to the FEHBP.

The FEHBP is due lost investment income on defective pricing findings in the amount of \$203,858.

FEHBAR 1652.215-70 provides that, if any rate established in connection with the FEHBP contract was increased because the carrier furnished cost or pricing data that was not complete, accurate, or current as certified in its Certificate of Accurate Pricing, the rate shall be reduced by the amount of the overcharge caused by the defective data. In addition, when the rates are reduced due to defective pricing, the regulation states that the government is entitled to a refund and simple interest on the amount of the overcharge from the date the overcharge was paid to the carrier until the overcharge is liquidated.

Our calculation of lost investment income is based on the United States Department of the Treasury’s semiannual cost of capital rates.

Plan’s Comments (see Appendix):

The Plan agrees that an adjustment to lost investment income should be made based on the adjusted findings; however, the Plan did not express an opinion on the amount of lost investment income due.

Recommendation 2

We recommend that the contracting officer require the Plan to return \$203,858 to the FEHBP for lost investment income, calculated through January 31, 2015. We also recommend that the contracting officer recover lost investment income on amounts due for the period beginning February 1, 2015, until all defective pricing amounts have been returned to the FEHBP.

3. Records Retention

The Plan did not comply with the records retention clause of its FEHBP contract. After several requests, the Plan could not provide sufficient and appropriate documentation to support the 2008 [REDACTED] age/gender adjustments, the 2009 [REDACTED] age/gender adjustments, and the 2010 [REDACTED] medical trend factor. Although we ultimately developed audited rates using alternative methods, the FEHBP contract requires the Plan to retain and make available all records supporting its rate submissions for a period of six years after the end of the contract term to which the records relate.

Plan's Comments (see Appendix):

The Plan agrees to maintain original documents for future audits.

Recommendation 3

We recommend that the contracting officer assess the maximum penalty allowed in the contract between OPM and the Plan for the Plan's non-compliance with the records retention clause.

In addition, we recommend that the contracting officer inform the Plan that:

- OPM expects it to fully comply with the records retention provision of the contract and all applicable regulations;
- it should maintain copies of all pertinent rating documents that show the factors and calculations the Plan uses in developing the actual rates for the FEHBP and the groups closest in size to the FEHBP for each unaudited year; and
- the applicable community-rated performance factors described in FEHBP 1609.7101-2 will be enforced if information requested during an audit is not provided.

4. Rating System Controls

The Plan does not have adequate rating system controls to ensure that the FEHBP and groups closest in size are rated consistently and in accordance with the Plan's standard rating methodology. This condition is mostly due to the following rating system control weaknesses:

Separation of Duties

The Plan's marketing department is responsible for both the sale and pricing of employer group products. This is an internal control weakness in the Plan's rating system that may lead to improper rate application, inconsistent rate development and non-compliance with the Plan's standard rating methodology.

Insufficient Rating System Policies and Procedures

The Plan's rating system policies and procedures are outdated and are not always followed consistently. The Plan provided its 2003 underwriting and rating manual to document its current rating methodology. According to the Plan, it has had very little turnover in the marketing department and its rating policies and procedures are known by staff. However, we found that these policies were not followed consistently among all groups reviewed. For example, although the Plan's stated policy was to adjust for benefit changes in the claims experience used in pricing groups, the adjustment was not always applied. In another case, the Plan removed catastrophic claims from a 500+ life group and applied a pooling charge, contrary to the Plan's rating policies that stated groups over 500 lives do not receive a catastrophic claim adjustment.

Rate Review Process

The Plan's group rating system and group rate development does not include an underwriting review process to minimize the risk of errors or non-compliance with internal policies and procedures.

Failure to correct these issues may result in: 1) the FEHBP receiving a defective price; 2) the potential for inaccurate or inconsistent pricing of the FEHBP rates; and, 3) the potential for future inaccurate and inconsistent calculations and reporting of OPM's new medical loss ratio methodology requirements.

Plan's Comments (see Appendix):

Separation of Duties

The Plan states that they will be working on reorganization of the Marketing and Underwriting departments in 2015.

Rating System Policies and Procedures

The Plan states that they will be implementing updated written policies and procedures for their large groups by December 31, 2014.

Rate Review Process

The Plan contends that they have adequate rating system controls to ensure that the FEHBP and the groups closest in size are rated consistently and receive sufficient review.

Recommendation 4

We recommend that the contracting officer require the Plan to submit a corrective action plan within 60 days of final report issuance, which addresses actions taken to mitigate internal control weaknesses related to its rating system.

Recommendation 5

We also recommend that the contracting officer require the Plan to develop and implement updated written rating policies and procedures.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

COMMUNITY-RATED AUDITS GROUP

[REDACTED], Auditor-in-Charge

[REDACTED], Lead Auditor

[REDACTED], Lead Auditor

[REDACTED], Senior Team Leader

[REDACTED], Chief

EXHIBIT A

The Health Plan of the Upper Ohio Valley, Inc. Summary of Questioned Costs

Defective Pricing Questioned
Costs

Contract Year 2008	\$140,296	
Contract Year 2010	<u>\$1,799,953</u>	
	-	
Total Defective Pricing Questioned Costs		\$1,940,249
Lost Investment Income		<u>\$203,858</u>
Total Questioned Costs		<u>\$2,144,107</u>

EXHIBIT B

The Health Plan of the Upper Ohio Valley, Inc. Defective Pricing Questioned Costs

Contract Year 2008

	<u>Self</u>	<u>Family</u>	
FEHBP Line 5 - Reconciled Rate	██████████	██████████	
FEHBP Line 5 - Audited Rate	██████████	██████████	
Bi-weekly Overcharge	██████████	██████████	
To Annualize Overcharge:			
March 31, 2008 enrollment	██████████	██████████	
Pay Periods	<u>26</u>	<u>26</u>	
Subtotal	██████████	██████████	\$140,296

Contract Year 2010

	<u>Self</u>	<u>Family</u>	
FEHBP Line 5 - Reconciled Rate	██████████	██████████	
FEHBP Line 5 - Audited Rate	██████████	██████████	
Bi-weekly Overcharge	██████████	██████████	
To Annualize Overcharge:			
March 31, 2010 enrollment	██████████	██████████	
Pay Periods	<u>26</u>	<u>26</u>	
Subtotal	██████████	██████████	<u>\$1,799,953</u>
Total Defective Pricing Questioned Costs			<u>\$1,940,249</u>

EXHIBIT C

The Health Plan of the Upper Ohio Valley, Inc. Lost Investment Income

Year	2008	2009	2010	2011	2012	2013	2014	January 31, 2015	Total
Audit Findings:									
1. Defective Pricing	\$140,296	\$0	\$1,799,953	\$0	\$0	\$0	\$0	\$0	\$1,940,249
Totals (per year):	\$140,296	\$0	\$1,799,953	\$0	\$0	\$0	\$0	\$0	\$0
Cumulative Totals:	\$140,296	\$140,296	\$1,940,249	\$1,940,249	\$1,940,249	\$1,940,249	\$1,940,249	\$1,940,249	\$0
Avg. Interest Rate (per year):	4.9375%	5.2500%	3.1875%	2.5625%	1.8750%	1.5625%	2.0625%	2.1250%	
Interest on Prior Years Findings:	\$0	\$7,366	\$4,472	\$49,719	\$36,380	\$30,316	\$40,018	\$3,436	\$171,707
Current Years Interest:	\$3,464	\$0	\$28,687	\$0	\$0	\$0	\$0	\$0	\$32,151
Total Cumulative Interest Calculated Through January 31, 2015:	\$3,464	\$7,366	\$33,159	\$49,719	\$36,380	\$30,316	\$40,018	\$3,436	\$203,858

APPENDIX

November 25, 2014

Deleted by OIG-Not Relevant to Final Report

U.S. Office of Personnel Management
Office of Inspector General
800 Cranberry Woods Drive
Suite 270
Cranberry Township, Pennsylvania 16066

Response to draft report for FEHBP.

Deleted by OIG-Not Relevant to Final Report

The Health Plan of the Upper Ohio Valley wishes to dispute the findings in the Draft Report of defective pricing for 2008 and 2010 **Deleted by OIG-Not Relevant to Final Report**

The Health Plan provides the following documents and facts that rebut the findings in your letter of September 30, 2014:

2008 Deleted by OIG-Not Relevant to Final Report

Finding: The Health Plan did not take into account the benefit option differences or benefit changes in the claims experience period for the 2008 [REDACTED] renewal.

Facts and Observations: The [REDACTED] did in fact have a deductible change in July, 2007 to \$100 (across all three medical benefit options). The experience period used in the audited ACR model calculation contained 3 months of claims that had no benefit deductible. Consequently, the last 9 months of claims used in the ACR model were reflective of the \$100 deductible benefit and claims. Based upon that, a Benefit Plan Factor adjustment would need to have been used to adjust (lower) the claims to account for the \$100 deductible not in force (3 of 12 months) during the experience period.

Deleted by OIG-Not Relevant to Final Report The Benefit Plan Factor of [REDACTED] was derived by multiplying 3 months/12 months ([REDACTED]) times the rate reduction factor of [REDACTED] difference between the [REDACTED] plan vs. the [REDACTED] plan. Step 1 thus reduces the [REDACTED] renewal from the [REDACTED] increase to a [REDACTED] increase.

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Deleted by OIG-Not Relevant to Final Report The Health Plan's recalculation represents a minor miscalculation which only provided a [REDACTED] discount to the medical component of The [REDACTED] 2008 renewal rather than [REDACTED]. This would reduce the FEHBP calculation of the discount from [REDACTED] to [REDACTED].

Finding: The Health Plan applied an FEHBP pharmacy trend factor that was lower than the state-filed pharmacy trend factor that was correctly applied to the SSSGs.

Facts and Observations: The pharmacy trend factors compared between the FEHBP Rx ACR model and the [REDACTED] Rx ACR model differ due to the point in time in which each group's renewal was developed. The FEHBP 2008 premium was developed in May 2007; while the SSSG [REDACTED] 2008 premium renewal was not developed until March 2008. In May 2007, the State filed and approved Rx trend factor was [REDACTED]. The Health Plan's 2008 Rx factors ([REDACTED]) were not filed and approved by State regulators until the fourth quarter of 2007. Had the 2008 Rx trend factor of [REDACTED] been used, the FEHBP Rx premium would have increased by [REDACTED]. **Deleted by OIG-Not Relevant to Final Report**

In conclusion, The Health Plan has calculated the net result of discount to SSSG [REDACTED] to be [REDACTED].

2010 **Deleted by OIG-Not Relevant to Final Report**

Finding: The Health Plan rated the group as one product and did not adjust the experience to account for product benefit differences.

Facts and Observations: The Health Plan would initially contend that [REDACTED] was not an appropriate SSSG due to the fact that over 50% of the covered lives were enrolled in a PPO product underwritten by *THP Insurance Co.* in 2010.

The Health Plan originally calculated the 2010 renewal for [REDACTED] two (2) ways. First, the renewal rate was calculated combining the experience and demographics of both the HMO and PPO members. **Deleted by OIG-Not Relevant to Final Report** This method resulted in an overall [REDACTED] increase for each of the separate product offerings. This increase was applied to each product's in-force premium.

A second ACR Model was also developed that calculated the renewal for the HMO and PPO "separately". This method would account for *specific benefit differentials*. **Deleted by OIG-Not Relevant to Final Report** This method resulted in a [REDACTED] increase for the HMO and a [REDACTED] increase for the PPO. The combined increase under this method was [REDACTED]. At this point in the renewal process, [REDACTED] and the broker had asked if everyone enrolled in the HMO, would the HMO rate increase remain [REDACTED]. **Deleted by OIG-Not Relevant to Final Report** The Health Plan informed the group that the HMO price would need to be modified/increased to reflect the higher claims experience of the PPO members if everyone was to be enrolled in the HMO.

The broker pointed out that the renewal under the “combined” method was a [REDACTED] increase, but [REDACTED] under the “separate” rating method. Deleted by OIG-Not Relevant to Final Report [REDACTED] wanted the HMO rate increase to remain at [REDACTED] as calculated under the “separate” rating method and asked if the [REDACTED] PPO rate increase could be adjusted downward to arrive at the [REDACTED] overall increase indicated by “combined” rating method. The Health Plan did adjust the PPO renewal down to a [REDACTED] rate increase which made the overall rate increase [REDACTED]. Deleted by OIG-Not Relevant to Final Report [REDACTED] This premium adjustment represented an effective discount to the PPO rate of [REDACTED]. This equates to [REDACTED] pm/pm for [REDACTED] PPO members over 12 months totaling [REDACTED].

[REDACTED] had then asked for rates if the benefits for the HMO were adjusted to reflect a change from an HMO \$15/\$100 to a HMO Value \$15/\$250. The HMO value includes 20% co-insurance on things such as lab, x-ray, MRI, Chemotherapy, and other copay changes. This benefit change resulted in an [REDACTED] reduction to the [REDACTED] rate increase calculated under the separate method. Deleted by OIG-Not Relevant to Final Report [REDACTED] then asked for rates if the benefits for the PPO were adjusted to reflect a change from the PPO 100%/\$15/\$100 to the PPO 90%/\$15/\$250. The renewal rates were adjusted by [REDACTED] from the [REDACTED] rate increase to reflect this benefit change. Deleted by OIG-Not Relevant to Final Report [REDACTED].

Finding: The HMO product had a preventative benefit change in the HMO product that was not accounted for in the experience.

Facts and Observations: The Health Plan contends that the 2010 HMO trend factor used in the ACR Model included a component that accounted for the coverage of the preventative benefit change that was to take effect. Therefore, no discount should be applied to the HMO methodology.

Finding: The Health Plan pooled claims and applied a pooling charge to a group with over 500 covered lives.

Facts and Observations: The Health Plan’s Internal Underwriting Guidelines and ACR Model do require a pooling charge for groups with less than 500 covered lives. However, if a large group with greater than 500 covered lives makes a specific request of The Health Plan to pay the pooling charge in an effort to mitigate future catastrophic claim fluctuations, exceptions to the Internal Underwriting Guidelines (at the discretion of The Health Plan) may be granted to the request to include pooling in exchange for a pooling charge. This decision has to be made in advance and a pooling charge included in the prior years’ rates in order to have claims pooled in the subsequent renewal calculation. In this case, [REDACTED] specifically requested that The Health Plan include the pooling charge in their renewal rates beginning in 2001. They have been pooled every year thereafter. Deleted by OIG-Not Relevant to Final Report [REDACTED] The Health Plan contends that the SSSG client requested pooled claims and a pooling charge, and are not a discount.

For the FEHBP 2010 renewal, a [REDACTED] credit for catastrophic claims was given without a corresponding pooling charge having been paid in the prior year or included in the renewal

premium. This credit reduced the medical renewal rate increase from [REDACTED] to [REDACTED] or the equivalent of a [REDACTED] discount not afforded [REDACTED] or [REDACTED].

Finding: The Health Plan could not support the use of an [REDACTED] medical trend factor used in the [REDACTED] rate development.

Facts and Observations: The Health Plan can only apply trend factors in the ACR model that are consistent with the State rate filing in force at the time the renewal premium rate is developed.

The 2010 FEHBP rate was developed in May 2009. At that point in time, the State approved trend factor for the HMO product was [REDACTED]. In January 2010, the [REDACTED] rate development was calculated separately using the State approved trend factors of [REDACTED] for the HMO and [REDACTED] for the PPO. Deleted by OIG-Not Relevant to Final Report The “combined” ACR model proportionately blended the two separate trend factors that resulted in an overall [REDACTED] trend factor. Deleted by OIG-Not Relevant to Final Report The final, unadjusted rate was based on rating the HMO and PPO separately as described above. The Health Plan asserts there was no discount given to [REDACTED] in that we used the appropriate filed and approved trend factors.

Finding Deleted by OIG-Not Relevant to Final Report

Facts and Observations: The draft report does not specify the reasons for the [REDACTED] discount of the 2010 [REDACTED] rate. We have assumed that this perceived discount was calculated when this group switched from an HMO product in 2009 to a POS product in 2010. At that time, *The Health Plan* had higher base community rates for an HMO plan than a comparable *THP Insurance Co.* POS plan. [REDACTED] evaluated the HMO products and asked for other product alternatives and selected a POS product. We applied the State approved product pricing differentials to alternative POS plan designs requested by the group. Additionally, The Health plan offered similar opportunities to the FEHBP but was declined. Deleted by OIG-Not Relevant to Final Report .

Given this information, The Health Plan did not provide a discount to [REDACTED], but rather they selected a more affordable alternative to their HMO.

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Response: Although The Health Plan contends that [REDACTED] should not be considered a 2010 SSSG due to their majority PPO composition, we have recalculated their effective discount to have been [REDACTED].

We have also addressed the minor miscalculation to the 2008 [REDACTED] ACR Model and determined their effective discount to have been [REDACTED].

Recommendation 2: Lost investment income Deleted by OIG-Not Relevant to Final Report

Response: This amount should be reduced commensurate with a downward adjustment to the “SSSG” discount calculations above.

Recommendation 3: Records not retained for 6 years.

Response: The draft reports states that “The Health Plan could not provide sufficient and appropriate documentation to support the 2008 [redacted] age/gender adjustments.” The Health Plan does not generate age/gender reports for groups that are 100% experience rated because age/gender adjustments only impact the community rate portion of the ACR Model which is not used for 100% experience rated groups.

The age/gender report used to calculate the age/gender factor for [redacted] was misplaced during the numerous times the report was copied for various audits. While the age/gender report can be regenerated at any time, it is always updated to reflect changes in enrollment. As a result, we were unable to exactly match the numbers used in the original calculation. To prevent this in the future, The Health Plan will put age/gender reports (when applicable) and copies of current bills on the disk along with the MK-150 claim reports to preserve the original documents for future audits.

The 2010 [redacted] medical trend factor is discussed above Deleted by OIG-Not Relevant to Final Report .

Recommendation 4: Rating System Controls

Response: The Health Plan does not agree with the assertion that we do not have adequate rating system controls to ensure that the FEHBP and the groups closest in size are rated consistently. Monthly meetings were held to review commercial group renewals by the CEO, CFO, VP Marketing and Director of Marketing/Underwriting. We are also addressing re-organization of the Marketing and underwriting departments in 2015.

Recommendation 5: Updated Policies & Procedures

Response: The Health Plan’s large group rating model and methodology have remained consistent for years. As a result, no significant updates to the policy and procedures have been updated. The Health Plan contracting officer is taking the opportunity of this audit to implement written updated policy and procedures for rating of large employer groups to implement controls to minimize any impact of non-compliance. This process should be fully completed by December 31, 2014.

In conclusion, The Health Plan has provided data, facts and observations to the findings of the FEHBP audit and maintains the actual discounts provided to the SSSGs total [redacted] plus any

accrued interest. The Health Plan has always made every effort to develop renewal rates for potential SSSG's without applying any discounts. We remain hopeful this letter has demonstrated that these renewals were in fact conducted within the parameters of our rating model(s).

Sincerely,

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Vice President, Marketing
The Health Plan

Attachments

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