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 PRESBYTERIAN HEALTH PLAN

Report Number 1C-P2-00-15-022

July 29, 2015

-- CAUTION --

EXECUTIVE SUMMARY

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

Report No. 1C-P2-00-15-022 **July 29, 2015**

Why Did We Conduct the Audit?

The primary objective of this performance audit was to determine whether Presbyterian Health Plan (Plan) was in compliance with the provisions of its contract and the laws and regulations governing the Federal Employees Health Benefits Program (FEHBP). We determined if the Plan met the Medical Loss Ratio (MLR) requirements established by the U.S. Office of Personnel Management (OPM). We also verified whether the Plan developed the FEHBP premium rates using complete, accurate and current data.

What Did We Audit?

Under contact CS 2627, the Office of the Inspector General completed a performance audit of the Plan's FEHBP premium rates and MLR submission to OPM for contract year 2013. Our audit fieldwork was conducted from January 5, 2015 through January 16, 2015 at the Plan's office in Albuquerque, New Mexico.

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Assistant Inspector General for Audits

What Did We Find?

We determined that the Plan's 2013 FEHBP MLR submission was prepared in accordance with the laws and regulations governing the FEHBP and met the requirements established by OPM.

We also determined that the Plan's 2013 FEHBP premium rates were developed in accordance with applicable laws, regulations, and OPM's Rate Instructions to Community-Rated Carriers.

Consequently, a draft report was not issued and no corrective action is necessary.

ABBREVIATIONS

ACA	**Affordable Care Act**
CFR	**Code of Federal Regulations**
COB	**Coordination of Benefits**
CPT	**Current Procedural Terminology**
FEHBAR	**Federal Employees Health Benefits Acquisition Regulations**
FEHBP	**Federal Employees Health Benefits Program**
MLR	**Medical Loss Ratio**
NPI	**National Provider Identifier**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**Presbyterian Health Plan**
SSSG	**Similarly Sized Subscriber Group**
TCR	**Traditional Community Rating**
U.S.C.	**United States Code**

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I. BACKGROUND

We completed an audit of the Federal Employees Health Benefits Program (FEHBP) operations at Presbyterian Health Plan (Plan). The audit covered contract year 2013, and was conducted at the Plan's office in Albuquerque, New Mexico.

The audit was conducted pursuant to the provisions of Contract CS 2627; 5 United States Code 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 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.

In April 2012, OPM issued a final rule establishing an FEHBP-specific Medical Loss Ratio (MLR) requirement to replace the similarly sized subscriber group (SSSG) comparison requirement for most community-rated FEHBP carriers (77 FR 19522). MLR is the proportion of FEHBP premiums collected by a carrier that is spent on clinical services and quality health improvements. The MLR for each carrier is calculated by dividing the amount of dollars spent for FEHBP members on clinical services and health care quality improvements by the total amount of FEHBP premiums collected in a calendar year.

The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act (ACA, P.L. 111-148) and defined by the U.S. Department of Health and Human Services in 45 CFR Part 158. In 2012, community-rated FEHBP carriers could elect to follow the FEHBP-specific MLR requirements, instead of the SSSG requirements. Beginning in 2013, the MLR methodology is required for all community-rated carriers, except those that are state mandated to use traditional community rating (TCR). State mandated TCR carriers continue to be subject to the SSSG comparison rating methodology.

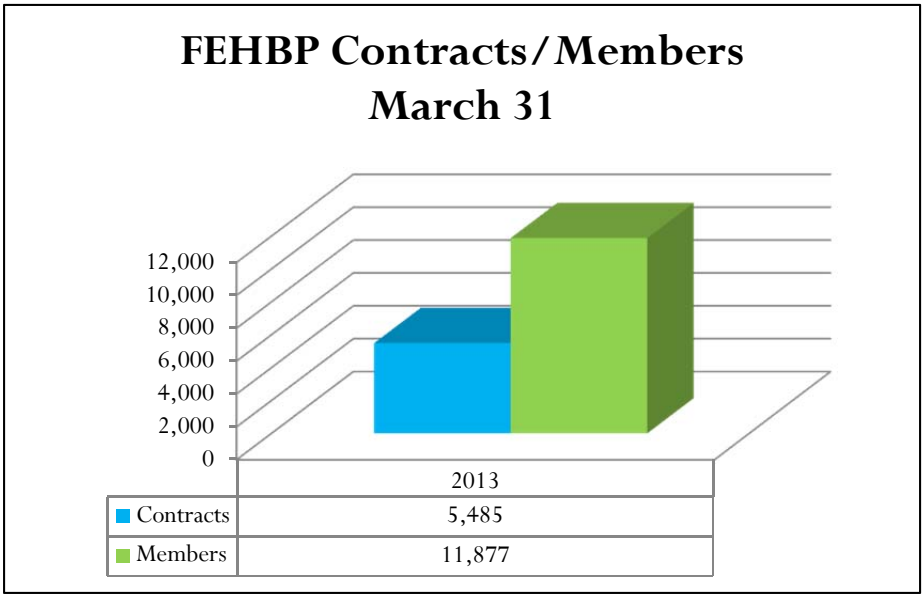
Starting with the pilot program in 2012 and for all non-TCR FEHBP carriers in 2013, OPM required the carriers to submit an FEHBP-specific MLR. OPM required that the FEHBP-specific MLR threshold calculation take place after the ACA-required MLR calculation, and that any rebate amounts due to the FEHBP as a result of the ACA-required calculation be excluded from the FEHBP-specific MLR threshold calculation. Carriers were required to report information related to earned premiums and expenditures in various categories, including reimbursement for

clinical services provided to enrollees, activities that improve health care quality, and all other non-claims costs.

If a carrier fails to meet the FEHBP-specific MLR threshold, it must make a subsidization penalty payment to OPM within 60 days of notification of amounts due. This payment would take place via wire transfer.

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 Plan reported 5,485 contracts and 11,877 members as of March 31, 2013, as shown in the chart below.



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 Plan has participated in the FEHBP since 1991 and provides health benefits to FEHBP members in the state of New Mexico. A prior audit of the Plan covered contract years 2010 through 2012. That audit questioned $1,933,916 in defective pricing for years 2010 and 2011. The findings were resolved and closed out by OPM's audit resolution process.

The preliminary results of this audit were discussed with the Plan officials at an exit conference and in subsequent correspondence. Since this audit concluded that the Plan's FEHBP MLR submission and FEHBP premium rates were developed in accordance with applicable laws, regulations, and OPM's Rate Instructions to Community-Rated Carriers (rate instructions), a draft report was not issued.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The primary objective of this performance audit was to determine whether the Plan was in compliance with the provisions of its contract and the laws and regulations governing the FEHBP. Specifically, we verified that the Plan met the MLR requirements established by OPM and paid the correct amount to the Subsidization Penalty Account, if applicable. We also verified whether the Plan developed the FEHBP premium rates using complete, accurate and current data.

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 year 2013. For this year, the FEHBP paid approximately $68.6 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 auditing procedures. However, the audit included tests of the Plan's FEHBP claims data, quality health expenses, and all other applicable costs considered in the calculation of its MLR. Our review of internal controls is limited to the procedures the Plan has in place to ensure that:

- The rates charged to the FEHBP are developed in accordance with the Plan's standard rating methodology and the claims, factors, trends, and other related adjustments are supported by complete, accurate and current source documentation; and

- The FEHBP MLR calculation is accurate, complete, and valid, and claims are processed accurately; appropriate allocation methods for quality health expenses are used; and any other costs associated with its MLR calculation are appropriate.

In conducting the audit, we relied to varying degrees on computer-generated 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.

We identified a total universe of 465,891 medical claim lines and 153,733 pharmacy claim lines incurred from January 1, 2013 through December 31, 2013, and paid through June 30, 2014. The audit universe attributes are the mandatory medical and pharmacy claim field requirements included in FEHB Carrier Letter 2014-01, Audit Requirements for 2013 MLR Program Carriers.

The audit fieldwork was performed at the Plan's office in Albuquerque, New Mexico during January 2015. Additional audit work was completed at our offices in Washington, D.C. and Jacksonville, Florida.

Methodology

We examined the Plan's MLR calculation and related documents as a basis for validating the MLR. Further, we examined claim payments and quality health expenses to verify that the cost data used to develop the MLR was accurate, complete and valid. We also examined the methodology used by the Plan in determining the premium in the MLR calculation. Finally, we used the contract, the Federal Employees Health Benefits Acquisition Regulations (FEHBAR), and the rate instructions to determine the propriety of the Plan's MLR calculation.

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

To test whether the Plan accurately processed and paid FEHBP claims for contract year 2013 and complied with its contract, we tested for potential claim errors within the full claims population of 465,891 medical claim lines and 153,733 pharmacy claim lines, totaling $46,604,948 and $9,288,765, respectively.

The tests performed, along with the methodology, are detailed below by Medical and Pharmacy claims:

Medical Claims Sample Selection Criteria/Methodology

Medical Claims Review Area	Sample Criteria	Sample Universe (Number)	Sample Universe (Dollars)	Sample Size (Claim Lines/Total Dollars)	Sample Type	Results Projected to the Universe?
Coordination of Benefits (COB) - Medicare	Member age 65+ and paid Claim over $50,000	21	$1,973,808	All	Judgmental	No
Bundling/ Unbundling	All Claim Lines with CPT 80047 (Basic Metabolic Panel)	No Hits	N/A	N/A	N/A	N/A
Duplicate Claims – Best Match Criteria	Compared patient ID, patient name, incurred date, covered charges, provider ID, CPT code, ICD-9 code, type of service, and provider specialty and all claims >$25,000	No Hits	N/A	N/A	N/A	N/A
Gender-Specific Review	All claims for Cervical PAP Smear, Hysterectomy and Vasectomy	No Hits	N/A	N/A	N/A	N/A
Non-Covered Benefits	Tested claims for: elective abortions, alternative treatments, contact lenses, eye glasses, hearing aids and in-vitro fertilization	19	$2,039	All	Judgmental	No

Pharmacy Claims Sample Selection Criteria/Methodology

Pharmacy Claims Review Area	Sample Criteria	Sample Universe (Number)	Sample Universe (Dollars)	Sample Size (Claim Lines/Total Dollars)	Sample Type	Results Projected to the Universe?
Pharmacy Claims - Dependent Eligibility	All Claim Lines Dependents age 26+	326	$6,994	All	Judgmental	No
High Dollar Drugs	Claim lines > $8,000	175	$597,956	All	Judgmental	No
Zero Quantity Prescriptions	All claim lines with paid amounts but had zero quantity	No Hits	N/A	N/A	N/A	N/A

We also examined the rate build-up of the Plan's contract year 2013 Federal rate submission and related documents as a basis for validating the Plan's standard rating methodology. We verified that the factors, trends, and other related adjustments used to determine the FEHBP premium rate(s) were sufficiently supported by source documentation. Further, we examined claim payments to verify that the cost data used to develop the FEHBP rates was accurate, complete and valid. 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 and interviewed Plan officials regarding the controls in place to ensure that the appropriate rates were charged. Other auditing procedures were performed as necessary to meet our audit objectives.

In addition, we examined the Plan's financial information and evaluated the Plan's financial condition and ability to continue operations as a viable ongoing business concern.

III. RESULTS OF THE AUDIT

Our audit determined that the Plan's 2013 FEHBP MLR submission was accurate, complete, and valid, and was developed in accordance with the applicable laws and regulations governing the FEHBP.

Our audit also determined that the Plan's FEHBP premium rates were developed in accordance with applicable laws, regulations, and the rate instructions for contract year 2013. Consequently, the audit did not identify any questioned costs and no corrective action is necessary.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

COMMUNITY-RATED AUDITS GROUP

[redacted], Auditor-In-Charge

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[redacted], Senior Team Leader

[redacted], Group Chief

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