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 CALIFORNIA, INC. - SOUTHERN REGION

Report Number 1C-LP-00-16-022
February 24, 2017

-- CAUTION --

EXECUTIVE SUMMARY

Audit of the Federal Employees Health Benefits Program Operations at Health Net of California, Inc. - Southern Region

Report No. 1C-LP-00-16-022 **February 24, 2017**

Why Did We Conduct the Audit?

The primary objective of the audit was to determine if Health Net of California, Inc. - Southern Region (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 2002, 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) in contract years 2012 and 2013. We also verified whether the Plan developed the FEHBP premium rates using complete, accurate, and current data in contract years 2012 and 2013. Our audit fieldwork was conducted from February 1, 2016, through October 11, 2016, at the Plan's office in Woodland Hills, California and in our OIG offices.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

This report identifies an understated OPM MLR penalty of $137,197 for contract year 2013. We determined that portions of the MLR calculation were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM. Specifically, our audit identified the following:

- In contract years 2012 and 2013, the Plan did not apply the allocation method proportionately and appropriately to determine the tax expenses related to the FEHBP for the MLR submissions. The 2012 errors did not result in a material adjustment to the 2012 MLR submission.

- In contract years 2012 and 2013, the Plan included fees not allowed by the FEHBP to determine the tax expense. The 2012 errors did not result in a material adjustment to the 2012 MLR submission.

- The Plan included medical and pharmacy claims not allowed by the FEHBP in the incurred claims used to develop the 2013 MLR submission.

The audit also showed that the rating documentation provided was sufficient to support the 2012 and 2013 FEHBP premium rates.

ABBREVIATIONS

CFR	**Code of Federal Regulations**
E&M	**Evaluation and Management**
FEHBAR	**Federal Employees Health Benefits Acquisition Regulation**
FEHBP	**Federal Employees Health Benefits Program**
HMO	**Health Maintenance Organization**
HNCA	**Health Net of California, Inc.**
MLR	**Medical Loss Ratio**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**Health Net of California, Inc. – Southern Region**
SSSG	**Similarly-Sized Subscriber Group**

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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 California, Inc. - Southern Region (Plan). The audit was conducted pursuant to the provisions of Contract CS 2002; 5 United States Code 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 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.

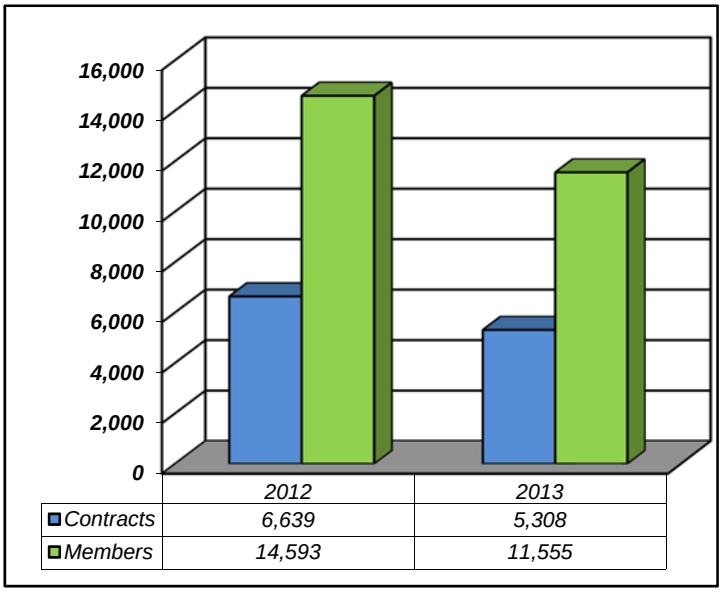
The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act (P.L. 111-148) and defined by the U.S. Department of Health and Human Services in 45 CFR Part 158. In 2012, community-rated FEHBP carriers could elect to follow the FEHBP-specific MLR requirements, instead 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 1980 and provides health benefits to FEHBP members in Southern California. A prior audit of the Plan covered contract year 2011. That audit determined that the Plan's rating of the FEHBP was in accordance with the applicable laws, regulations, and the OPM rating instructions.

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.

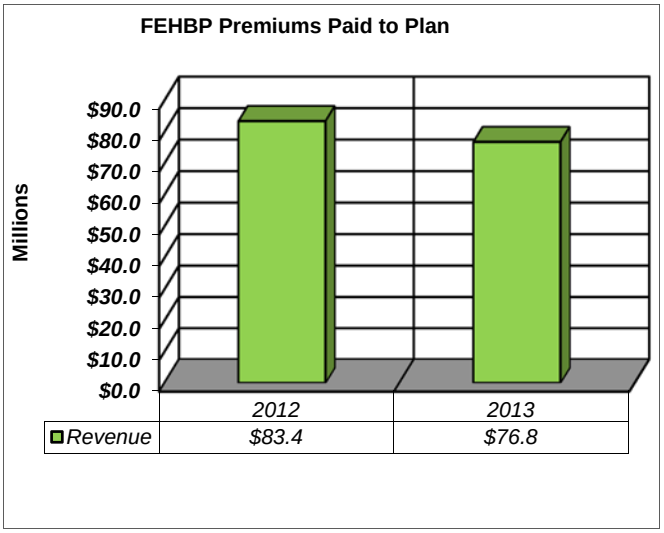
II. OBJECTIVES, SCOPE, AND METHODOLOGY

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 $160.2 million in premiums to the Plan.

The Office of the Inspector General's (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 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 February 1, 2016, through February 12, 2016, at the Plan's office in Woodland Hills, California. Additional fieldwork was completed through October 11, 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 below 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 – Medicare 2013	Queried medical claims for members greater than or equal to age 65	[redacted] claims	$[redacted]	Judgmentally selected 18 claim lines greater than or equal to $45,000 totaling $1,509,561.	Judgmental	No
Dependent Eligibility 2013	Queried members greater than or equal to age 26 designated as dependent	[redacted] members[1]; [redacted] claims	$[redacted]	Selected all [redacted] members from the universe. [redacted] claims, one for each member, totaling $22,720. The claims were selected by sorting the universe claims data by member last name and then selecting the first claim for each member.	Judgmental	No
Member Eligibility 2013	Queried medical claims for members greater than or equal to $90,000	[redacted] members; [redacted] claims	$[redacted]	Selected all [redacted] members from the universe. [redacted] claims, one for each member, totaling $3,674,703. The claims were selected by using a no duplicate key function within SAS EG.	Judgmental	No

Additionally, we reviewed a sample of non-covered benefits from the 2013 medical claims data. We filtered the Plan's medical claims data for 1,677 potentially non-covered procedure codes from an OIG list of compiled non-covered benefit procedure codes from other health plans. Of

[1] Some of these members also appeared within the Dependent Eligibility 2013 Pharmacy Claim sample. Together the Dependent Eligibility reviews covered a total of 28 members.

the 1,677 procedure codes, 61 were included in the claims data, encompassing 518 claims, totaling $84,637. From those 61 procedure codes, we selected:

- Procedure codes which are known to be non-covered based on our audit group's claims manual and the FEHBP benefit brochure (1 procedure code, 18 claims);
- Procedure codes that showed up on multiple lists from other health plans (1 procedure code, 3 claims);
- The top three most expensive procedure codes based on the total paid for the procedure divided by the number of occurrences (3 procedure codes, 4 claims);
- The top five procedure codes which have the highest frequency of occurrences (5 procedure codes, 160 claims); and
- Two other procedures codes based on auditor judgment (2 procedure codes, 12 claims).

From the 12 procedure codes identified above, we judgmentally selected one claim for review per procedure code. Based on the results of our initial review, we expanded our review by judgmentally selecting an additional 32 claims from the 12 procedure codes in our original sample. Total claims reviewed were 44 claims, totaling $41,030. The results were not projected to the universe.

Finally, we reviewed a sample of evaluation and management (E&M) claims with and without the modifier 25 from the 2013 medical claims data. Modifier 25 allows multiple E&M claims from the same provider on the same date to be billed and adjudicated in the Plan's system. We filtered the Plan's medical claims data for 222 E&M procedure codes, which resulted in [redacted] claims, totaling [redacted]. Next, we created two sets of data from the [redacted] claims; one with the modifier 25 and one without the modifier 25. Using the SAS Enterprise Guide random sample function, we selected a random sample of 10 claims with modifier 25 that were greater than or equal to $100. From the set of data created without the modifier 25, we used the SAS Enterprise Guide random sample function to select 50 claims that were greater than or equal to $100. We judgmentally selected 10 claims without the modifier 25 from the 50 random claims based on high dollar and high utilization. This resulted in a sample of 20 claims, totaling $7,307, that were sent to the Plan. The results were not projected to the universe.

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?
High Dollar Scripts 2013	Queried pharmacy claims greater than or equal to $7,500	[redacted] claims	$[redacted]	Removed duplicate patient IDs and selected the first claims for each unique ID; 14 claims from universe totaling $151,031.	Judgmental	No
Member Eligibility 2013	Queried pharmacy claims for members greater than $4,800	[redacted] members; [redacted] claims	$[redacted]	Selected all [redacted] members from the universe. [redacted] claims, one for each member, totaling $221,325. The claims were selected using a no duplicate key function within SAS EG.	Judgmental	No
Dependent Eligibility 2013	Queried members greater than or equal to age 26 designated as dependent	[redacted] members[2]; [redacted] claims	$[redacted]	Selected all [redacted] members from the universe. [redacted] claims, one claim for each member, totaling $1,464. The claims were selected using a no duplicate key function within SAS EG.	Judgmental	No

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.

[2] Some of these members also appeared within the Dependent Eligibility 2013 Medical Claim sample. Together the Dependent Eligibility reviews covered a total of [redacted] members.

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. 2013 MEDICAL LOSS RATIO PENALTY UNDERPAYMENT $137,197

In order to assess the appropriateness of the Plan's premium rates in 2012 and 2013, it was required to file an MLR ratio submission under OPM's MLR program. The MLR program replaced the SSSG 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 2012, the MLR pilot program carriers must have met the OPM-established MLR threshold of 89 percent. Therefore, 89 cents of every health care premium dollar must have been spent on health care expenses. If the MLR threshold was less than 89 percent, the carrier owed a subsidization penalty equal to the difference between the threshold and the carrier's actual MLR.

The Plan calculated an MLR of [redacted] percent for contract year 2012, which met the OPM-established MLR threshold. However, during our review of the Plan's submission, we identified the procedural findings listed below, which resulted in adjustments to the Plan's MLR calculation. These adjustments, however, resulted in no penalty due for this contract year.

For contract year 2013, the OPM-established MLR threshold was 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 the 85 percent threshold, a carrier owed a subsidization penalty equal to the difference between the threshold and the carrier's actual MLR. If the MLR was 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.

Federal enrollees did not receive full value for their premium dollars due to expense overpayments. Consequently, in addition to the penalty paid of $426,729, another $137,197 is owed to the Program.

The Plan calculated an MLR of [redacted] percent for contract year 2013. Since this ratio was under the established threshold of 85 percent, the Plan paid a penalty to OPM of $426,729. However,

during our review of the Plan's MLR submission, we identified additional issues that resulted in an audited MLR that was lower than that calculated by the Plan. Consequently, this audit determined that the Plan owes OPM an additional subsidization penalty of $137,197 for contract year 2013. The specific issues that led to the additional penalty include the following.

1) Tax Allocation

The Plan is under the legal entity of Health Net of California, Inc. (HNCA), which is a subsidiary of Health Net, Inc. HNCA is comprised of three comprehensive health coverages: individual, small employer group, and large employer group, along with other business segments. The Plan's large employer group contains five market segments, one of which is the Health Maintenance Organization (HMO) Fully Insured Group. While the FEHBP is part of the HMO Fully Insured Group, the Plan separates the FEHBP (north and south) into their own sub-categories of the HMO Fully Insured Group. In spite of this separation however, expenditures are not tracked at an FEHBP-specific level.

During our review of the Plan's allocated Federal and State income and payroll taxes, we determined that the allocation was based on member months. However, the Plan calculated the member month ratio by dividing the FEHBP South member months by the member months for the HMO Fully Insured Group, instead of using the member months of the large employer group.

45 CFR §158.170(b) requires that the Plan's allocation method be based on a generally accepted accounting method that is expected to yield the most accurate results. Many entities operate within a group where personnel and facilities are shared. Shared expenses must be apportioned pro rata to the entities incurring the expense.

Based on the above criteria, we found that the Plan's methodology used to allocate the Federal and State income and payroll taxes to the FEHBP was not applied proportionately or appropriately, and was not based on a generally accepted accounting method. Also, it is not suitable to treat the FEHBP as its own entity since expenses are not tracked at the FEHBP-specific group level and the methodology is not related to the actual expenses incurred. We determined that a more appropriate methodology to calculate the member month ratio was to divide the FEHBP South member months by the Total Large Group member months. We used this methodology for the member months because the FEHBP sub-categories are part of the HMO Fully Insured Group which is part of the Total Large Group. This methodology can be supported using the Supplemental Health Care Exhibit and yields a more accurate result.

As a result of using the adjusted allocation methodology based on Total Large Group member months, we have removed $[redacted] in Federal Payroll Taxes, $[redacted] in Federal Income Taxes, and added $[redacted] in State Income Taxes to the overall tax amount for contract year 2012. Additionally, we have removed $[redacted] in Federal Payroll Taxes, $[redacted] in in Federal Income Taxes, and $[redacted] in State Income Taxes for contract year 2013.

Plan Response:

The Plan disagrees with the tax allocation finding in 2012 and 2013. It maintains that the method of allocation it used applies costs proportionally and appropriately to the FEHBP and is consistent with generally accepted accounting methods.

The Plan asserts that its "general ledger system applies a method consistent with generally accepted accounting methods to allocate costs to the specific market segment within which the FEHBP resides: HMO Fully Insured Large Group. Health Net of CA allocates from this market segment level aggregated federal and state income and payroll taxes down to the FEHBP in proportion to the covered population using the FEHBP member months divided by total HMO Fully Insured Large Group member months. Both member months for the population and the tax amounts for the total population are consistent, facilitating an apples-to-apples allocation."

The Plan also states that if it were to change its approach to the OIG's recommended approach, the allocated amount to the FEHBP would not be consistent with its general ledger amounts or its annual statement and other filings with regulators. It states that the OIG's methodology would "add complexity to the Plan's allocation process and financial tracking without addressing any identified material deficiencies that exist in the current allocation methodology."

OIG Comment:

The OIG disagrees with the Plan's position and contends that our method of deriving the member month ratio is a more appropriate accounting method. We base this position on two factors:

i. The FEHBP sub categories are part of the HMO Fully Insured Group, which is part of the Total Large Group; and

ii. Although the Plan separated the FEHBP from the HMO Fully Insured Group, it did not track FEHBP expenses at a group-specific level.

Consequently, we maintain that dividing the FEHBP member months by the Total Large Group member months yields a more accurate allocation result.

2) Inclusion of Unallowable Fees

The Plan allocated a portion of the City Business License fees to the FEHBP. According to 5 United States Code 8909(f)(1), the imposition of taxes, fees, or other monetary payment, directly or indirectly, on FEHBP premiums by any governmental authority of those entities is prohibited. The Plan agrees that the City Business License fees should not have been allocated to the FEHBP State taxes. We have removed the allocated City Business License fees of $[redacted] and $[redacted] for contract years 2012 and 2013, respectively, from the Plan's State tax calculation.

The Plan also allocated a portion of its Appointment fees to the FEHBP tax calculation. As explained by the Plan, Appointment fees are fees paid by brokers and agents to any regulatory agency to keep its license current. However, 48 CFR 52.203-5(a) states, "The Contractor warrants that no person or agency has been employed or retained to solicit or obtain this contract upon an agreement or understanding for a contingent fee." A contingent fee is defined as any commission, percentage, brokerage, or other fee that is contingent upon the success that a person or concern has in securing a Government contract. Therefore, we have removed $[redacted] and $[redacted] from the FEHBP tax calculation for contract years 2012 and 2013, respectively.

The Plan did not have sufficient controls in place to exclude unallowable fees from the FEHBP's MLR calculation.

Based on the adjusted payroll tax allocation methodology and the removal of the unallowable fees, we determined that the FEHBP's total calculated taxes are $[redacted] and [redacted] for contract years 2012 and 2013, respectively.

Plan Response:

The Plan agrees that specified unallowable fees were included in the tax allocations.

3) MLR Claims Data

a) Oncology Claims

During our MLR calculation review for contract years 2012 and 2013, we determined that the oncology claims costs were accounted for twice. The costs were included in

the capitation manual adjustments and within its own claims category, which overinflated the MLR numerator. We have removed $[redacted] and $[redacted] in oncology costs from the audited MLR calculation for contract years 2012 and 2013, respectively.

Plan Response

The Plan agrees that the oncology claims costs were accounted for twice, and should be removed from the audited MLR calculation for contract years 2012 and 2013.

b) Improper Claim Payments for Contract Year 2013

During our review of the Plan's MLR submission for contract year 2013, we determined that the incurred claims amount was incorrect. Specifically, the Plan included medical and pharmacy claim amounts not allowed by the FEHBP.

In our coordination of benefits review, we reviewed a sample of 18 claims for 16 members age 65 or over to determine whether the sampled claims were properly coordinated and paid by the Plan. The results of our review identified one claim, totaling $[redacted], which was incorrectly coordinated and paid for contract year 2013. The Plan stated that an examiner failed to coordinate benefits and that the overpayment had been set up for recoupment and a refund had been received. However, 45 CFR 158.140(b)(ii) requires that overpayment recoveries received from providers be deducted from the incurred claims reported in the Plan's MLR numerator. Consequently, we removed the erroneously paid claim of $[redacted] from the MLR numerator.

The Plan did not have sufficient controls in place to exclude unallowable claims from the FEHBP's MLR calculation.

Plan Response:

The Plan agrees that the specified claim above was not properly coordinated and paid.

During our review of overage dependents, we reviewed a sample of medical and pharmacy claims for 28 members age 26 or over that were not identified as subscribers, spouses, or disabled dependents to determine if the Plan stopped coverage timely or retained the appropriate support for the members. According to

the FEHBP's certificate of coverage, dependent coverage ends once dependents turn 26 years of age, unless they are incapable of self-support. Based on our review of the 28 dependent members, we determined that the Plan did not maintain proper certification of disability for 6 of the dependents. Standard Contract CR-2013, Section 1.11(b) requires the Plan to make available records for audit in accordance with the record retention period specified within the FEHBAR and 48 CFR 1652.204-70. Furthermore, 48 CFR 1652.204-70 requires the Plan make available records applicable to a contract term, including individual enrollee and/or patient claim records, for a period of six years after the end of the contract term. According to the Plan, the storage of the disability documentation had been in a microfiche based system that had been replaced by a new system. In the upgrade process, the disability documentation was lost. Without proper disability certification for these dependents, we were unable to verify that the dependents were eligible for coverage during 2013. Consequently, we removed a total of $[redacted] for the six overage dependents from the MLR numerator for contract year 2013.

Plan Response:

The Plan agrees that it did not maintain proper certification of disability for disabled dependents for the term of the disability.

Finally, we reviewed a sample of 44 claims based on non-covered procedure codes to determine if any non-covered benefits were paid by the Plan. We identified a procedure code, 92310, related to the fitting of contact lenses that was being paid by the Plan although it was defined as a non-covered benefit per the 2013 FEHBP Benefit Brochure. The Plan stated that these claims went through the Plan's auto adjudication process and its system has since been updated to deny claims with this procedure code. Eighteen claims were paid for the non-covered benefit, totaling $[redacted]. We removed these claims from the MLR numerator for contract year 2013.

Plan Response:

The Plan agrees that a non-covered service for procedure code 92310 was incorrectly adjudicated in its claims system during contract year 2013.

Conclusion

We recalculated the Plan's 2012 and 2013 MLR submissions with the adjustments described above. The audited MLR calculation for contract year 2012 resulted in no underpayment of

the MLR subsidization penalty. However, the audited MLR calculation for contract year 2013 resulted in an MLR subsidization penalty underpayment of $137,197. (See Exhibit B)

Plan Response:

The Plan disagrees with the OIG's tax allocation adjustments to the 2012 and 2013 MLR calculations and agrees with the remaining adjustments. Based on this position, applying the adjustments for the unallowable fees, oncology claims, and improper payments to the 2012 MLR calculation only changes the submitted MLR of [redacted] percent to [redacted] percent, and changes the 2013 MLR calculation from the submitted MLR of [redacted] percent to [redacted] percent. The Plan agrees with the OIG that the change in MLR for 2012 does not require an adjustment to the MLR credit. However, it contends that the change in MLR for 2013 only requires an additional payment of $133,676, instead of $137,197 as reported in the draft report.

OIG Comment:

The OIG disagrees with the Plan and asserts that our adjustments to the Plan's 2012 and 2013 MLR calculations were in accordance with the regulations. We maintain that the Plan did not apply the allocation method proportionately and appropriately to determine the tax expenses related to the FEHBP for the 2012 and 2013 MLR submissions as required by 45 CFR 158.170(b). Consequently, while we concur that there should be no adjustment to the 2012 MLR calculation, we maintain that there is an MLR subsidization penalty underpayment of $137,197 for contract year 2013.

Recommendation 1

We recommend that the contracting officer require the Plan to return $137,197 to the MLR subsidization penalty account for contract year 2013.

Recommendation 2

We recommend that the contracting officer require the Plan to use the entire large group member months when deriving the FEHBP's State and Federal income and payroll tax allocations.

Recommendation 3

We recommend that the contracting officer require the Plan to remove the City Business License fees and Appointment fees and any other unallowable fees from the MLR denominator for future submissions.

Recommendation 4

We recommend that the contracting officer require the Plan to test and implement proper system configurations to prevent non-covered benefit claims from being adjudicated.

Recommendation 5

We recommend that the contracting officer require the Plan to maintain proper certification of disability for disabled dependents for the term of the disability.

Recommendation 6

We recommend that the contracting officer require the Plan to institute internal controls to mitigate the use of incorrect and unsupported data in the MLR calculation prior to filing with OPM.

EXHIBIT A

Health Net of California - Southern Region
Summary of Medical Loss Ratio Penalty Underpayment

Contract Year 2012

Medical Loss Ratio Penalty	$0
Total Penalty Due OPM	**$0**

Contract Year 2013

Medical Loss Ratio Penalty	$563,926
Amount Paid	$426,729
Total Penalty Due to OPM	**$137,197**

Report No. 1C-LP-00-16-022

EXHIBIT B

Health Net of California, Inc. - Southern Region
2013 Medical Loss Ratio Penalty Underpayment

	Plan	Audited
2013 FEHBP MLR Lower Threshold (a)	85%	85%
2013 FEHBP MLR Upper Threshold (b)	89%	89%
Claims Expense		
Incurred Claims (Medical and Pharmacy)	[redacted]	[redacted]
Less: Oncology Claims		[redacted]
Less: Coordination of Benefit Claims		[redacted]
Less: Dependent Claims		[redacted]
Less: Non-Covered Benefits Claims		[redacted]
Adjusted Incurred Claims	[redacted]	[redacted]
Quality Health Improvement Expenses	[redacted]	[redacted]
Total Adjusted Incurred Claims	[redacted]	[redacted]
Premium Income	**$76,762,319**	**$76,762,319**
Taxes and Regulatory Fees		
Federal / State Taxes and Fees	[redacted]	[redacted]
Less: Federal Payroll Taxes		[redacted]
Less: Federal Income Taxes		[redacted]
Less: State Payroll, Real Estate, Personal Property Taxes		[redacted]
Less: State Income Taxes		[redacted]
Less: Regulatory Authority Licenses and Fees		[redacted]
Adjusted Federal / State Taxes and Fees	[redacted]	[redacted]
Total Adjusted Premium (c)	[redacted]	[redacted]
FEHBP Medical Loss Ratio Calculation (d)	[redacted]%	[redacted]%
Penalty Calculation (If (d) is less than (a), ((a-d)*c)		$563,926
Amount Paid to OPM		$426,729
Questioned Costs		**$137,197**

APPENDIX

Health Net of California, Inc.
2370 Kerner Blvd.
San Rafael, CA 94901

Health Net®

December 5, 2016

[redacted]
Chief, Community-Rated Audits Group
U.S. Office of Personnel Management
1900 E Street, NW
Room 6400
Washington, DC 20415-1100

Re: Health Net of CA – Southern Region DRAFT Audit Report 1C-LP-00-16-022

Dear [redacted]:

Your letter to [redacted] dated October 19, 2016, communicated the findings, conclusions, and recommendations from the Health Net of CA, Inc. – Southern Region DRAFT Audit Report 1C-LP-00-16-022. Health Net agrees with three of the four findings regarding the MLR submissions for the 2012 and 2013 FEHBP contract years, specifically that (1) specified unallowable fees were included in the tax allocations, (2) some oncology claims costs were accounted for twice, and (3) specified improper claim payments were made for contract year 2013. Health Net of CA does not agree with the fourth finding regarding the method applied when allocating federal and state income and payroll taxes. Health Net of CA maintains that the method of allocation is both consistent with generally accepted accounting methods and applies costs proportionally and appropriately to the FEHBP.

The Health Net of CA general ledger system applies a method consistent with generally accepted accounting methods to allocate costs to the specific market segment within which the FEHBP resides: HMO Fully Insured Large Group. Health Net of CA allocates from this market segment level aggregated federal and state income and payroll taxes down to the FEHBP in proportion to the covered population using FEHBP member months divided by total HMO Fully Insured Large Group member months. Both the member months for the total population and the tax amounts for the total population are consistent, facilitating an apples-to-apples allocation. This allocation approach is consistent with generally accepted accounting methods.

If we were to change our applied approach in the manner recommended in the draft audit report, and, instead, allocate taxes from the higher level of aggregated taxes at the Total Large Group coverage level down to the FEHBP, the amount allocated to the FEHBP would not be consistent with our general ledger amounts, and, therefore, would not be consistent with our annual statement and other filings with regulators. This would also add complexity to the allocation process and financial tracking without addressing any identified material deficiencies that exist in the current allocation methodology.

The draft audit report identified the following dollar adjustments to the MLR calculations for contract years 2012 and 2013, respectively:

	2012	2013
(1) Unallowable Fees in Tax Allocations		
(i) City Business License Fees	[redacted]	[redacted]
(ii) Appointment Fees		
(2) Double Counting of Oncology Costs	[redacted]	[redacted]
(3) Improper Claim Payments		
(i) Related to Overage Dependents	[redacted]	[redacted]
(ii) Related to Procedure Code 92310		
(iii) Related to Coordination of Benefits		
(4) Allocation of Fed/State Income & Payroll Taxes		
(i) Federal Payroll Taxes	[redacted]	[redacted]
(ii) Federal Income Taxes		
(iii) State Income Taxes		

Health Net of CA maintains that the adjustments in Section (4) above should not be made to the 2012 and 2013 MLR calculations. If we apply only the adjustments in Sections (1), (2), and (3), above, the MLR calculation for 2012 changes from the submitted MLR of [redacted]% to [redacted]%; the MLR calculation for 2013 changes from the submitted MLR of [redacted]% to [redacted]%. The change in MLR for 2012 does not require any payment from Health Net of CA or any adjustments to MLR credits. The change in MLR for 2013 requires an additional payment in the 2013 contract year in the amount of $133,676. Health Net of CA believes that this is the appropriate MLR adjustment to the 2013 contract year.

Deleted by OIG - Not Relevant to the Final Report

Please let us know if you have any questions about the foregoing comments, or if there is additional support that we can provide to assist you.

Sincerely,

[redacted]

Director, Actuarial Services
Health Net of CA

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

Report No. 1C-LP-00-16-022

-- CAUTION --