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 HEALTHPLUS OF MICHIGAN

Report Number 1C-X5-00-17-032
April 24, 2018

EXECUTIVE SUMMARY

Audit of the Federal Employees Health Benefits Program
Operations at HealthPlus of Michigan

Report No. 1C-X5-00-17-032 **April 24, 2018**

Why Did We Conduct the Audit?

The primary objective of the audit was to determine if HealthPlus of Michigan (Plan) was in compliance with the provisions of its contract and the laws and regulations governing the Federal Employees Health Benefits Program (FEHBP). To accomplish this objective, we verified whether the Plan met the Medical Loss Ratio (MLR) requirements and thresholds established by the U.S. Office of Personnel Management (OPM).

Because of Program changes resulting from OPM's roll-out of its MLR Program, we are no longer performing a review of the FEHBP's rates. Consequently, this change to our audit process only allows us to verify whether the calculated percentage of the premium paid is spent on patient related health care expenses. It does not allow us to assess the fairness of the premium paid for benefits received.

What Did We Audit?

Under Contract CS 2712, the Office of the Inspector General (OIG) completed a performance audit of the FEHBP MLR submissions to OPM for contract years 2013 through 2015. Our audit fieldwork was conducted from May 15, 2017, through October 11, 2017, at the Plan's office in Flint, Michigan and in our OIG offices.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

This report questions $527,027 for overstating the OPM MLR credits in contract years 2013 through 2015. Specifically, our audit identified the following:

- In contract year 2013, we determined that the Plan used its own unsupported premium amount and an inaccurate adjusted incurred claims amount in its MLR calculation. These errors resulted in an overstatement of the Plan's 2013 OPM MLR credit totaling $188,957.

- In contract year 2014, we found errors in the Plan's adjusted incurred claims total, in the coordination of benefits claims review, and in the high dollar pharmacy prescriptions review. These errors resulted in an overstatement of the Plan's 2014 OPM MLR credit totaling $315,052.

- In contract year 2015, we identified errors within the adjusted incurred claims total, as well as the expense allocations for the Quality Healthcare Improvement and the Health Insurance Provider Fee expenses. These errors resulted in an overstatement of the Plan's 2015 OPM MLR credit totaling $23,018.

- Material weaknesses in the Plan's internal control structure that resulted in their inability to adequately support the 2013 through 2015 MLRs filed with OPM.

- For contract years 2013 and 2014, the Plan did not maintain a required Fraud, Waste, and Abuse (FWA) Manual or provide all FWA potential case notifications to the OPM OIG, as required by Carrier Letters 2011-13 and 2014-29.

- Our audit did not disclose any findings related to the Plan's policies and procedures for debarment or off-shore contracting. Additionally, our audit did not disclose any findings related to our claim reviews for deceased members, dependent eligibility, member eligibility, or non-covered benefits.

ABBREVIATIONS

CFR	**Code of Federal Regulations**
Contract	**OPM Contract CS-2712**
FAR	**Federal Acquisition Regulation**
FEHBAR	**Federal Employees Health Benefits Acquisition Regulations**
FEHBP	**Federal Employees Health Benefits Program**
FWA	**Fraud, Waste, and Abuse**
HIPF	**Health Insurance Providers Fee**
MLR	**Medical Loss Ratio**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**HealthPlus of Michigan**
QHI	**Quality Healthcare Improvement**
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 HealthPlus of Michigan (Plan). The audit was conducted pursuant to the provisions of Contract CS 2712 (Contract); 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 2013 through 2015, and was conducted at the Plan's office in Flint, Michigan.

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 was established to ensure that healthplans are meeting specified thresholds for spending on medical care and health care quality improvement measures, and thus limiting spending on administrative costs, such as executive salaries, overhead, and marketing. For example, the threshold of 85 percent requires carriers to spend 85 cents of every premium dollar on patient care and limits the amount that can go to administrative expenses and profit to 15 cents of every dollar. However, the MLR does not provide an assessment of the fairness of the premium paid for benefits received, only that the calculated percentage of the premium paid is spent on patient related health care expenses.

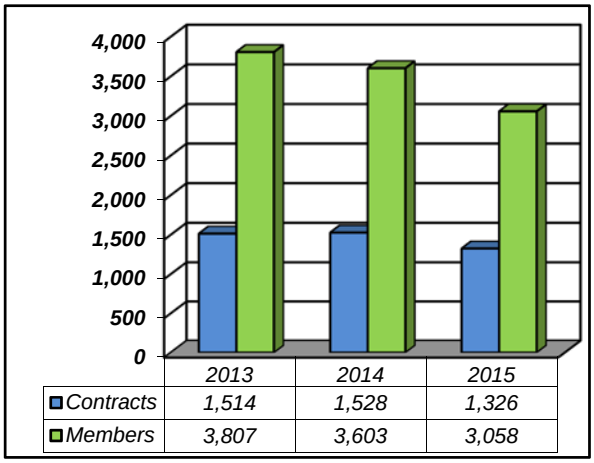
The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act (P.L. 111-148) and defined by the U.S. Department of Health and Human Services in 45 CFR Part 158. In 2012, community-rated FEHBP carriers could elect to follow the FEHBP-specific MLR requirements, instead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



	2013	2014	2015
Contracts	1,514	1,528	1,326
Members	3,807	3,603	3,058

The Plan has participated in the FEHBP since 1995 and provides health benefits to FEHBP members in the eastern Michigan area. However, effective January 1, 2017, the Plan merged with Health Alliance Plan. Consequently, it is no longer a participating FEHBP carrier.

There were no previous MLR audits of the Plan. However, a prior audit of the Plan covered contract years 2011 and 2012. The audit found that the FEHBP premium rates were developed in accordance with the Office of Personnel Management's rules and regulations for contract year 2011. However, the Plan was not compliant with its FEHBP record retention clause in contract year 2012. The audit report did not identify any questioned costs, but recommended that the Contracting Officer assess the maximum allowed penalty in the Plan's contract with OPM for breach of the record retention clause and to inform the Plan that they are expected to fully comply with the record retention provisions of the Contract and applicable regulations.

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 and thresholds 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. Further, we reviewed the Plan's internal controls; compliance with fraud, waste, and abuse (FWA) requirements; debarment; and offshore contracting program areas to ensure that the Plan had adequate policies and procedures covering these areas.

Our audits of the MLR submission filed with OPM are completed in accordance with the criteria expressed in OPM's rating instructions. The MLR audit evaluation includes an assessment of key components of the MLR calculation, including allowable claims, health care expenses, and quality health improvements (numerator), and the premium received, excluding applicable tax expenses (denominator). The result of the MLR calculation must meet OPM's prescribed thresholds. If the calculation falls below the threshold, the health plan must pay a penalty determined by the variance between the actual MLR ratio and the established threshold.

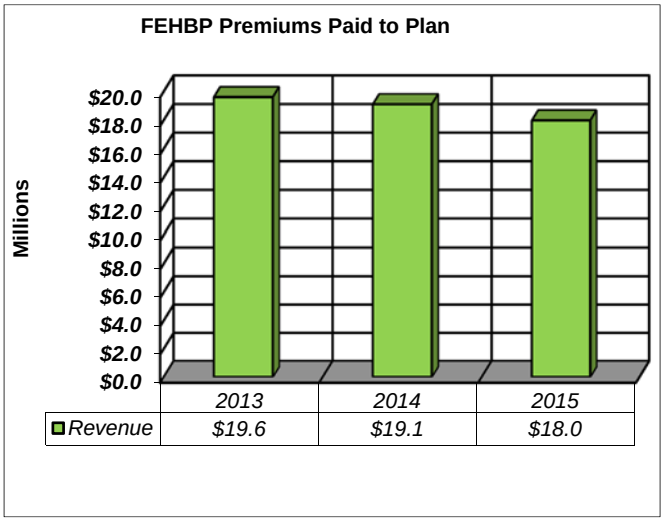
Although the FEHBP premiums used in the MLR calculation are ultimately determined by the premium rates proposed by the Plan and certified and paid by OPM, the OPM rating instructions no longer provide sufficient criteria to evaluate the fairness of those rates against the standard market value of similarly-sized groups. Furthermore, per the OPM rating instructions, health plans can utilize OPM's total reported premium, as the denominator in the MLR calculation, which when utilized is not subject to audit. Since the majority of health plans choose this option, the premiums utilized in the MLR calculation are very frequently not available for audit and the fairness of the FEHBP premium rates cannot be evaluated.

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 2013 through 2015. For these years, the FEHBP paid approximately $56.7 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. Our review of internal controls was limited to the procedures the Plan has in place to ensure that:

- 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 May 15, 2017, through October 11, 2017, at the Plan's office in Flint, Michigan and in 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, quality health expenses, taxes and regulatory fees

and any other applicable costs 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 calculations.

To gain an understanding of the internal controls over the Plan's MLR process, we reviewed the Plan's MLR policies and procedures and interviewed appropriate Plan officials regarding the controls in place to ensure that MLR calculations were completed accurately and appropriately. Other auditing procedures were performed as necessary to meet our audit objectives.

We also interviewed Plan officials and reviewed the Plan's policies and procedures associated with its internal controls over the claims processing system, FWA, debarment and offshore contracting programs.

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 2014	Queried high dollar medical claims for members greater than or equal to age 65	7,333 claims	$1,678,198	Judgmentally selected 14 claims greater than or equal to $8,000 totaling $387,085 for 10 members	Judgmental	No
Coordination of Benefits with Medicare 2014	Queried medical claims (excluding high dollar claims from the COB sample above) for members greater than or equal to age 65	7,319 claims	$1,291,113	Randomly selected 15 claims from the universe using SAS EG, totaling $2,901 for 12 members	Random	No

Member Eligibility 2014	Queried members with at least one medical claim during FY 2014.	3,294 members	N/A	Randomly selected 25 members from the universe using SAS EG	Random	No
Dependent Eligibility 2014	Queried members greater than or equal to age 26 designated as dependent	42 members	N/A	Selected the full universe of 42 members	N/A	N/A
Deceased Member 2014	Queried medical claims for members greater than or equal to age 80	12 members	N/A	Selected the full universe of 12 members	N/A	N/A

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?
Dependent Eligibility 2014	Queried members greater than or equal to age 26 designated as dependent	40 members	N/A	Selected all members that were NOT part of the medical dependent eligibility review sample, which totaled 2 members	N/A	N/A
High Dollar Pharmacy Prescriptions 2014	Queried pharmacy claims greater than or equal to $5,000	28 claims	$227,996	Selected all pharmacy claims, representing 9 members, from the universe.	N/A	N/A

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

Effective January 1, 2017, the Plan merged with Health Alliance Plan. Consequently, it is no longer a participating FEHBP carrier. As a result of the merger, this report does not offer recommendations on audit issues that could only be remedied if the Plan continued to operate as a going concern.

A. Medical Loss Ratio Review

1. Overstated Medical Loss Ratio Credit $527,027

Beginning with its pilot program in 2012, OPM's MLR program replaced SSSG requirements with an MLR threshold. Simply stated, the MLR is the ratio of the FEHBP incurred claims (including expenses for health care quality improvements (QHI)) to total premium revenue determined by OPM.

For contract years 2013 through 2015, OPM established an MLR threshold of 85 percent and created an MLR corridor. This threshold requires carriers to spend 85 cents of every health care premium dollar on health care expenses. If a carrier's MLR falls between 85 and 89 percent, no penalty is due. If a carrier's MLR is less than 85 percent, the carrier will owe 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 receives a credit equal to the difference between the carrier's reported MLR and 89 percent, multiplied by the denominator of the MLR. For contract year 2013, the credit can be used to offset any future MLR penalties and is available until it is used up by the Plan or the Plan exits the FEHBP. For the remaining contract years, the credit can be used to offset any future MLR penalties for a period of five years subsequent to the current contract year.

The Plan's non-compliance with Program requirements and its inability to support its MLR calculations resulted in a total overstated MLR credit of $527,027 for contract years 2013 through 2015.

The Plan calculated an MLR of 96.82 percent, 102.49 percent, and 106.30 percent for contract years 2013, 2014, and 2015, respectively. Since these ratios exceeded the OPM established threshold of 89 percent, the Plan received a 2013 MLR credit of $1,539,615, a 2014 MLR credit of $2,562,532, and a 2015 MLR credit of $3,033,892. However, during our review of the Plan's MLR submissions in each of these years, we identified issues

that resulted in audited MLR percentages that were lower than those calculated by the Plan. Consequently, this audit determined that the Plan's MLR credits should be reduced by $188,957, $315,052, and $23,018 for contract years 2013 through 2015, respectively. The specific issues that led to the overstated credits include the following.

a. Adjusted Incurred Claims

During our claims review, we determined that the Plan's adjusted incurred claims were not fully supported and included erroneous prior year adjustments. Specifically, it erroneously included prior year medical claim adjustments in the 2013 and 2014 medical claims, it included unsupported indirect healthcare expenses in its 2015 incurred claims amount, and we identified variances within the Plan's pharmacy rebates, as well as unexplained medical claims variances in the 2013 through 2015 incurred claims.

OPM's Carrier Letters 2014-18 and 2015-11 require carriers to only include claims incurred during the current calendar year and paid through June 30 of the following year as part of their MLR calculation.

Additionally, the 2013, 2014, and 2015 OPM Rating Instructions require that Carriers "maintain all MLR documentation ... to fully support all claim values." OPM Contract Section 1.11(b) further requires insurance carriers to maintain all records relating to the Contract and to make these records available for a period of time specified by the FEHBAR 1652.204-70. The referenced clause is also incorporated at Section 3.4, which requires the carrier to maintain individual enrollee and/or patient claim records "for six years after the end of the contract term to which the claim records relate."

Finally, Section 5.7(f) of the Contract states that "The Contractor shall make available at its office at all reasonable times the records, materials, and other evidence ... for examination, audit, or reproduction, until 3 years after final payment under this contract or for any shorter period specified in Subpart 4.7, Contractor Records Retention, of the Federal Acquisition Regulation (FAR), or for any longer period required by statute or by other clauses of this contract."

The Plan explained that its actuarial reports used to support the medical claims totals included claims paid through June 30 of the following calendar year. However, those claims also included prior year dates of service claims totaling $83,035 and ($17,742) for 2013 and 2014, respectively. The Plan did not adjust its claims totals to remove

the unallowable prior years' claims. As a result, we did not include the unallowable claim amounts in our audited 2013 and 2014 claims figures.

The Plan also included indirect healthcare expenses for the Affordable Care Act Vision/Dental and Other categories, totaling $12,964, in its 2015 adjusted incurred claims. Due to its merger with another health plan and key personnel no longer being available to provide supporting documentation, the Plan was unable to support the indirect healthcare expenses. Consequently, we removed it from our audited MLR calculation for 2015.

After incorporating the adjustments for the prior year's claims and the indirect healthcare expenses in the medical claims for 2013 through 2015, variances still existed. The Plan was unable to account for the remaining medical claim variances of $125,307, $49,761, and ($5,065) for 2013 through 2015, respectively. Therefore, these medical claims variances were removed from our audited 2013 through 2015 MLR calculations.

Finally, the Plan stated that pharmacy claim variances of $44,971, $96,385, and $62,487 for 2013 through 2015, respectively, were due to the pharmacy rebates. The variances occurred because of the difference between the estimated pharmacy rebates used at the time of the original MLR submissions and the actual rebate amounts reported a year later, which the Plan provided as support during the audit. The Plan was unable to duplicate the data used for the estimated pharmacy rebates to quantify the pharmacy variances. Consequently, we removed the pharmacy claims variances from our audited 2013 through 2015 MLR calculations.

As a result of the issues explained above, our audited adjusted incurred claims varied from the Plan's calculated totals for 2013 through 2015. The results are summarized in the following table. As stated above, we used our audited incurred claims amounts in our audited MLR calculations for each contract year.

Contract Years	Initial Adjusted Incurred Claims Totals	Audited Adjusted Incurred Claims Totals	Variance
2013	$18,128,545	$17,875,232	$253,313
2014	$18,666,717	$18,538,313	$128,404
2015	$17,953,896	$17,883,510	$70,386

b. MLR Claims Data

During our 2014 claims review, we determined that the Plan included unsupported medical and pharmacy claim amounts in its MLR calculation.

i. Coordination of Benefits

The Plan could not support that seven claims, totaling $164,081 were properly coordinated with Medicare.

We reviewed a combined sample of 29 claims for 20 unique members (2 members were included in both samples) age 65 or over from the 2014 medical claims data to determine whether the sampled claims were properly coordinated with Medicare and paid by the Plan. The results of our review identified seven claims, totaling $164,081, which the Plan could not support, in spite of numerous requests for the documentation.

The 2014 OPM rating instructions require that Carriers "maintain all MLR documentation ... to fully support all claim values." As mentioned previously, Section 1.11(b) of the Contract additionally requires the Plan to maintain all records relating to the Contract and to make the records available for a period of time specified by FEHBAR 1652.204-70. The referenced clause is also incorporated at Section 3.4, which requires the carrier to maintain individual enrollee and/or patient claim records "for six years after the end of the contract term to which the claim records relate."

Because the Plan could not support the proper coordination with Medicare for these seven claims totaling $164,081, they were removed from our audited 2014 MLR numerator.

ii. High Dollar Pharmacy Prescriptions

We reviewed a sample of 28 claims for nine members from the 2014 pharmacy claims data, where the amount paid was greater than or equal to $5,000, to determine if the claims were supported by an original prescription. The results of our review identified two claims that were not supported by an original prescription.

The Plan could not support three high dollar pharmacy claims, totaling $22,567.

As stated previously, OPM's 2014 Community Rating Guidelines require the Plan "to maintain all MLR documentation ... to fully support all claim values." Furthermore, Section 1.11(b) of the Contract requires the Plan to maintain all records relating to the Contract and to make the records available for a period of time specified by FEHBAR 1652.204-70. The referenced clause is also incorporated at Section 3.4, which requires the carrier to maintain individual enrollee and/or patient claim records "for six years after the end of the contract term to which the claim records relate."

The Plan stated that it had attempted several times to obtain the original prescriptions from its pharmacy benefit manager but was unable to do so. We extracted all additional prescription refills associated with both of the impacted prescription numbers. Consequently, we removed three unsupported claims, totaling $22,567, from our audited 2014 MLR numerator.

iii. Deceased Member

Based on our review, we concluded that the Plan did not pay any medical or pharmacy claims for deceased members.

iv. Dependent Eligibility

Based on our review, we concluded that the Plan did not pay any medical or pharmacy claims for ineligible dependents age 26 and over.

v. Member Eligibility

Based on our review, we concluded that the Plan did not pay any medical benefits for members after they were terminated by the Plan, dropped coverage, or during a gap in coverage.

vi. Non-Covered Benefits

Based on our review, we concluded that the Plan did not pay for benefits not covered in the FEHBP Plan brochure.

c. QHI and HIPF Expenses

QHI and HIPF expenses were understated due to allocation errors.

The Plan's 2015 administrative expense percentage used to allocate its QHI and Health Insurance Providers Fee (HIPF) expenses was inaccurate due to the removal of an unsupported $154,170 tax credit.

Section 1.11(b) of the Contract requires insurance carriers to maintain all records relating to the Contract and to make these records available for a period of time specified by FEHBAR 1652.204-70. The referenced clause is also incorporated at Section 3.4, which requires the carrier to maintain individual enrollee and/or patient claim records "for six years after the end of the contract term to which the claim records relate."

Furthermore, Section 5.7(f) of the Contract states that "The Contractor shall make available at its office at all reasonable times the records, materials, and other evidence ... for examination, audit, or reproduction, until 3 years after final payment under this contract or for any shorter period specified in Subpart 4.7, Contractor Records Retention, of the [FAR], or for any longer period required by statute or by other clauses of this contract."

In spite of numerous requests for documentation, the Plan was unable to support the removal of the $154,170 tax credit. Consequently, the $154,170 was added back into the audited FEHBP administrative expense total for 2015. Adding the tax credit back into the administrative expense total increased the overall allocation percentage from 9.25 percent to 9.99 percent. This percentage increase raised the QHI expenses by $16,977, resulting in an audited expense total of $228,763, which decreased the FEHBP MLR claims total. Similarly, the percentage increase raised the HIPF expense by $34,147, resulting in an audited Federal and State Taxes and Regulatory Fees expense total of $460,105, which increased the Plan's allowable deduction from its premium totals for 2015.

d. 2013 Premium Income

The Plan used its own internal premium income amount of $19,685,242 in its 2013 FEHBP MLR filing.

OPM's 2013 Community Rating Guidelines state that the Plan may use its own premium income, but it will be subject to audit and must be justified with supporting

documentation at the time of audit. The Plan stated that it could not support its internal premium income amount because personnel who could have explained and supported the amount were no longer with the Plan at the time of our audit. Consequently, we adjusted the premium income amount used in the 2013 MLR calculation to OPM's premium income amount of $19,612,931. The Plan stated that it agreed with the use of OPM's premium income amount.

Conclusion

We recalculated the Plan's 2013 through 2015 MLRs, incorporating the adjustments mentioned above. A comparison of our audited MLR calculations to those submitted by the Plan showed overstated MLR credits of $188,957 for 2013, $315,052 for 2014, and $23,018 for 2015. (see Exhibits B, C, and D)

Plan Response:

The Plan agrees with all of our findings.

Recommendation 1

We recommend that the contracting officer instruct OPM's Office of the Actuary to reduce the Plan's 2013 credit by $188,957.

Recommendation 2

We recommend that the contracting officer instruct OPM's Office of the Actuary to reduce the Plan's 2014 credit by $315,052.

Recommendation 3

We recommend that the contracting officer instruct OPM's Office of the Actuary to reduce the Plan's 2015 credit by $23,018.

B. Internal Controls Review

The Plan did not have any written policies and procedures regarding the FEHBP MLR process and was unable to provide all of the necessary supporting documentation during the audit.

A lack of internal controls over the MLR process resulted in inaccurate MLR submissions to OPM and overstated MLR credits for 2013 through 2015.

Section 5.64(c)(2)(ii)(A) of the Contract states that the Contractor's internal control system will at a minimum provide for "Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the business ethics awareness and compliance program and internal control system." The Contract further states at Section 5.64(c)(2)(ii)(C)(1), (2) and (3) that the Contractor's internal control system should provide "Periodic reviews of company business practices, procedures, policies, and internal controls for compliance with the Contractor's code of business ethics and conduct and the special requirements of Government contracting, including--

(1) Monitoring and auditing to detect criminal conduct;

(2) Periodic evaluation of the effectiveness of the business ethics awareness and compliance program and internal control system, especially if criminal conduct has been detected; and

(3) Periodic assessment of the risk of criminal conduct, with appropriate steps to design, implement, or modify the business ethics awareness and compliance program and the internal control system as necessary to reduce the risk of criminal conduct identified through this process."

Additionally, Section 1.11(b) of the Contract requires insurance carriers to maintain all records relating to the Contract and to make these records available for a period of time specified by FEHBAR 1652.204-70. The referenced clause is also incorporated at Section 3.4, which requires the carrier to maintain individual enrollee and/or patient claim records "for six years after the end of the contract term to which the claim records relate."

Furthermore, Section 5.7(f) of the Contract states that "The Contractor shall make available at its office at all reasonable times the records, materials, and other evidence described ... for examination, audit, or reproduction, until 3 years after final payment under this contract or for any shorter period specified in Subpart 4.7, Contractor Records Retention, of the [FAR], or for any longer period required by statute or by other clauses of this contract."

The Plan did not maintain written policies and procedures regarding its FEHBP MLR process for the scope of our audit. As mentioned previously, effective January 1, 2017, the Plan merged with another health plan. Due to the merger, key staff members at the Plan were not available to answer audit requests and provide supporting documentation. As a result of the lack of written policies and procedures, we were unable to determine if the Plan had sufficient oversight over its MLR calculation for our audit scope and were unable to obtain supporting documentation for various pieces of the MLR calculation in each year.

C. Fraud, Waste and Abuse Review

During our review of the Plan's FWA policies and procedures, we found that it did not provide all potential case notifications to the OPM OIG for contract years 2013 and 2014 as required by Carrier Letter 2011-13, and it did not have a separate FWA Manual as required by OPM's Carrier Letter 2014-29.

According to Carrier Letter 2011-13, Carriers "are required to submit a written notification to the OPM OIG … within 30 working days of becoming aware of a fraud, waste, or abuse issue where there is a reasonable suspicion that a fraud has occurred or is occurring against the Federal Employees Health Benefits … Program. … Furthermore, it is understood that in order to meet the 30 day notification requirement, Carriers may provide notification on cases where their investigation is still in the early stages and the Carrier has not yet determined whether there is sufficient evidence to substantiate the allegation."

The Plan did not make the OPM OIG aware of potential fraud, waste, or abuse issues which could have impacted premium rates and patient safety of FEHBP members.

Additionally, Carrier Letter 2014-29 required carriers to publish a FWA manual that includes all plans, policies, and procedures, which are involved in the Carrier's FWA program.

As a result of its non-compliance with Carrier Letters 2011-13 and 2014-29, OPM OIG was not aware of potential fraud, waste, or abuse that could have negatively impacted the premium rates charged during our audit scope, as well as impacted the safety of FEHBP members enrolled in the Plan during this time.

D. Debarment Review

Based on our review, we concluded the Plan had procedures in place to identify providers that are debarred or suspended from participation in the FEHBP. Also, we determined the Plan had procedures in place to notify both the provider and the subscriber and to stop payment to debarred or suspended providers.

E. Offshore Contracting Review

Based on our review, we concluded that the Plan had adequate procedures to ensure oversight of its offshore activities.

EXHIBIT A

HealthPlus of Michigan
Summary of MLR Credit Adjustment

2013 Overstated MLR Credit	($188,957)
2014 Overstated MLR Credit	($315,052)
2015 Overstated MLR Credit	($23,018)
Total Overstated MLR Credit	**($527,027)**

EXHIBIT B

HealthPlus of Michigan
2013 MLR Credit Adjustment

	Plan	Audited
2013 FEHBP MLR Lower Corridor (a)	85%	85%
2013 FEHBP MLR Upper Corridor (b)	89%	89%
Claims Expense		
Incurred Claims (Medical and Pharmacy)	$18,128,545	$18,128,545
Less: Claims from prior year date of service	$0	$83,035
Less: Unexplained Medical Variance	$0	$125,307
Less: Pharmacy Claims Variance	$0	$44,971
Adjusted Incurred Claims	$18,128,545	$17,875,232
Paid Medical Incentive Pools and Bonuses	$532,587	$532,587
Expenses to Improve Health Care Quality	$398,348	$398,348
Total MLR Numerator	**$19,059,480**	**$18,806,167**
Premium Expense		
Premium Income	$19,685,242	$19,612,931
Total MLR Denominator (c)	**$19,685,242**	**$19,612,931**
FEHBP MLR Calculation (d)	96.82%	95.89%
Penalty Calculation (If (d) is less than (a), ((a-d)*c)	$0	$0
Credit Calculation (If (d) is greater than (b), ((d-b)*c)	$1,539,615	$1,350,658
Overstated Credit Amount		**($188,957)**

EXHIBIT C

HealthPlus of Michigan
2014 MLR Credit Adjustment

	Plan	Audited
2014 FEHBP MLR Lower Corridor (a)	85%	85%
2014 FEHBP MLR Upper Corridor (b)	89%	89%
Claims Expense		
Incurred Claims (Medical and Pharmacy)	$18,666,717	$18,666,717
Less: Claims from prior year date of service	$0	($17,742)
Less: Unexplained Medical Variance	$0	$49,761
Less: Pharmacy Claims Variance	$0	$96,385
Less: Coordination of Benefits Claims Finding	$0	$164,081
Less: Prescription High Dollar Finding	$0	$22,567
Adjusted Incurred Claims	$18,666,717	$18,351,665
Paid Medical Incentive Pools and Bonuses	$371,356	$371,356
Expenses to Improve Health Care Quality	$433,405	$433,405
Total MLR Numerator	**$19,471,478**	**$19,156,426**
Premium Expense		
Premium Income	$19,150,647	$19,150,647
Federal and State Taxes and Regulatory Fees	$151,831	$151,831
Total MLR Denominator (c)	**$18,998,816**	**$18,998,816**
FEHBP MLR Calculation (d)	102.49%	100.83%
Penalty Calculation (If (d) is less than (a), ((a-d)*c)	$0	$0
Credit Calculation (If (d) is greater than (b), ((d-b)*c)	$2,562,532	$2,247,480
Overstated Credit Amount		**($315,052)**

EXHIBIT D

HealthPlus of Michigan
2015 MLR Credit Adjustment

	Plan	Audited
2015 FEHBP MLR Lower Corridor (a)	85%	85%
2015 FEHBP MLR Upper Corridor (b)	89%	89%
Claims Expense		
Incurred Claims (Medical and Pharmacy)	$17,953,896	$17,953,896
Less: Indirect Healthcare Expenses	$0	$12,964
Less: Unexplained Medical Variance	$0	($5,065)
Less: Pharmacy Claims Variance	$0	$62,487
Adjusted Incurred Claims	$17,953,896	$17,883,510
Paid Medical Incentive Pools and Bonuses	$478,090	$478,090
Expenses to Improve Health Care Quality	$211,786	$228,763
Total MLR Numerator	**$18,643,772**	**$18,590,363**
Premium Expense		
Premium Income	$17,965,149	$17,965,149
Federal and State Taxes and Regulatory Fees	$425,958	$460,105
Total MLR Denominator (c)	**$17,539,191**	**$17,505,044**
FEHBP MLR Calculation (d)	106.30%	106.20%
Penalty Calculation (If (d) is less than (a), ((a-d)*c)	$0	$0
Credit Calculation (If (d) is greater than (b), ((d-b)*c)	$3,033,892	$3,010,874
Overstated Credit Amount		**($23,018)**

APPENDIX

December 21, 2017

Plan X5 Response to Draft Audit Report

From: [redacted]
To: [redacted]
Cc: [redacted]
Subject: RE: HealthPlus (Plan Code X5) Draft Report and Transmittal Letter
Date: Thursday, December 21, 2017 11:14:20 AM
Attachments: image001.png

Hi [redacted],

This email is to let you know that we are in agreement with the draft report findings for HealthPlus (X5) and will not be disputing anything.
Please proceed accordingly.

Best regards,
[redacted]
Senior Director, Revenue Management
2050 S. Linden Rd, Flint, MI, 48532
Phone: [redacted] | Fax: [redacted]
[redacted]@hap.org

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