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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 HMO  
HEALTH OHIO**

**Report Number 1C-L4-00-16-013  
September 23, 2016**

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# EXECUTIVE SUMMARY

## *Audit of the Federal Employees Health Benefits Program Operations at HMO Health Ohio*

Report No. 1C-L4-00-16-013

September 23, 2016

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

The primary objectives of the audit were to determine if HMO Health Ohio (Plan) developed the Federal Employees Health Benefits Program (FEHBP) premium rates using complete, accurate, and current data, and that the rates were equivalent to the Plan's Similarly Sized Subscriber Groups (SSSG), as provided in Federal Employees Health Benefits Acquisition Regulation 1652.215-70(a). 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 2015, the Office of the Inspector General (OIG) completed a performance audit of the FEHBP's rates offered for contract years 2010 through 2012. Our audit fieldwork was conducted from November 2, 2015, through February 22, 2016, at the Plan's office in Cleveland, Ohio and in our OIG offices.



**Michael R. Esser**  
*Assistant Inspector General  
for Audits*

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

This report questions \$3,483,988 for inappropriate health benefit charges to the FEHBP in contract years 2011 and 2012. The questioned amount includes \$3,177,807 for defective pricing and \$306,181 for lost investment income. Specifically, our audit identified the following:

- The Plan has two separate entities and lines of business. However, our audit was limited to the review of one entity and line of business due to the FEHBP's contracting arrangement with the Plan. In spite of this arrangement, we found the Plan used data from both entities to influence the rates for an SSSG, the [REDACTED], in contract years 2011 and 2012. As a result:
  - 1) The [REDACTED] received a [REDACTED] percent discount in contract year 2011. We applied this discount to the FEHBP rates, which resulted in a \$1,953,801 overcharge to the FEHBP.
  - 2) The [REDACTED] received a [REDACTED] percent discount in contract year 2012. We applied this discount to the FEHBP rates, which resulted in a \$1,224,006 overcharge to the FEHBP.
- The FEHBP is due \$306,181 for lost investment income on the identified overcharges calculated through August 31, 2016.

We found that the FEHBP rates were developed in accordance with applicable laws, regulations, and the U. S. Office of Personnel Management's rules and regulations in contract year 2010.

# ABBREVIATIONS

<b>FEHBAR</b>	<b>Federal Employees Health Benefits Acquisition Regulations</b>
<b>FEHBP</b>	<b>Federal Employees Health Benefits Program</b>
<b>HMO</b>	<b>Health Maintenance Organization</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>HMO Health Ohio</b>
<b>PPO</b>	<b>Preferred Provider Organization</b>
<b>SSSG</b>	<b>Similarly Sized Subscriber Group</b>
<b>U.S.C.</b>	<b>United States Code</b>

# TABLE OF CONTENTS

	<u>Page</u>
<b>EXECUTIVE SUMMARY</b> .....	i
<b>ABBREVIATIONS</b> .....	ii
<b>I. BACKGROUND</b> .....	1
<b>II. OBJECTIVES, SCOPE, AND METHODOLOGY</b> .....	3
<b>III. AUDIT FINDINGS AND RECOMMENDATIONS</b> .....	5
1. Defective Pricing .....	5
2. Lost Investment Income.....	10
<b>IV. MAJOR CONTRIBUTORS TO THIS REPORT</b> .....	12
Exhibit A (Summary of Questioned Costs)	
Exhibit B (Defective Pricing Questioned Costs)	
Exhibit C (Lost Investment Income)	
Appendix (HMO Health Ohio’s response to the draft report, received on May 10, 2016)	
<b>REPORT FRAUD, WASTE, AND MISMANAGEMENT</b>	

# I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at HMO Health Ohio (Plan). The audit was conducted pursuant to FEHBP contract CS 2015; 5 U.S.C. Chapter 89; and 5 Code of Federal Regulations 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 and is administered by OPM's Healthcare and Insurance Office. Health insurance coverage is provided through contracts with health insurance carriers who provide service benefits, indemnity benefits, or comprehensive medical services.

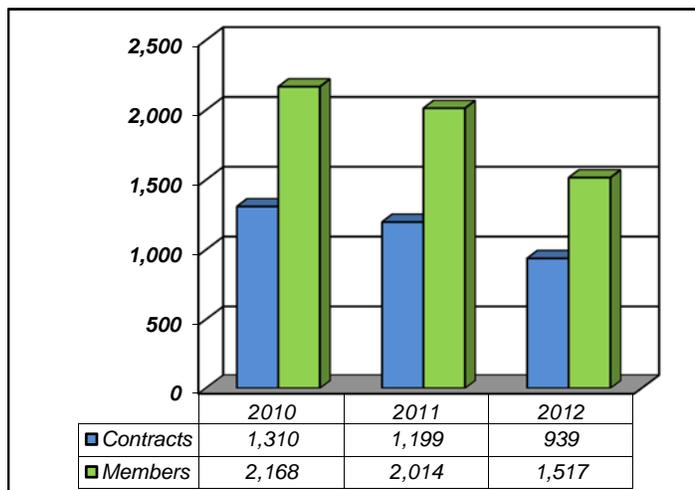
Community-rated carriers participating in the FEHBP are subject to various Federal, state and local laws, regulations, and ordinances. In addition, participation in the FEHBP subjects the carriers to the Federal Employees Health Benefits Act and implementing regulations promulgated by OPM.

The FEHBP should pay a premium rate that is equivalent to the best rate given 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 the Plan as of March 31 for each contract year audited.

The Plan has participated in the FEHBP since 1985 and provides health benefits to FEHBP members in the Northeast Ohio area. However, as of December 31, 2012, the Plan opted to cease its FEHBP participation. A prior audit of this plan code was conducted in 2010. There were no findings reported for the prior audit.

FEHBP Contracts/Members  
March 31



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 response was considered in preparation of this report and is included, as appropriate, as the Appendix to the report.

## II. OBJECTIVES, SCOPE, AND METHODOLOGY

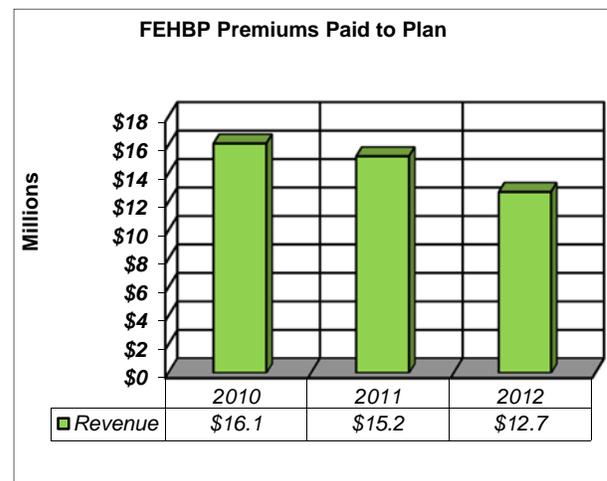
### Objectives

The primary objectives of the audit were to determine if the FEHBP premium rates were developed using complete, accurate and current data, and were equivalent to the Plan's Similarly-Sized Subscriber Groups (SSSG), as provided in Federal Employees Health Benefits Acquisition Regulation (FEHBAR) 1652.215-70(a). 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 2010 through 2012. For these years, the FEHBP paid approximately \$44 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 to Community-Rated Carriers (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 had in place to ensure that:

- The appropriate SSSGs were selected;

- the rates charged to the FEHBP were developed using complete, accurate, and current data, and were equivalent to the best rate given 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 utilizing the computer-generated data to cause us to doubt its reliability. We believe that the available data was sufficient to achieve our audit objectives. Except as noted above, the audit was conducted in accordance with generally accepted government auditing standards, issued by the Comptroller General of the United States.

The audit fieldwork was performed from November 2, 2015, through February 22, 2016, at the Plan's office in Cleveland, Ohio. Additional audit work was completed at our Cranberry Township, Pennsylvania; Jacksonville, Florida; and Washington, D.C. offices.

### **Methodology**

We examined the Plan's Federal rate submission and related documents as a basis for validating its Certificates of Accurate Pricing. In addition, we examined the rate development documentation and billings to other groups, such as the SSSGs, to determine if the FEHBP rates were reasonable and equitable. Finally, we used the contract, the FEHBAR, 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

## 1. Defective Pricing

\$3,177,807

The Certificate of Accurate Pricing HMO Health Ohio signed for contract years 2011 and 2012 was 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 totaling \$3,177,807 (see Exhibit A). We found that the FEHBP rates were developed in accordance with applicable laws, regulations, and OPM's rules and regulations in contract year 2010.

**The Plan improperly used data from both of its business entities to influence an SSSG's rates, resulting in defective pricing overcharges of \$3,177,807 in contract years 2011 and 2012.**

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 are complete, accurate and current. Furthermore, FEHBAR 1652.216-70 states that the subscription rates agreed to in the contract shall be equivalent to the subscription rates given to the community-rated carrier's SSSGs as defined in FEHBAR 1602.170-13. SSSGs are the Plan's two employer groups closest in subscriber size to the FEHBP. If it is found that the FEHBP rates were increased because of defective pricing or defective cost or pricing data, then the rates shall be reduced in the amount by which the price was increased because of the defective data or information.

### Separate Lines of Business

The Plan has two separate entities for which it conducts business. Medical Health Insuring Corporation of Ohio, also known as HMO Health Ohio, offers health maintenance organization (HMO) products. Medical Mutual of Ohio offers preferred provider organization (PPO) products.

During our review of the [REDACTED] in 2012, we found that the Plan was basing various factors of their rate calculation on combined HMO and PPO subscriber contracts. This prompted us to gather more information from the Plan about these entities and whether they were separate lines of business. The Plan stated the two entities were separate lines of business and, therefore, our SSSG selection should only be based on the HMO population, since that was the product that was offered to the FEHBP.

We do not agree that these entities are separate lines of business. According to OPM's Rating Instructions, separate lines of business must "meet all of the following criteria:

- It must be a separate organizational unit, such as a division.
- It must have separate financial accounting with ‘books and records that provide separate revenue and expense information.’
- It must have a separate work force and separate management involved in the design and rating of the healthcare product.”

The fact that the Plan blends HMO and PPO rates for certain SSSGs proves the entities are not separate lines of business as the revenues are affected for each entity. In addition, through discussions with the Plan, the workforce is shared between the two entities.

However, we determined that OPM’s contract for health benefits was with HMO Health Ohio, which offered HMO products. Therefore, we agreed with the Plan that we should only be auditing HMO groups. This also means that the Plan should not be using PPO data in any capacity when calculating the rates for its HMO population.

**Plan Response (see Appendix):**

*The Plan states that regardless of the entity structure, under Ohio law HMO and PPO products are two distinct types of business with two distinct types of rating formulas. Since the Plan only offers its HMO product to FEHBP members due to its contracting arrangement with OPM, only commercial groups offering an HMO product are appropriate to select as the SSSGs.*

**OIG Comment:**

It is not uncommon for the OIG to audit plans offering different product lines such as an HMO and a PPO, even if the FEHBP purchases a different product line than an SSSG. However, our decision to audit only SSSGs purchasing an HMO product is based solely on the contract between OPM and the Plan. As mentioned above, OPM’s contract is with HMO Health Ohio, which only offers HMO products. Therefore, we limited our SSSG selections to commercial groups who also purchased insurance through HMO Health Ohio.

**2011**

The Plan selected [REDACTED] and the [REDACTED] as the SSSGs for contract year 2011. We agree with the Plan’s selections. Our analysis of the rates charged shows that the [REDACTED] received a [REDACTED] percent discount, which was not applied to the FEHBP’s rates. Our review also showed that [REDACTED] did not receive a discount.

The [REDACTED] offered both an HMO and PPO product to its members. However, as discussed above, we limited our review of the [REDACTED] to its HMO product due to the FEHBP's contracting arrangement with HMO Health Ohio. Yet, in deriving the [REDACTED]'s final rates, we discovered that the final rates were a blend of its HMO and PPO rates. Since the Plan refused to provide documentation supporting the [REDACTED]'s PPO rates, we only considered the group's HMO rates in our audited rate calculations. A comparison of our audited rates to the group's billed rates resulted in a [REDACTED] percent discount to the [REDACTED].

Because the FEHBP is entitled to a discount equivalent to the largest discount given to an SSSG, we recalculated the FEHBP's rates using the [REDACTED] percent discount given to the [REDACTED]. A comparison of our audited line 5 rates to the Plan's reconciled line 5 rates shows the FEHBP was overcharged \$1,953,801 in contract year 2011 (see Exhibit B).

**Plan Response (see Appendix):**

*The Plan does not agree that any amounts are due to OPM in 2011.*

**OIG Comment:**

We disagree with the Plan's position and are questioning \$1,953,081 for defective pricing in contract year 2011. See the "OIG Comment Regarding the Blending of HMO and PPO Rates" below for further explanation.

**2012**

The Plan selected the [REDACTED] and [REDACTED] as the SSSGs for contract year 2012. We agree with the Plan's selections. Our analysis of the rates charged shows that the [REDACTED] received a [REDACTED] percent discount, which was not applied to the FEHBP's rates. Our review also showed that [REDACTED] did not receive a discount.

As in 2011, the [REDACTED] offered both an HMO and PPO product to its members in 2012. However, we again limited our review of the [REDACTED] to its HMO product due to the FEHBP's contracting arrangement with HMO Health Ohio. In deriving the [REDACTED]'s rates we determined that the Plan made multiple errors. First, the Plan used the group's total HMO and PPO contracts in determining its pooling level, resulting in a pooling level of \$ [REDACTED] and a pooling charge of [REDACTED] percent. However, since our audit was limited to the HMO population as discussed previously, we only used the group's HMO contracts to derive the group's audited rates, resulting in a pooling level of \$ [REDACTED] and a pooling charge of [REDACTED] percent.

The Plan also incorrectly applied a completion factor of [REDACTED] to the adjusted pooled claims. Based on the support provided, we determined the completion factor to be [REDACTED]. Additionally, the Plan incorrectly rated the [REDACTED] as [REDACTED] percent credible based on its total HMO and PPO contracts. We found the credibility level should have been [REDACTED] percent based solely on its HMO contracts.

Finally, in deriving the [REDACTED]'s rates, we again discovered that the rates were a blend of its HMO and PPO rates. Since the Plan refused to provide documentation supporting the [REDACTED]'s PPO rates, we only considered the group's HMO rates in our audited rate calculations. After adjusting the audited rates for the other above-mentioned adjustments, we compared these rates to the group's billed rates. The result of this comparison showed that the [REDACTED] received a [REDACTED] percent discount.

Because the FEHBP is entitled to a discount equivalent to the largest discount given to an SSSG, we recalculated the FEHBP's rates using the [REDACTED] percent discount given to the [REDACTED]. A comparison of our audited line 5 rates to the Plan's reconciled line 5 rates shows the FEHBP was overcharged \$1,224,006 in contract year 2012 (see Exhibit B).

**Plan's Response (see Appendix):**

*The Plan agrees that the pooling level, pooling charge, and credibility factor should have been based on the [REDACTED]'s HMO contracts in 2012. The Plan also agrees with our audited completion factor of [REDACTED]. The change to the credibility factor alone may result in a small refund due to OPM. The changes to the pooling charge would not have a material impact on the rates. In total, any changes the OIG suggests would not be material and there are no amounts due to OPM.*

**OIG Comment:**

We disagree with the Plan's position and are questioning \$1,224,006 for defective pricing in contract year 2012. See the "OIG Comment Regarding the Blending of HMO and PPO Rates" below for further explanation.

**Plan Response Regarding the Blending of HMO and PPO Rates (see Appendix):**

*The Plan disagrees with our approach of not blending the HMO and PPO rates for the [REDACTED] in 2011 and 2012. The result of not blending the rates created a discount to the [REDACTED], which we then applied to the FEHBP rates. The Plan argues:*

- 1. In a previous audit conducted in 2010, the Plan states we agreed that the blending of PPO and HMO rates was appropriate and did not result in any additional discounts to the selected SSSGs. The Plan relied on this assessment for future rating of the SSSGs.*
- 2. The Plan provided an excerpt from their state filing which states rates may be re-allocated between HMO Health Ohio and Medical Mutual of Ohio. The excerpt also shows a sample calculation for how the rates would be re-allocated. The Plan states they followed the guidance provided in the filing when renewing rates for the [REDACTED].*
- 3. Finally, the Plan provided a reallocation calculation for the [REDACTED] in 2011. The Plan states the re-allocation between HMO and PPO rates does not cause an overall discount. It only changes the amount of premium which should be collected under each product (95 percent of which is enrolled in the PPO product and 5 percent of which is enrolled in the HMO product), which ultimately affects the rates charged to the employees of the group.*

#### **OIG Comment Regarding the Blending of HMO and PPO Rates:**

We would like to make it clear that we believe the practice of blending rates between two different products such as HMO and PPO is acceptable. In this case, the Plan has two different entities that provide two different products. If a commercial group has both products, the rates are blended to arrive at the final rates.

However, there are other factors we need to take into consideration to determine our final position. HMO Health Ohio signed a contract with OPM to offer only an HMO product for each year under review. Therefore, our SSSG selections were limited to commercial groups purchasing insurance through HMO Health Ohio. As mentioned previously, the [REDACTED] offered both an HMO and a PPO product to its members. The PPO portion of the rates was developed by Medical Mutual of Ohio. The HMO and PPO rates are then re-allocated in a revenue neutral manner.

The Plan would like us to accept the [REDACTED]'s PPO rates, despite the fact that the PPO enrollment makes up 95 percent of the group's total enrollment, without auditing those rates. In other words, the Plan wants us to accept the re-allocation of the rates based on verification of only 5 percent of the group's total rate development. In order for us to re-allocate the group's rates as the Plan suggests, we would have to audit the PPO rate build-up, as any identified discounts or overcharges would affect the HMO rates during the re-allocation.

However, the Plan states that because the PPO rates were developed by a separate line of business, we are not able to audit the PPO rates. As we explained in the beginning of the report, we do not believe Medical Mutual of Ohio is a separate line of business based on the guidance provided by OPM in the Rating Instructions. However, because our contract is with HMO Health Ohio, we cannot pursue obtaining documentation from Medical Mutual of Ohio unless the Plan agrees to provide it. The Plan was adamant against providing any documentation relating to their PPO business during this audit.

In regards to the previous audit covering contract years 2006 through 2009, it is incumbent on the Plan to follow the regulations and instructions in place for each year in developing the FEHBP's and SSSGs' rates and not rely on previous audit results in determining the appropriateness of a rating methodology. That being said, our current audit findings are not indicative of a disagreement with the Plan's rating methodology. In fact, we agree that the blending of a group's rates amongst different product lines can produce a valid rate for the group. However, for audit purposes, when this type of methodology is utilized, we need to be able to audit the rates for both product lines to determine the validity of the final blended rate. In this instance the Plan refused to produce the documentation needed to support the [REDACTED]'s PPO rate. Therefore, we were only able to audit its HMO rate, which by the Plan's own admission covers only 5 percent of the group's total enrollment. Because we were not provided with rating documentation to support the PPO product's rates, we had no choice but to base our audit results on the discount that was given to the HMO product.

As a result, we calculated an audited rate adjustment factor based on HMO-only data with which the Plan agrees. We applied this factor to the group's HMO billed rates in each year to calculate our final audited renewal rates.

### **Recommendation 1**

We recommend that the Contracting Office either require the Plan to reimburse the FEHBP \$3,177,807 for defective pricing, or provide sufficient documentation to support the rate build-up for the [REDACTED]'s PPO product's rates in 2011 and 2012 so that the revenue neutrality resulting from the blending of the HMO and PPO rates can be validated.

## **2. Lost Investment Income**

**\$306,181**

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 2011 and 2012. We determined the FEHBP is due \$306,181 for lost investment income, calculated through August 31, 2016 (see Exhibit C). In addition, the

FEHBP is entitled to lost investment income for the period beginning September 1, 2016, until all defective pricing amounts have been returned to the FEHBP.

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.

**The FEHBP is due  
\$306,181 in lost  
investment income  
due to FEHBP  
overcharges.**

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

**Plan Response (see Appendix):**

*The Plan did not comment on the lost investment income finding.*

**Recommendation 2**

We recommend that the contracting officer require the Plan to return \$306,181 to the FEHBP for lost investment income, calculated through August 31, 2016. We also recommend that the contracting officer recover lost investment income on amounts due for the period beginning September 1, 2016, until all defective pricing amounts have been returned to the FEHBP.

# IV. MAJOR CONTRIBUTORS TO THIS REPORT

## COMMUNITY-RATED AUDITS GROUP

██████████, Auditor-in-Charge

██████████, Auditor

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██████████, Senior Team Leader

██████████, Group Chief

# EXHIBIT A

## HMO Health Ohio Summary of Questioned Costs

### Defective Pricing Questioned Costs

Contract Year 2011	\$1,953,801	
Contract Year 2012	<u>\$1,224,006</u>	
Total Defective Pricing Questioned Costs		\$3,177,807
Lost Investment Income		<u>\$306,181</u>
Total Questioned Costs		<u><b>\$3,483,988</b></u>

# EXHIBIT B

## HMO Health Ohio Defective Pricing Questioned Costs

### Contract Year 2011

	<u>Self</u>	<u>Family</u>
FEHBP Line 5 - Reconciled Rate	\$ [REDACTED]	\$ [REDACTED]
FEHBP Line 5 - Audited Rate	\$ [REDACTED]	\$ [REDACTED]
Bi-weekly Overcharge	\$ [REDACTED]	\$ [REDACTED]
To Annualize Overcharge:		
March 31, 2011 Enrollment	[REDACTED]	[REDACTED]
x 26 Pay Periods	<u>26</u>	<u>26</u>
Subtotal	\$909,090	\$1,044,711

### **2011 Defective Pricing Questioned Costs**

**\$1,953,801**

### Contract Year 2012

	<u>Self</u>	<u>Family</u>
FEHBP Line 5 - Reconciled Rate	\$ [REDACTED]	\$ [REDACTED]
FEHBP Line 5 - Audited Rate	\$ [REDACTED]	\$ [REDACTED]
Bi-weekly Overcharge	\$ [REDACTED]	\$ [REDACTED]
To Annualize Overcharge:		
March 31, 2012 Enrollment	[REDACTED]	[REDACTED]
x 26 Pay Periods	<u>26</u>	<u>26</u>
Subtotal	\$618,040	\$605,966

### **2012 Defective Pricing Questioned Costs**

**\$1,224,006**

### **Total Defective Pricing Questioned Costs**

**\$3,177,807**

# EXHIBIT C

## HMO Health Ohio Lost Investment Income

Year	2011	2012	2013	2014	2015	31-August-2016	Total
<b>Audit Findings:</b>							
1. Defective Pricing	\$1,953,801	\$1,224,006	\$0	\$0	\$0	\$0	\$3,177,807
Totals (per year):	\$1,953,801	\$1,224,006	\$0	\$0	\$0	\$0	\$3,177,807
Cumulative Totals:	\$1,953,801	\$3,177,807	\$3,177,807	\$3,177,807	\$3,177,807	\$3,177,807	
Avg. Interest Rate (per year):	2.5625%	1.8750%	1.5625%	2.0625%	2.2500%	2.1875%	
Interest on Prior Years Findings:	\$0	\$36,634	\$49,653	\$65,542	\$71,501	\$46,343	\$269,673
Current Years Interest:	\$25,033	\$11,475	\$0	\$0	\$0	\$0	\$36,508
Total Cumulative Interest Calculated Through August 31, 2016:	\$25,033	\$48,109	\$49,653	\$65,542	\$71,501	\$46,343	<b>\$306,181</b>

# APPENDIX



## MEDICAL MUTUAL OF OHIO®

Medical Mutual®  
2060 East Ninth Street  
Cleveland, Ohio 44115-1355

MedMutual.com



May 10, 2016

██████████  
Chief, Community-Rated Audits Group  
United States Office of Personnel Management  
Washington, D.C. 20415

*Via Email*

Re: Audit of HMO Health Ohio 2010 - 2012

Dear ██████████,

This letter is Medical Mutual's response to the draft audit report issued by your office on March 7, 2016. Medical Mutual respectfully disagrees with the amount of calculated inappropriate benefit charges as detailed in our comments below.

### Defective Pricing

- a. Separate Lines of Business - The draft audit report notes that Medical Mutual's wholly owned subsidiary, Medical Health Insuring Corporation of Ohio (MHICO) offers HMO products while Medical Mutual of Ohio offers PPO products. The report states that the auditors became aware of these two separate product lines during the course of this audit. We would like to make sure that you are aware that this division of products has existed for many years. **DELETED BY OIG – NOT RELEVANT TO THE FINAL REPORT** But regardless of whether the HMO plans and PPO plans are in one company or two companies, under Ohio law they are two distinct types of business with two distinct types of rating formulas. This is why an SSSG offering an HMO, not a PPO, is the appropriate group to choose as an SSSG. This is only a point of clarification, not a disagreement with the audit itself.
- b. ██████████ Pricing – 2011 and 2012
  - i. Medical Mutual agrees that in 2012, ██████████ pooling and pooling charge should have been calculated using only the HMO population, and that the pooling and pooling charge calculations provided by OPM are accurate. Further, we agree that the correct completion factor is ██████████. We do not believe this calculation was an error

because the factor used ( ) was intended to be applied to running paid rather than incurred and paid claims to provide customers with a more accurate picture of their experience. However, the intent of the change in factor is for display purposes, not to change the actual completed incurred claims, and therefore, we can accept OPMs calculation. Finally, we agree with OPMs use of an % credibility factor based solely on HMO contracts. This change may result in a small refund to OPM, but we believe the pooling change alone is immaterial.

- ii. Medical Mutual strongly disagrees with the conclusion that its blending of HMO and PPO rates in calculating the 's renewal rates (current income) was an improper calculation that provided the with an additional discount in its HMO premiums that was not afforded to the FEHB plan. This conclusion is not consistent with OPM historical audit practice and not consistent with our HMO rate filings. MHICO's HMO rating formula has been filed with and approved by the Ohio Department of Insurance and is clear that when a group offers both PPO and HMO products with Medical Mutual, the renewal rate calculations will be blended so that the prices reflect the actuarial value and the differences in benefits. Specific arguments regarding Medical Mutual's position are set forth below.

1. This rating methodology has been in place for several years and was actually discussed with the OPM auditors in the last two audits of the HMO Health Ohio plan. OPM conducted its previous audit in 2010 covering the years 2006-2009. During that audit, the auditor agreed that the blending of rates was appropriate and did not result in any additional discount provided to **DELETED BY THE OIG – NOT RELEVANT TO THE FINAL REPORT** an SSSG plan in 2007 or **DELETED BY THE OIG – NOT RELEVANT TO THE FINAL REPORT** an SSSG in 2009. The result of that audit was that “. . . the Plan's rating of the FEHBP was in accordance with applicable laws, regulations, and OPM's rating instructions to carriers for contract years 2006 through 2009. Consequently, the audit did not identify any questioned costs and no corrective action is necessary.”

Medical Mutual relied on this 2010 finding in continuing to calculate blended renewal rates for the plan during the 2011 and 2012 periods.

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2. MHICO filed a specific formula for calculation of renewal rates with the Ohio Department of Insurance. This formula must be the basis for determining renewal rates, and was a key element of the 2015 audit. OPM auditors reviewed the MHICO (HMO Health Ohio) filing, and reviewed the calculations of the FEHBP rates and the rates for the SSSGs to determine if the renewals were calculated according to the filing. OPM auditors received the entire filing, but Attachment 3 is the relative portion of the filing, which specifically mentions the reallocation (blending) between MHICO and MMO products in Step C of the calculation. The second page of Attachment 3 is also part of the filing and is a rating example

showing the blending, and is consistent with our process in renewing the [REDACTED] and other groups with HMO and PPO offerings for the last decade.

3. Lastly, the use of the calculated rate increases from 2011 for the [REDACTED] is demonstrated in Attachment 4. Note that the process of re-allocation does not give an overall discount to the [REDACTED], it simply changes the presentation of the total cost (95% of which is PPO because only 5% of the enrollment is in the HMO product), into a single increase for this single group, which maintains an actuarially sound difference in cost between the PPO and HMO employee plan offerings. There is no HMO product discount in the overall rates charged to [REDACTED].

Based on the above, it is Medical Mutual's position that there are no errors in the calculation of the FEHB rates due to the blending of the [REDACTED] HMO and PPO rates. Therefore, we do not agree that any amounts are due to OPM for the 2010 – 2012 audit. Please feel free to call me ([REDACTED]) or [REDACTED] ([REDACTED]) with any questions.

Sincerely,

[REDACTED]

[REDACTED]

Senior Vice President, General Counsel & Secretary



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