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 Health Net of Arizona, Inc.

Report Number 1C-A7-00-15-017
December 9, 2015

-- CAUTION --

EXECUTIVE SUMMARY

Audit of the Federal Employees Health Benefits Program Operations at Health Net of Arizona, Inc.

Report No. 1C-A7-00-15-017 **December 9, 2015**

Why Did We Conduct the Audit?

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

What Did We Audit?

Under Contract CS 2121, the Office of the Inspector General performed an audit of the FEHBP operations at the Plan. The audit covered the Plan's 2012 and 2013 FEHBP premium rate build-ups and MLR submissions. Our audit fieldwork was conducted from January 12, 2015 through January 23, 2015, at the Plan's office in Woodland Hills, California.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

This report questions $261,280 for inappropriate health benefit charges to the FEHBP in contract year 2013. The questioned amount includes $249,954 for defective pricing and $11,326 for lost investment income, calculated through September 30, 2015. Specifically, the audit identified an error in the Plan's pooled claims calculation causing the FEHBP's claims experience and resulting premiums to be overstated by $249,954.

However, the audit also showed that the FEHBP rates were developed in accordance with applicable laws, regulations, and OPM's Rate Instructions to Community-Rated Carriers for contract year 2012.

Finally we determined that the Plan's 2012 and 2013 FEHBP MLR submissions were prepared in accordance with the laws and regulations governing the FEHBP and met the requirements established by OPM.

ABBREVIATIONS

ACA	**Affordable Care Act**
CFR	**Code of Federal Regulations**
FEHBP	**Federal Employees Health Benefits Program**
FEHBAR	**Federal Employees Health Benefits Acquisition Regulations**
HHS	**U.S. Department of Health and Human Services**
MLR	**Medical Loss Ratio**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**Health Net of Arizona, Inc.**
TCR	**Traditional Community Rating**
U.S.C.	**United States Code**

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I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at Health Net of Arizona, Inc. (Plan). The audit was conducted pursuant to the provisions of Contract CS 2121; 5 United States Code (U.S.C.) Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract years 2012 and 2013, and was conducted at the Plan's office in Woodland Hills, California.

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 the U.S. Office of Personnel Management's (OPM) 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.

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.

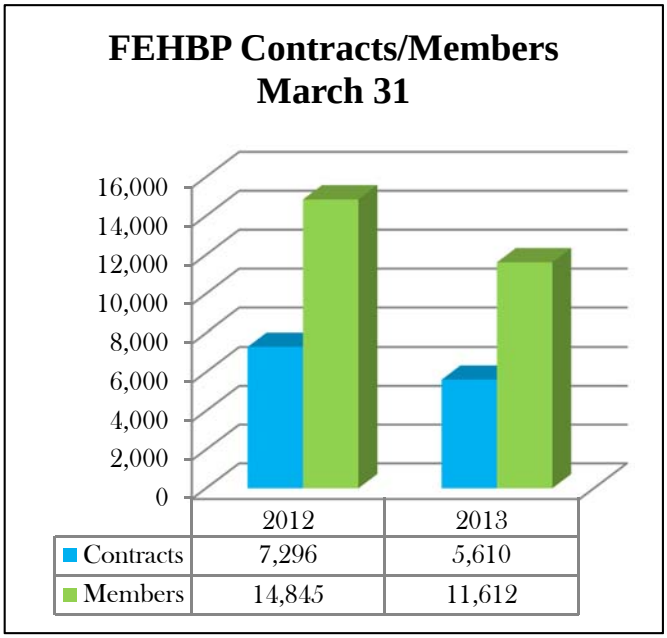
The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act (ACA, P.L. 111-148) and defined by the U.S. Department of Health and Human Services (HHS) in 45 CFR Part 158. In 2012, community-rated FEHBP carriers could elect to follow the FEHBP-specific MLR requirements, 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.

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 7,296 contracts and 14,845 members as of March 31, 2012, and 5,610 contracts and 11,612 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 1987 and provides health benefits to FEHBP members in the Arizona counties of Cochise, Gila, Maricopa, Pima, Pinal and Santa Cruz. A prior audit of the Plan covered contract years 2009 through 2011. All issues from the prior audit have been resolved.

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 comments were considered in preparation of this report and are included, as appropriate, as the Appendix to the report.

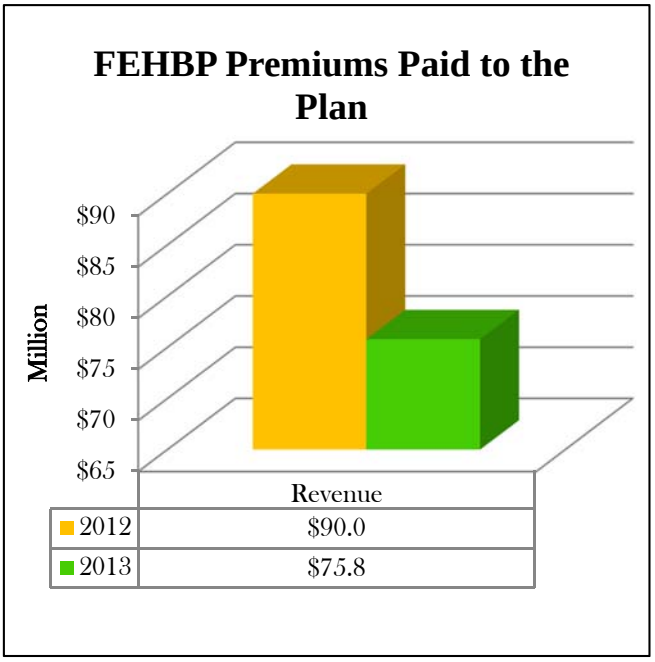
II. OBJECTIVES, SCOPE, AND METHODOLOGY

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 whether the Plan met the MLR requirements established by OPM and paid the correct amount to the Subsidization Penalty Account, if applicable. 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 2012 and 2013. For contract years 2012 and 2013, the FEHBP paid approximately $90.0 million and $75.8 million in premiums to the Plan, respectively.

Office of the Inspector General (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 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 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; claims were processed accurately; appropriate allocation methods are used; and, that any other costs associated with its MLR calculation are appropriate.

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 January 12, 2015 through January 23, 2015, at the Plan's office in Woodland Hills, California.

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 appropriate Plan officials regarding the controls in place to ensure that claims were processed accurately. Other auditing procedures were performed as necessary to meet our audit objective.

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 2012	Paid claims over $30,000 for patients age 65+	22	[redacted]	All	Judgmental	No
Coordination of Benefits (COB) – Medicare 2013	Paid claims over $25,000 for patients age 65+	36	[redacted]	10	Judgmental	No
Bundling/ Unbundling	All claim lines with CPT codes 80047 and 80048 (Basic Metabolic Panel)	0	[redacted]	N/A	N/A	N/A
Deceased Member Review	All claims paid for identified deceased members	12	[redacted]	All	Judgmental	No
Non-Covered Benefits (Abortion)	All claim lines with elective abortion CPT codes 59812, 59820, 59821, 59830, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 59866	2	[redacted]	All	Judgmental	No
Non-Covered Benefits (Radial Keratotomy)	All claim lines with LASIK CPT code 65771	1	[redacted]	All	Judgmental	No
Non-Covered Benefits (sex transformation)	All claim lines with CPT code 55970 for males and 55980 for females	0	[redacted]	N/A	N/A	N/A
Non-Covered Benefits (Hearing aids)	Paid claims over $4,000 with CPT codes 92591,92595, and 92593	0	[redacted]	N/A	N/A	N/A
Dependent Eligibility	All claims for dependent members over age 26	28	[redacted]	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?
Dependent Eligibility	All pharmacy claims paid for members over age 26	150	[redacted]	All	Judgmental	No
High Dollar Drugs	All pharmacy claims > $5,000	243	[redacted]	10	Random	No
Ineligible Group Number	Group numbers provided by Plan	0	[redacted]	N/A	N/A	N/A

We also examined the rate build-up of the Plan's 2012 and 2013 Federal rate submissions 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.

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. AUDIT FINDINGS AND RECOMMENDATIONS

1. Defective Pricing **$249,954**

The Certificate of Accurate Pricing the Plan signed for contract year 2013 was defective. In accordance with federal regulations, the FEHBP is therefore due a rate reduction for this year. Application of the defective pricing remedy shows that the FEHBP is due a premium adjustment totaling $249,954 (see Exhibit A). We found that the FEHBP rates were developed in accordance with applicable laws, regulations, and the U.S. Office of Personnel Management (OPM) Rate Instructions to Community-Rated Carriers (rate instructions) in contract year 2012.

Carriers proposing rates to OPM are required to submit a Certificate of Accurate Pricing certifying that the cost or pricing data submitted in support of the FEHBP rates were developed in accordance with the requirements of 48 Code of Federal Regulations, Chapter 16, and the FEHBP contract.

2013

In contract year 2013, the Plan offered the FEHBP a high and standard option. Our review found that the FEHBP's standard option premium rates were defective. The Plan had one member in the standard option whose claims exceeded the $500,000 pooling level within the prior experience period. Therefore, the pooling level should have been $500,000 when adding the pooled claims into the calculation to determine its adjusted claims Per-Member Per-Month (PMPM). However, the plan erroneously used $5,000,000 when adding the pooled claims into the calculation to determine its adjusted claims PMPM.

We calculated our audited standard option FEHBP rates by correcting the above noted exception. A comparison of our audited line 5 rates to the Plan's reconciled line 5 rates shows the FEHBP was overcharged $249,954 in contract year 2013 for its standard option rates (see Exhibit B).

2. Lost Investment Income **$11,326**

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 finding in contract year 2013. We determined that the FEHBP is due $11,326 for lost investment income, calculated through September 30, 2015 (see Exhibit C). In addition, the FEHBP is entitled to lost investment income for the period beginning October 1, 2015, until all defective pricing finding amounts have been returned to the FEHBP.

Federal Employees Health Benefits Acquisition Regulations 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.

Recommendation 1

We recommend that the contracting officer require the Plan to return $249,954 to the FEHBP for defective pricing in contract year 2013.

Recommendation 2

We recommend that the contracting officer require the Plan to return $11,326 to the FEHBP for lost investment income, calculated through September 30, 2015. We also recommend that the contracting officer recover lost investment income on amounts due for the period beginning October 1, 2015, until all defective pricing finding amounts have been returned to the FEHBP.

Plan's Response:

The Plan agrees with the defective pricing finding and the calculated lost investment income.

OIG Comment:

Should the Plan return the amounts questioned related to the defective pricing and the calculated lost investment income findings, the recovery of these amounts may affect the Plan's MLR calculation. Therefore, once OPM has verified the recovery of these amounts, they should review the Plan's MLR calculation to determine any potential impact.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

COMMUNITY-RATED AUDITS GROUP

[redacted], Auditor-in-Charge

[redacted], Auditor

[redacted], Auditor

[redacted], Auditor

[redacted], Auditor

[redacted], Senior Team Leader

[redacted], Group Chief

EXHIBIT A

Health Net of Arizona, Inc.
Summary of Questioned Costs

Defective Pricing Questioned Costs:		
Contract Year 2013	$249,954	
Total Defective Pricing Questioned Costs:		$249,954
Lost Investment Income:		$11,326
Total Questioned Costs:		**$261,280**

EXHIBIT B

Health Net of Arizona, Inc.
Defective Pricing Questioned Costs

2013

Standard Option	Self	Family	
FEHBP Line 5 - Reconciled Rate	$259.13	$655.98	
FEHBP Line 5 - Audited Rate	$251.68	$637.11	
Biweekly Overcharge	$7.45	$18.87	
To Annualize Overcharge:			
3/31/13 enrollment	[redacted]	[redacted]	
Pay Periods	26	26	
	$49,781	$200,173	
Subtotal			**$249,954**

Total 2013 Questioned Costs **$249,954**

EXHIBIT C

Health Net of Arizona, Inc.
Lost Investment Income

Year	2013	2014	2015	Total
1. Defective Pricing	$249,954	$0	$0	$249,954
Totals (per year):	$249,954	$0	$0	$249,954
Cumulative Totals:	$249,954	$249,954	$249,954	$249,954
Avg. Interest Rate (per year):	1.563%	2.063%	2.250%	
Interest on Prior Years Findings:	$0	$5,155	$4,218	$9,373
Current Years Interest:	$1,953	$0	$0	$1,953
Total Cumulative Interest Calculated Through September 30, 2015:	$1,953	$5,155	$4,218	**$11,326**

Appendix

August 7, 2015

[redacted]

U.S. Office of Personnel Management
Office of the Inspector General
800 Cranberry Woods Drive, Suite 270
Cranberry Township, PA 16066

Re: Draft of Audit Report No. 1C-A7-00-15-017
Health Net of Arizona, Inc.

Dear [redacted],

This letter is in response to the above-referenced Draft Audit Report on the Federal Employees Health Benefits Program Operations at Health Net of Arizona, Inc. (the "Plan") for contract years 2012 through 2013.

I. PLAN RESPONSE

In this section, we summarize the findings and recommendations contained in the Draft Audit Report and any additional considerations.

DELETED BY THE OIG - Not applicable for Final Report

B. 2013 Pooling Charge Calculation for the Standard Option

As stated in the Draft Audit Report for contract year 2013, the Plan offered the FEHBP a high and standard option. The review found that the FEHBP's standard option premium rates were defective. The Plan had one member in the standard option whose claims exceeded the $500,000 pooling level within the prior experience period. Therefore, the pooling level should have been $500,000 when adding the pooled claims into the calculation to determine its adjusted claims Per-Member Per-Month (PMPM). However, the plan erroneously used $5,000,000 when adding the pooled claims into the calculation to determine its adjusted claims PMPM.

Health Net acknowledges the error in the pooling level line of the calculation and will return the amount of $249,954 to OPM.

II. CONCLUSION

As discussed above and accompanying exhibit(s), the Draft Audit Report contains a finding with a recommended adjustment for 2013 Claims Pooling on the Standard Option, DELETED BY THE OIG – NOT APPLICABLE FOR FINAL REPORT. Health Net will return the premium amount of $249,954, and the appropriate lost investment income amount to OPM. DELETED BY THE OIG – NOT APPLICABLE FOR FINAL REPORT.

Sincerely,

Rose Megian
President, Health Net of Arizona

Enclosure:

AZ FEHB - Supporting Documentation.pdf

CC: [redacted], HNI
[redacted], HNI

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Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, NW
Room 6400
Washington, DC 20415-1100