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

Final Audit Report

Subject:

AUDIT OF
HEALTH ALLIANCE HMO
URBANA, ILLINOIS

Report No. 1D-FX-00-14-001

Date: May 5, 2014

--CAUTION--

AUDIT REPORT

Federal Employees Health Benefits Program
Experience-Rated Health Maintenance Organization

Health Alliance HMO
Contract CS 1980 Plan Codes FM/FX
Urbana, Illinois

REPORT NO. 1D-FX-00-14-001 DATE: May 5, 2014

Michael R. Esser
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for Audits

--CAUTION--

EXECUTIVE SUMMARY

Federal Employees Health Benefits Program
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Health Alliance HMO
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Urbana, Illinois

REPORT NO. 1D-FX-00-14-001 DATE: May 5, 2014

We conducted a limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at Health Alliance HMO (Plan), located in Urbana, Illinois. Our audit was conducted in accordance with Government Auditing Standards. The audit covered miscellaneous health benefit payments and credits, such as refunds, subrogation recoveries, and pharmacy drug rebates, from 2008 through June 30, 2013 as reported in the Annual Accounting Statements. In addition, we reviewed the Plan's cash management activities and practices related to FEHBP funds from 2008 through June 30, 2013 and the Plan's Fraud and Abuse Program from 2012 through June 30, 2013.

The audit disclosed no significant findings pertaining to miscellaneous health benefit payments and credits, the Plan's cash management activities and practices, and the Plan's Fraud and Abuse Program. Accordingly, this final report contains no questioned charges or recommendations.

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I. INTRODUCTION AND BACKGROUND

INTRODUCTION

This final audit report details the findings, conclusions, and recommendations resulting from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at Health Alliance HMO (Plan). The Plan is located in Urbana, Illinois.

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 (FEHB) 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. OPM's Healthcare and Insurance Office has overall responsibility for administration of the FEHBP. The provisions of the FEHB Act are implemented by OPM through regulations, which are codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations (CFR). Health insurance coverage is made available through contracts with various health insurance carriers.

The Plan is an experience-rated health maintenance organization (HMO) that provides health benefits to federal enrollees and their families.[1] Enrollment is open to all federal employees and annuitants in the Plan's service area, which includes Illinois, Western Indiana, and Central and Eastern Iowa.

The Plan's contract (CS 1980) with OPM is experience-rated. Thus, the costs of providing benefits in the prior year, including underwritten gains and losses that have been carried forward, are reflected in current and future years' premium rates. In addition, the contract provides that in the event of termination, unexpended program funds revert to the FEHBP Trust Fund. In recognition of these provisions, the contract requires an accounting of program funds be submitted at the end of each contract year. The accounting is made on a statement of operations known as the Annual Accounting Statement.

Compliance with laws and regulations applicable to the FEHBP is the responsibility of the Plan's management. Also, management of the Plan is responsible for establishing and maintaining a system of internal controls.

[1] Members of an experience-rated HMO have the option of using a designated network of providers or using non-network providers. A member's choice in selecting one healthcare provider over another has monetary and medical implications. For example, if a member chooses a non-network provider, the member will pay a substantial portion of the charges and benefits available may be less comprehensive.

All findings from our prior audit of the Plan (Report No. 1D-FX-00-04-001, dated December 20, 2004) for contract years 2000 through 2002 have been satisfactorily resolved.

The results of this audit were provided to the Plan in written audit inquiries (AI), and were discussed with Plan officials throughout the audit and at an exit conference on December 11, 2013. The Plan's comments and supporting documentation offered in response to the AIs were considered when preparing our final report. Also, additional documentation provided by the Plan and OPM's contracting officer on various dates through February 24, 2014 was considered in preparing our final report. Since our audit disclosed no significant findings, a draft report was not issued.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The objectives of our audit were to determine whether the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract. Specifically, our objectives were as follows:

Miscellaneous Health Benefit Payments and Credits

- To determine whether miscellaneous payments charged to the FEHBP were in compliance with the terms of the contract.

- To determine whether credits and miscellaneous income relating to FEHBP benefit payments were returned promptly to the FEHBP.

Cash Management

- To determine whether the Plan handled FEHBP funds in accordance with applicable laws and regulations concerning cash management in the FEHBP.

Fraud and Abuse Program

- To determine whether the Plan's communication and reporting of fraud and abuse cases were in compliance with the terms of Contract CS 1980 and the applicable FEHBP Carrier Letters.

SCOPE

We conducted our limited scope performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient and 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.

We reviewed the Plan's Annual Accounting Statements for contract years 2008 through 2012. During this period, the Plan paid approximately $144.4 million in health benefit charges (see Figure 1 and Schedule A). Specifically, we reviewed the Plan's miscellaneous health benefit payments and credits (e.g., refunds, subrogation recoveries, and pharmacy drug rebates) and cash management activities (e.g., letter of credit account drawdowns and interest income) for 2008 through June 30, 2013. We also reviewed the Plan's Fraud and Abuse (F&A) Program for 2012 through June 30, 2013.

In planning and conducting our audit, we obtained an understanding of the Plan's internal control structure to help determine the nature, timing, and extent of our auditing procedures. This was determined to be the most effective approach to select areas of audit. For those areas selected,

we primarily relied on substantive tests of transactions and not tests of controls. Based on our testing, we did not identify any significant matters involving the Plan's internal control structure and its operations. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the Plan had complied with the FEHBP contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations and Federal Employees Health Benefits Acquisition Regulations, as appropriate), and the laws and regulations governing the FEHBP. The results of our tests indicate that, with respect to the items tested, the Plan complied with all applicable provisions of the contract and federal procurement regulations. With respect to the items not tested, nothing came to our attention that caused us to believe that the Plan had not complied, in all material respects, with those provisions.

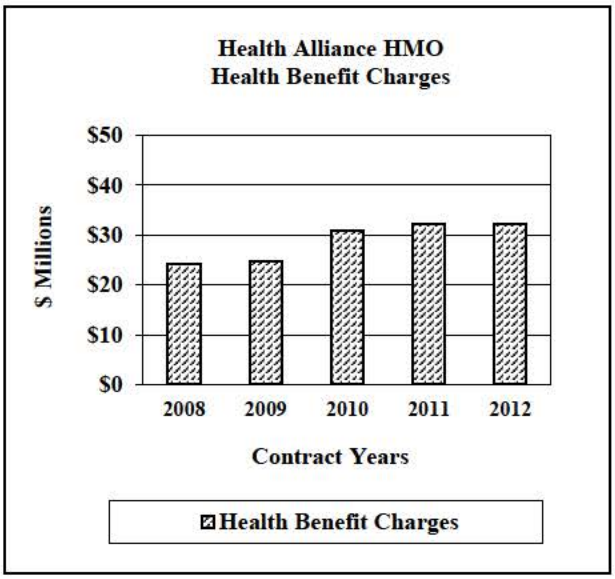

Figure 1 – Health Benefit Charges

In conducting our audit, we relied to varying degrees on computer-generated data provided by the Plan. Due to time constraints, we did not verify the reliability of the data generated by the various information systems involved. However, while utilizing the computer-generated data during our audit testing, nothing came to our attention to cause us to doubt its reliability. We believe that the data available was sufficient to achieve our audit objectives.

The audit was performed at the Plan's office in Urbana, Illinois from November 5, 2013 through November 21, 2013. Audit fieldwork was also performed at our office in Jacksonville, Florida.

METHODOLOGY

We obtained an understanding of the internal controls over the Plan's financial and cash management systems by inquiry of Plan officials.

We interviewed Plan personnel and reviewed the Plan's policies, procedures, and accounting records during our audit of miscellaneous health benefit payments and credits. We also judgmentally selected and reviewed 86 high dollar health benefit refunds, totaling $1,043,972 (from a universe of 2,429 refunds, totaling $1,698,346); 34 high dollar subrogation recoveries and adjustments, totaling $931,132 (from a universe of 156 recoveries and adjustments, totaling $1,071,950); 5 hospital and provider audit recoveries, totaling $8,984 (from a universe of 25 audit recoveries, totaling $11,505); 177 pharmacy drug rebate amounts, totaling $1,531,427 (from a universe of [redacted] drug rebate amounts, totaling $[redacted]; 10 uncashed health benefit

checks, totaling $95,238 (from a universe of 147 uncashed checks, totaling $118,375); and all other refund adjustments, totaling $118,758, to determine if refunds and recoveries were promptly returned to the FEHBP and if miscellaneous payments were properly charged to the FEHBP.[2] The results of these samples were not projected to the universe of miscellaneous health benefit payments and credits.

We reviewed the Plan's cash management activities and practices to determine whether the Plan handled FEHBP funds in accordance with Contract CS 1980 and applicable laws and regulations. We also interviewed the Plan's Special Investigations Unit regarding the effectiveness of the F&A Program, as well as reviewed the Plan's communication and reporting of fraud and abuse cases to test compliance with Contract CS 1980 and the applicable FEHBP Carrier Letters.

[2] The sample of health benefit refunds included all refund receipts of $5,000 or more from 2008 through June 2013, and three judgmentally selected provider offsets for each year from 2011 through June 2013. For the subrogation sample, we selected all recoveries of $5,000 or more for the audit scope and the highest repayment adjustment (i.e., a refund of a subrogation recovery) from each year. The sample of hospital and provider audit recoveries included all recoveries of $500 or more. For pharmacy drug rebates, we selected all rebate amounts of $5,000 or more for Plan code FX and $300 or more for Plan code FM. The sample of uncashed health benefit checks included all uncashed checks of $1,000 or more that were voided during the audit scope.

III. RESULTS OF AUDIT

The audit disclosed no significant findings pertaining to miscellaneous health benefit payments and credits, the Plan's cash management activities and practices, and the Plan's Fraud and Abuse Program. Overall, we concluded that the Plan returned health benefit refunds and recoveries, including pharmacy drug rebates, to the FEHBP in a timely manner, and properly charged miscellaneous payments to the FEHBP. We also concluded that the Plan handled FEHBP funds in accordance with Contract CS 1980 and applicable laws and regulations. In addition, we determined that the Plan is complying with the communication and reporting requirements for fraud and abuse cases that are set forth in Contract CS 1980 and FEHBP Carrier Letter 2011-13.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

[redacted], Auditor-In-Charge

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V. SCHEDULE A

HEALTH ALLIANCE HMO
URBANA, ILLINOIS

HEALTH BENEFIT CHARGES

HEALTH BENEFIT CHARGES*	2008	2009	2010	2011	2012	TOTAL
HEALTH BENEFIT CHARGES						
CLAIM PAYMENTS	$24,815,595	$25,695,238	$31,722,032	$32,939,383	$33,559,164	$148,731,412
OTHER HEALTH BENEFIT ADJUSTMENTS	(609,991)	(896,200)	(812,810)	(659,243)	(1,372,444)	(4,350,688)
TOTAL HEALTH BENEFIT CHARGES	$24,205,604	$24,799,038	$30,909,222	$32,280,140	$32,186,720	$144,380,724

*** This audit only covered miscellaneous health benefit payments and credits and cash management activities from 2008 though June 30, 2013.**