



**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
BLUE CARE NETWORK OF MICHIGAN**

Report Number 1C-LX-00-18-031

June 4, 2019

EXECUTIVE SUMMARY

Audit of the Federal Employees Health Benefits Program Operations at Blue Care Network of Michigan

Report No. 1C-LX-00-18-031

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Why Did We Conduct The Audit?

The primary objective of the audit was to determine whether Blue Care Network of Michigan (Plan) complied 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, which is a concern we intend to address with OPM in a separate report.

What Did We Audit?

Under Contract CS 2011, the Office of the Inspector General (OIG) performed an audit of the FEHBP MLR submissions to OPM for contract years 2013 through 2016. Our audit fieldwork was conducted from July 16, 2018, through November 27, 2018, at the Plan's offices in Southfield, Michigan, and our OIG offices.



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What Did We Find?

We determined that portions of the MLR calculations were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM for contract years 2013 through 2016. This resulted in overstated MLR credits of \$879,925 for contract years 2013 through 2015. Although we identified issues in contract year 2016, it did not result in a penalty due to OPM or a credit due to the Plan. Specifically, our audit identified the following:

- The Plan included claims for ineligible non-disabled dependents in 2013 through 2016.
- The Plan terminated coverage early for eligible non-disabled dependents in 2013 through 2016.
- The Plan was unable to support its medical incentive pool and bonus amount in contract year 2013.
- The Plan erred in its pharmacy rebates calculation in contract year 2013. Additionally, the Plan used an unsupported pharmacy rebate amount in contract year 2016.
- The Plan was unable to provide support for its basis of allocations for contract years 2013 through 2016.

Our audit did not disclose any findings related to the following review areas: premium income; quality health improvements; taxes and fees; debarment; audited financial statements; capitations; claim reviews (coordination of benefits and non-covered benefits); fraud, waste, and abuse; and offshore contracting.

ABBREVIATIONS

BCN	Blue Care Network of Michigan
CFR	Code of Federal Regulations
Contract	U.S. Office of Personnel Management Contract CS 2011
FEHBAR	Federal Employees Health Benefits Acquisition Regulations
FEHBP	Federal Employees Health Benefits Program
FWA	Fraud, Waste, and Abuse
HHS	Health and Human Services
MLR	Medical Loss Ratio
OIG	Office of the Inspector General
OPM	US Office of Personnel Management
QHI	Quality Health Improvement
Plan	Blue Care Network of Michigan
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 Blue Care Network of Michigan (Plan). The audit was conducted pursuant to the provisions of Contract CS 2011 (Contract); 5 United States Code Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract years 2013 through 2016, and was conducted at the Plan's office in Southfield, 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). The 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 health plans 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. As this continues to be a significant Program concern for us, we will be addressing this issue with OPM in a separate report.

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

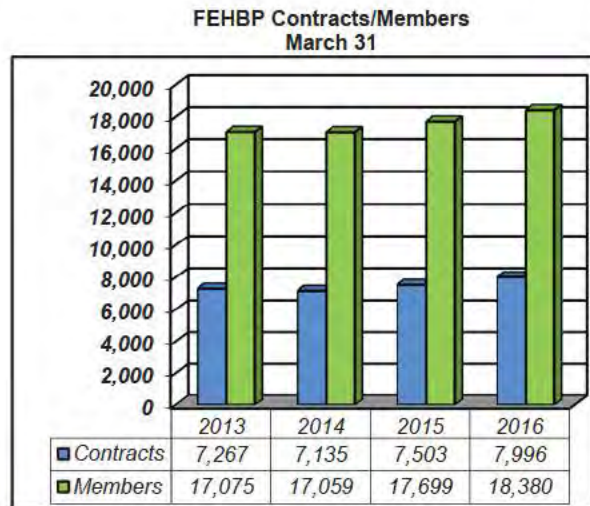
MLR methodology was required for all community-rated carriers, except those that are state-mandated to use traditional community rating. State-mandated traditional community-rated carriers continue to be subject to the SSSG comparison rating methodology.

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.

The Plan has participated in the FEHBP since 1984 and provides health benefits to FEHBP members in East and Southeast Michigan.



There were no previous MLR audits of the Plan. However, a prior SSSG audit of the Plan covered contract years 2010 through 2011. The audit did not identify any findings or questioned costs, and no corrective action was necessary.

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 complied 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. We also performed additional testing to determine whether the Plan complied 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 from the FEHBP; 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, capitations, 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. As this continues to be a significant Program concern for us, we will be addressing this issue with OPM in a separate report.

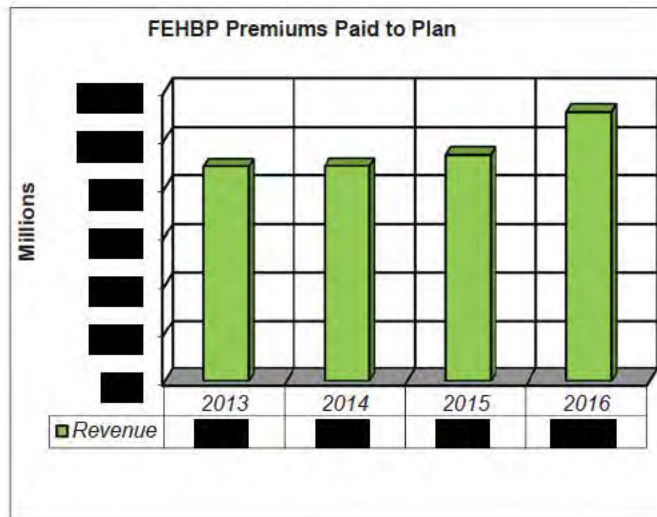
SCOPE

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 2016. 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
- 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 July 16, 2018, through November 27, 2018, at the Plan's offices in Southfield, Michigan, as well as in our offices in Washington, D.C.; Jacksonville, Florida; and Cranberry Township, Pennsylvania.

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 for the medical and pharmacy claims, along with the methodology, are detailed in Exhibits F at the end of this report.

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 Health and Human Services (HHS) and OPM regulations and instructions.

We derived the percentage of quality health improvement (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 if 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 verified that the tax amount allocated to the consumer groups was equal to the actual tax paid.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. MEDICAL LOSS RATIO REVIEW

The Certificates of Accurate MLR that the Plan signed for contract years 2013 through 2016 were defective because the Plan submitted MLR calculations to OPM that were inaccurate. In accordance with Federal regulations and the OPM Community Rating Guidelines, we determined that the Plan overstated its 2013 through 2015 MLR credits by a total of \$879,925. Additionally, although we identified issues in contract year 2016, they did not result in a penalty due to OPM or a credit due to the Plan. Specifically, our audit identified the following issues:

1. Overstated MLR Credits \$879,925

During the 2013 through 2015 MLR filing periods, the Plan calculated MLR ratios that exceeded the OPM prescribed upper threshold of 89 percent, resulting in credits for the Plan. However, during our review of the Plan’s FEHBP MLR submissions for all three years, we identified issues that resulted in lower audited MLR percentages than those calculated by the Plan. Table I illustrates the credit adjustments due to OPM. The specific issues that led to the overstated credits, listed in Table I below, are discussed beginning in section A.3 on page 7.

Year	Plan's MLR Ratio	Audited MLR Ratio	Plan's Current Credit	Audited Credit	Credit Reduction
2013					
2014					
2015					
Total Reduction					\$879,925

2. No Penalty or Credit Due \$0

During the 2016 MLR filing period, the Plan calculated an MLR ratio that met the OPM prescribed lower threshold of 85 percent, but did not exceed the upper threshold of 89 percent (see Table II on page 7). However, our review of the Plan’s MLR submission disclosed issues within the MLR calculation, as discussed beginning in section A.3. These adjustments, while reportable, were not significant enough to result in a penalty due to OPM or a credit due the Plan, as seen in Table II.

Table II – No Penalty or Credit Due					
Year	Plan's MLR Ratio	Audited MLR Ratio	Plan's Current Penalty/Credit	Audited Penalty/Credit	Penalty/Credit Due
2016			\$0	\$0	\$0

Plan Response:

The Plan did agree that adjustments to their 2013 through 2015 credit amounts were warranted, but did not necessarily agree with all of our identified audit issues, as evidenced by its responses to the issues below.

OIG Comment:

We reviewed the Plan's response to the draft report, which included supplemental responses and additional supporting documentation. The results of this review still showed that reductions to the 2013 through 2015 credit amounts were warranted. However, we did revise the 2013 through 2015 credit reduction amounts included in this report based upon our review of the Plan's response.

3. MLR Claims Data

a. Untimely Termination of Dependent Coverage

We reviewed a judgmental sample of 60 members who were age 26 or older in contract years 2015 and 2016. Based on our review, we determined that claims were (i) paid for members whose coverage was not terminated timely, and (ii) possibly excluded claims for members whose coverage was terminated early. This could potentially skew the claims costs used in the Plan's FEHBP MLR submissions.

The Plan's 2015 and 2016 MLRs included improperly paid claims for dependents over the age of 26, and potentially excluded claims for eligible dependents.

i. Late Terminations

The Plan did not timely terminate coverage for dependent members who had become ineligible for coverage in contract years 2013 through 2016.

Per the FEHBP's benefit brochure, dependent coverage ends once dependents turn 26 years of age, unless they are incapable of self-support. The dependents are entitled to coverage for an additional 31 days after their 26th birthday.

During our review of the 2015 and 2016 medical claims data, we found that the Plan did not properly terminate dependent coverage for 21 members and 17 members, respectively. This error resulted because the Plan did not terminate dependent coverage for overage dependents until the end of the calendar year. Consequently, we expanded our review to include the 2015 and 2016 pharmacy claims data for the 38 overage dependents in question. Based on the results of our review, we removed 136 medical claims, totaling [REDACTED] and 52 pharmacy claims, totaling [REDACTED] for 21 members from the numerator of the 2015 MLR calculation. Similarly, we removed 90 medical claims, totaling [REDACTED], and 49 pharmacy claims, totaling [REDACTED], for 17 members from the numerator of the 2016 MLR calculation.

As this error was a systemic issue, we queried the 2013 through 2016 medical and pharmacy claim universes for members over age 26 up to age 27 identified as a son, daughter, or other. Once we identified our target universe for testing, we queried for any claims processed for these members beyond 31 days after the member's 26th birthday. We removed the 38 members identified above in our 2015 and 2016 review from this query. We also removed from the numerator of our audited MLR calculations the claims identified as being improperly paid. Specifically, we removed the following claims per year:

- We removed 478 medical claims, totaling [REDACTED], and 625 pharmacy claims, totaling [REDACTED], for 106 members from the numerator of the 2013 MLR calculation.
- We removed 421 medical claims, totaling [REDACTED], and 490 pharmacy claims, totaling [REDACTED], for 123 members from the numerator of the 2014 MLR calculation.
- We removed 668 medical claims, totaling [REDACTED] and 687 pharmacy claims, totaling [REDACTED], for 125 members from the numerator of the 2015 MLR calculation.
- We removed 404 medical claims, totaling [REDACTED], and 500 pharmacy claims, totaling [REDACTED], for 102 members from the numerator of the 2016 MLR calculation.

In total, we removed the following amounts from the numerator of each year's MLR calculation:

Table III – Untimely Overage Dependent Terminations							
Contract Year	Number of Members	Medical Claims	Medical Dollars	Pharmacy Claims	Pharmacy Dollars	Total Claims	Total Dollars
2013	106	478		625		1,103	
2014	123	421		490		911	
2015	125	668		687		1,355	
2016	102	404		500		904	
Total	456					4,273	

ii. Early Terminations

The Plan terminated coverage early for eligible non-disabled dependents in contract years 2013 through 2016.

As mentioned previously, the FEHBP's benefit brochure states that dependent coverage ends once dependents turn 26 years of age, unless they are incapable of self-support. The dependents are entitled to coverage for an additional 31 days after their 26th birthday.

For contract years 2013 through 2016, we determined that the Plan improperly terminated coverage for two dependents in 2013, two dependents in 2014, three dependents in 2015, and four dependents in 2016. These members had birthdays in the month of December and were entitled to coverage for an additional 31 days after their 26th birthday. This error resulted from the Plan's use of a manual enrollment process that terminates overage dependents at the end of the year instead of 31 days after their 26th birthday. Consequently, there is a risk that the Plan could have improperly excluded claims for other members who were eligible for coverage, which would decrease the claims used in the Plan's FEHBP MLR submissions; potentially skewing the MLR ratio. However, due to the timing and nature of our review, we were unable to determine if there were any denied claims that should have been paid for these members during the dependents' eligibility timeframes. The Plan stated that in June 2017, it updated its system to automatically terminate dependents each month as they age out, 31 days after they turn 26, per the FEHBP's benefit brochure requirements. However, as 2017 is outside of our current audit scope, the effectiveness of this program improvement will have to be tested on a future audit.

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 the Plan did not pay for benefits not covered by the FEHBP Plan brochure.

Plan Response:

The Plan agreed with the issues identified regarding untimely terminations of dependent coverage during 2013 through 2016. The Plan also stated that beginning in July 2017, it automated the termination process for dependents 31 days after their 26th birth date through system edits, and therefore, this issue was remedied.

The Plan disagreed with the quantification of the medical claims for the disabled dependents. The Plan stated that it believes some truly disabled dependents are included within each year. It recommends that the OIG adjust the medical quantification to remove the truly disabled dependent member's claims from consideration. The Plan estimates it would result in a reduction of [REDACTED] from the medical claims for the years 2013 through 2016.

OIG Comment:

We agree that some of the members were permanently disabled, based on the additional documentation provided by the Plan, which showed that some members were eligible for Medicare. Disabled individuals automatically receive Medicare Parts A and B after their eligibility for 24 months of disability benefits from Social Security, or 24 months of certain disability benefits from the Railroad Retirement Board. However, the Plan's additional documentation did not support that all of the questioned members were eligible for Medicare during our audit scope. Specifically, the eligibility start date for one member was in 2017, and the eligibility for another member appears to have ended in 2012. Since we are unable to verify that some members either received Medicare benefits in 2013 through 2016 or were certified as disabled or incapable of self-support by the payroll office, we are continuing to question the eligibility and claims for these members. Additionally, our questioned claims included four members who had claims paid after their extension of coverage or termination dates and three of the four members' coverages were terminated late.

Based on our review of the additional documentation provided by the Plan, we updated the questioned costs in Table III above.

4. Medical Incentive Pool and Bonus

The Plan was unable to provide sufficient documentation to support the incurred amounts that should have been used to calculate the medical incentive pool and bonus amounts for contract year 2013. The documentation provided to support the Plan's calculation disclosed that the Plan used its 2013 paid medical incentives figure to allocate to the FEHBP rather than its 2013 incurred medical incentive pool and bonus amount. The instructions on OPM's MLR Form, Line 2.11a, state the amount should be the "Paid medical incentive pools and bonuses incurred in 2013 and paid through 6/30/2014." Since the Plan's paid amount was greater than the amount incurred for 2013, we discerned that the paid amount included payments incurred in prior years. These payments were outside of the allowable timeframes specified by the instructions. Consequently, the Plan was not in compliance with the form's instructions. Therefore, we calculated an audited medical incentive pool and bonus expense using the Plan's incurred number, which resulted in a variance of [REDACTED]

The Plan's inability to support its MLR calculation resulted in an incentive pool and bonus variance of [REDACTED] in 2013.

Plan Response:

The Plan agreed with the 2013 medical incentive pool and bonus finding.

5. Pharmacy Rebates

The Plan's 2013 and 2016 pharmacy rebate amounts were overstated by [REDACTED] and understated by [REDACTED] respectively, resulting in incurred claim under/overstatements in both year's MLR calculations

Discrepancies were identified in the pharmacy rebate calculations used in the Plan's 2013 and 2016 FEHBP-specific MLRs that were filed with OPM. During the course of the audit, the Plan determined that its submitted 2013 pharmacy rebates calculation was incorrect. In deriving our audited rebate amount, we applied a consistent methodology, used by the Plan, to calculate the revised

rebate amount. The result of our audited calculation showed that the pharmacy rebates were overstated by [REDACTED] for 2013.

Our review of the 2016 rebate amount showed that the Plan did not adequately support the original amount used in its pharmacy rebate calculation. Using documentation provided by the Plan, we derived an audited rebate amount. A comparison of our audited rebate amount to the amount included on the Plan's FEHBP-specific MLR form showed that the pharmacy rebates were understated by [REDACTED] in 2016.

Plan Response:

The Plan agreed that the 2013 pharmacy rebate allocation should be revised, however the Plan suggested that this calculation be done using the separate pharmacy rebate information for commercial and BCN65.

Further, the Plan did not “object to the 2016 variance calculation of [REDACTED] even though (1) there was no formal request for 2016 pharmacy rebate documentation during the audit process and (2) we believe our 2016 pharmacy rebate methodology is the most accurate estimate of incurred pharmacy rebates (and will be used going forward with appropriate documentation).”

OIG Comment:

While we acknowledge that the Plan agreed with the 2016 pharmacy rebate finding, we disagree that a formal request for the 2016 Pharmacy information was not made during the audit process. In fact, we did request this information as part of Information Request 22 issued on July 13, 2018.

Conclusion

We recalculated the Plan's 2013 through 2016 MLRs, incorporating the above-mentioned adjustments. A comparison of our audited MLR calculations to those submitted by the Plan showed overstated MLR credit amounts of [REDACTED] for 2013, [REDACTED] for 2014, and [REDACTED] for 2015. For contract year 2016, the MLR fell between OPM's thresholds so no penalty or credit was due to OPM or the Plan.

Recommendation 1

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

Recommendation 2

We recommend that the contracting officer instruct OPM’s Office of the Actuary to reduce the Plan’s 2014 credit by [REDACTED]

Recommendation 3

We recommend that the contracting officer instruct OPM’s Office of the Actuary to reduce the Plan’s 2015 credit by [REDACTED]

Recommendation 4

We recommend that the Plan incorporate system edits to terminate non-disabled dependents 31 days after their 26th birthday.

Recommendation 5

We recommend that the Plan ensure that the data used in the creation of the OPM MLR form, which is submitted to OPM, is accurate, complete, and consistent with the methodology stated in 5 Code of Federal Regulations Sec. 1615.402(c)(3)(ii) and can be produced upon request during future audits.

B. INTERNAL CONTROLS REVIEW

The Plan did not have written policies and procedures to govern the MLR process and was unable to provide all of the necessary supporting documentation during the audit, including the number of contracts for 2013, the member months for 2013 through 2016, and the large group premiums for 2013 and 2014 to support its basis of allocations. We also noted that allocation ratios were either not supported or varied from the support provided in the Plan’s workbooks. In addition to not being in compliance with the Contract’s records retention requirements, this lack of internal controls over the MLR process resulted in significant discrepancies in the MLRs that were filed with OPM in each year and required material changes in the credit amounts for 2013 through 2015 and a penalty amount in 2016, as discussed above.

A lack of sufficient policies and procedures over the MLR process resulted in significant discrepancies to the FEHBP-specific MLR forms filed with OPM.

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 ... 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 special requirements of Government contracting, including--

- (1) Monitoring and auditing to detect criminal conduct;
- (2) Periodic evaluation of the effectiveness of the ... 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 internal control system as necessary to reduce the risk of criminal conduct identified through this process.”

Additionally, OPM’s Contract Section 1.11(b) 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 incorporated into the contracts at Section 3.4, which requires the carrier to maintain “all records applicable to a contract term ... for a period of six years after the end of the contract term to which the claim records relate.”

The Plan was able to recreate the necessary reports with reasonable variances that had an immaterial impact on the allocations. The Plan explained that the original support was difficult to duplicate due to system changes, staffing changes, and the level of documentation that was maintained for 2013, but the process had improved for years 2014 and thereafter. However, as mentioned previously, due to a lack of written policies and procedures over the MLR process, 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.

Plan Response:

The Plan stated, “OPM provided two recommendations to BCN relating to internal controls. BCN responds to each recommendation as follows:

- ***Policies and Procedures – As shared during the audit, the actuarial team has written policies and procedures that govern the FEP MLR calculation process. However, these policies and procedures will be enhanced going forward to (1) include more detail and (2) cover more departments than just the actuarial team. These updated policies and procedures will be provided in future MLR audits.***

- ***Record retention requirements*** – *As mentioned in the Draft Audit Report, several issues experienced during the audit work were driven by BCN staffing and system changes over time. Many of these issues were specific to the 2013 and 2014 benefit years. Improvements have already been made in BCN’s documentation practices for more recent years, but we will continue to refine our practices with specific focus on items such as:*
 - *Contract counts and membership months*
 - *Allocation support*
 - *Financial restatements[.]”*

OIG Comment:

While we acknowledge that the Plan has taken steps to address issues with its written policies and procedures governing the FEP MLR and records retention requirements, the implementation of these procedures and controls occurred outside the scope of our audit and we cannot comment on their effectiveness.

Recommendation 6

We recommend that the Plan develop written, standardized policies and procedures over its MLR calculation and reporting process.

Recommendation 7

We recommend that the Plan comply with the record retention requirements of its contract.

C. PREMIUM INCOME REVIEW

The Plan opted to use its own subscription income in its 2013 FEHBP MLR calculations. As a result, the 2013 subscription was subject to audit. Based on our review, we determined that the Plan’s 2013 amounts were accurate and acceptable. We confirmed that the Plan accurately reported OPM’s subscription income in its FEHBP MLR submissions for 2014 through 2016.

D. 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.

E. FEDERAL AND STATE TAXES AND LICENSING OR REGULATORY FEES

Our review determined that the amounts reported in Section 3 “Federal and State Taxes and Licensing or Regulatory Fees” on the Plan's MLR filing are supported, allowable and consistently allocated based on the principles and methods described in the Public Health Service Act section and the Federal Register.

F. DEBARMENT REVIEW

Our review determined that the Plan had procedures in place to identify providers debarred or suspended from participation in the FEHBP. Additionally, the Plan had procedures in place to notify both the provider and the subscriber and to stop payment to debarred or suspended providers.

G. FINANCIAL REVIEW

Our limited review of the Plan’s audited financial statements found that the Plan maintained sufficient financial resources to be compliant with its OPM contract.

H. CAPITATION REVIEW

Our review of the capitated claim amounts reported on the Plan’s 2013 through 2016 MLR submission showed the amounts to be reasonable, accurate, and acceptable under the MLR requirements established by OPM and the laws and regulations governing the FEHBP.

I. FRAUD, WASTE, AND ABUSE REVIEW

Our review of the fraud, waste, and abuse documents maintained by the Plan determined that it has sufficient policies and procedures in place, in accordance with the FEHBP Carrier Letter 2017-13.

J. OFFSHORE CONTRACTING REVIEW

Our review determined that the Plan has appropriate procedures and processes in place to meet the requirements of OPM Carrier Letter 2012-23 and provided adequate oversight of offshore contracting activities.

Exhibit A

Blue Care Network of Michigan Summary of MLR Credit Adjustments

2013 Overstated MLR Credit	██████████
2014 Overstated MLR Credit	██████████
2015 Overstated MLR Credit	██████████
2016 No MLR Adjustment	<u>\$0</u>
Total Overstated MLR Credits	██████████

Exhibit B

Blue Care Network of Michigan 2013 MLR Credit Adjustment

	Plan	Audited
2013 FEHBP MLR Lower Corridor (a)	85%	85%
2013 FEHBP MLR Upper Corridor (b)	89%	89%
<u>Claims Expense</u>		
Medical Incurred Claims	[REDACTED]	[REDACTED]
Pharmacy Incurred Claims	[REDACTED]	[REDACTED]
Less: Incorrectly Paid Medical Dependent Claims		[REDACTED]
Less: Incorrectly Paid Pharmacy Dependent Claims		[REDACTED]
Adjusted Incurred Claims	[REDACTED]	[REDACTED]
Plus: Paid Medical Incentive Pools and Bonuses	[REDACTED]	[REDACTED]
Less: Healthcare Receivables	[REDACTED]	[REDACTED]
Plus: Quality Health Improvement Expenses	[REDACTED]	[REDACTED]
Total MLR Numerator	[REDACTED]	[REDACTED]
Premium Income	[REDACTED]	[REDACTED]
Less: Federal and State Taxes and Licensing or Regulatory Fees	[REDACTED]	[REDACTED]
Total MLR Denominator (c)	[REDACTED]	[REDACTED]
FEHBP Medical Loss Ratio (d)	[REDACTED]	[REDACTED]
Credit Calculation (If (d) is greater than (b), $((d-b)*c)$)	[REDACTED]	[REDACTED]
Credit Adjustment Due To OPM		[REDACTED]

¹ Due to rounding the Audited MLR percentage, the totals may not mathematically tie.

Exhibit C

Blue Care Network of Michigan 2014 MLR Credit Adjustment

	Plan	Audited
2014 FEHBP MLR Lower Corridor (a)	85%	85%
2014 FEHBP MLR Upper Corridor (b)	89%	89%
<u>Claims Expense</u>		
Medical Incurred Claims	[REDACTED]	[REDACTED]
Pharmacy Incurred Claims	[REDACTED]	[REDACTED]
Less: Incorrectly Paid Medical Dependent Claims		[REDACTED]
Less: Incorrectly Paid Pharmacy Dependent Claims		[REDACTED]
Adjusted Incurred Claims	[REDACTED]	[REDACTED]
Plus: Paid Medical Incentive Pools and Bonuses	[REDACTED]	[REDACTED]
Less: Healthcare Receivables	[REDACTED]	[REDACTED]
Plus: Quality Health Improvement Expenses	[REDACTED]	[REDACTED]
Total MLR Numerator	[REDACTED]	[REDACTED]
Premium Income	[REDACTED]	[REDACTED]
Less: Federal and State Taxes and Licensing or Regulatory Fees	[REDACTED]	[REDACTED]
Total MLR Denominator (c)	[REDACTED]	[REDACTED]
FEHBP Medical Loss Ratio (d)	[REDACTED]	[REDACTED]
Credit Calculation (If (d) is greater than (b), ((d-b)*c))	[REDACTED]	[REDACTED]
Credit Adjustment Due To OPM		[REDACTED]

Exhibit D

Blue Care Network of Michigan 2015 MLR Credit Adjustment

	Plan	Audited
2015 FEHBP MLR Lower Corridor (a)	85%	85%
2015 FEHBP MLR Upper Corridor (b)	89%	89%
<u>Claims Expense</u>		
Medical Incurred Claims	[REDACTED]	[REDACTED]
Pharmacy Incurred Claims	[REDACTED]	[REDACTED]
Less: Incorrectly Paid Medical Dependent Claims	[REDACTED]	[REDACTED]
Less: Incorrectly Paid Pharmacy Dependent Claims	[REDACTED]	[REDACTED]
Adjusted Incurred Claims	[REDACTED]	[REDACTED]
Plus: Paid Medical Incentive Pools and Bonuses	[REDACTED]	[REDACTED]
Less: Healthcare Receivables	[REDACTED]	[REDACTED]
Plus: Quality Health Improvement Expenses	[REDACTED]	[REDACTED]
Total MLR Numerator	[REDACTED]	[REDACTED]
Premium Income	[REDACTED]	[REDACTED]
Less: Federal and State Taxes and Licensing or Regulatory Fees	[REDACTED]	[REDACTED]
Total MLR Denominator (c)	[REDACTED]	[REDACTED]
FEHBP Medical Loss Calculation (d)	[REDACTED]	[REDACTED]
Credit Calculation (If (d) is greater than (b), ((d-b)*c))	[REDACTED]	[REDACTED]
Credit Adjustment Due To OPM		\$ [REDACTED]

Exhibit E

Blue Care Network of Michigan 2016 No MLR Adjustment

	Plan	Audited
2015 FEHBP MLR Lower Corridor (a)	85%	85%
2015 FEHBP MLR Upper Corridor (b)	89%	89%
<u>Claims Expense</u>		
Medical Incurred Claims	██████████	██████████
Pharmacy Incurred Claims	██████████	██████████
Less: Incorrectly Paid Medical Dependent Claims	██████████	██████████
Less: Incorrectly Paid Pharmacy Dependent Claims	██████████	██████████
Adjusted Incurred Claims	██████████	██████████
Plus: Paid Medical Incentive Pools and Bonuses	██████████	██████████
Less: Healthcare Receivables	██████████	██████████
Plus: Quality Health Improvement Expenses	██████████	██████████
Total MLR Numerator	██████████	██████████
Premium Income	██████████	██████████
Less: Federal and State Taxes and Licensing or Regulatory Fees	██████████	██████████
Total MLR Denominator (c)	\$ ██████████	\$ ██████████
FEHBP Medical Loss Calculation (d)	██████████	██████████
Penalty Calculation (If (d) is less than (a), ((a-d)*c))	\$0	\$0
Credit Calculation (If (d) is greater than (b), ((d-b)*c))	\$0	\$0
Credit or Penalty Adjustment		\$0

Exhibit F

Medical Claims Sample Selection Criteria and Methodology

Medical Claims Sample

Claims Review Area	Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
2015 Dependent Eligibility	Dependent members age ≥ 26 , who incurred medical claims in 2015 after the 31 day extension of benefits period	92 members	N/A	Queried SAS ² to randomly select 30 members after removing duplicate members	Random	No
2016 Dependent Eligibility	Dependent members age ≥ 26 , who incurred medical claims in 2016 after the 31 day extension of benefits period	100 members	N/A	Queried SAS ² to randomly select 30 members after removing duplicate members	Random	No
2015 Coordination of Benefits	Incurred medical claims for members age ≥ 65	38,525 claims	██████████	Incurred medical claims greater than or equal to \$20,000; 17 claims, totaling ██████████	Judgmental	No
2016 Coordination of Benefits	Incurred medical claims for members age ≥ 65	44,589 claims	██████████	Incurred medical claims greater than or equal to \$20,000; 21 claims, totaling ██████████	Judgmental	No
2015 and 2016 Non-Covered Benefits	Incurred medical claims $> \$0$ for 20 ³ elective abortion codes paid in 2015 through 2016	No Claims in the universe	\$0	N/A	N/A	No

² SAS Enterprise Guide

³ Elective abortion procedure codes used were 59812, 59820, 59821, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 59866, 59870, S0190, S0191, S0199, S2260, S2265, S2266, and S2267.

Appendix

**Blue Care
Network**
of Michigan



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

Re: Audit of the Federal Employees Health Benefits Program Operations at Blue Care Network of Michigan (report number 1C-LX-00-18-031, draft issued December 20, 2018)

[REDACTED]

Thank you for providing Blue Care Network (BCN) the opportunity to review and reply to the findings within the Draft Audit Report issued to us on December 20, 2018. We have reviewed all contents of the Draft Audit Report including supplementary support data provided to us by the Office of Personnel Management (OPM) staff. This memo is intended to document our commentary in response to the Draft Audit Report along with any of our additional findings or suggested revisions (**shown as "BCN Recommendations" in bold blue font**). As you are aware, OPM agreed to extend the deadline for BCN's response to February 10, 2019.

Draft Audit Report Summary

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Medical Loss Ratio Review

Deleted by the OIG – Not Relevant to the Final Report

MLR Claims Data

Deleted by the OIG – Not Relevant to the Final Report

BCN does not dispute the issues identified with the timing of dependent eligibility terminations during contract years 2013 through 2016. At the time of the audit, BCN acknowledged that its eligibility system did not have edits in place to terminate 26-year-old dependents 31 days after their 26th birthdate. BCN was using a manual process to terminate the members at that time. Beginning in July 2017, BCN implemented systems edits to automate the termination process for dependents 31 days after their 26th birthdate.

OPM provided BCN with the detailed membership information supporting the amounts summarized in the Draft Audit Report for each year. Upon review of this information we found that several members in the sample (for each year) are disabled dependents, and as such should not be part of the dependent eligibility termination issues outlined by OPM. The results of our analysis are shown in the table below. The revised medical claims amount shown in yellow adjusts the medical claims from the Draft Audit Report for the impact of disabled dependent members as calculated by BCN.

- **BCN Recommendation #1:** The medical claims calculated by OPM for untimely dependent terminations appear to include some disabled dependents within each year. We recommend that the OPM medical claims quantification be adjusted to remove these disabled dependents from consideration. BCN's estimate is that this would result in a reduction of [REDACTED] from the medical claims quantified by OPM for the years 2013 through 2016.

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Deleted by the OIG – Not Relevant to the Final Report

Medical Incentive Pool and Bonus

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- 2013: We agree that an adjustment to the original FEP MLR calculation is warranted given that a paid number was used for benefit year 2013. The OPM variance of [REDACTED] uses an appropriate methodology to calculate a revised medical incentive pool and bonus amount on an incurred basis for the 2013 benefit year.

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Pharmacy Rebates

The Draft Audit Report noted that discrepancies exist within both the 2013 and 2016 MLR calculations due to pharmacy rebate allocations.

- 2013: During the audit, BCN noted an issue with the 2013 pharmacy rebate calculation. The methodology used in 2013 differs from all other years of the MLR audit scope and was not appropriate for capturing pharmacy rebate amounts incurred during the 2013 benefit year. BCN

agrees the 2013 pharmacy rebate allocation should be revised, however we suggest that this calculation be done using the separate pharmacy rebate information for commercial and BCN65. The table below demonstrates the difference between using the "Separate" method (i.e. rebate specific information for commercial and BCN65) and the "Combined" method which is what OPM used to calculate the variance listed in the Draft Audit Report. The "Separate" method is also consistent with the pharmacy rebate allocation method suggested in the Draft Audit Report for benefit year 2016.

- **BCN Recommendation #4:** To appropriately capture the pharmacy rebate differences between commercial and BCN65 populations, BCN recommends that the 2013 pharmacy rebate variance calculated by OPM be adjusted downward to [REDACTED].

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Medical Loss Ratio Review Conclusion

A summary of our commentary above relating to the three categories of variances noted in the MLR review:

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- Pharmacy rebate variances

- **Deleted by the OIG – Not Relevant to the Final Report**
- We do not object to the 2016 variance calculation of [REDACTED] even though (1) there was no formal request for 2016 pharmacy rebate documentation during the audit process and (2) we believe our 2016 pharmacy rebate methodology is the most accurate estimate of incurred pharmacy rebates (and will be used going forward with appropriate documentation).

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Year	Plan's MLR Ratio	Audited MLR Ratio	Plan's Current Penalty/Credit	Audited Penalty	Penalty Due to OPM
2016	[REDACTED]	[REDACTED]	\$0	\$0	\$0

Internal Controls Review

In the Draft Audit Report, OPM provided two recommendations to BCN relating to internal controls. BCN responds to each recommendation as follows:

- Policies and Procedures – As shared during the audit, the actuarial team has written policies and procedures that govern the FEP MLR calculation process. However, these policies and procedures will be enhanced going forward to (1) include more detail and (2) cover more departments than just the actuarial team. These updated policies and procedures will be provided in future MLR audits.
- Record retention requirements – As mentioned in the Draft Audit Report, several issues experienced during the audit work were driven by BCN staffing and system changes over time. Many of these issues were specific to the 2013 and 2014 benefit years. Improvements have already been made in BCN's documentation practices for more recent years, but we will continue to refine our practices with specific focus on items such as:
 - o Contract counts and membership months
 - o Allocation support
 - o Financial restatements

Closing

Once again, we appreciate the opportunity to review and respond to the Draft Audit Report. Please feel free to reach out if you have any follow-up questions regarding our response document and resulting recommendations.

Thank you,

[Redacted]

[Redacted]

February 8, 2019

Date

[Redacted]

[Redacted]

600 Lafayette East
Detroit, MI 48226

[Redacted]

Appendix

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Report Fraud, Waste, and Mismanagement

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

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

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

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