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

Final Audit Report

Subject:

Audit of the Federal Employees Health Benefits Program Operations of Humana Health Plan, Inc. – South Florida

Report No. 1C-EE-00-09-057

Date: May 6, 2010

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

AUDIT REPORT

Federal Employees Health Benefits Program
Community-Rated Health Maintenance Organization
Humana Health Plan, Inc. – South Florida
Contract Number 2110 - Plan Code EE
Louisville, Kentucky

Report No. 1C-EE-00-09-057 **Date:** May 6, 2010

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UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
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EXECUTIVE SUMMARY

Federal Employees Health Benefits Program
Community-Rated Health Maintenance Organization
Humana Health Plan, Inc. – South Florida
Contract Number 2110 - Plan Code EE
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Report No. 1C-EE-00-09-057 **Date:** May 6, 2010

The Office of the Inspector General performed an audit of the Federal Employees Health Benefits Program (FEHBP) operations at Humana Health Plan, Inc. – South Florida (Plan). The audit covered contract years 2006 through 2009 and was conducted at the Plan's office in Louisville, Kentucky. This report details a procedural finding related to the Plan's claims data submission. We found that the Plan's ratings of the FEHBP were developed in accordance with applicable laws, regulations, and the Office of Personnel Management's rating instructions for the years audited.

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Appendix (Humana Health Plan, Inc. – South Florida's April 6, 2010, response to the draft report)

I. INTRODUCTION AND BACKGROUND

Introduction

We completed an audit of the Federal Employees Health Benefits Program (FEHBP) operations at Humana Health Plan, Inc. – South Florida (Plan) in Louisville, Kentucky. The audit covered contract years 2006 through 2008. The audit was conducted pursuant to the provisions of Contract CS 2110; 5 U.S.C. Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit was performed by the Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

Background

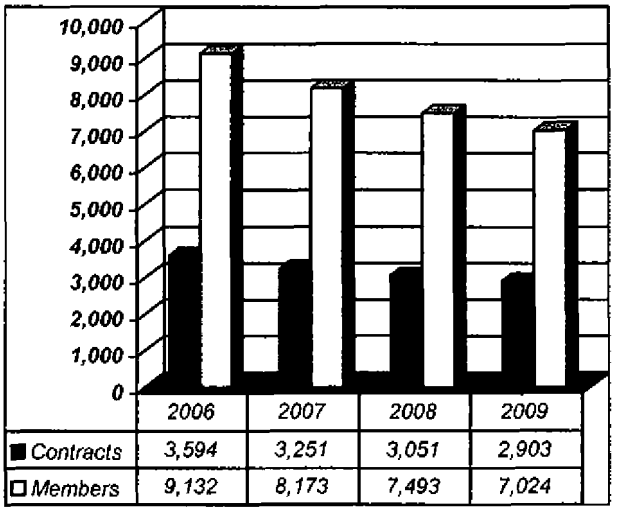
The FEHBP was established by the Federal Employees Health Benefits Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for federal employees, annuitants, and dependents. The FEHBP is administered by OPM's Retirement and Benefits Office. The provisions of the Federal Employees Health Benefits Act are implemented by OPM through regulations codified in Chapter 1, Part 890 of Title 5, CFR. 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. 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 the Plan as of March 31 for each contract year audited.

FEHBP Contracts/Members
March 31



	2006	2007	2008	2009
Contracts	3,594	3,251	3,051	2,903
Members	9,132	8,173	7,493	7,024

The Plan has participated in the FEHBP since 1989 and provides health benefits to FEHBP members in South Florida. The last full-scope audit conducted by our office covered contract years 2001 through 2005. All noted exceptions were resolved and amounts disallowed were returned to the FEHBP.

The preliminary results of this audit were discussed with Plan officials at an exit conference and through subsequent correspondence. A draft report was also provided to the Plan for review and comment. The Plan's comments were considered in the preparation of this final report and are included, as appropriate, as the Appendix.

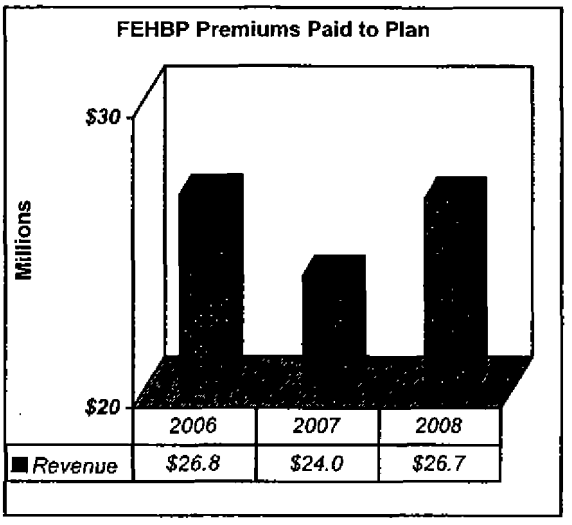
II. OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The primary objectives of the audit were to verify that the Plan offered market price rates to the FEHBP and to verify 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 2006 through 2009. For contract years 2006 through 2008, the FEHBP paid approximately $77.5 million in premiums to the Plan. [1] The premiums paid for each contract year audited are shown on the chart to the right.

OIG audits of community-rated carriers are designed to test carrier compliance with the FEHBP contract, applicable laws and regulations, and OPM 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 SSSGs); and
- the loadings to the FEHBP rates were reasonable and equitable.

[1] The Subscription Income Report for 2009 was not available at the time this report was completed.

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 Louisville, Kentucky during August 2009. Additional audit work was completed at our office in Jacksonville, Florida.

Methodology

We examined the Plan's federal rate submissions and related documents as a basis for validating the market price rates. Further, we examined claim payments to verify that the cost data used to develop the FEHBP rates was accurate, complete, and valid. 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 OPM's Rate Instructions to Community-Rated Carriers 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's policies and procedures, interviewed appropriate Plan officials, and performed other auditing procedures necessary to meet our audit objectives.

III. AUDIT FINDINGS AND RECOMMENDATION

Premium Rate Review

Our audit showed that the Plan's rating of the FEHBP was in accordance with the 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.

Claims Review

According to annual FEHBP Program Carrier Letters, OPM requires all carriers to keep on file all data necessary to justify its Adjusted Community Rating rate development and save back-up copies of its claims databases for audit purposes. As part of verifying the FEHBP's rate development, we reviewed FEHBP claims data for contract years 2007 through 2009. We ran queries on the claims data that relate to hospital services, physician services, out-of-area services, prescription and injectible drugs, large claims, coordination of benefits, bundling of claims, and non-covered benefits according to the FEHBP benefit brochures.

Bundling/Unbundling Claims

During the review of the FEHBP claims for contract years 2007 through 2009, we identified several unbundled claims. A claim is considered bundled when multiple procedures use a designated panel primary code, based on currently professional terminology (CPT) instructions, to charge for all laboratory tests performed on the same date. However, sometimes a laboratory will intentionally divide and charge for each procedure independently, instead of using the designated panel primary code for the bundled services and in effect un-bundle the claim. Therefore, the laboratory, in this case, can overcharge for these services if not monitored.

For our review, the audit team ran queries on the laboratory services claims for contract year 2007 (March 1, 2005-February 28, 2006), 2008 (March 1, 2006-February 28, 2007), and 2009 (March 1, 2008-February 29, 2008). The sample of queries was based on frequently used CPT codes. The specific CPT codes queried were for the basic metabolic panels (CPT code 80048) and electrolyte panels (CPT code 80051). We isolated any claims that contained charges for all of the individual procedures included within each panel. We found claims that charged for procedures independently instead of by one CPT code. We sent the claims in question to the Plan for further explanation.

The Plan responded that its system was not set up to check claims with place of treatment (POT) 1, 2, or R with CPT code range of 70000 through 90000, which are the designated codes for all radiology, pathology, laboratory, and other medical related services. The POT 1, 2, and R are used to identify where the service was performed; Inpatient Hospital (1), Outpatient Hospital (2), or Hospital-Emergency Room (R). The Plan stated that POT claims are not reviewed. The Plan further stated that a project work request (PWR) was being prioritized to correct these deficiencies.

The removal of the questioned claims from the rate development for contract years 2007 through 2009 did not have a monetary impact on the total rates. However, not monitoring this within the system affects all claims processed by Humana in all its regions. Therefore, this is considered a procedural finding.

Recommendation

We recommend that the contracting officer require the Plan to ensure that claims are not inappropriately unbundled.

Plan's Comments (See Appendix):

The Plan agrees with the OIG's opinion that its claims system was lacking internal controls to prevent claims unbundling in certain circumstances. A claims system enhancement was activated on March 19, 2010 from a PWR designed to address unbundling for POT code 1.

"Claims logic to prevent unbundling is already in place for POT codes 2 and R, although apparently this edit was implemented between the effective dates of the claims review and the time of the onsite audit visit."

OIG Reply to the Plan's Comments:

We acknowledge the Plan's agreement and we will verify the effectiveness of the corrective actions during the next audit.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Community-Rated Audits Group

[redacted] Auditor-In-Charge

[redacted] Staff

[redacted] Staff

[redacted] CRAG Group Chief

[redacted] Senior Team Leader

HUMANA RESPONSE TO DRAFT AUDIT REPORT NO. 1C-EE-00-09-057

2010 APR -6 PM 12: 13

This document is submitted by Humana Inc. and responds to the Draft Audit Report dated February 2, 2010 (the "Audit Report") issued by the Office of Inspector General of the Office of Personnel Management ("OPM") regarding the Humana Inc. – South Florida Area FEHBP Contract Number CS 2110 for contract years 2006-2009.

The Draft Audit Report discusses Claims Unbundling issues uncovered by the auditors in the course of a detailed claims review, specifically for CPT codes 80048 and 80051 and recommends Humana display a corrective action plan to address such lack of internal controls, specifically for Places of Treatment (POT) codes 1, 2, and R.

Humana's IT Claims area was engaged on this matter and the feedback received was addressed separately for a) POT code 1, and b) POT codes 2 and R.

A claims system enhancement was activated on 3/19/2010 from a Project Work Request (PWR) designed to address unbundling for POT code 1. The project description of this PWR was as follows, but the attached file "ClaimCheck POT 1.doc" provides further detail.

Project Description
"claims billed on a HCFA form, with a place of treatment (POT) one (Inpatient), with laboratory services ranging between 79999 and 90000 are excluded from the ClaimCheck Auditing logic. This enhancement will allow this exclusion to be included in the ClaimCheck Auditing logic. The implementation of this PWR will allow Humana to save dollars lost on claims not adjudicating against the auditing logic today."

Claims logic to prevent unbundling is already in place for POT codes 2 and R, although apparently this edit was implemented between the effective dates of the claims review and the time of the onsite audit visit. The attached file "ClaimCheck Interface Document (MC18GMIS) (Last Updated – 07/25/2006) outlines the process already in place for codes 2 and R.