



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 at Union Health Service, Inc.**

Report No. 1C-76-00-12-006

Date: August 20, 2012

-- CAUTION --

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AUDIT REPORT

**Federal Employees Health Benefits Program
Community-Rated Health Maintenance Organization
Union Health Service, Inc.
Contract Number CS 1571 - Plan Code 76
Chicago, Illinois**

Report No. 1C-76-00-12-006

Date: August 20, 2012



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

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EXECUTIVE SUMMARY

**Federal Employees Health Benefits Program
Community-Rated Health Maintenance Organization
Union Health Service, Inc.
Contract Number CS 1571 - Plan Code 76
Chicago, Illinois**

Report No. 1C-76-00-12-006

Date: August 20, 2012

The Office of the Inspector General performed an audit of the Federal Employees Health Benefits Program (FEHBP) operations at Union Health Service, Inc. (Plan). The audit covered contract years 2007 through 2011, and was conducted at the Plan's office in Chicago, Illinois.

This report questions \$1,110,730 for inappropriate health benefit charges to the FEHBP in contract years 2007 through 2011. The questioned amounts include \$1,035,784 for defective pricing, and \$74,946 due the FEHBP for lost investment income, calculated through June 30, 2012.

In contract years 2007 through 2011, the Plan gave a similarly sized subscriber group (SSSG) a discount; however, the same discount was not given to the FEHBP. Applying the SSSG discounts to our audited rates results in overcharges to the FEHBP of \$35,499; \$68,307; \$270,745; \$612,425; and \$48,808 in 2007, 2008, 2009, 2010, and 2011, respectively. Consistent with the FEHBP regulations and contract, the FEHBP is due \$74,946 for lost investment income, calculated through June 30, 2012, on the defective pricing findings.

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I. INTRODUCTION AND BACKGROUND

Introduction

We completed an audit of the Federal Employees Health Benefits Program (FEHBP) operations at Union Health Service, Inc. (Plan). The audit covered contract years 2007 through 2011, and was conducted at the Plan's office in Chicago, Illinois. The audit was conducted pursuant to the provisions of Contract CS 1571; 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.

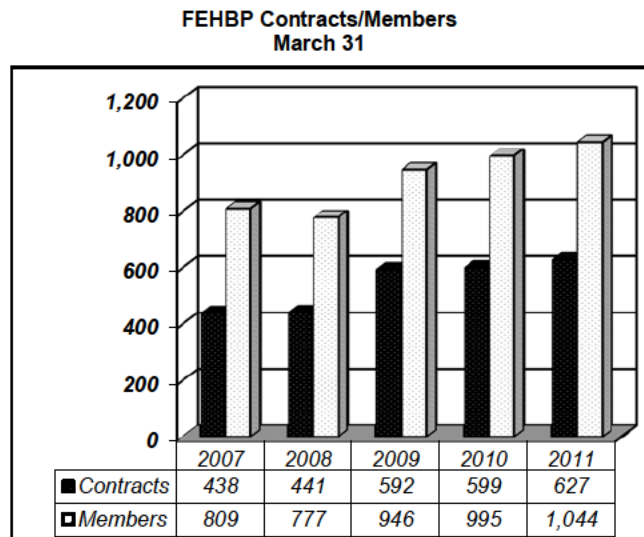
Background

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 Healthcare and Insurance 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.



The Plan has participated in the FEHBP since 1975 and provides health benefits to FEHBP members in the Chicago, Illinois area. The last audit of the Plan conducted by our office was in 2006. All issues from that audit have been resolved.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

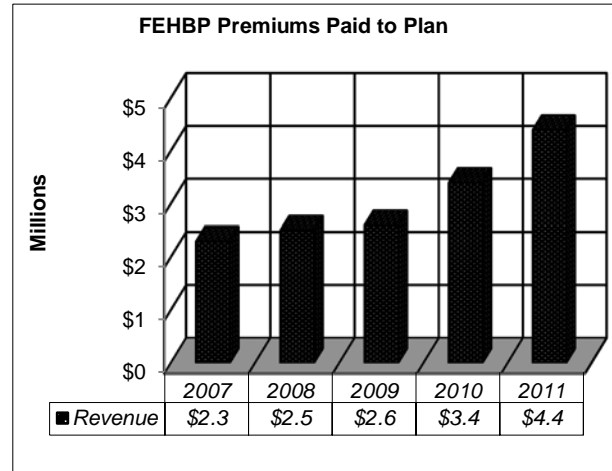
Objectives

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 2007 through 2011. For these contract years, the FEHBP paid approximately \$15.2 million in premiums to the Plan. The premiums paid for each contract year audited are shown on the chart above.



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 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 Chicago, Illinois, during October 2011. Additional audit work was completed at our offices in Jacksonville, Florida and Cranberry Township, Pennsylvania.

Methodology

We examined the Plan's Federal rate submissions 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 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 policies and procedures, interviewed appropriate Plan officials, and performed other auditing procedures necessary to meet our audit objectives.

III. AUDIT FINDINGS AND RECOMMENDATIONS

1. Premium Rate Review

\$1,035,784

The Certificates of Accurate Pricing Union Health Service, Inc. (Plan) signed for contract years 2007 through 2011 were defective. In accordance with the Federal regulations, the Federal Employees Health Benefits Program (FEHBP) is therefore due a rate reduction for these years. Application of the defective pricing remedies shows that the FEHBP is entitled to premium adjustments totaling \$1,035,784 (see Exhibit A).

Federal Employees Health Benefits Acquisition Regulations (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 a similarly sized subscriber group (SSSG). If it is found that the FEHBP was charged higher than a market price rate (i.e., the 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.

2007

The Plan selected [REDACTED] and [REDACTED] as SSSGs for contract year 2007. We disagree with these selections. We selected [REDACTED] and [REDACTED] as the SSSGs for contract year 2007, because they were closest in size to the FEHBP.

Our analysis of the rates charged to the SSSGs shows that [REDACTED] received a [REDACTED] percent discount and [REDACTED] received a [REDACTED] percent discount. The FEHBP received a discount of [REDACTED] percent for contract year 2007. Since the FEHBP is entitled to a discount equivalent to the largest discount given to an SSSG, we recalculated the FEHBP rates using the [REDACTED] percent discount given to [REDACTED]. A comparison of our audited rates to the Plan's reconciled rates shows that the FEHBP was overcharged \$35,499 in contract year 2007 (see Exhibit B).

2008

As in contract year 2007, the Plan selected [REDACTED] and [REDACTED] as SSSGs for contract year 2008. We disagree with these selections. Again, we selected [REDACTED] and [REDACTED] as the SSSGs for contract year 2008, because they were closest in size to the FEHBP.

Our analysis of the rates charged to the SSSGs shows that [REDACTED] received a [REDACTED] percent discount and [REDACTED] received a [REDACTED] percent discount. The FEHBP received a discount of [REDACTED] percent for contract year 2008. Since the FEHBP is entitled to a discount equivalent to the largest discount given to an SSSG, we recalculated the FEHBP rates using the [REDACTED] percent discount given to [REDACTED]. A comparison of our audited rates to the Plan's

reconciled rates shows that the FEHBP was overcharged \$68,307 in contract year 2008 (see Exhibit B).

2009

As in previous years, the Plan selected [REDACTED] and [REDACTED] as SSSGs for contract year 2009. We disagree with these selections. Again, we selected [REDACTED] and [REDACTED] as the SSSGs for contract year 2009, because they were closest in size to the FEHBP.

Our analysis of the rates charged to the SSSGs shows that [REDACTED] received a [REDACTED] percent discount and [REDACTED] received a [REDACTED] percent discount. The FEHBP received a discount of [REDACTED] percent for contract year 2009. Since the FEHBP is entitled to a discount equivalent to the largest discount given to an SSSG, we recalculated the FEHBP rates using the [REDACTED] percent discount given to [REDACTED]. A comparison of our audited rates to the Plan's reconciled rates shows that the FEHBP was overcharged \$270,745 in contract year 2009 (see Exhibit B).

2010

As in previous years, the Plan selected [REDACTED] and [REDACTED] as SSSGs for contract year 2010. We disagree with these selections. Again, we selected [REDACTED] and [REDACTED] as the SSSGs for contract year 2010, because they were closest in size to the FEHBP.

Our analysis of the rates charged to the SSSGs shows that [REDACTED] received a [REDACTED] percent discount and [REDACTED] received a [REDACTED] percent discount. The FEHBP received a discount of [REDACTED] percent for contract year 2010. Since the FEHBP is entitled to a discount equivalent to the largest discount given to an SSSG, we recalculated the FEHBP rates using the [REDACTED] percent discount given to [REDACTED]. A comparison of our audited rates to the Plan's reconciled rates shows that the FEHBP was overcharged \$612,425 in contract year 2010 (see Exhibit B).

2011

As in previous years, the Plan selected [REDACTED] and [REDACTED] as SSSGs for contract year 2011. We disagree with these selections. Again, we selected [REDACTED] and [REDACTED] as the SSSGs for contract year 2011, because they were closest in size to the FEHBP.

Our analysis of the rates charged to the SSSGs shows that [REDACTED] received a [REDACTED] percent discount and [REDACTED] received a [REDACTED] percent discount. The FEHBP received a discount of [REDACTED] percent for contract year 2011. Since the FEHBP is entitled to a discount equivalent to the largest discount given to an SSSG, we recalculated the FEHBP rates using the [REDACTED] percent discount given to [REDACTED]. A comparison of our audited rates to the Plan's reconciled rates shows that the FEHBP was overcharged \$48,808 in contract year 2011 (see Exhibit B).

Plan's Comments (see Appendix):

The Plan disagrees with our selections of [REDACTED] and [REDACTED] as SSSGs for all years in question. They believe that:

- a. Comparing the FEHBP to [REDACTED] and [REDACTED] does not show that “OPM receives an equitable and reasonable market-based rate” due to their enrollment size;
- b. Neither group satisfies OPM's definition of “Employer Group”;
- c. [REDACTED] and [REDACTED] consist of mainly subscribers that have Medicare coverage;
- d. [REDACTED] qualifies as a purchasing alliance;
- e. New members are not being added to these groups; and
- f. Underwriting guidelines will not allow the Plan to enroll a group of less than 10 subscribers without individual underwriting.

Other concerns expressed by the Plan are:

- The word discount is used improperly. They believe that the meaning of “discount” should not include such things as routine errors or normal statistical variation;
- the auditors should not have omitted the reconciliation adjustment which was included in the Plan's model;
- the auditors should have included the cost of printing the FEHBP brochures in our computation;
- the amount used for the Rx rider in the audited rates is incorrect;
- the SSSGs should receive a Medicare credit or the FEHBP should receive a Medicare loading due to the SSSGs having a higher percentage of subscribers with Medicare coverage; and
- the audited rates should include the cost of the smoking cessation benefits for all contract years under review.

OIG's Comments:

We disagree with the Plan's comments regarding the SSSG selection. The OPM rate instructions specifically state that the two groups closest in subscriber size must be selected as SSSGs, regardless of the size of the SSSG. [REDACTED] and [REDACTED] are eligible SSSGs even though there is no employer contribution. They are still classified as an employer group for SSSG purposes. According to OPM's rating instructions, groups that consist entirely of Medicare enrollees are excluded as SSSGs, however, [REDACTED] and [REDACTED] do not consist of only Medicare enrollees. Regarding [REDACTED] qualifying as a purchasing alliance, the contract between the Plan and the group did not support this argument. The Plan's argument about the groups not having any new members being added does not affect their eligibility to be an SSSG nor does the Plan's comments about their underwriting guidelines not allowing them to enroll a group of less than 10 subscribers without individual underwriting. Based on the OPM rate instructions, [REDACTED] and [REDACTED] are the SSSGs for contract years 2007 through 2011.

The Plan's comments regarding the term discount in the draft report do not have an effect on the questioned cost. For the purposes of the audit, the term discount refers to any differences between the audited rates and the Plan's reconciled rates.

The OIG audited rates include the actual capitation rates filed with the State of Illinois. No valid support was provided for a reconciliation adjustment.

The auditor's calculations only go to Line 5 rates of the Attachment III of the reconciliations that are submitted to OPM. The cost of printing the FEHBP benefit brochures is applied after Line 5 and has no bearing on our audited rates. The audited rates correctly exclude the printing cost of the FEHBP benefit brochures.

According to the OPM benefit brochures, the FEHBP did not receive the smoking cessation benefit until 2011; therefore, the smoking cessation benefit should not have been charged to the FEHBP in contract years 2007 through 2010.

We do not agree that the Plan should give the SSSGs a Medicare credit or the FEHBP a Medicare loading. The Plan's rating methodology does not include Medicare credits or loadings and, therefore, neither can be added to the FEHBP's rate or the SSSGs' rates. Our audited rates properly exclude any Medicare adjustments since it is not the Plan's practice.

Recommendation 1

We recommend that the contracting officer require the Plan to return \$1,035,784 to the FEHBP for defective pricing in contract years 2007 through 2011.

2. Lost Investment Income

\$74,946

In accordance with the 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 2007 through 2011. We determined that the FEHBP is due \$74,946 for lost investment income, calculated through June 30, 2012 (see Exhibit C). In addition, the FEHBP is entitled to lost investment income for the period beginning July 1, 2012, until all defective pricing finding amounts have been returned to the FEHBP.

Federal Employees Health Benefits Acquisition Regulation 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 did not comment on this finding.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Community-Rated Audits Group

██████████, Auditor-in-Charge

██████████, Auditor

██████████, Jr., Chief

██████████ Senior Team Leader

**Union Health Service, Inc.
Summary of Questioned Costs**

Defective Pricing Questioned Costs:

Contract Year 2007	\$35,499
Contract Year 2008	\$68,307
Contract Year 2009	\$270,745
Contract Year 2010	\$612,425
Contract Year 2011	<u>\$48,808</u>
Total Defective Pricing Questioned Costs	\$1,035,784
Lost Investment Income	<u>\$74,946</u>
Total Questioned Cost	<u>\$1,110,730</u>

Union Health Service, Inc.

Defective Pricing Questioned Costs

	<u>Single</u>	<u>Family</u>	
2007 Contract Year			
Plan's Reconciled Rates	██████████	██████████	
Audited Line 5 Rates	██████████	██████████	
Overcharge	██████████	██████████	
March 31, 2007 Enrollment x 26 pay periods	██████████ ██████████	██████████ ██████████	
Amount Due FEHBP in 2007			\$35,499
2008 Contract Year			
Plan's Reconciled Rates	██████████	██████████	
Audited Line 5 Rates	██████████	██████████	
Overcharge	██████████	██████████	
March 31, 2008 Enrollment x 26 pay periods	██████████ ██████████	██████████ ██████████	
Amount Due FEHBP in 2008			\$68,307
2009 Contract Year			
Plan's Reconciled Rates	██████████	██████████	
Audited Line 5 Rates	██████████	██████████	
Overcharge	██████████	██████████	
March 31, 2009 Enrollment x 26 pay periods	██████████ ██████████	██████████ ██████████	
Amount Due FEHBP in 2009			\$270,745

Union Health Service, Inc.

Defective Pricing Questioned Costs

	<u>Single</u>	<u>Family</u>	
2010 Contract Year			
Plan's Reconciled Rates	██████████	██████████	
Audited Line 5 Rates	██████████	██████████	
Overcharge	██████████	██████████	
March 31, 2010 Enrollment x 26 pay periods	██████████	██████████	
Amount Due FEHBP in 2010			\$612,425
2011 Contract Year			
Plan's Reconciled Rates	██████████	██████████	
Audited Line 5 Rates	██████████	██████████	
Overcharge	██████████	██████████	
March 31, 2011 Enrollment x 26 pay periods	██████████	██████████	
Amount Due FEHBP in 2011			<u>\$48,808</u>
Total Defective Pricing Questioned Cost			<u>\$1,035,784</u>

**Union Health Service, Inc.
Lost Investment Income**

Year	2007	2008	2009	2010	2011	Jun-12	Total
Audit Findings:							
Defective Pricing	\$35,499	\$68,307	\$270,745	\$612,425	\$48,808	\$0	\$1,035,784
Totals (per year):	\$35,499	\$68,307	\$270,745	\$612,425	\$48,808	\$0	\$1,035,784
Cumulative Totals:	\$35,499	\$103,806	\$374,551	\$986,976	\$1,035,784	\$1,035,784	\$1,035,784
Average Annual Interest Rate:	5.500%	4.938%	5.250%	3.188%	2.563%	2.000%	
Interest on Prior Years Findings:	\$0	\$1,753	\$5,450	\$11,939	\$25,291	\$10,358	\$54,791
Current Years Interest:	\$976	\$1,686	\$7,107	\$9,761	\$625	\$0	\$20,155
Total Cumulative Interest Through June 30, 2012	\$976	\$3,439	\$12,557	\$21,700	\$25,916	\$10,358	\$74,946



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May 21, 2012

██████████ Chief
Community-Rated Audits Group
U.S. Office of Personnel Management
Office of the Inspector General
800 Cranberry Woods Drive, Suite 270
Cranberry Township, Pennsylvania 16066

Re: Response to draft audit report of Union Health Service, Inc., Chicago, Illinois,
Report No. 1C-76-00-12-006

Note: This document references supporting information accessible via hyperlinks. It is recommended that the document be viewed from a computer file opened from the accompanying CD or from a hard drive in which all of the accompanying files are stored in the same folder.

Dear ██████████:

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The above paragraphs quote statements by OIG in 2007 and I agree with them. Our circumstances have not changed since then regarding the selection of SSSGs.

The various observations described in the draft report are not significantly challenged in this response, but the conclusion is. I agree with most of the numbers although a few differences will be mentioned and I will identify some items that were apparently overlooked. But in general, I believe the reported observations are insufficient to support the draft recommendations. My main interest now is to present additional information that I think is essential for correctly assessing our overall compliance with OPM's rating guidelines and objectives. This response will focus on the following areas that I believe are most relevant.

- The suitability of the selected SSSGs
- Observations with the draft calculations and reported findings
- Other relevant information for supporting a conclusion
- Our conclusion and recommended actions

Selected SSSGs

We were surprised that OIG selected [REDACTED] and [REDACTED]. We initially expressed our reservations with the auditor-in-charge and he encouraged us to not be overly concerned at that point because the issues we identified should be addressed at another level in the process. I inferred that he was basically saying, in so many words, “I will proceed with the general audit template we routinely use, and at a later stage you can work with others to determine how the findings should be interpreted and applied”. I was comfortable with that approach believing that we should reach the same conclusions regardless of what was selected for SSSGs because all premiums are calculated from common base capitation rates (applicable to either a “clinic-only” or a “clinic and non-clinical” benefit package). However, I now see two developments that I did not expect —

- We made two administrative mistakes over the years; (1) our billing department failed to bill the newly calculated rates for one of the selected SSSGs in one year, and (2) I erred in adjusting the step-up factors for one selected SSSG when we eventually started combining the two small groups for rating purposes.
- I did not foresee OIG extrapolating such heavy conclusions from the limited observations.

Suitability of the selected SSSGs:

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The selected SSSGs violate requirements of OPM’s guidelines.

- Neither group ensures that “OPM receives an equitable and reasonable market-based rate”. The groups do not shop their premium; they have no negotiating clout; there is no employer-paid premium contribution for [REDACTED] and the current active [REDACTED] employees are excluded from joining the Plan (retirees only are enrolled with us).
- The members are not employees and, further, [REDACTED] would satisfy OPM’s definition of a “Purchasing Alliance” (requiring exclusion of the group as an SSSG). OPM’s guidelines exclude Purchasing Alliances with less than 100 enrollees from eligibility as an SSSG.

In addition to OPM’s published guidelines, other reasons to exclude [REDACTED] and [REDACTED] as eligible SSSGs include:

- New members are not being added to these groups. The groups have been reorganized; [REDACTED] was in receivership and [REDACTED] is now administered by another union. Although we have maintained the “group” structure for administrative purposes (list billing), the remaining members are, in substance, individuals that otherwise we would be obligated to cover with the same benefits under state required individual conversion privileges (one member has a dependent with a serious pre-existing condition).
- Our underwriting guidelines, like most carriers, will not allow us to enroll a group of less than 10 employees without individual underwriting.
- Most of the subscribers have Medicare coverage.
- Extrapolation of measurements from an SSSG (*e.g.*, SSSG variance values) to estimate corresponding amounts in a target population (*e.g.*, FEHBP corresponding values) requires that the SSSG has a statistically credibility database (this is not the case for very small groups). The implications are extreme. The sensitivity of this issue can be seen by going to an Excel

spreadsheet that shows the change in premium for [REDACTED] resulting from a slight change in the demographics. Change the value in cell C27 from 1 to zero (eliminating the one family of three members). The calculated premium yield PMPM (capitation) shown in cell H30 drops from [REDACTED] to [REDACTED], a decrease of more than 20%. The annual premium of the FEHBP is roughly \$5 million dollars. A refund of 20% of the FEHBP premium for a single year would be approximately \$1 million (20% of \$5 million). The combined annual premium of both SSSGs is roughly \$65,000. Clearly something is wrong with an approach that could cause an adjustment equal to fifteen times the SSSG's annual premium if the SSSG merely loses one family subscriber.

Calculations and reported findings

Discount

Text from the draft report's executive summary states,

“For contract years 2007, 2008, 2009, 2010, and 2011, we determined that the FEHBP's rates were overstated by \$35,499, \$68,307, \$270,745, \$612,425, and \$48,808, respectively. More specifically, the Plan did not apply a similarly sized subscriber group (SSSG) discount to the FEHBP's rates.”

In the Audit Findings and Recommendations section of the draft report, the first three sentences of the findings paragraph for each year of the audit are based on the issue of discounts. The text is:

“Our analysis of the rates charged to the SSSGs shows that [REDACTED] received a ___ percent discount and [REDACTED] received a ___ percent discount. The FEHBP received a discount of ___ percent for contract year _____. Since the FEHBP is entitled to a discount equivalent to the largest discount given to an SSSG, we recalculated the FEHBP rates using the _____ percent discount given to Local _____”.

OIG is using the term “discount” in the draft report as a catch-all word related to any and all observable differences. But that is not the meaning constructed from OPM's guidelines and reconciliation instructions.

The context from OPM's guidelines and instructions consistently implies that the term “discount” is intended to have a common usage meaning that essentially indicates a willful price mark-down made to create an economic benefit. The meaning of “discount” does not include such things as routine errors (e.g., a procedural mistake within an organization to properly bill a communicated price change) or normal statistical variation (e.g., sudden enrollment changes in very small groups).

Evidence of what “discount” means within the context of OPM's guidelines includes:

- The format of the OPM reconciliation form shows that many factors affecting rates are distinct from what is labeled “discount” (e.g., benefit loadings, standard loadings, brochure printing, and reconciliation adjustments from the previous year).
- The “Example of TCR/ACR Comparison Sheet” within “OPM's Rate Reconciliation Instructions” shows that the first-level step-up factor and the family/self ratio are clearly distinct from what is labeled “Total Discount”.
- OPM's Community Rating Guidelines indicate that rates cannot be changed once they are proposed, but discounts can later be offered. It follows that discounts are distinct from the other factors that go into establishing rates.

Proper understanding of the term “discount” is not intended to be an argument of semantics. It is central to an auditor’s effort to fairly apply marketplace accountability. It would be an issue of fairness (or lack of) if there is a practice of denying the FEHBP an advantage that is applied to benefit other groups; however, that is not what we’re dealing with in these audit calculations. I believe no group except the FEHBP ever received a real discount. Further, even if OIG takes the position that one or both of the two small groups received a larger “discount”, it remains true that the vast majority of our members (from [REDACTED] [REDACTED]) did not have a discount at all, according to OIG’s usage of the term. FEHBP received favorable treatment relative to the marketplace.

Prior/Post Reconciliation Adjustments

The auditor’s work papers supporting the draft report include worksheets for calculating the difference between the Plan’s rates and the reconciled rates established by the audit. The amounts shown for the Plan’s rates do not include the Plan’s reconciliation adjustments from either the prior or subsequent year. Therefore, recognized differences that have been properly corrected via the annual reconciliation process are ignored in the draft audit report.

Perhaps OIG is assuming that reconciliation adjustments offset one another from year to year and, thus, can be ignored; in other words, reconciliation adjustments are mere timing differences. That assumption might be reasonable (although not precise) if we were attempting to calculate the accumulated effect of errors and corrections over a span of time. However, that is not what the auditor is attempting to calculate. The auditor is attempting to independently define the rate components of each respective year, add them together, compare the sum to the amount charged by the Plan, and define the difference as a discount. Aside from my earlier discussion of the meaning of “discount”, the effect of prior and subsequent reconciliation adjustments must be included to recognize corrections already made by the Plan.

Overlooked or incorrectly calculated items

The calculated rates per the audit do not include the cost of the smoking cessation benefits (\$ [REDACTED] per-member-per-month).

The calculated rates per the audit do not include the cost of printing the FEHBP brochure. The costs vary slightly from year to year; it was \$11,966 in 2010.

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Prescription drugs benefit variance

The premium rates developed for all of the years covered by this audit were prepared without any loading for the prescription drugs benefit. Prior to 2011, we did not have group-specific data showing the cost of the group’s prescription drugs benefit for the FEHBP. During the years covered by the audit we did not have groups with a prescription drugs benefit except (1) the comprehensive benefits offered to the FEHBP, [REDACTED] and [REDACTED] and (2) a minimal benefit offered to [REDACTED] covering only limited items on a

restricted formulary of low-cost generic drugs. For the FEHBP we did not even have any claims data; all of the prescriptions were dispensed directly from our clinic's internal pharmacy, without generating a claim. In other words, our total book of business for prescription drugs benefits was predominately [REDACTED] minimal generic program, the FEHBP's comprehensive program, and the comprehensive benefits for the two small groups that, together, were too small to produce any credible data.

We knew that the aggregate cost of all prescription drugs benefits was about [REDACTED] in 2011 (even less in the earlier years when the formulary was more limited). We also knew that the cost for the FEHBP should be more because it covers brand-name drugs as well as many popular generics that were not on [REDACTED] formulary, but we had no idea that the costs would be [REDACTED] times more. We now know that the prescription drugs benefit cost for the comprehensive program (FEHBP's) was [REDACTED] per-member-per-month, a figure OIG confirmed in the audit. This knowledge was learned only after we started contracting with Walgreens to provide pharmacy benefit management (PBM) services. The PBM reports provided the group specific data and we were surprised at what we saw. With the help of the physicians on our Pharmaceutical and Therapeutics Committee, and with consulting input from Walgreens, we reviewed the differences in the experience of [REDACTED] (with the limited benefits) compared to the FEHBP (with the comprehensive benefits). We now understand the FEHBP cost is not abnormal; commercial groups with comprehensive benefits and conventional copayments commonly have expenses in the range of [REDACTED] per-member-per-month. The cost for the [REDACTED] benefits is not comparable.

Question: What does all of this pharmacy history have to do with the FEHBP reconciliation?

Answer: Connecting this history with an understanding of how the baseline premium capitation rates were developed shows that [REDACTED] and [REDACTED] (the two large groups not considered by OIG as SSSGs) have been heavily subsidizing the FEHBP.

Our rating methodology builds the FEHBP premium from two baseline capitation rates, one rate for services generally rendered in our clinics (e.g., physician services) and another for non-clinical benefits (e.g., hospital services). The "clinical" rate is derived from a financial forecast prepared each fall that determines the January renewal premiums charged to the large groups, [REDACTED] and [REDACTED]. All known or estimated factors are loaded into the forecast model before locking in on the clinical rate in the final step. The clinical rate is a plugged amount that will yield the desired level of profitability. If values loaded into the forecast model for the FEHBP premium (earlier steps in the forecast) are inadequate because the cost of prescription drugs is understated, the understatement will cause an offsetting increase to the capitation rate for clinical services. Yes, that offset is charged to the FEHBP, too; nevertheless, the large groups have borne the vast majority of the burden.

Medicare offset

OPM recognizes that it is important to adjust the premium for the impact of Medicare benefits offsetting risk that otherwise would be payable by the Plan. Line 4 (c) of OPM's form for premium reconciliation is entitled "Medicare loading". Most commercial employers would not have retirees included in their group with Medicare benefits (at least not to the extent as within the FEHBP group). However, as stated above in the section entitled "Suitability of the selected SSSGs", most of the subscribers in [REDACTED] and [REDACTED] have Medicare coverage.

Medicare impacts the net claims cost with a very large reduction for the SSSGs ([REDACTED] & [REDACTED] relative to the FEHBP. Our analysis shows the combined SSSGs should have a Medicare loading, relative to the FEHBP, of a negative [REDACTED] PMPM; that is, the SSSGs risk to the Plan is [REDACTED] PMPM less than the risk of FEHBP due to the SSSGs having more help from Medicare. However, since the loading was not built into the SSSG's premium, the SSSGs were effectively overcharged [REDACTED] (all else being equal)

relative to the FEHBP. A reconciliation of FEHBP and SSSGs should apply this observation as either an increase in the SSSG's premium or a reduction of the FEHBP premium to make them comparable.

Premium stability and step-up factors

OPM understands the importance of price stability. And OPM understands the need to build safeguards into the calculations that will protect against price spikes from year to year. This is why OPM's Office of Actuaries negotiates and administers contingency reserves with the plans. Establishment of a contingency reserve is not feasible for groups such as [REDACTED] and [REDACTED] but at least we can avoid abrupt major changes in demographic assumptions (*e.g.*, caused by the routine enrollment or disenrollment of a few members, perhaps only one family) and, thus, avoid whiplashing the premium up and down.

In most circumstances, it is important to use a group's actual demographic data in developing step-up factors. Otherwise, the blended premium per member can be distorted (unwittingly or by willful manipulation). For traditional community rated premium, OPM's guidelines require the usage of group specific data for the SSSGs if group specific data is used for the FEHBP. If the FEHBP and the SSSGs were all groups large enough to have credible demographic data (a reasonably predictable distribution of contract types), the guidelines would work as expected. The FEHBP is large enough, but the SSSGs are not. We need to consider the implications as well as the intent of the guidelines and balance the competing objectives of price stability and usage of actual data.

Unfortunately, I caused a complication by incorrectly entering a wrong value for the conversion factor in 2011. The auditor is correct that the capitation to single premium conversion factor used in 2011 must be greater than [REDACTED] if the ratio of single to family premium in a three-tiered structure is less than [REDACTED]. I greatly regret that error; however, we must ask, "What now is the correct response to that mistake?" I believe the auditor should either ignore the error with consideration to the entire context or should fully adjust for all of the differences between the assumed and actual demographics for all years.

My preferred choice is to accept the error and move on rather than make adjustments for all prior years: I say that because the demographic data is not sufficiently reliable with such small groups to extrapolate aggregate premium adjustments to the much larger FEHBP group. Otherwise, the calculations for all of the prior years in which this error was not made would show that that [REDACTED] was significantly overcharged (*i.e.*, [REDACTED] or [REDACTED] *PMPM overcharged in 2009*). But that's not my interpretation; I do not view this as an over-charge to the SSSG because a very slight change membership could swing the numbers radically in the other direction. Nevertheless, that would indeed be the picture if we look solely to the actual demographics of a very small group each year. Further, looking solely to the actual demographics each year would make it impossible to have any semblance of price stability for the small groups. I think it makes much more sense to assure the demographics are reasonable with respect to the FEHBP, they are generally consistent for the small SSSGs, and the charged premium is derived from a common base capitation.

Other relevant information

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Conclusion and Recommended Action

I believe the audit observations and other supporting information indicate compliance with the rating guidelines; the FEHBP has not been charged more than any other group for reconciled benefits. Although I have argued that [REDACTED] and [REDACTED] are not groups eligible to be considered SSSGs, a corrected reconciliation on a per-member-per-month basis would, nevertheless, show a pattern of charging less to the FEHBP. Another approach for making a corrected reconciliation would be to retain the current structure used by OIG but make additional adjustments as described in this response. Considerations for these two approaches include:

1. A reconciliation of premium per member per month eliminates distortions caused by demographics and calculated step-up factors: it exposes the main issue — that is, the actual amount paid by and on behalf of each member.
2. Reconciliation with the current structure adopted by OIG would add adjustment(s) as described in this response, but not every adjustment necessarily has to be developed. As I see it, the process can stop once the conclusion is reached that the FEHBP rates do not exceed the SSSG rates for reconciled benefits and no other foreseeable adjustment remains that could push the conclusion in the other direction. I suggest starting with the most powerful and most persuasive adjustments; such as, the described adjustments for Medicare loading or the costs of prescription drugs subsidized by the large groups. Either of those issues, alone, should successfully complete the

needed reconciliation. If not, I suggest taking the next items that are the easiest to address; such as, inclusion of brochure cost, smoking cessation benefits, and correcting for a miscalculation of the blended discount for 2010. After that, if needed, I suggest applying the annual reconciliation adjustments from prior years built into the rate proposals.

My preference for resolving this audit would take an approach that does not rely solely on [REDACTED] and [REDACTED]. Although they do provide some minimal enlightenment, they do not provide sufficient grounds for OIG's draft conclusions. There are other approaches from reaching the correct conclusion. I do not have a preference on the general approach OIG should take, but I can identify the following options:

1. Abandon the current structure and continue with the SSSG selection used in OIG's prior audit, using the larger groups [REDACTED] and [REDACTED]. Although the benefit variances for these groups would make the reconciliation more difficult, it is, nevertheless, feasible. [REDACTED] and [REDACTED] are valid groups and have the marketplace accountability properties that are needed for an SSSG.
2. Expand the current structure of the draft audit and, as previously done by OIG, use all four groups as SSSGs ([REDACTED], [REDACTED], [REDACTED], [REDACTED]). This approach might show some rough spots (depending on what modifications are adopted from this response), but the prevalent pattern will be clear — favorable of the FEHBP.
3. Conclude that a conventional SSSG audit is not the best means of assessing compliance under the circumstances found for this Plan. In this case, alternative tests should be given primacy. OIG might find that a review of the Plan's historical rates relative to competitors', or its filed medical loss ratio, establish the best support for a conclusion.

* * *

My conclusion is significantly different from what the draft report shows. Yet most of our observations (not those focused on in this document) are the same. The on-site auditors were courteous, professional, and worked very hard on the report; for that I am grateful. But I think much of the story here is that OIG set out on a course that appeared to be relatively simple and straightforward, rational, and likely to show an outcome consistent with our long-term track record. That is what I expected, too. However, we found a few things we didn't expect (the pharmacy variance, the conversion factor error with one group in 2011, and an administrative oversight in correctly billing the [REDACTED] premium in 2010). These issues required us to look deeper; and, as a result, we have now connected the dots on issues that were not previously so apparent (disqualification of the selected SSSGs, distinction between a discount and a difference for another reason, Medicare loading, and MLR performance).

I hope this response enables us improve our understandings.

Very truly yours,

[REDACTED]

Executive Director.