



---

**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  
UNION HEALTH SERVICE, INC.**

Report Number 1C-76-00-16-042

May 10, 2017

-- CAUTION --

This report has been distributed to Federal officials who are responsible for the administration of the subject program. This non-public version may contain confidential and/or proprietary information, including information protected by the Trade Secrets Act, 18 U.S.C. § 1905, and the Privacy Act, 5 U.S.C. § 552a. Therefore, while a redacted version of this report is available under the Freedom of Information Act and made publicly available on the OIG webpage (<http://www.opm.gov/our-inspector-general>), this non-public version should not be further released unless authorized by the OIG.

# EXECUTIVE SUMMARY

## *Audit of the Federal Employees Health Benefits Program Operations at Union Health Service, Inc.*

Report No. 1C-76-00-16-042

May 10, 2017

### **Why Did We Conduct the Audit?**

The primary objective of the audit was to determine if Union Health Service, 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).

### **What Did We Audit?**

Under Contract CS 1571, the Office of the Inspector General (OIG) performed an audit of the FEHBP operations at the Plan. We verified whether the Plan met the Medical Loss Ratio (MLR) requirements established by the U.S. Office of Personnel Management (OPM) for contract year 2013. We also verified whether the Plan developed the FEHBP premium rates using complete, accurate, and current data for contract years 2012 and 2013. Our audit fieldwork was conducted from June 13, 2016, through November 21, 2016, at the Plan's office in Chicago, Illinois, and in our OIG offices.



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

### **What Did We Find?**

This report identifies defective pricing for contract years 2012 and 2013. Although there were findings related to defective pricing for contract year 2012, they did not result in a material penalty. For contract year 2013, we identified defective pricing of \$52,620, as well as \$4,270 for lost investment income on the defective pricing overcharges calculated through April 30, 2017. Additionally, we identified an understated OPM MLR credit totaling \$436,287 for contract year 2013. Lastly, we determined that the Plan did not submit its pharmacy claims data in accordance with the requirements of Carrier Letter 2014-18. Specifically, these issues were questioned due to the following identified errors:

- In contract year 2012, the Plan applied an incorrect step-up factor to the FEHBP rates.
- In contract years 2012 and 2013, the Plan erroneously modified its reconciled rates with adjustments that were already captured in its proposed rates. It also did not provide sufficient support for its transplant benefit costs, and it erroneously charged additional benefit costs for a growth hormone therapy benefit, which was already covered as part of the Plan's base benefit package.
- The Plan used an incorrect number of member months to determine the 2013 office visit adjustment and other benefit variances loadings.
- The Plan submitted incomplete pharmacy claims data for its 2013 MLR submission, which impacted the MLR numerator.
- Finally, the 2013 MLR denominator was adjusted for the 2013 defective pricing of \$52,620.

# ABBREVIATIONS

<b>CFR</b>	<b>Code of Federal Regulations</b>
<b>FEHBAR</b>	<b>Federal Employees Health Benefits Acquisition Regulation</b>
<b>FEHBP</b>	<b>Federal Employees Health Benefits Program</b>
<b>MLR</b>	<b>Medical Loss Ratio</b>
<b>OIG</b>	<b>Office of the Inspector General</b>
<b>OPM</b>	<b>U.S. Office of Personnel Management</b>
<b>Plan</b>	<b>Union Health Service, Inc.</b>
<b>PMPM</b>	<b>Per Member Per Month</b>
<b>SSSG</b>	<b>Similarly-Sized Subscriber Group</b>
<b>U.S.C.</b>	<b>United States Code</b>

# TABLE OF CONTENTS

	<u>Page</u>
<b>EXECUTIVE SUMMARY</b> .....	i
<b>ABBREVIATIONS</b> .....	ii
<b>I. BACKGROUND</b> .....	1
<b>II. OBJECTIVES, SCOPE, AND METHODOLOGY</b> .....	3
<b>III. AUDIT FINDINGS AND RECOMMENDATIONS</b> .....	9
A. Defective Pricing .....	9
B. Lost Investment Income.....	15
C. 2013 Medical Loss Ratio Credit Underpayment .....	16
D. Pharmacy Claims Data Submission .....	18
<b>EXHIBIT A</b> (Summary of Defective Pricing Questioned Costs)	
<b>EXHIBIT B</b> (Defective Pricing Questioned Costs)	
<b>EXHIBIT C</b> (Lost Investment Income)	
<b>EXHIBIT D</b> (Summary of Medical Loss Ratio Credit Adjustment)	
<b>EXHIBIT E</b> (Medical Loss Ratio Credit Adjustment)	
<b>APPENDIX</b> (Union Health Service, Inc.’s January 13, 2017 Response to the Draft Report)	
<b>REPORT FRAUD, WASTE, AND MISMANAGEMENT</b>	

# I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at Union Health Service, Inc. (Plan). The audit was conducted pursuant to the provisions of Contract CS 1571; 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 Chicago, Illinois.

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 5 CFR Chapter 1, Part 890. 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 MLR is important because it requires health insurers to provide consumers with value for their premium payments by limiting the percentage of premium dollars that can be spent on administrative expenses and profit. For example, an MLR threshold of 85 percent requires carriers to spend 85 cents of every premium dollar on claims and limits the amount that can be spent on administrative expenses and profit to 15 cents of every dollar.

The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act (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, however, the MLR methodology was required for all community-rated carriers, except those that are state-mandated to use traditional community rating. State-mandated traditional community-rated carriers continue to be subject to the SSSG comparison rating methodology.

Starting with the pilot program in 2012 and for all non-traditional community-rated FEHBP

carriers in 2013, OPM required the carriers to submit an FEHBP-specific MLR. This FEHBP-specific MLR calculation required carriers 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. In addition, participation in the FEHBP subjects the carriers to the Federal Employees Health Benefits Act and implementing regulations promulgated by OPM.

The number of FEHBP contracts and members reported by the Plan as of March 31 for each contract year audited is shown in the chart below.

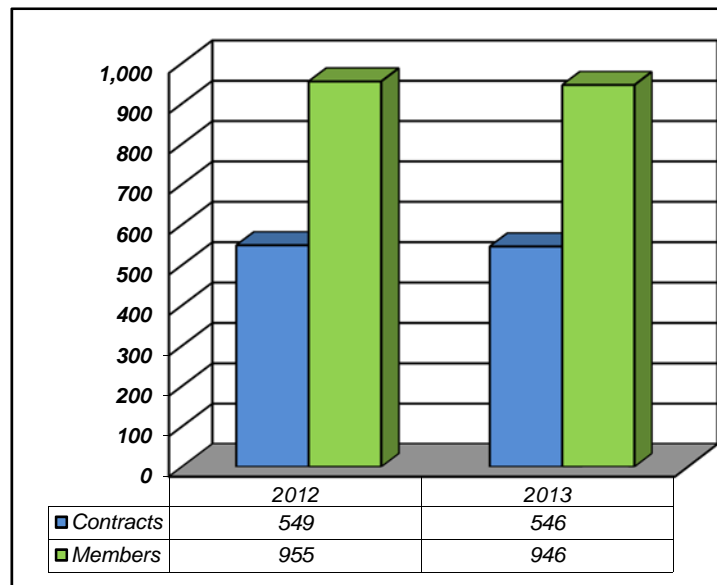
In contracting with community-rated carriers, OPM relies on carrier compliance with appropriate laws and regulations and, consequently, does not negotiate base rates. OPM negotiations relate primarily to the level of coverage and other unique features of the FEHBP.

The Plan has participated in the FEHBP since 1975 and provides health benefits to FEHBP members in the Chicago Area. A prior audit of the Plan covered contract years 2007 through

2011. We determined that all prior Office of the Inspector General (OIG) audit issues 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 an Appendix to the report.

**FEHBP Contracts/Members  
March 31**



# 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 also performed to determine whether the Plan was in compliance with the provisions of other applicable laws and regulations.

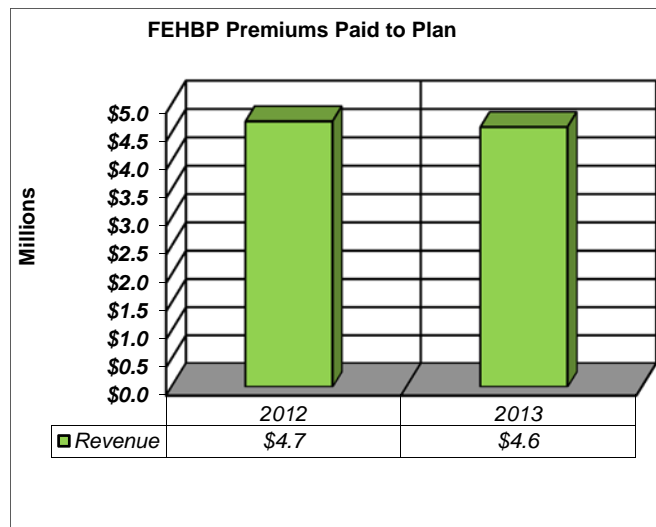
## SCOPE

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 these years, the FEHBP paid approximately \$9.3 million in premiums to the Plan.

The OIG’s 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 were developed in accordance with the Plan’s standard rating methodology and the claims, factors, trends, and other related adjustments were supported by complete, accurate, and current source documentation; and
- The FEHBP MLR calculations were accurate, complete, and valid; claims were processed accurately; appropriate allocation methods were used; and, that any other costs associated with its MLR calculations were 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 June 13, 2016, through June 24, 2016, at the Plan’s office in Chicago, Illinois. Additional fieldwork was completed through November 21, 2016, at our offices in Jacksonville, Florida; Cranberry Township, Pennsylvania; and Washington, D.C.

## **METHODOLOGY**

We examined the Plan’s MLR calculations 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 calculations. 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 objectives.

The tests performed, along with the methodology, are detailed in the following charts by Medical and Pharmacy claims:



## Medical Claims Sample Selection Criteria/Methodology

Medical Claims Review Area	Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Coordination of Benefits with Medicare 2013	Queried medical claims for members greater than or equal to age 65	█ claims	█	Judgmentally selected 26 claims greater than or equal to \$4,000 totaling \$146,174	Judgmental	No
Member Eligibility 2013	Queried medical claims for members greater than or equal to \$12,000	█ members; █ claims	█	Selected all █ members; █ claims totaling █ from the universe	N/A	N/A
Dependent Eligibility 2013	Queried members greater than or equal to age 26 designated as dependent	█ members; █ claims	█	Selected all █ members; █ claims totaling █ from the universe	N/A	N/A
Deceased Member 2013	Queried medical claims for members greater than or equal to age 83	█ members; █ claims	█	Selected all █ members; █ claims totaling █ from the universe	N/A	N/A
Medical Paper Claims 2013	Queried medical claims with amount paid not equal to \$0.00	█ claims	█	Selected a random sample of 25 claims using SAS EG; totaling \$2,749	Random	No

## Medical Encounter<sup>1</sup> Claims Sample Selection Criteria/Methodology

Medical Claims Review Area	Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Medical Encounters - Member Eligibility 2013	Queried medical encounters for amount paid greater than \$600	█ members; █ claims	█	Selected all █ members; █ claims totaling █ from the universe	N/A	N/A
Medical Encounters - Dependent Eligibility 2013	Judgmental sample of dependents over the age 26	█ members; █ claims	█	Selected █ members; █ claims totaling █ from the universe	N/A	N/A
Medical Encounters - Paper Claims 2013	Full universe of medical encounters	█ claims	█	Selected a sample of 9 highest paid claims; totaling \$8,712	Judgmental	No

<sup>1</sup> An encounter is a clinical service rendered directly by the Plan's staff and facilities.

## Pharmacy Claims Sample Selection Criteria/Methodology

Pharmacy Claims Review Area	Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Member Eligibility 2013	Queried members with pharmacy claims greater than or equal to \$1,000	█ members; █ claims	█	Selected 26 members; 36 claims with amount paid greater than or equal to \$2,000 totaling \$96,876	Judgmental	No
Dependent Eligibility 2013	Queried members greater than or equal to age 26 designated as dependent	█ members; █ claims	█	Selected 5 members; sorted claims by highest dollar and removed duplicate patient IDs <sup>2</sup> to sample the highest dollar paid claim for each patient ID; 7 claims totaling \$1,295	Judgmental	No
Deceased Member	Queried pharmacy claims for members greater than or equal to age 83	█ members; █ claims	█	Selected all █ members; █ claims totaling █ from universe	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 rates were sufficiently supported by source documentation. We also 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.

<sup>2</sup> The Plan re-submitted its pharmacy claims data during the audit because in 2013 it switched its system and the original claims submission only contained data from the new system. The revised data, which includes information from both the old and new systems, also contains two patient IDs for some members. This occurred because the patients (members) had different IDs within the two systems. Two members with two different patient IDs were captured within our sample, causing there to be five members but seven patient IDs, and therefore, also seven claims.

Finally, 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

## A. DEFECTIVE PRICING

\$52,620

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 CFR, Chapter 16 and the FEHBP contract. The Certificates of Accurate Pricing that the Plan signed for contract years 2012 and 2013 were defective. Although there were findings related to contract year 2012, they did not result in a material penalty. In accordance with federal regulations, the FEHBP is, therefore, due a rate reduction for contract year 2013. Application of the defective pricing remedy shows that the FEHBP is due a premium adjustment totaling \$52,620 for contract year 2013 (see Exhibit A).

**The Plan did not have sufficient controls in place to use accurate data in the FEHBP's premium calculations.**

### 1) 2012

#### a) Reconciled Rates

Our review of the 2012 FEHBP rates determined that the Plan inappropriately increased the 2012 reconciled rates for adjustments, totaling \$ [REDACTED] for the single rate and \$ [REDACTED] for the family rate, that were already accounted for in the 2012 proposed rates. These adjustments were added to the 2012 proposed rates as a result of the 2011 FEHBP reconciliation. Consequently, as the adjustments were already captured in the 2012 proposed rates, they should not have been included in the 2012 reconciled rates.

#### Plan Response:

*The Plan did not state whether it agreed or disagreed with our finding in its response. However, it claimed that there were no reconciliation adjustments made in contract year 2012, and provided its 2012 premium based on preliminary calculations. It demonstrated the amounts of \$ [REDACTED] and \$ [REDACTED] in Q2, the 2011 reconciliation amounts of \$ [REDACTED] and \$ [REDACTED] in Q3, and the sum of these amounts of \$ [REDACTED] and \$ [REDACTED] in Q4 applied in the 2012 Rate Proposal - Small Carriers, Attachment I. The Plan stated that the amounts in Q4 are only used to help the Plan assess the overall proposed percentage*

*increase which might influence the decision toward applying a potential discount.*

**OIG Comment:**

The OIG disagrees with the Plan's response and our position has not changed since the draft report. Per the Plan's 2012 reconciliation, the line 1 rates of \$ [REDACTED] for the single rate and \$ [REDACTED] for the family rate included adjustments of \$ [REDACTED] and \$ [REDACTED] respectively. The actual line 1 reconciled rates should have been reported as \$ [REDACTED] single and \$ [REDACTED] family, which are the amounts without the adjustments. Since these adjustments were added to the 2012 proposed rates as a result of the 2011 FEHBP reconciliation, these adjustments should not be included in the 2012 reconciled rates.

**b) Step-Up Factor**

The Plan also applied an incorrect step-up factor to the FEHBP's rates. This error occurred because the Plan could not accurately support its enrollment data for single and family tiers. It provided an enrollment report that showed the total membership for May 2011, but it was not broken into tiers. Therefore, we used OPM's Table One enrollment data, which included single and family enrollment, to calculate our audited step-up factor. Our calculation resulted in a lower step-up factor, [REDACTED], than that used by the Plan, [REDACTED], in its FEHBP rate calculation.

**Plan Response:**

*The Plan disagrees with the findings because of the difference in the months of enrollment values used in the calculation. It used the May 2011 values while the OIG used the April 2011 values. The Plan claimed that the instructions do not prescribe the use of April values, instead the instruction asks about the source of the demographic assumptions, whether they are group specific or apply to the whole community rated population.*

**OIG Comment:**

We do not have an issue with the Plan using May 2011 enrollment data for the 2012 step-up factor calculation, as suggested by the Plan. The support provided by the Plan in its response to the draft is the exact same report that the Plan provided during the audit fieldwork. The enrollment report shows the total

membership for May 2011, however, the report does not separate the data into the single and family tiers that are used to calculate the 2012 step-up factor. After discussing this issue with the Plan, the Plan provided an additional membership report that showed the total subscribers. However, the report still does not separate the subscribers into single and family contracts. Therefore, we used OPM's 2011 Table One Report to determine the single and family contracts. The variance between the Plan's [REDACTED] step-up factor and our [REDACTED] step-up factor is immaterial. When applying our step-up factor of [REDACTED] in our audited rate development, the questioned costs were \$ [REDACTED], which is [REDACTED] percent of the total subscription income. Although there is an immaterial difference, the Plan should be able to produce documentation for the FEHBP's single and family tier contracts.

c) **Transplant Benefit Support**

The Plan did not provide support for its transplant per member per month (PMPM) single rate of \$ [REDACTED] and family rate of \$ [REDACTED]. Consequently, we applied a [REDACTED] percent trend to documentation provided during a previous OPM OIG audit of the Plan (Report #1C-76-00-12-006) to determine an audited single and family cost for this benefit. Since the Plan cannot support its calculation and using its amounts is in the FEHBP's favor, we applied the transplant benefit amounts to the Plan's original amounts.

**Plan Response:**

*The Plan did not suggest an adjustment to this finding from its original numbers, and acknowledged that it overlooked updating the calculation from the support given to the OIG during a prior audit.*

**OIG Comment:**

Initially, our audited calculation was modified due to the lack of support for this calculation. After reviewing the Plan's response, we removed the additional trend of [REDACTED] percent applied to the transplant PMPM in our transplant calculation. We applied our 2012 step-up factors to the transplant PMPM.



d) **Growth Hormone Therapy**

We removed the growth hormone therapy PMPM single rate of \$ [REDACTED] and family rate of \$ [REDACTED] from the FEHBP's special benefit loadings because the benefit was covered under the Plan's prescription drug costs.

**Plan Response:**

*The Plan disagrees with the adjustment for growth hormone therapy. It claimed that it is not a redundant cost with its prescription drug costs. Furthermore, it stated the growth hormone therapy related to this benefit variance is neither self-administered nor dispensed to the patient by a pharmacy, and it is a floor-stock medication administered intravenously by medical professionals in its main clinic.*

**OIG Comment:**

We have reviewed the Plan's response and our position has not changed since the issuance of the draft report. Per the 2012 FEHBP Plan Brochure, the growth hormone is covered under the prescription drug benefit. We will continue to question the inclusion of this charge in contract year 2012.

**2012 Conclusion**

We calculated our audited FEHBP rates by correcting the above noted exceptions. A comparison of our audited line 5 rates to the Plan's reconciled line 5 rates did not result in a material penalty for this contract year.

2) **2013**

a) **Reconciled Rates**

Our review of the 2013 FEHBP rates determined that the Plan inappropriately increased the 2013 reconciled rates for adjustments, totaling \$ [REDACTED] for the single rate and \$ [REDACTED] for the family rate, that were already accounted for in the 2013 Proposal rates. These adjustments were added to the 2013 proposed rates as a result of the 2012 FEHBP reconciliation. Consequently, as the adjustments were already captured in the 2013 proposed rates, they should not be included in the 2013 reconciled rates.

**Plan Response:**

***The Plan agrees with our finding that the 2013 FEHBP rates were inappropriately increased by 2013 reconciled rates for adjustments.***

**b) Member Months**

The Plan erroneously used 11,352 member months instead of the 11,625 member months submitted in its proposal when determining the PMPM rates for the FEHBP's office visit copays and other benefit variances special benefit loadings. Using the 11,352 member months, the Plan calculated a PMPM single and family rate credit of \$ [REDACTED] and \$ [REDACTED], respectively, related to the office visit copays. However, we calculated an audited single and family rate credit of \$ [REDACTED] and \$ [REDACTED], respectively, using the 11,625 member months. Similarly, for the other benefit variances loading, the Plan used 11,352 member months to calculate a PMPM single and family cost of \$ [REDACTED] and \$ [REDACTED], respectively. However, we utilized 11,625 member months to derive an audited PMPM single and family cost of \$ [REDACTED] and \$ [REDACTED], respectively.

**Plan Response:**

***The Plan did not state whether it agrees or disagrees with our finding. Instead, it noted that the 11,827 member months that the OIG initially used in its calculation were derived from all of its HMO members. It also pointed out that the numerator of the PMPM calculation for the office visit copay shows 3,952 office visits is the data only for the FEHBP group, therefore, the denominator should be 11,625, which reflects only the FEHBP portion.***

***Additionally, the Plan noted that the other benefit variance loadings were not calculated with a numerator of actual experience and denominator of member months. The PMPM amounts are carried forward from the support used in prior audits and are only adjusted for the trend factors in 2012 and 2013.***

**OIG Comment:**

We agree with the Plan's response in applying only the FEHBP member months in our denominator, therefore, we used the 11,625 member months for the office visits. Our calculation of the other benefit variance were based on the filed rates that were used for contract year 2012 and claims data provided by the Plan to

determine the other benefit variance PMPM rates using the 11,625 member months. We determined that the other benefit variance is a single rate of \$ [REDACTED] and a family rate of \$ [REDACTED], instead of the Plan's single rate of \$ [REDACTED] and family rate of \$ [REDACTED].

c) **Transplant Benefit Support**

The Plan did not provide support for its transplant PMPM rates of \$ [REDACTED] for single and \$ [REDACTED] for family. Consequently, we used support that was provided during a previous OPM OIG audit of the Plan (Report #1C-76-00-12-006) to determine an audited single and family cost for this benefit. The Plan contended that there should be no adjustment to the 2012 transplant PMPM within its draft response to the 2012 Defective Pricing Finding. Therefore, we trended the 2011 PMPM by [REDACTED] percent and determined the 2013 transplant PMPM rates to be \$ [REDACTED] for single and \$ [REDACTED] for family.

**Plan Response:**

*The Plan did not state whether it agrees or disagrees with our finding. It acknowledged that we used the same source except the 2011 rates should be trended [REDACTED] percent for 2013.*

**OIG Comment:**

Initially, our audited calculation was modified due to the lack of support for this calculation. After reviewing the Plan's response, we applied the [REDACTED] percent trend to the transplant PMPM for contract year 2013. Our audited calculation shows the transplants rates are slightly higher than the Plan's reconciliation.

d) **Growth Hormone Therapy**

We removed the growth hormone therapy PMPM single rate of \$ [REDACTED] and family rate of \$ [REDACTED] from the FEHBP's special benefit loadings because the benefit was covered under the Plan's prescription drug costs.

**Plan Response:**

*The Plan disagrees with the adjustment for growth hormone therapy. It claimed that it is not a redundant cost with its prescription drug costs.*

*Furthermore, it stated that the growth hormone therapy related to this benefit variance is neither self-administered nor dispensed to the patient by a pharmacy, and it is a floor-stock medication administered intravenously by medical professionals in its main clinic.*

**OIG Comment:**

We have reviewed the Plan's response and our position has not changed since the issuance of the draft report. Per the 2013 FEHBP Plan Brochure, the growth hormone is covered under the prescription drug benefit. We will continue to question the inclusion of this charge in contract year 2013.

**2013 Conclusion**

We calculated our audited FEHBP rates by correcting the above noted exceptions. A comparison of our audited line 5 rates to the Plan's reconciled line 5 rates show the FEHBP was overcharged by \$52,620 in contract year 2013 (see Exhibit B).

**Recommendation 1**

We recommend the contracting officer require the Plan to fully comply with the OPM rate reconciliation instructions and all applicable regulations, to maintain original copies of all pertinent rating documents that support the calculations used in the rate development, and to eliminate repeated charges of benefits covered in the FEHBP benefit brochures.

**Recommendation 2**

We recommend that the contracting officer require the Plan to return \$52,620 to the FEHBP for defective pricing in contract year 2013.

**B. LOST INVESTMENT INCOME**

**\$4,270**

In accordance with the FEHBP regulations and the contract between OPM and the Plan, the

**The FEHBP is entitled to recover lost investment income on the 2013 defective pricing finding.**

FEHBP is entitled to recover lost investment income on the defective pricing finding in contract year 2013. We determined that the FEHBP is due \$4,270 for lost investment income, calculated through April 30, 2017 (see Exhibit C). In addition, the FEHBP is entitled to lost investment income for

the period beginning May 1, 2017, until all defective pricing finding amounts have been returned to the FEHBP.

The FEHBAR 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 semi-annual cost of capital rates.

**Plan Response:**

*The Plan did not respond to this finding in its response to the draft report.*

**Recommendation 3**

We recommend that the contracting officer require the Plan to return \$4,270 to the FEHBP for lost investment income, calculated through April 30, 2017. We also recommend that the contracting officer recover lost investment income on amounts due for the period beginning May 1, 2017, until all defective pricing finding amounts have been returned to the FEHBP.

**C. 2013 MEDICAL LOSS RATIO CREDIT UNDERPAYMENT      \$436,287**

In order to assess the appropriateness of the Plan's premium rates in 2013, the Plan was required to file an MLR under OPM's MLR program. The MLR program replaced Similarly-Sized Subscriber Group requirements with an MLR threshold. Simply stated, the MLR is the ratio of FEHBP incurred claims (including expenses for health care quality improvement) to total premium revenue determined by OPM.

For contract year 2013, OPM established an MLR threshold of 85 percent. Therefore, 85 cents of every health care premium dollar must have been spent on health care expenses. If carriers met the MLR threshold, no penalty was due. In contract year 2013, OPM also created an MLR corridor from the established threshold of 85 percent to 89 percent. If the MLR was less than 85 percent, a carrier owed a subsidization penalty equal to the difference between the threshold and the carrier's actual MLR, multiplied by the denominator of the

MLR. If the MLR is over 89 percent, the carrier received a credit equal to the difference between the carrier's reported MLR and 89 percent, multiplied by the denominator of the MLR. This credit can be used to offset any future MLR penalty and is available until it is used up by the Plan or the Plan exits the FEHBP.

The Plan calculated an unadjusted MLR of [REDACTED] percent for contract year 2013. Since this ratio exceeded the OPM established threshold of 89 percent, the Plan received an OPM credit of \$3,014. However, during our review of the Plan's MLR submission, we identified additional issues that resulted in an audited MLR of [REDACTED] percent, which was higher than that calculated by the Plan. Consequently, this audit determined that the Plan's credit from OPM should be increased for contract year 2013. The specific issues that led to the additional credit include the following.

**1) Pharmacy Claims Data**

Our review of the Plan's MLR submission determined that the dollar amount of the pharmacy claims data submitted to OPM OIG did not match the amount used in the Plan's MLR numerator. Per Carrier Letter 2014-18, all 2013 MLR carriers must submit to the OIG the detailed FEHBP claims data used in its MLR calculations.

**The Plan did not have sufficient controls in place to ensure inclusion of pharmacy claims data for its 2013 MLR submission.**

The Plan stated that when it filed the MLR, it had used an allocation method for the pharmacy claims and did not use the actual pharmacy claims data. Furthermore, it was determined during the audit that the Plan's pharmacy benefit manager failed to capture data from an old system when it switched to a new system in September 2013. See "D. Pharmacy Claims Data Submission" below for further analysis.

The Plan's FEHBP MLR submission used a claims amount of \$ [REDACTED]. Once we determined that this amount did not match the claims totals submitted to the OIG, we requested that the Plan resubmit the actual claims data that should have been used in their MLR submission to OPM. This claims data was provided during our audit and upon our review of this data, we determined that the claims amount had increased to \$ [REDACTED]. This increase ultimately resulted in an increase to the Plan's MLR numerator of \$ [REDACTED].

## 2) Defective Pricing

As mentioned above, our audit identified a defective pricing finding for contract year 2013 totaling \$52,620. The 2013 Community Rating Guidelines state that the denominator of the FEHBP MLR calculation will be equal to the OPM supplied 2013 premium income or carrier supplied 2013 premium income less any amount recovered from the carrier due to an audit. Therefore, we have removed the \$52,620 from the Plan's premium income, which in turn reduced the FEHBP MLR denominator.

### Conclusion

We recalculated the Plan's 2013 MLR submission with the adjustments described above. The audited MLR calculation resulted in an increased OPM MLR credit of \$436,287 (see Exhibits D and E).

### Plan Response:

*The Plan did not challenge the methodology described in the draft report, but stated that the MLR percentage should be adjusted based on the Plan's detailed responses. It claimed that, as a staff model plan, its allocations of medical costs provided by in-house salaried staff are relatively complicated, and the MLR calculation is not a simple total of paid claims. The Plan emphasized its appreciation for the auditors' work in carefully reviewing and understanding the allocations.*

### OIG Comment:

We agree with the Plan and have adjusted the value of the MLR credit underpayment section based on the responses and adjustments to the 2013 defective pricing issues.

### Recommendation 4

We recommend that the contracting officer instruct OPM's Office of the Actuary to increase the Plan's 2013 MLR carryover credit by \$436,287.

## **D. PHARMACY CLAIMS DATA SUBMISSION**

## **Procedural**

The Plan did not provide pharmacy claims data in accordance with the requirements of Carrier Letter 2014-18. This carrier letter required all 2013 MLR carriers to submit to the



OIG detailed FEHBP claims data used in its MLR calculations in the specified format.

Because this data was not provided in a timely manner, we were not able to determine until the audit that the Plan's data submitted to the OIG did not match the values that the Plan used in its 2013 MLR calculation. As stated previously, when the Plan filed the MLR with OPM, it used an allocation method to determine the pharmacy claims to include as part of the MLR's incurred claims cost and did not use the actual pharmacy claims data. Furthermore, we determined that the Plan's pharmacy benefit manager failed to capture data from an old system when it switched to a new system in September 2013. Once the correct claims information was provided, it ultimately resulted in an adjustment to the Plan's MLR percentage, which increased the MLR credit it was due.

**Plan Response:**

*The Plan did not respond to this finding in its response to the draft report.*

**Recommendation 5**

We recommend that the contracting officer require the Plan to comply with the annual MLR carrier letter, which specifies required claims data submissions to the OIG.

# EXHIBIT A

## Union Health Service, Inc. Summary of Defective Pricing Questioned Costs

### Defective Pricing Questioned Costs

Contract Year 2013	<u>\$52,620</u>
Lost Investment Income	<u>\$4,270</u>
Total Questioned Costs	<u><b>\$56,890</b></u>

Report No. 1C-76-00-16-042

# EXHIBIT B

## Union Health Service, Inc. Defective Pricing Questioned Costs

### Contract Year 2013

	<u>Self</u>	<u>Family</u>
FEHBP Line 5 - Reconciled Rate	\$ [REDACTED]	\$ [REDACTED]
FEHBP Line 5 - Audited Rate	\$ [REDACTED]	\$ [REDACTED]
Bi-weekly Overcharge	\$ [REDACTED]	\$ [REDACTED]
To Annualize Overcharge:		
March 31, 2013 enrollment	[REDACTED]	[REDACTED]
Pay Periods	<u>26</u>	<u>26</u>
Subtotal	\$18,179	\$34,441
<b>Total Defective Pricing Questioned Costs</b>		<b><u>\$52,620</u></b>

Report No. 1C-76-00-16-042

# EXHIBIT C

## Union Health Service, Inc. Lost Investment Income

<b>Year</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>30-Apr-17</b>	<b>Total</b>
<b>Audit Findings:</b>						
1. Defective Pricing	\$52,620	\$0	\$0	\$0	\$0	\$62,620
Totals (per year):	\$52,620	\$0	\$0	\$0	\$0	\$52,620
Cumulative Totals:	\$52,620	\$52,620	\$52,620	\$52,620	\$52,620	\$52,620
Avg. Interest Rate (per year):	1.5625%	2.0625%	2.2500%	2.1875%	2.5000%	
Interest on Prior Years Findings:	\$0	\$1,085	\$1,184	\$1,151	\$439	\$3,859
Current Years Interest:	\$411	\$0	\$0	\$0	\$0	\$411
Total Cumulative Interest Calculated Through April 30, 2017:	\$411	\$1,085	\$1,184	\$1,151	\$411	<b>\$4,270</b>

Report No. 1C-76-00-16-042

# EXHIBIT D

## Union Health Service, Inc. Summary of Medical Loss Ratio Credit Adjustment

### Contract Year 2013

Credit Calculated	\$439,301
Credit Received	\$3,014
Total Credit Adjustment Due to Plan	<b><u>\$436,287</u></b>

Report No. 1C-76-00-16-042

# EXHIBIT E

## Union Health Service, Inc. Medical Loss Ratio Credit Adjustment

	Plan	Audited
2013 FEHBP MLR Lower Threshold (a)	85%	85%
2013 FEHBP MLR Upper Threshold (b)	89%	89%
Incurred Claims (Medical and Pharmacy) Quality Health Improvement Expenses		
<b>MLR Numerator</b>		
Premium Income	\$4,630,617	\$4,630,617
Less: Federal and State Taxes and Licensing or Regulatory Fees		
Less: 2013 RBA Finding	\$0	\$52,620
<b>MLR Denominator (c)</b>		
<b>FEHBP Unadjusted Medical Loss Ratio (d)</b>		
<b>Credit Calculation (If (d) is greater than (b), ((d-b)*c)</b>	<b>\$3,014</b>	<b>\$439,301</b>
<b>Credit Adjustment Due To Plan</b>		<b>\$436,287</b>

Report No. 1C-76-00-16-042

# APPENDIX

January 13, 2017

## Plan 76 Response to Draft Audit Report

Our responses to the draft report are inserted below using red-font text immediately following the black text pasted from the draft report. We have not responded to conclusions (e.g., lost investment income) or recommendation that are driven by details to which we've responded.

In some cases, we think there was lack of clarity regarding the supporting source and we are now identifying what we think addresses the issue. In other cases, you didn't have the supporting information (we weren't aware of the issue) and the accompanying files should correct that.

We especially want to acknowledge our appreciation for the manner in which this audit was conducted, with courtesy and professionalism. In particular, we are grateful for your inclusion of the 2013 contract year in the audit to help us confirm (or correct) issues related to the MLR calculation (complicated by the nature of a staff-model organization with allocated direct-service costs in the numerator). Working with the audit team has given us confidence in our approach with the relatively near MLR methodology as we go forward

### 2012

Our review of the 2012 FEHBP rates determined that the Plan inappropriately increased the 2012 reconciled rates for adjustments, totaling \$ [REDACTED] for the single rate and \$ [REDACTED] for the family rate, that were already accounted for in the 2012 proposed rates. These adjustments were added to the 2012 proposed rates as a result of the 2011 FEHBP reconciliation. Consequently, as the adjustments were already captured in the 2012 proposed rates, they should not be included in the 2012 reconciled rates.

**Deleted by OIG - Not Relevant to the Final Report** we see no redundant reconciliation adjustment in the 2012. **Deleted by OIG - Not Relevant to the Final Report** The amounts shown there of \$ [REDACTED] and \$ [REDACTED], single and family, respectively, are calculated without regard to any reconciliation adjustment and they are then carried to Q2 of Attachment I in our 2012 proposal. The 2011 reconciliation amounts of \$ [REDACTED] and \$ [REDACTED] are properly reported in Q3 of Attachment I. **Deleted by OIG - Not Relevant to the Final Report** although they do properly appear in Q4 due to Attachment I's internal calculation. The amounts on rows 199 and 200 may look like "the bottom line", but they are only used to help us assess the overall proposed percentage increase which might influence our decision toward applying a potential discount.

The Plan also applied an incorrect step-up factor to the FEHBP's rates. This error occurred because the Plan incorrectly used its own 2011 enrollment data to derive the factor instead of the 2011 Table 1 enrollment data submitted to OPM. Therefore, we used the Table 1 enrollment data to calculate our audited step-up factor. Our calculation resulted in a lower step-up factor ([REDACTED]) than that used by the Plan ([REDACTED]) in its FEHBP rate calculation. Consequently, we used our audited step-up factor in deriving the FEHBP's audited rates.

We disagree with the findings. The difference between OIG's factor ([REDACTED]) and our factor ([REDACTED]) is entirely related to OIG's usage of the available enrollment numbers in April, 2011, (the Table 1 amounts) and our usage of the May, 2011, enrollment numbers

**Deleted by OIG - Not Relevant to the Final Report**

Report No. 1C-76-00-16-042



The instructions do not prescribe usage of April values, but Q. 32 through Q. 35 in the instructions asks about the source of the demographic assumptions, whether they are group specific or apply to the whole community rated population.

**Deleted by OIG - Not Relevant to the Final Report**

Additionally, the Plan did not provide support for its transplant per member per month (PMPM) single rate of \$ [REDACTED] and family rate of \$ [REDACTED]. Consequently, we used support that was provided during a previous Office of Inspector General (OIG) audit (Report #1C-76-00-12-006) to determine an audited single and family cost for this benefit. Using this support, we derived a PMPM single rate of \$ [REDACTED] and a family rate of \$ [REDACTED].

Although this draft adjustment would be “in our favor”, we suggest making no adjustment. **Deleted by OIG - Not Relevant to the Final Report** Yes, we overlooked updating the calculation from the support given to a prior auditor **Deleted by OIG - Not Relevant to the Final Report**

Furthermore, we removed the growth hormone therapy PMPM single cost of \$ [REDACTED] and family cost of \$ [REDACTED] from the FEHBP’s special benefit loadings because the benefit was covered under the Plan’s prescription drug costs.

We disagree with the adjustment for growth hormone therapy; it is not a redundant cost with our prescription drug costs. The growth hormone therapy related to this benefit variance is neither self-administered nor dispensed to the patient by a pharmacy. It is a floor-stock medication administered intravenously by medical professionals in our main clinic.

**Deleted by OIG - Not Relevant to the Final Report**

Report No. 1C-76-00-16-042

## 2013

Our review of the 2013 FEHBP rates determined that the Plan inappropriately increased the 2013 reconciled rates for adjustments, totaling \$ [REDACTED] for the single rate and \$ [REDACTED] for the family rate, that were already accounted for in the 2013 Proposal rates. These adjustments were added to the 2013 proposed rates as a result of the 2012 FEHBP reconciliation. Consequently, as the adjustments were already captured in the 2013 proposed rates, they should not be included in the 2013 reconciled rates.

We agree.

The Plan also erroneously used 11,352 member months instead of the 11,827 member months submitted in its proposal when determining the PMPM rates for the FEHBP's office visit copays and other benefit variances special benefit loadings. Using the 11,352 member months, the Plan calculated a PMPM single and family rate credit of \$ [REDACTED] and \$ [REDACTED], respectively, related to the office visit copays. However, we calculated an audited single and family rate credit of \$ [REDACTED] and \$ [REDACTED], respectively, using the 11,827 member months. Similarly, for the other benefit variances loading, the Plan used 11,352 member months to calculate a PMPM single and family cost of \$ [REDACTED] and \$ [REDACTED], respectively. However, we utilized 11,827 member months to derive an audited PMPM single and family cost of \$ [REDACTED] and \$ [REDACTED], respectively.

**Deleted by OIG - Not Relevant to the Final Report** The 11,827 member months that you used are derived from all of our HMO members, Deleted by OIG - Not Relevant to the Final Report The numerator of your PMPM calculations for the office visit copay shows 3,952 office visits. The pivot table source of that number is properly filtered to include only FEHBP group. Deleted by OIG - Not Relevant to the Final Report I believe your calculated visits per month (which drives the calculated loading) should use 3,952 in the numerator and 11,625 in the denominator (using your source but only included the FEHBP portion).

The other benefits variance loadings Deleted by OIG - Not Relevant to the Final Report are not calculated with a numerator of actual experience Deleted by OIG - Not Relevant to the Final Report and a denominator of member months. The PMPM amounts are carried forward from the support used in prior audits and are only adjusted for the trend factor ( [REDACTED] % in 2012 and the same for 2013). Deleted by OIG - Not Relevant to the Final Report

Additionally, the Plan did not provide support for its transplant PMPM single rate of \$ [REDACTED] and family rate of \$ [REDACTED]. Consequently, we used support that was provided during a previous OIG audit (Report #1C-76-00-12-006) to determine an audited single and family cost for this benefit. Using this support, we derived a PMPM single rate of \$ [REDACTED] and a family rate of \$ [REDACTED].

**Deleted by OIG - Not Relevant to the Final Report** You have correctly referenced the 2011 audit Deleted by OIG - Not Relevant to the Final Report Our numbers are the same except the 2011 rates should be trended [REDACTED] % Deleted by OIG - Not Relevant to the Final Report

Finally, we removed the growth hormone therapy PMPM single cost of \$ [REDACTED] and family cost of \$ [REDACTED] from the FEHBP's special benefit loadings because the benefit was covered under the Plan's prescription drug costs.

As described above for the 2012 rates, the growth hormone therapy related to this benefit variance is not self-administered nor dispensed to the patient by a pharmacy. It is a floor-stock medication administered intravenously by medical professionals in our main clinic.

Report No. 1C-76-00-16-042

## **1. Medical Loss Ratio Credit Underpayment \$542,488**

We do not challenge the methodology described in this MLR section of the draft report (not shown in this response document), but the value should be adjusted based on the above detailed responses. We should also mention that, as a staff model plan, the allocations of medical costs provided by in-house salaried staff are relatively complicated. The numerator of the MLR calculation is not a simple total of paid claims. We again want to emphasize our appreciation for the auditors' work in carefully reviewing and understanding the allocations (similar to those used in our Medicare cost reports).

**Deleted by OIG - Not Relevant to the Final Report**

Report No. 1C-76-00-16-042



## **Report Fraud, Waste, and Mismanagement**

Fraud, waste, and mismanagement in Government concerns everyone: Office of the Inspector General staff, agency employees, and the general public. We actively solicit allegations of any inefficient and wasteful practices, fraud, and mismanagement related to OPM programs and operations. You can report allegations to us in several ways:

**By Internet:** <http://www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse>

**By Phone:** Toll Free Number: (877) 499-7295  
Washington Metro Area: (202) 606-2423

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

Report No. 1C-76-00-16-042

-- CAUTION --

This report has been distributed to Federal officials who are responsible for the administration of the subject program. This non-public version may contain confidential and/or proprietary information, including information protected by the Trade Secrets Act, 18 U.S.C. § 1905, and the Privacy Act, 5 U.S.C. § 552a. Therefore, while a redacted version of this report is available under the Freedom of Information Act and made publicly available on the OIG webpage (<http://www.opm.gov/our-inspector-general>), this non-public version should not be further released unless authorized by the OIG.