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 SELECTHEALTH

Report Number 1C-SF-00-14-060

January 29, 2015

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EXECUTIVE SUMMARY

Audit of the Federal Employees Health Benefits Program Operations at SelectHealth

Report No. 1C-SF-00-14-060 **January 29, 2015**

Why Did We Conduct the Audit?

The primary objective of this performance audit was to determine whether the SelectHealth (Plan) was in compliance with the provisions of its contract and the laws and regulations governing the Federal Employees Health Benefits Program (FEHBP). Specifically, we verified if the Plan met the Medical Loss Ratio (MLR) requirements established by OPM. Additional tests were performed to determine whether the Plan was in compliance with the provisions of the laws and regulations governing the FEHBP.

What Did We Audit?

Under contact CS 2925, the Office of the Inspector General completed a performance audit of the FEHBP operations at the Plan. The audit covered the Plan's 2012 MLR submission, and was conducted at the Plan's office in Murray, Utah during June 2014. Additional audit work was completed at our offices in Washington, D.C. and Jacksonville, Florida.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

We determined that the Plan's 2012 FEHBP MLR submission was accurate, complete, and current, and was developed in accordance with the laws and regulations governing the FEHBP. Consequently, a draft report was not issued because the audit did not identify any questioned costs. No corrective action is necessary.

ABBREVIATIONS

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

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I. INTRODUCTION AND BACKGROUND

Introduction

We completed an audit of the Federal Employees Health Benefits Program (FEHBP) operations at SelectHealth (Plan). The audit covered contract year 2012, and was conducted at the Plan's office in Murray, Utah. The audit was conducted pursuant to the provisions of Contract CS 2925; 5 U.S.C. Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit was performed by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

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.

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

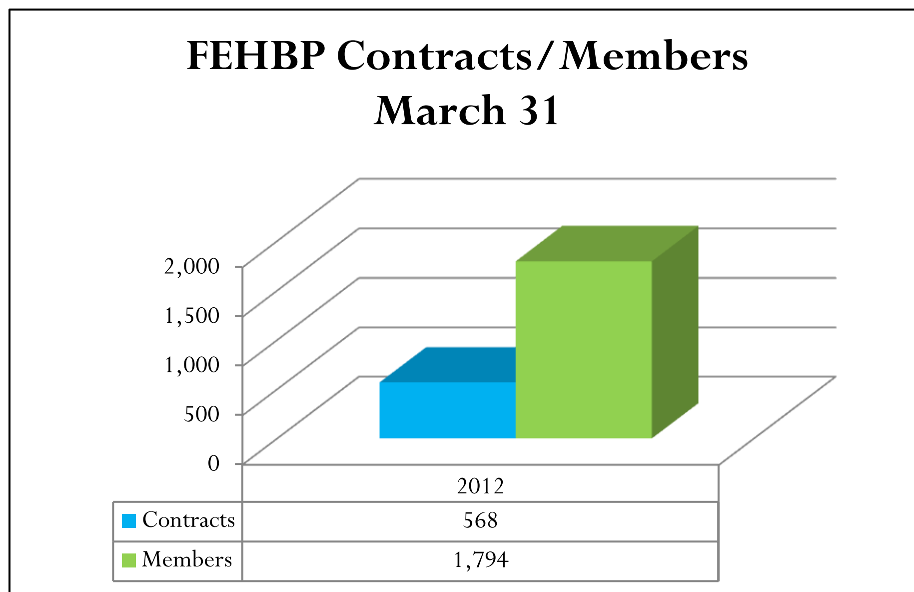
The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act (ACA, P.L. 111-148) and defined by the U.S. Department of Health and Human Services in 45 CFR Part 158. In 2012, community-rated FEHBP carriers could elect to follow the FEHBP-specific MLR requirements,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

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

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

Community-rated carriers participating in the FEHBP are subject to various federal, state and local laws, regulations, and ordinances. While most carriers are subject to state jurisdiction, many are further subject to the Health Maintenance Organization Act of 1973 (Public Law 93-222), as amended (i.e., many community-rated carriers are federally qualified). In addition, participation in the FEHBP subjects the carriers to the Federal Employees Health Benefits Act and implementing regulations promulgated by OPM.

The Plan reported 568 contracts and 1,794 members as of March 31, 2012, 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 2011 and provides health benefits to FEHBP members in the state of Utah. A prior audit of the Plan covered the premium rate buildup for contract year 2012. In that audit, we determined that the FEHBP premiums were developed in accordance with applicable laws, regulations and OPM's Rate Instructions to Community Rated Carriers (rate instructions) for contract year 2012.

The preliminary results of this audit were discussed with the Plan officials at an exit conference and in subsequent correspondence. Since this audit concluded that the Plan's FEHBP MLR submission was developed in accordance with applicable laws, regulations, and the rate instructions, a draft report was not issued.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

Objective

The primary objective of this performance audit was to determine whether the Plan was in compliance with the provisions of its contract and the laws and regulations governing the FEHBP. Specifically, we verified that the Plan met the MLR requirements established by OPM and paid the correct amount to the Subsidization Penalty Account, if applicable. 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 year 2012. For this year, the FEHBP paid approximately $7.9 million in premiums to the Plan.

OIG audits of community-rated carriers are designed to test carrier compliance with the FEHBP contract, applicable laws and regulations, and the rate instructions. These audits are also designed to provide reasonable assurance of detecting errors, irregularities, and illegal acts.

We obtained an understanding of the Plan's internal control structure, but we did not use this information to determine the nature, timing, and extent of our auditing procedures. However, the audit included tests of the Plan's FEHBP claims data, quality health expenses, and all other applicable costs considered in the calculation of its MLR. Our review of internal controls is limited to the procedures the Plan has in place to ensure that the FEHBP MLR calculation is accurate, complete, and valid, FEHBP claims are processed accurately, appropriate allocation methods for quality health expenses 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 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.

Based on the survey work performed, we identified a total universe of 44,073 medical claim lines and 22,788 pharmacy claim lines incurred from January 1, 2012 through December 31, 2012, and paid through March 31, 2013. The audit universe attributes are the mandatory medical

and pharmacy claim field requirements included in FEHB Carrier Letter 2014-01, Audit Requirements for 2012 MLR Pilot Program Carriers.

The audit fieldwork was performed at the Plan's office in Murray, Utah during June 2014. Additional audit work was completed at our offices in Washington, D.C. and Jacksonville, Florida.

Methodology

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

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

To test whether the Plan accurately processed and paid FEHBP claims for contract year 2012 and complied with its contract, we tested for potential claim errors within the full claims universes of 44,073 medical claim lines and 22,788 pharmacy claim lines, totaling $6,979,439 and $1,423,265, respectively.

During our claim reviews, the samples were not statistically based. Consequently, the results could not be projected to the universe since it is unlikely that the results are representative of the universe as a whole.

However, we did use statistical sampling software to select a discovery sample for the coordination of benefits (COB) review. A discovery sample is the smallest sample size capable of providing a specified confidence level of detecting a misstatement in the population or tolerable rate of deviation in the population. Additionally, the discovery sample was selected randomly from a universe using random numbers, in which each item has an equal chance of being selected. The use of statistical sampling also requires the selection of confidence levels and precision rates. For the sample selected, we used a confidence level of 90 percent and a maximum precision rate of 5 percent. This means we are 90 percent confident that the difference between the projected questioned claims and the actual questioned claims is no more than 5 percent. The results from the discovery sample would determine if a larger sample would be required. Results of a larger sample could be projected over the entire universe, since it is likely that the results would be representative of the universe as a whole.

The following audit steps were performed:

Claims Review

Medical Claims

- We identified a potential COB error universe of 3,303 claim lines totaling $510,160 for contract year 2012. The universe contained all claim lines for members over age 64. We selected a statistical sample of 46 claim lines totaling $2,868, and pulled the highest 5 claim lines from the COB universe totaling $185,080 for review in determining if the claims were coordinated with Medicare properly and accurately processed.

- We identified a potential member enrollment error universe of 295 claim lines totaling $2,379,910 for contract year 2012. Our sample contained all claim lines over $2,500. We judgmentally selected a sample of 13 claim lines for 7 members, totaling $240,064, to determine if the claims were accurately processed.

- We identified a potential dependent eligibility error universe of 13 claim lines for one member totaling $435 for contract year 2012. The universe contained all claims for members over age 26 and excluded all patients identified as a subscriber or spouse. We sent the entire universe of 13 claim lines to the Plan for review to determine if the claims were accurately processed.

- We identified a potential bundling/unbundling error universe of 331 claim lines totaling $3,911. The universe contained all claims lines associated with the current procedural terminology (CPT) codes related to the primary panel code 80048, Basic Metabolic Panel (Calcium, total). We identified 4 possible claims line errors totaling $53. We sent the claim lines to the Plan for review to determine if the claims were accurately processed for contract year 2012.

Pharmacy Claims

- We identified a potential member enrollment error universe of 17 claim lines totaling $108,467 for contract year 2012. The universe contained all claim lines over $5,000. We sent the entire universe of 17 claim lines to the Plan for review to determine if the claims were accurately processed.

- We identified a potential dependent eligibility error universe of 23 claim lines for one member totaling $11 for contract year 2012. The universe contained all claims for members over age 26 and excluded all patients identified as a subscriber or spouse. We sent the entire universe of 23 claim lines to the Plan for review to determine if the claims were accurately processed.

- We identified a potential high dollar drug script error universe of 45 claim lines for 26 members totaling $82,926 for contract year 2012. The universe contained all claim lines

over $1,000. We sent the entire universe of 45 claim lines to the Plan for review to determine if the claims were accurately processed.

- We identified a potential high quantity dispensed error universe of 19,759 claim lines totaling $1,085,399 for contract year 2012. The universe contained all claim lines with a drug unit measure as EA (for each). We then identified and reviewed the claims with high quantities that appeared unusual. We also included several claims that had a large quantity, but no descriptive information such as drug name, drug strength, and drug unit of measure. We judgmentally selected a sample of 14 claim lines totaling $8,761, to determine if the claims were accurately processed.

We also completed the following reviews which produced no results:

- We completed a duplicate claims review of the medical and pharmacy claim universes (using "best match" criteria) to identify claims that have all the same fields or duplicate claims where only the claim number is different. We chose which fields to match against and the order of precedence. We selected the following fields for medical claims: patient ID number, patient (first and last) name, incurred date, covered charges, provider ID, procedure code, diagnosis code, type of service, and provider specialty. For the pharmacy claims, we selected all of the provided fields. We used the sort data function in our statistical software and selected the "keep only one entire duplicate if entirely duplicated" option. This would generate the possible duplicates as a separate run. We then reviewed the results for duplicate claims or any claims that have the same selected fields, but different claim numbers.

- We completed a duplicate claims review of the medical and pharmacy claim universes (using "near match" criteria) to identify claims for which some of the fields are the same or are duplicates but do not exactly match within the medical and pharmacy claim universe. We chose which fields to match against and the order of precedence. We selected the following fields for medical claims: patient ID number, patient (first and last) name, incurred date, covered charges, provider ID, procedure code, and procedure modifier code. However, for the pharmacy claims, we selected the member number, subscriber number, and drug code, and the prescription fill date had to be within five days of each other. We used the sort data function in our statistical software and selected the "keep only one entire duplicate if entirely duplicated" option. This would generate the possible duplicates as a separate run. We then reviewed the results for duplicate claims or any claims that have the same selected fields, but different claim numbers.

- We completed a debarred pharmacist and pharmacies review to determine if the Plan paid any pharmacy claims to debarred pharmacists or pharmacies. We requested a list of debarred pharmacists and pharmacies in the Plan's service area from the OIG Administrative Sanctions Branch (ASB). We ran a query on the claims data to determine if any debarred pharmacists or pharmacies were included in the pharmacy data.

- We completed a review of debarred providers to determine if the Plan paid any medical claims to debarred providers. The review compared the list of debarred providers to the

medical claims data. We requested a list of debarred providers in the Plan's service area from the ASB. We identified the debarred providers and compared each one to the medical claims data. The debarred provider list included the provider names and the provider National Provider Identifier (NPI) numbers, when available. We used the NPI number to query against the medical claims, but used the provider name if the NPI number was unavailable.

- We completed a zero quantity review to determine if any pharmacy claims were paid that had a zero quantity amount. We attempted to identify all pharmacy claims that had zero in the quantity field and a dollar amount in the paid field.

- We completed an ineligible group number review on the medical and pharmacy universes to determine if any claims were paid for non-FEHBP members or for members enrolled in a different employer group. We requested a list of group numbers and group names for both the medical and pharmacy claims data and sorted this data by the group number to identify any exceptions. We used the statistical summary function within our statistical software to determine the universe of group numbers. We compared the universe to the list of group numbers provided by the Plan to determine if there were any results.

- We completed a non-covered benefits review on the medical claims universe. We reviewed the 2012 FEHBP benefit brochure to determine non-covered benefits. We tested the medical claims data to determine if any of the following non-covered benefits were paid in error: elective abortions, sex transformations, reversal of sterilization, radial keratotomy, eye exercises, hypnotherapy, and in-vitro fertilization.

- We completed a deceased member review on the medical and pharmacy universe. We selected a sample from the older population in the claims data. The claims were sorted by member age (over age 70). Claims were extracted from data for the oldest members. We removed any duplicate patient IDs. We obtained a sample of 20 members. The sample was sent to the OIG Office of Investigations to determine if a death record existed for the member.

All samples selected (except for COB) during our audit were not statistically based. Consequently, the results could not be projected to the universe, since it is unlikely that the results are representative of the universe, as a whole. The COB sample was statistically based and the results could have been projected to the universe. However, we did not find errors in our COB sample.

III. RESULTS OF THE AUDIT

Our audit determined that the Plan's 2012 FEHBP MLR submission was accurate, complete, and valid, and was developed in accordance with the applicable laws and regulations governing the FEHBP. For the claims testing described in the Methodology section, we found that all of the potential processing errors identified were in fact processed correctly. Consequently, a draft report was not issued because the audit did not identify any questioned costs. No corrective action is necessary.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

COMMUNITY-RATED AUDITS GROUP

[redacted], Auditor-In-Charge

[redacted], Auditor

[redacted], Auditor

[redacted], Senior Team Leader

[redacted], Group Chief

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