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**U.S. OFFICE OF PERSONNEL MANAGEMENT  
OFFICE OF THE INSPECTOR GENERAL  
OFFICE OF AUDITS**

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# **Final Audit Report**

**Audit of the Federal Employees Health Benefits Program  
Operations at Humana Health Plan, Inc. - Chicago**

**Report Number 1C-75-00-17-040**

**November 1, 2018**

# EXECUTIVE SUMMARY

## *Audit of the Federal Employees Health Benefits Program Operations at Humana Health Plan, Inc. - Chicago*

Report No. 1C-75-00-17-040

November 1, 2018

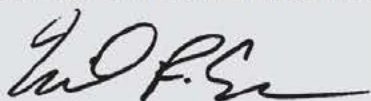
### **Why Did We Conduct the Audit?**

The primary objective of the audit was to determine if Humana Health Plan, Inc. - Chicago (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 methodology, 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 1570, the Office of the Inspector General (OIG) completed a performance audit of the FEHBP MLR submissions to OPM for contract years 2013 and 2014. Our audit fieldwork was conducted from December 4, 2017, through April 12, 2018, at the Plan's office in Louisville, Kentucky and in our OIG Offices.



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

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

The Certificates of Accurate MLR Calculation signed by the Plan in 2013 and 2014 were defective, resulting in a [REDACTED] MLR credit overstatement in contract year 2013, and an understated MLR credit of [REDACTED] for contract year 2014. Specifically, our audit identified the following:

- The Plan included claims for unsupported and ineligible overage disabled dependents in their 2013 and 2014 claims data.
- The Plan allocated a negative tax liability for the Federal Income and State Income Tax in the 2014 MLR calculation.
- The Plan adjusted the FEHBP's 2013 and 2014 MLR calculations, based on a Centers for Medicare and Medicaid Services audit, to limit the allowable fraud reduction expenses to those incurred or recovered by its Special Investigations Unit.

Our audit did not disclose any findings related to the Plan's procedures for premium income, quality health improvement expenses, and capitation expenses. Finally, our audit also did not disclose any findings related to our claim reviews for coordination of benefits and non-covered benefits.

# ABBREVIATIONS

<b>CFR</b>	<b>Code of Federal Regulations</b>
<b>CMS</b>	<b>Centers for Medicare and Medicaid Services</b>
<b>FEHBAR</b>	<b>Federal Employees Health Benefits Acquisition Regulations</b>
<b>FEHBP</b>	<b>Federal Employees Health Benefits Program</b>
<b>FIT</b>	<b>Federal Income Tax</b>
<b>OIG</b>	<b>Office of the Inspector General</b>
<b>OPM</b>	<b>U.S. Office of Personnel Management</b>
<b>MLR</b>	<b>Medical Loss Ratio</b>
<b>Plan</b>	<b>Humana Health Plan, Inc. – Chicago</b>
<b>QHI</b>	<b>Quality Health Improvement Expenses</b>
<b>SIT</b>	<b>State Income Tax</b>
<b>SIU</b>	<b>Special Investigations Unit</b>
<b>SSSG</b>	<b>Similarly-Sized Subscriber Group</b>
<b>U.S.C.</b>	<b>United States Code</b>

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# I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at Humana Health Plan, Inc. - Chicago (Plan). The audit was conducted pursuant to the provisions of Contract CS 1570; 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 and 2014, and was conducted at the Plan's office in Louisville, Kentucky.

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 plans are spending more on medical care and health care quality improvement measures as opposed to 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 the benefits received, only that the calculated percentage of the premium paid is spent on patient related health care expenses.

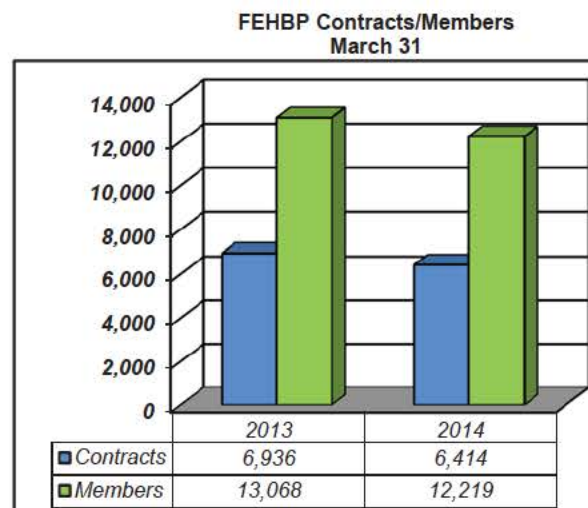
The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act (P.L. 111-148) and defined by the U.S. Department of Health and Human Services (HHS) in 45 CFR Part 158. In 2012, community-rated FEHBP carriers could elect to follow the FEHBP-specific MLR requirements, instead of the SSSG requirements. Beginning in 2013, 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.

The Plan has participated in the FEHBP since 1975 and provides health benefits to FEHBP members in the Chicago, Illinois metropolitan area.



There were no previous MLR audits of the Plan. However, a prior SSSG audit of the Plan covered contract year 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 2012 and did not identify any questioned costs.

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 premium income, quality health improvement expenses (QHI), and capitation expenses to ensure that the Plan had adequate policies and procedures covering these areas.

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 the 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 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 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, plans can utilize OPM's total reported premium as the denominator of the MLR, 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 and 2014. For these years, the FEHBP paid approximately [REDACTED] 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 December 4, 2017, through April 12, 2018, at the Plan's office in Louisville, Kentucky, 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 calculation.

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 calculation was 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.

We determined the basis for the premium amount used in the MLR calculation for all years of the audit scope and verified the accuracy and acceptability based on HHS and OPM regulations and instructions.

We derived the percentage of QHI expenses to total claims cost for all years of the audit scope, and determined whether the expenses for QHI activities, included in the plan's MLR calculation, were in accordance with HHS regulations and OPM regulations and instructions. Next, we obtained the Plan's methodology for identifying and allocating QHI costs to the FEHB program and evaluated whether the costs were allowed under HHS and OPM regulations. Finally, we evaluated the allocation methods to ensure the FEHB was receiving an equitable allocation of the QHI expense.

We obtained and reviewed supporting documentation for the tax amounts reported on the Plan's FEHBP MLR form. We also verified that the tax amount allocated to the consumer groups were equal to the actual tax paid.

We evaluated the Plan's capitated claims cost reported on the Plan's MLR submissions for all contract years in the scope for reasonableness, accuracy and acceptability under the MLR requirements established by OPM and the laws and regulations governing the FEHBP. However, we limited our testing to the most current contract year, 2014, which was tested to ensure the capitation payments were accurate. As no issues were identified during this review, we did not expand the sampling to contract year 2013.

The tests performed for the medical and pharmacy claims, along with the methodology, are detailed in Exhibits D and E at the end of this report.

# III. AUDIT FINDINGS AND RECOMMENDATIONS

## A. Medical Loss Ratio Review

In accordance with Federal regulations and OPM's Community Rating Guidelines, our audit identified the following issues:

### 1. Overstated Medical Loss Ratio Credit

For contract year 2013, the Plan filed an MLR of [REDACTED] percent. Since this ratio exceeded the OPM established threshold of 89 percent, the Plan received an MLR credit of [REDACTED]. However, during our review of the Plan's MLR submission, we identified issues that resulted in an audited MLR of [REDACTED] percent, which was lower than what the Plan filed in 2013. For further analysis of the issues identified in contract year 2013, see sections 3a. Overage Disabled Dependents (page 6) and 5. Allowable Fraud Reduction Expenses (page 10) below. As a result, we determined that the Plan's MLR credit should be reduced by [REDACTED] for contract year 2013.

### 2. Understated Medical Loss Ratio Credit

For contract year 2014, the Plan filed an MLR of [REDACTED] percent. Since this ratio exceeded OPM's threshold of 89 percent, the Plan received an MLR credit of [REDACTED]. However, during our review of the Plan's MLR submission, we identified issues that resulted in an audited MLR of [REDACTED] percent, which was higher than what the Plan filed in 2014. For further analysis of the issues identified in contract year 2014, see sections 3a. Overage Disabled Dependents (page 6), 4. Negative Federal and State Income Tax (page 9), and 5. Allowable Fraud Reduction Expenses (page 10) below. As a result, we determined that the Plan's MLR credit should be increased by [REDACTED] for contract year 2014.

### 3. MLR Claims Data

#### a. Overage Disabled Dependents

We selected a random sample of 21 overage dependent medical members and 29 overage dependent pharmacy members to determine if any benefits were paid for ineligible dependent members in contract year 2014.

The Plan's 2013 and 2014 FEHBP benefit brochures state that it covers dependents age 26 and over when they are deemed disabled and incapable of self-support prior to

age 26. Both brochures also state that if a dependent is deemed ineligible for coverage after turning 26, the dependent will receive an additional 31 days of coverage for no additional premium before termination. The results of our medical and pharmacy dependent eligibility reviews identified 10 medical and 11 pharmacy members whose overage dependent status could not be fully supported, in spite of numerous requests for the documentation.

The Plan did not maintain adequate supporting documentation for disabled overage dependents and was unable to retrieve documentation to support their eligibility determination. While the FEHBP Handbook states that it is the responsibility of the subscriber's employing office to provide documentation for disabled dependents, the Plan is responsible for maintaining this documentation per OPM Contract 1570 Section 1.11(b). This contract clause 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.

**A lack of supporting documentation resulted in the payment of claims for unsupported dependent members.**

Additionally, FEHBAR 1652.204-670 is incorporated into the contracts 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.” By not maintaining eligibility documentation, which is necessary to ensure that the Plan is properly including claims for eligible disabled dependents in its incurred claims amounts, the Plan is not only potentially overstating its MLR, but it is also not in compliance with contractual and regulatory requirements for the maintenance of records.

Finally, Section 5.7(f) of the 2014 standard HMO contract states that “The Contractor shall make available at its office at all reasonable times the records, materials, and other evidence described in paragraphs (a), (b), (c), (d), and (e) of this clause, 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.” Consequently, we expanded our review to query all 2013 and 2014 medical and pharmacy claims for the impacted overage disabled dependents.

Once these members were identified, we used SAS to query all 2013 and 2014 claims for these members.



The claims identified from the above medical and pharmacy query were removed from the numerator of our audited 2013 and 2014 MLR calculations. Specifically, we removed the following claims from the 2013 and 2014 MLR calculations:

MLR Year	Total Number of Medical Claims	Total \$ of Medical Claims	Total Number of Rx Claims	Total \$ of Rx Claims
2013	256	\$103,029	296	\$12,661
2014	88	\$173,140	332	\$19,933

**b. Coordination of Benefits**

Based on our review, we concluded that the Plan correctly coordinated claims for members over age 65.

**c. Non-Covered Benefits**

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

**Plan Response:**

*Humana stated in its original response received June 28, 2018, that “Humana will provide 25 screenshots in total, contained in two separate Word documents, those being from Humana’s Customer Interface system, the Person Demographics screen. These screenshots display the Disabled categorization as ‘Y’ (stands for Yes) for each individual.”*

*In conclusion, “The OPM-OIG should reinstate the claims amounts removed in the Draft Audit Report, for 2013 those amounts are \$103,029 Medical and \$12,661 for RX, and for 2014 those amounts are \$173,140 Medical and \$19,932 for RX.”*

**OIG Comment:**

We acknowledge that the Plan provided the 25 screenshots from its Customer Interface system that displayed the Disabled categorization as “Y” (stands for Yes) for each



individual. However, we were unable to determine when the individual's disabled categorization became effective. As a result, we gave the Plan until July 19, 2018, to provide support that confirmed the effective date of the disabled designation for each individual.

**Plan's Revised Response:**

*In its revised response submitted on July 19, 2018, Humana acknowledged that it could not produce source documentation to support the actual dates of Disabled status.*

*“However, during the past ten years Humana has implemented better records retention processes. Now the letters are scanned and retrievable upon request. Thus, the contractual obligation is met; therefore neither an audit remedy nor corrective action is necessary.”*

**OIG Comment to Plan Revised Response:**

We acknowledge the steps the Plan has taken to improve its records retention processes. However, because the Plan did not provide any written policies and procedures for us to review as part of its draft responses, we cannot express an opinion on their effectiveness, as well as whether their implementation addresses the records retention concerns raised in this report.

**4. Negative Federal and State Income Tax**

During our analysis of the Plan's 2014 Federal Income Tax (FIT) and State Income Tax (SIT) expenses, we noted that they allocated a negative FIT and SIT expense of [REDACTED] and [REDACTED] respectively to the FEHBP's MLR calculation. In a normal tax situation, the negative tax (deferred tax) would carry forward to future years to offset any tax liabilities. The Financial Accounting Standards Board Summary of Statement 109: Accounting for Income Taxes states that “The objectives of accounting for income taxes are to recognize ... (b) deferred tax liabilities and assets for the future tax consequences of events that have been recognized in an enterprise's financial statements or tax returns.” Based on this guidance, the negative tax reported on the FEHBP MLR form (classified as a deferred tax asset) would be expected to carry forward to future years to offset any tax liabilities. However, since the FEHBP MLR forms represent one reporting year with no carryover to future years, plans showing deferred tax assets for the FEHBP would need to report these assets as zero for MLR purposes.

Consequently, we removed the ( [REDACTED] FIT and ( [REDACTED] SIT amounts from the 2014 audited MLR denominator.

**Plan Response:**

*The Plan does not dispute this finding.*

**5. Allowable Fraud Reduction Expenses**

Under 45 CFR 158.140(b)(1) and (2)(iv), allowable fraud reduction expenses are an approved deduction from incurred claims. However, the amount of claim payments recovered through fraud reduction efforts should not to exceed the amount of fraud reduction expenses.

In 2013 and 2014, the Plan reported [REDACTED] as allowable fraud reduction expenses, respectively. However, in the course of the Plan's most recent Centers for Medicare and Medicaid Services (CMS) audit of the Health and Human Services MLR filings for the 2014 coverage year, a preliminary finding was noted.

The third party examiner's definition of includable fraud recoveries and fraud reduction expenses was restricted to those expenses incurred by and recoveries made by the Plan's Special Investigations Unit (SIU). This definition differed from the Plan's interpretation. Based on the audit position taken by CMS, the Plan adjusted the 2013 and 2014 FEHBP MLR calculations to remove any fraud reduction expenses that were not incurred or recovered by its SIU and self-disclosed this adjustment to us during the audit. We agreed with the adjustment, and therefore, removed [REDACTED] from our audited 2013 and 2014 MLR calculations, respectively.

**Plan Response:**

*The Plan does not dispute this finding.*

**Conclusion**

We corrected the 2013 and 2014 MLR calculations for the errors and the fraud reduction expense adjustment mentioned above. A comparison of our audited 2013 and 2014 MLR calculations to the 2013 and 2014 MLR calculations included in the Plan's submissions to

OPM showed an overstated credit of [REDACTED] for 2013, and an understated credit of [REDACTED] in 2014.

### **Recommendation 1**

We recommend that the contracting officer instruct OPM's Office of the Actuary to decrease the Plan's MLR credit by [REDACTED] for 2013.

### **Recommendation 2**

We recommend that the contracting officer instruct OPM's Office of the Actuary to increase the Plan's MLR credit by [REDACTED] for 2014.

### **Recommendation 3**

We recommend that the Plan provide its written policies and procedures to assess their effectiveness in meeting the Contract's records retention requirements specifically as it relates to designated FEHBP disabled dependents.

### **Recommendation 4**

We recommend that the Plan establish written policies and procedures that require the exclusion of negative tax liability adjustments for FEHBP MLR purposes.

### **Recommendation 5**

We recommend that the contracting officer uphold our exclusion of the negative tax liability adjustments in our audited 2014 MLR calculation.

## **B. Premium Review**

The Plan opted to use OPM's subscription income in its FEHBP 2013 and 2014 MLR calculations. We confirmed that the Plan accurately reported OPM's subscription income in its FEHBP MLR submissions.

## **C. Quality Health Improvements Review**

Our review determined that the Plan's quality health improvements included in its MLR filing were allowable and equitably allocated to the FEHBP-specific MLR using a reasonable allocation method.

#### **D. Capitation Expense Review**

Our review determined that the Plan's capitated claims cost reported on the Plan's 2013 and 2014 MLR submission were reasonable, accurate, and acceptable under the MLR requirements established by OPM and the laws and regulations governing the FEHBP.



# EXHIBIT A

## Humana Health Plan, Inc. Summary of MLR Credit Adjustment

2013 Overstated MLR Credit	██████████
2014 Understated MLR Credit	██████████
Total Understated MLR Credit	██████████

# EXHIBIT B

## Humana Health Plan, Inc. 2013 MLR Credit Adjustment

	Plan	Audited
2013 FEHBP MLR Lower Corridor (a)	85%	85%
2013 FEHBP MLR Upper Corridor (b)	89%	89%
<b><u>Claims Expense</u></b>		
Incurred Claims (Medical and Pharmacy)	[REDACTED]	[REDACTED]
Less: Dependent Eligibility Review 2013 Associated Medical Sample Claims	[REDACTED]	[REDACTED]
Less: Dependent Eligibility Review 2013 Associated Medical Query Claims	[REDACTED]	[REDACTED]
Less: Dependent Eligibility Review 2013 Associated Pharmacy Sample Claims	[REDACTED]	[REDACTED]
Less: Dependent Eligibility Review 2013 Associated Pharmacy Query Claims	[REDACTED]	[REDACTED]
<b>Adjusted Incurred Claims</b>	[REDACTED]	[REDACTED]
Paid Medical Incentive Pools and Bonuses	[REDACTED]	[REDACTED]
Healthcare Receivables	[REDACTED]	[REDACTED]
Allowable Fraud Reduction Expense	[REDACTED]	[REDACTED]
Expenses to Improve Health Care Quality	[REDACTED]	[REDACTED]
<b>Total MLR Numerator</b>	[REDACTED]	[REDACTED]
<b><u>Premium Expense</u></b>		
Premium Income	[REDACTED]	[REDACTED]
Taxes and Regulatory Fees	[REDACTED]	[REDACTED]
<b>Total MLR Denominator (c)</b>	[REDACTED]	[REDACTED]
FEHBP MLR Calculation (d)	[REDACTED]	[REDACTED]
Penalty Calculation (If (d) is less than (a), $((a-d)*c)$ )	[REDACTED]	[REDACTED]
Credit Calculation (If (d) is greater than (b), $((d-b)*c)$ )	[REDACTED]	[REDACTED]
<b>Overstated Credit Amount</b>	[REDACTED]	[REDACTED]

# EXHIBIT C

## Humana Health Plan, Inc. 2014 MLR Credit Adjustment

	Plan	Audited
2014 FEHBP MLR Lower Corridor (a)	85%	85%
2014 FEHBP MLR Upper Corridor (b)	89%	89%
<b><u>Claims Expense</u></b>		
Incurred Claims (Medical and Pharmacy)		
Less: Dependent Eligibility Review 2014 Medical Sample Claims		
Less: Dependent Eligibility Review 2014 Pharmacy Query Claims		
Less: Dependent Eligibility Review 2014 Pharmacy Sample Claims		
Less: Dependent Eligibility Review 2014 Medical Query Claims		
<b>Adjusted Incurred Claims</b>		
Paid Medical Incentive Pools and Bonuses		
Healthcare Receivables		
Allowable Fraud Reduction Expense		
Expenses to Improve Health Care Quality		
<b>Total MLR Numerator</b>		
<b><u>Premium Expense</u></b>		
Premium Income		
Federal and State Taxes and Regulatory Fees		
<b>Total MLR Denominator (c)</b>		
FEHBP MLR Calculation (d)		
Penalty Calculation (If (d) is less than (a), $((a-d)*c)$ )		
Credit Calculation (If (d) is greater than (b), $((d-b)*c)$ )		
<b>Understated Credit Amount</b>		

# EXHIBIT D

## 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 – High Dollar	Members greater than or equal to age 65.	23,436 claims	[REDACTED]	[REDACTED] high dollar claims > = \$50,000 amount paid totaling [REDACTED]	Judgmental	No
Coordination of Benefits Medicare – Random	Members greater than or equal to age 65.	23,436 claims	[REDACTED]	Used SAS to randomly select 25 claims totaling [REDACTED]	Random	No
Dependent Eligibility	Medical claims for dependents greater than or equal to age 26.	21 members	N/A	Full universe selected	N/A	N/A



# EXHIBIT E

## 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	Medical claims for dependents greater than or equal to age 26.	29 members	N/A	Selected all members from the universe that were NOT part of the medical dependent eligibility review sample.	N/A	N/A

# APPENDIX A

## HUMANA RESPONSE TO DRAFT AUDIT REPORT NO. 1C-75-00-17-040

This document is submitted by Humana Health Plan, Inc. ("Humana") and responds to the Draft Audit Report dated June 1, 2018 issued by the Office of Inspector General of the Office of Personnel Management ("OPM-OIG") regarding the Humana FEHBP Contract Number 1570 – Plan Code 75 for contract years 2013-2014.


The OPM-OIG Draft Audit Report mentions three items potentially worthy of adjustments to the MLR outcomes previously determined: 1) the inclusion of claims data for Overage Disabled Dependents (from a random sample) for which Humana has failed to provide sufficient support of those folks being Disabled; 2) Negative Federal and State Income Tax; 3) some Allowable Fraud Reduction Expenses.

Humana will provide 25 screenshots in total, contained in two separate Word documents, those being from Humana's Customer Interface system, the Person Demographics screen. These screenshots display the Disabled categorization as "Y" (stands for Yes) for each individual. The documents are not included in this response because they contain PII and therefore cannot be sent via Secured Email. Instead these documents will be placed on OPM's server via SFTP by Humana's Electronic Transmissions Group. This process follows the recommendation of the OPM-OIG Auditor-in-Charge, who will be notified when the transfer takes place.

Humana does not dispute items 2) and 3).

### Conclusion

The OPM-OIG should reinstate the claims amounts removed in the Draft Audit Report, for 2013 those amounts are \$103,029 Medical and \$12,661 for RX, and for 2014 those amounts are \$173,140 Medical and \$19,932 for RX.

  
Humana Inc.  
500 West Main Street, HUM-17  
Louisville KY 40202

# APPENDIX B

## **HUMANA RESPONSE TO DRAFT AUDIT REPORT NO. 1C-75-00-17-040- REVISED 7/19/2018**

This document is submitted by Humana Health Plan, Inc. ("Humana") and responds to the Draft Audit Report dated June 1, 2018 issued by the Office of Inspector General of the Office of Personnel Management ("OPM-OIG") regarding the Humana FEHBP Contract Number 1570 – Plan Code 75 for contract years 2013-2014.

The OPM-OIG Draft Audit Report mentions three items worthy of adjustments to the MLR outcomes previously determined: 1) the inclusion of claims data for Overage Disabled Dependents (from a random sample) for which Humana has failed to provide sufficient support of those folks being Disabled; 2) allocation of Negative Federal and State Income Tax; 3) removal of some Allowable Fraud Reduction Expenses.


With regards to item 1), Humana was able to provide screenshots; contained in two separate Word documents, those being from Humana's Customer Interface system, the Person Demographics screen. These screenshots validated the Disabled categorization in Humana's system for each individual as evidenced by a "Y" (stands for Yes). The documents contained PII and therefore could not be sent via Secured Email. Instead these documents were placed on OPM's server via SFTP by Humana's Electronic Transmissions Group.

To this point, Humana has been unable to produce source documentation, including either letters sent by OPM or a system dump of effective dates, to support the actual date of Disabled status. Those letters were mailed to Humana from OPM more than ten years back and in some cases prior to 2000. In that era Humana failed to maintain sufficient source documentation of this type, note that the existence of this plan in the FEHB spans over 30 years. However, during the past ten years Humana has implemented better records retention processes. Now the letters are scanned and retrievable upon request. Thus, the contractual obligation is met; therefore neither an audit remedy nor corrective action is necessary.

Humana does not dispute items 2) and 3).

### Conclusion

The OPM-OIG should reinstate the claims amounts removed in the Draft Audit Report, for 2013 those amounts are \$103,029 Medical and \$12,661 for RX, and for 2014 those amounts are \$173,140 Medical and \$19,932 for RX.

  
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