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 HUMANA HEALTH PLAN OF TEXAS

Report Number 1C- UR-00-19-040
December 14, 2020

EXECUTIVE SUMMARY

Audit of the Federal Employees Health Benefits Program Operations at Humana Health Plan of Texas

Report No. 1C-UR-00-19-040 **December 14, 2020**

Why Did We Conduct The Audit?

The primary objective of the audit was to determine if Humana Health Plan of Texas (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).

Due to changes to our audit procedures resulting from OPM's implementation of its MLR methodology, we cannot express an opinion on the fairness of the premium paid for benefits received. Our audit process was limited to an assessment of the Plan's MLR, which is representative of the Plan's cost of doing business with the FEHBP. In our opinion, the MLR calculation is neither transparent nor a fair assessment of the FEHBP rates, concerns that we are addressing with OPM through other channels.

What Did We Audit?

Under Contract CS 1895, the Office of the Inspector General (OIG) completed a performance audit of the FEHBP MLR submissions to OPM for contract years 2014 through 2015. We conducted our audit fieldwork from February 10, 2020, through June 25, 2020, at the Plan's offices in Louisville, Kentucky and in our OIG offices.

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. Specifically, our audit identified that the Plan had weak internal controls over portions of the FEHBP MLR reporting process. This control environment resulted in inaccurate reporting of fraud reduction and tax expenses on the 2014 and 2015 MLR submissions. In addition, the Plan overstated reported claims in 2014 and 2015 due to several errors that also stemmed from the Plan's internal control weaknesses.

The monetary impact of these issues was not significant enough to affect the 2014 and 2015 MLRs reported to OPM. However, if the issues outlined in this report are not addressed, they have the potential to affect the pricing and payment of FEHBP member claims and lead to incorrect reporting of the MLR in future years.

Michael R. Esser
Assistant Inspector General for Audits

ABBREVIATIONS

CFR	**Code of Federal Regulations**
CL	**Carrier Letter**
Contract	**OPM Contract CS 1895**
FEHBP	**Federal Employees Health Benefits Program**
FFM	**Federally Facilitated Marketplace**
MLR	**Medical Loss Ratio**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
PCP	**Primary Care Physician**
Plan	**Humana Health Plan of Texas**

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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 of Texas (Plan). The audit was conducted pursuant to the provisions of Contract CS 1895 (Contract); 5 United States Code (U.S.C.) Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, P art 890. The audit covered contract years 2014 through 2015, and was conducted at the Plan's offices 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 Federal Register 19522). The MLR is the proportion of FEHBP premiums collected by a carrier that is spent on clinical services and quality health improvements.

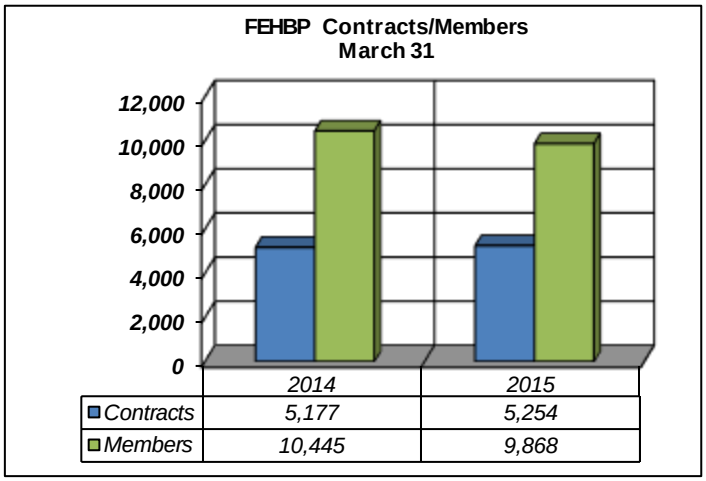
The MLR was established to ensure that health plans are meeting specified thresholds for spending on medical care and health care quality improvement measures, and thus limiting spending on administrative costs, such as executive salaries, overhead, and marketing of the health plan. However, in our opinion the FEHBP MLR is not as transparent as intended and does not provide an assessment of the fairness of the premium paid for benefits received. As this continues to be a significant Program concern for us, we are addressing this issue with OPM through other channels.

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. However, beginning in 2013, 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 1987 and provides health benefits to FEHBP members in San Antonio, Texas. This is the first audit of the Plan's MLR submissions; however, a 2018 audit of MLR processes at another Humana Health Plan entity identified findings specifically related to issues with dependent disability status, taxes, and fraud expenses and recoveries. These issues were considered in the planning and completion of this audit.

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.

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.

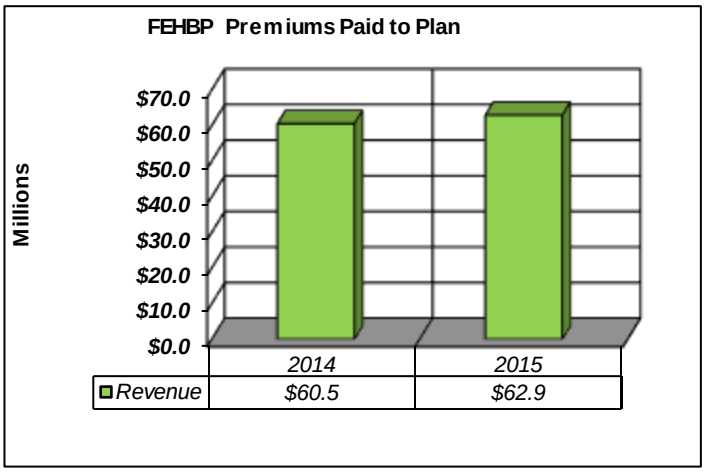
Although the FEHBP premiums used in the MLR calculation are ultimately determined by the premium rates proposed by the Plan and certified and paid by OPM, the OPM rating instructions no longer provide sufficient criteria to evaluate the fairness of those rates against the standard market value of similarly-sized 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 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 are addressing this issue with OPM through other channels.

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 2014 through 2015. For these years, the FEHBP paid approximately $123.4 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;
- medical 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.

We conducted our audit fieldwork from February 10, 2020, through June 25, 2020, at the Plan's offices in Louisville, Kentucky, as well as in our office in Cranberry Township, Pennsylvania.

METHODOLOGY

We examined the Plan's MLR calculations and related documents as a basis for validating the MLR. Further, we examined medical claim payments, quality health improvement expenses, taxes and regulatory fees, premium income, and any other applicable costs to verify that the cost data used to develop the MLR was accurate, complete, and valid. Finally, we used the Contract,

the OPM rate instructions, and applicable Federal regulations to determine the propriety of the Plan's MLR calculations.

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

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

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. INTERNAL CONTROLS REVIEW

Based on the results of our audit, we determined that the Plan did not have adequate internal controls over its FEHBP reporting process and aspects of its claims processing systems.

Per Contract Section 5.64, Contractor Code of Business Ethics and Conduct, "(c) … The Contractor shall establish the following within 90 days after the contract award … (2) An internal controls system. (i) The Contractor's internal control system shall-- (A) Establish standards and procedures to facilitate timely discovery of improper conduct in connection with Government contracts; and (B) Ensure corrective measures are promptly instituted and carried out. (ii) At a minimum, the Contractor's internal control system shall provide for … (A) 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."

However, we found that the Plan's internal controls system did not sufficiently meet the contractual criteria in the following ways:

1. Inaccurate MLR Reporting

We identified errors caused by insufficient controls and related oversight of the FEHBP MLR reporting process. Although these errors are procedural in nature, if left unaddressed they could materially affect future FEHBP MLR reporting requirements. As such, we identified the following:

a. Inaccurate Fraud Reduction Expenses and Recoveries

The Plan did not report allowable fraud reduction expenses on its 2014 and 2015 MLR submissions in accordance with applicable criteria.

45 CFR 158.140(b)(2)(iv) requires that incurred claims be adjusted by the amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. This is also noted on the 2014 and 2015 FEHBP MLR forms, Part 2, Line 2.16, where allowable fraud reduction expenses are defined as the lesser of fraud reductions expenses (reported on Line 2.16a) or fraud recoveries that reduced paid claims (reported on Line 2.16b). However, previous Centers for Medicare & Medicaid Services and OPM OIG audits noted that the Plan used overpayment recoveries that were not related to fraud activities to identify allowable fraud reduction expenses that it reported on its 2014 and 2015 MLR

submissions. The Plan interpreted the regulatory guidance to include recoveries from audits directed at identifying fraud and abuse, not just Special Investigations Unit activities that resulted in recoveries from litigation. As a result, the FEHBP's fraud reduction expenses and recoveries were incorrectly reported in 2014 and 2015.

In addition, the Plan did not complete Line 2.16a on Part 2 of the 2014 and 2015 FEHBP MLR submissions and instead reported fraud expenses as fraud recoveries on Line 2.16b. The oversight was due to human error; the Plan did not realize that Line 2.16a required a response because within the FEHBP MLR reporting template the text from an adjacent cell overlapped the cell and blocked the outline that indicated a response was required. Although the Plan did appropriately determine the lesser of expenses and recoveries in a separate file prior to reporting it on the MLR submissions, it did not complete the form in compliance with applicable criteria. The error also demonstrates a weakness in the Plan's internal controls over MLR reporting.

Plan's Response:

The Plan agrees with the finding. According to the Plan, it stopped reporting these expenses on the MLR submission starting in 2016.

OIG Comment:

We will not include a recommendation for this issue as we intend to evaluate the Plan's process change during future audits.

b. Inappropriate Exclusion of Taxes and Fees from Premium

The Plan incorrectly excluded certain taxes and fees from the premium on its 2014 and 2015 FEHBP MLR Submissions.

Specifically, the Plan included sales and use taxes on its MLR submissions because it had inappropriately mapped these taxes to a premium reduction category in its system. However, state sales tax should only be included in premium under defined circumstances per 45 CFR Part 158.161(b)(2)(i). The Plan noted that this issue had been identified during a previous Health and Human Services audit, and as a result, it changed its allocation methodology for this tax expense starting in 2016.

The Plan also mistakenly included the risk adjustment user fee as a premium reduction on the 2014 and 2015 MLR submissions. This fee is related to the Plan's participation in the Federally Facilitated Marketplace (FFM), but the FEHBP is not on the FFM. Therefore, the FEHBP derives no benefit related to this fee, and the Plan should not allocate any portion of it to the FEHBP per Federal Acquisition Regulation 31.201-4(a).

Although the improper exclusion of these fees from the premium misstated the MLR denominator, the resulting misstatement was immaterial, and we did not adjust the denominator in our calculation.

Recommendation 1

We recommend that the Plan not exclude State Sales and Use Taxes from premium in the MLR Part 1, Section 3.2a - State Income, excise, business, and other taxes.

Recommendation 2

We recommend that the Plan not exclude the Risk Adjustment User Fee from premium in the MLR Part 1, Section 3.3 - Regulatory authority licenses and fees.

Recommendation 3

We recommend that the Contracting Officer verify that the Plan updated its policies and procedures to ensure that expenses from accounts that do not impact the FEHBP are excluded from allocations to the FEHBP's MLR calculations.

Plan's Response:

The Plan agrees with the finding and Recommendations 1, 2, and 3. According to the Plan, it has "implemented procedures to ensure that only appropriate tax accounts which comply with the reporting instructions are included in the MLR report to comply with applicable guidance."

OIG Comment:

Without additional supporting documentation, we cannot verify the improvements that the Plan described to its processes and procedures. We will evaluate the effectiveness of any process improvements during future audits.

c. Incomplete MLR Submission Part 4

The Plan did not complete Part 4, "Expense Allocation Methodology Report," of its 2014 and 2015 MLR submissions in accordance with applicable criteria. The employee responsible for the Plan's FEHBP MLR submission was unsure what information to report in Part 4 and, as such, did not complete this section. As a result, the Plan did not comply with 45 CFR 158.170(b) and (c), which require plans to provide detailed descriptions of the allocation methodologies for incurred claims, quality health improvement expenses, and taxes reported on the MLR submissions, including how these expenses are allocated to states and specific markets. Moreover, it did not comply with instructions on the MLR forms themselves that specify Part 4 should include descriptions of allocation methods.

Recommendation 4

We recommend that the Plan report the allocation methodologies used for expenses reported on the FEHBP MLR as required by 45 CFR 158.170 and Part 4 of the FEHBP MLR submission.

Recommendation 5

We recommend that the Plan strengthen its internal controls over MLR reporting to ensure compliance with allocation reporting requirements in 45 CFR 158.170 and Part 4 of the FEHB MLR submission.

Plan's Response:

The Plan agrees with the finding Recommendations 4 and 5 and stated that it "will strengthen internal controls to ensure that the Plan is in compliance with applicable criteria for Part 4 of the FEHBP MLR Form."

OIG Comment:

We will evaluate the effectiveness of any process improvements during future audits and FEHBP MLR submissions.

2. Inadequate Oversight to Ensure Accuracy of Claims Processing and Reporting

As part of the FEHBP MLR requirements and as specified in FEHBP Carrier Letter (CL) 2015-11 and CL 2016-10, all plans subject to OPM's MLR rules must submit detailed claims data used in the MLR calculation to OPM's Office of the Inspector General (OIG). This data is sampled and tested by the OIG to determine the level of reliance that can be attributed to each Plans' reported incurred claims total used in the numerator of the MLR. Specifically, we reviewed a statistical sample of 75 medical claims and a judgmental sample of 21 pharmacy claims from 2014 to determine if the Plan priced and paid claims for eligible members according to applicable criteria. Based on our review, we identified the following issues, which resulted in misstatements to the MLR numerator:

a. Medical Claims Pricing Errors

We identified five claims that were priced incorrectly due to the Plan's use of old or incorrect contracts, fees, and percentages to price procedures on the claims. This included one claim for which the Plan should have used a physician extender rate when the rendering provider was a nurse practitioner.

Contract Section 2.3(g) states that the Plan is responsible "to pro-actively identify overpayments through comprehensive, statistically valid reviews and a robust internal control program."

Ultimately, the Plan lacked adequate internal controls and oversight to update contract rates and fees in its system. Without adequate controls, FEHBP claims were paid at a rate that was not consistent with the terms of the provider contracts and fee schedules effective in 2014. As a result, four of the five claims were overpaid, and one claim was underpaid. Although the amounts of the errors were immaterial, we cannot measure the full impact of the incorrect contract rates and fees for all claims submitted by these providers. Moreover, the errors resulted in the understatement or overstatement of FEHBP adjusted incurred claims and the MLR calculation.

Recommendation 6

We recommend that the Plan strengthen claims processing procedures to indicate how and when contracts and fee schedules should be updated in the system.

Recommendation 7

We recommend that the Plan review the contracts in its system for the five questioned providers to ensure that the appropriate updates have been made to the system to price claims according to the most recent contracts and fee schedules and rates for the applicable procedures.

Plan's Response:

The Plan agrees with the finding and Recommendations 6 and 7.

b. Duplicate Payments

The Plan overpaid medical claims in 2014 as a result of duplicate claims payments.

Contract Section 2.3(g) states that the Plan is responsible "to pro-actively identify overpayments through comprehensive, statistically valid reviews and a robust internal control program."

We determined that the Plan erroneously paid a claim procedure code twice for one member. Specifically, the procedure code for the service on our sampled claim was billed twice on two separate claim numbers. According to the Plan, an adjustor erroneously allowed the payment for this procedure code to process twice.

As a result, we expanded our review and identified an additional 30 members with claims that potentially include duplicate claim payments. We cannot determine why the claims identified in our expansion were paid more than once. However, based on our sample review the Plan's existing system and claims processing controls did not effectively detect and prevent duplicate payments from being made.

Recommendation 8

We recommend that the Plan review existing system and procedural controls to identify and correct the weaknesses that led to the duplicate payments.

Plan Response

The Plan disagrees with the finding. The Plan provided narrative responses detailing the results of its review of the specific claims included in the finding.

OIG Comment

We reviewed the Plan's narrative responses to each of the claims and relevant supporting documentation. Although the Plan disagreed with the finding, its review confirmed that 16 claims included potential duplicate payments. In addition, we continued to have questions regarding 24 claims, including the original sample claims questioned in this finding. Without additional documentation that supports the Plan's narrative, we cannot verify that these claims were correctly paid.

c. Medical Claims Not Adjusted for Provider Settlements

The Plan could not incorporate the results of provider settlements related to medical claims overpayments into the 2014 and 2015 MLR submissions.

Contract Section 2.3(g) states that the Plan is responsible "to pro-actively identify overpayments through comprehensive, statistically valid reviews and a robust internal control program."

FEHBP CL 2013-11 and CL 2014-16 state that only claims incurred in the calendar year and paid through June 30 of the following year are to be included in the MLR submissions.

45 CFR 158.140(b)(ii) states that overpayment recoveries received from providers must reduce the incurred claims reported in the MLR submission.

As part of our review of a sample of 75 claims, we learned that the Plan received provider settlements in 2019 that affected the 2014 and 2015 medical claims reported on the MLR submissions in those years. Per the Plan, the overpayments occurred due to a variety of issues, including: incorrect provider contract loads, provider billing errors, and errors when coordinating benefits. The errors were not settled until 2019, and because of existing OPM guidance, the Plan could not adjust the MLR in the relevant years or subsequent periods to credit the FEHBP for the overstated claims as is required by regulation. As a result, the Plan's 2014 and 2015 MLR submissions included inflated claims data, which ultimately overstated the Plan's MLR credit. Although we did not adjust the claims reported in the MLR numerator, the issue demonstrates weaknesses in the Plan's internal control procedures over claims processing as well as for identifying and collecting overpayments when they do occur in a timely manner.

Recommendation 9

We recommend that the Plan develop and implement stronger system and procedural controls to pro-actively and timely identify and recoup claims overpayments so that claims adjustments can be reflected in the Plan's MLR submission for the given reporting period.

Plan's Response:

The Plan agrees with this finding. The Plan also stated that it "recognizes the importance of including timely claims adjustments so they can be reflected in the Plan's MLR submission for the given reporting period. The Plan continues to improve its controls to identify and recoup claims overpayments from providers in a timely manner."

OIG Comment:

We will evaluate the effectiveness of any process improvements during future audits.

d. Lab and Imaging Copayments Inappropriately Applied to Medical Claims

The Plan did not apply applicable copayments for lab and imaging procedures performed by independent lab and imaging facilities and primary care providers in 2014 and 2015, which did not comply with requirements in the benefit brochures and may negatively impact the accuracy of the Plan's reported FEHBP MLR.

Unless lab, x-ray, and diagnostic services occur during the member's office visit to a primary care physician (PCP) or specialist, Section 5(a) of the FEHB benefit brochure requires copayments from the member ranging from $20 to $40, depending on the member's plan and type of provider.

Specifically, we identified the following issues:

i. Services Provided at Independent Lab and Imaging Facilities

The Plan did not apply copayments on 11 of our sampled claims for three independent lab and imaging facilities as required by the FEHB brochures. Due to our initial findings, we judgmentally expanded our review to all 2014 and 2015 medical claims associated with these three providers. As a result, we identified an

additional 8,360 claims in 2014 and 12,086 claims in 2015 that may not have had the appropriate copayments applied in part or in total.

The Plan interpreted, and we agree, that the brochures cover lab and imaging services received during an office visit at 100 percent of the allowed amount. However, our review did not support that the services for these claims were performed during an office visit. Most of them were performed at a place of service defined as an independent laboratory, not a physician's office. In addition, other claims were coded as occurring at a physician's office, yet the providers were known independent lab and imaging facilities, not physician's offices. Moreover, there was no indication that the services coincided with a visit with a physician.

ii. Services Provided at PCP Offices

The Plan did not apply the appropriate copayment for two of our sampled claims for lab and imaging procedures that occurred in PCP offices, but not as part of a visit with the physician, as required by the FEHB brochures. The Plan stated that the offices did not bill for evaluation and management services; therefore, the claims did not trigger a copayment. However, when the service is not done as part of an office visit with the physician, then a copayment should apply, per the benefit brochure. The Plan's system and claims processing controls are not effectively identifying when copayments are applicable for lab and imaging services performed at PCP offices when they are not done in conjunction with a visit with the physician.

Recommendation 10

We recommend that the Plan work with OPM to revise and clarify language in its benefit brochures to more accurately represent the requirements for copayments related to lab and imaging services both at independent lab and imaging facilities, as well as PCP offices.

Recommendation 11

We recommend that the Plan strengthen its system controls and/or claims processing procedures to ensure that copayments are applied to lab and imaging services performed at PCP offices when they are not done in conjunction with a visit with the physician.

Plan's Response:

The Plan agrees with Recommendations 10 and 11 and stated that it will work with the OPM Contract Specialist to both determine the appropriate benefit and to clarify the benefits in the FEHB brochure.

e. Copayments Not Appropriately Applied to Urgent Care Claims

The Plan did not apply copayments for services at urgent care facilities.

Per the 2014 and 2015 FEHB brochures, copayments for urgent care visits are $35 for the high option plan and $40 for the standard option plan.

During our review, we identified a potential concern in a sample claim related to urgent care services for which a copayment was not applied. We judgmentally expanded our review to include all urgent care claims in 2014 and 2015. Although we did not ultimately identify an issue with the sample claim that generated the expansion, we identified 277 other urgent care claims in 2014 and 343 in 2015 that did not include a copayment.

Although we cannot identify the individual causes for why the copayments were not applied to the urgent care claims, the root cause is that the Plan's system and claims processing controls were not effective in identifying when procedures require a copayment, specifically for urgent care claims.

Recommendation 12

We recommend that the Plan strengthen its system controls and/or claims processing procedures to ensure that the appropriate copayment for the facility is applied when procedures are performed at urgent care facilities.

Plan's Response:

The Plan disagrees with the finding and provided additional narrative support for the questioned urgent care claims from 2014 and 2015.

OIG Comment:

We reviewed the Plan's narrative responses to each of the claims. Although the Plan disagreed with the finding, its review of the finding confirmed that a copayment was not applied to three claims in 2014. In addition, we continued to have concerns regarding the remaining questioned claims cited in the finding. Without additional documentation that supports the Plan's narrative, we cannot verify the Plan's responses.

f. Incorrect Pharmacy Claims Copayments

The Plan did not price pharmacy claims for the drug Gleevac using the correct copayment in 2014 and 2015.

During our review of the Plan's 2014 pharmacy claims, we identified one claim in our sample for which the Plan did not charge the correct copayment for the Level Four drug Gleevac. Specifically, the Plan assessed a $40 copayment, rather than 25 percent of the Plan's payment to the dispensing pharmacy (up to the applicable out-of-pocket maximum), which is required by the 2014 FEHBP benefit brochure. According to the Plan, it authorized an override for Gleevac starting in 2006 to apply that year's Level Three drug copayment of $40, rather than the applicable Level Four copayment. However, the Plan associate who set the override did not include the correct end date in the Plan's system. Ultimately, the Plan did not have effective internal controls to govern the authorization/copayment override process, which allowed Gleevac claims to be overpaid for 11 years, until December 31, 2017, when the Plan identified the issue and terminated the override.

We expanded our review to include all Gleevac claims in 2014 and 2015 and determined that the resulting overpayment identified for this drug was not material. Therefore, we did not adjust the MLR numerator in our recalculation. However, because the Plan was unable to determine if the override applied to other drugs or contracts, we cannot identify the full impact of the Plan's internal control weaknesses over the authorization and copayment override process, nor whether any potential overpayments on other drugs may have resulted.

Recommendation 13

We recommend that the Contracting Officer verify that the Plan developed documented procedures for audit processes over new authorizations for copayment overrides and end dates.

Recommendation 14

We recommend that the Plan identify and review all overrides currently in place over claims copayments to verify whether they should still be effective and to make adjustments to the copayments being applied as necessary.

Plan's Response:

The Plan agrees with this finding and Recommendations 13 and 14. The Plan stated that as of 2015, it updated all procedures to disallow lifetime authorizations unless required by law. In order to address all active lifetime authorizations, the Plan stated that it also implemented a process in 2015 to audit new authorizations that were entered with a lifetime end date or copayment override in error. However, the review and termination of the Gleevac authorization was not completed until 2017 because "Clinically based drug authorizations required additional time and care when the member was actively using the approved drug." The Plan noted that the authorization review "is a continuous process."

OIG Comment:

We reviewed a documented procedure that was approved in 2018 and revised in 2020, which includes a statement indicating that lifetime authorizations are prohibited unless an exception has been approved. We will evaluate the effectiveness of the Plan's procedural controls during future audits; however, without additional supporting documentation, we cannot verify what procedures, if any, govern the audit process described by the Plan.

Conclusion – Internal Controls Review

Based on our review, we found that the Plan had internal control weaknesses surrounding components of the FEHBP MLR calculations that resulted in inaccurate MLR reporting. Furthermore, the Plan does not have adequate oversight to ensure that FEHBP claims are priced according to the current provider contracts as of the date of service of the claim.

B. MEDICAL LOSS RATIO REVIEW

During the 2014 and 2015 MLR filing periods, the Plan's MLR was [redacted] and [redacted] respectively, which exceeded OPM's upper threshold of 89 percent, resulting in credits that can be used to offset future penalties through contract year 2019 and 2020. As stated in section A of this report, there were issues found in the reporting of the Plan's FEHBP MLRs for contract years 2014 and 2015; however, these issues were not material enough to monetarily impact the MLRs reported to OPM. We accept the Plan's filed FEHBP MLRs for contract years 2014 and 2015.

EXHIBIT A

Claims Sample Selection Criteria/Methodology

Medical and Pharmacy Claims Samples

Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Medical claims incurred from 1/1/2014 through 12/31/2014	135,750 claims	$45,093,625	Utilized RAT-STATS [1] (90% Confidence Level 50% Anticipated Rate of Occurrence and 20% Desired Precision Range), which generated a sample size of 75. Then utilized SAS [2] to randomly select 75 incurred, unadjusted medical claims.	Statistical	No
Pharmacy claims incurred from 1/1/2014 through 12/31/2014	226,383 claims	$12,351,713	Selected all (21) 2014 pharmacy claims greater than or equal to $10,000.	Judgmental	No

[1] RAT-STATS is a statistical software designed by the U.S. Department of Health and Human Services OIG to assist in selecting random samples.
[2] SAS Enterprise Guide is a software used to analyze data allowing users to access and manipulate data quickly.

APPENDIX

HUMANA RESPONSE TO DRAFT AUDIT REPORT NO. 1C-UR-00-19-040 – RECEIVED July 27, 2020

This document is submitted by Humana Health Plan, Inc. ("Humana") and responds to the Draft Audit Report dated June 29, 2020 issued by the Office of Inspector General of the Office of Personnel Management ("OPM-OIG") regarding the Humana FEHBP Health Plan of Texas Plan Code UR for contract years 2014-2015.

The OPM-OIG Draft Audit Report mentions 17 recommendations for the Plan to implement.

The Plan has provided responses to the Draft Audit Report below in the applicable section colored in blue.

The Plan is also submitting a zipped file containing five additional support documents:

- "Recommendation 3_UC Claims"
- "Recommendation 4_Additional Information"
- "Recommendation 4_Supporting Documents"
- "Recommendation 12_Supporting Documentation"
- "Recommendation 16 17_Commercial IRO Authorizations"

The Plan has requested redactions to the Final Audit Report under separate cover to [redacted] at [redacted]@opm.gov.

Casey Szulc, FSA, MAAA
Actuary
Humana Inc.
500 West Main Street
Louisville, KY 40202

Deleted by the OIG – Not Relevant to the Final Report

A. MEDICAL LOSS RATIO REVIEW

Deleted by the OIG – Not Relevant to the Final Report

2. Inaccurate Medical Claims Processing

Deleted by the OIG – Not Relevant to the Final Report

a. Copayments Not Appropriately Applied

ii. Copayments for Urgent Care Visits Not Applied

Deleted by the OIG – Not Relevant to the Final Report

Recommendation 3

We recommend that the Plan strengthen its system controls and/or claims processing procedures to ensure that the appropriate facility copayment is applied.

Plan Response

Deleted by the OIG – Not Relevant to the Final Report
The Plan disagrees with the urgent care finding.

Deleted by the OIG – Not Relevant to the Final Report

Draft Report Plan Response to Recommendation 3
See attachment Deleted by the OIG – Not Relevant to the Final Report *which provides additional information to support applicable copayment application based on the billed services for the expanded 2014 and 2015 claims examples identified as urgent care claims. As a result, Humana respectfully disagrees with the exam findings and the need to strengthen system controls and/or claims processing procedures.*

b. Duplicate Payments

Deleted by the OIG – Not Relevant to the Final Report

Recommendation 4

We recommend that the Plan review existing system and procedural controls to identify and correct the weaknesses that led to the duplicate payments.

Deleted by the OIG – Not Relevant to the Final Report

Plan Response

The Plan disagrees with the finding. The Plan provided narrative responses detailing the results of its review of the specific claims included in the finding.

Deleted by the OIG – Not Relevant to the Final Report

Draft Report Plan Response to Recommendation 4
See attachments **Deleted by the OIG – Not Relevant to the Final Report** *for the referenced claims. Additional information* **Deleted by the OIG – Not Relevant to the Final Report** *is also being provided for potential duplicates.*

3. Inaccurate Fraud Reduction Expenses and Recoveries

Deleted by the OIG – Not Relevant to the Final Report

Plan's Response:

The Plan agrees with the finding. According to the Plan, it stopped reporting these expenses on the MLR submission starting in 2016.

B. INTERNAL CONTROLS REVIEW

1. Inaccurate MLR Reporting

Deleted by the OIG – Not Relevant to the Final Report

a. Inappropriate Exclusion of Taxes and Fees from Premium

Recommendation 5

We recommend that the Plan not exclude State Sales and Use Taxes from premium in the MLR Part 1, Section 3.2a - State Income, excise, business, and other taxes.

Recommendation 6

We recommend that the Plan not exclude the Risk Adjustment User Fee from premium in the MLR Part 1, Section 3.3 - Regulatory authority licenses and fees.

Recommendation 7

We recommend that the Contracting Officer verify that the Plan updated its policies and procedures to ensure that expenses from accounts that do not impact the FEHBP are excluded from allocation to the FEHBP's MLR calculations.

Plan's Response:

The Plan agrees with the finding. According to the Plan, it has "implemented procedures to ensure that only appropriate tax accounts which comply with the reporting instructions are included in the MLR report to comply with applicable guidance."

b. Incomplete MLR Submission Part 4

Deleted by the OIG – Not Relevant to the Final Report

Recommendation 8

We recommend that the Plan report the allocation methodologies used for expenses reported on the FEHBP MLR as required by 45 CFR 158.170 and Part 4 of the FEHBP MLR submission.

Recommendation 9

We recommend that the Plan strengthen its internal controls over MLR reporting to ensure compliance with allocation reporting requirements in 45 CFR 158.170 and Part 4 of the FEHB MLR submission.

Deleted by the OIG – Not Relevant to the Final Report

Draft Report Plan Response to Recommendations 8 and 9

The Plan agrees with this finding and will strengthen internal controls to ensure that the Plan is in compliance with applicable criteria for Part 4 of the FEHBP MLR form.

2. Inadequate Oversight to Ensure Accuracy of Claims Processing and Reporting

Deleted by the OIG – Not Relevant to the Final Report

a. Medical Claims Pricing Errors

Recommendation 10

We recommend that the Plan strengthen claims processing procedures to indicate how and when contracts and fee schedules should be updated in the system.

Recommendation 11

We recommend that the Plan review the contracts in its system for the five questioned providers to ensure that the appropriate updates have been made to the system to price claims according to the most recent contracts and fee schedules and rates for the applicable procedures.

Deleted by the OIG – Not Relevant to the Final Report

b. Medical Claims Not Adjusted for Provider Settlements

Deleted by the OIG – Not Relevant to the Final Report

Recommendation 13

We recommend that the Plan develop and implement stronger system and procedural controls to pro-actively and timely identify and recoup claims overpayments so that claims adjustments can be reflected in the Plan's MLR submission for the given reporting period.

Plan's Response:

The Plan agrees with this finding. The Plan also stated that it "recognizes the importance of including timely claims adjustments so they can be reflected in the

Plan's MLR submission for the given reporting period. The Plan continues to improve its controls to identify and recoup claims overpayments from providers in a timely manner."

c. Lab and Imaging Copayments Inappropriately Applied to Medical Claims

Deleted by the OIG – Not Relevant to the Final Report

i. Services Provided at Independent Lab and Imaging Facilities

Deleted by the OIG – Not Relevant to the Final Report

ii. Services Provided at PCP Offices

Deleted by the OIG – Not Relevant to the Final Report

Recommendation 14

We recommend that the Plan work with OPM to revise and clarify language in its benefit brochures to more accurately represent the requirements for copayments related to lab and imaging services both at independent lab and imaging facilities as well as PCP offices.

Recommendation 15

We recommend that the Plan strengthen its system controls and/or claims processing procedures to ensure that copayments are applied to lab and imaging services performed at PCP offices when they are not done in conjunction with a visit with the physician.

Plan's Response:

The Plan disagrees with the finding. Its position is that independent diagnostic testing is covered with no copay per the FEHB brochure section 5(c), "Outpatient hospital or other ambulatory surgical center." According to the Plan, this is consistent with benefits in its community packages, which do not include copays for lab and x-ray services at free standing facilities. The Plan asserts that it is consistently applying the community benefit to FEHB members and further believes that it is not OPM's intent to place additional financial burden on its members when these services are rendered at a different time and location than

the member's visit to a PCP or specialist. As it relates to lab and imaging services that occurred at a PCP office, but not during a visit, the Plan believes that is in line with Section 5(a) "if a member returns to a receive a diagnostic test, no separate 'office visit' occurs, and thus the member should not be required to remit another copayment."

OIG Comment:

Because the Plan is treating FEHBP members consistently with its community benefits package, we will not report the monetary impact of this issue on the Plan's reported claims or adjust the MLR, except as otherwise noted in Section A of this report. However, we disagree that the benefit brochure Section 5(c) is applicable to services at the three free-standing facilities we identified in the finding because these facilities were not hospital locations or ambulatory surgical centers. Thus, they do not fit the category of services referenced in that section. If the Plan and OPM's intent is that these facilities should fall under this section, the brochure wording should be revised to clarify that intent.

We also disagree with the Plan's interpretation of Section 5(a). Although the Plan may infer the intent of the brochure to allow members not to remit a copayment under these circumstances, the brochure language does not support that conclusion. The Plan should work with OPM to clarify language to support the benefit that it intends to, and ultimately is, providing to FEHB members.

Draft Report Plan Response to Recommendation 14

Humana agrees with this recommendation and will work with the OPM Contract Specialist to more accurately represent when copays apply for lab and imaging services both at independent lab and imaging facilities as well as PCP offices.

Draft Report Plan Response to Recommendation 15

Humana agrees to work with the OPM Contract Specialist to determine the applicable member copay for the lab and imaging benefit based on the place of service and OPM's intent on how the benefit should pay. Once that is determined Humana will work with OPM to clarify the language in the Contract brochure.

d. Incorrect Pharmacy Claims Copayments

Deleted by the OIG – Not Relevant to the Final Report

Recommendation 16

We recommend that the Contracting Officer verify that the Plan developed documented procedures to disallow lifetime authorizations for copayment overrides as well as audit processes over new authorizations for copayment overrides and end dates.

Recommendation 17

We recommend that the Plan identify and review all overrides currently in place over claims copayments to verify whether they should still be effective and to make adjustments to the copayments being applied as necessary.

Plan's Response:

The Plan agrees with this finding. The Plan stated that it has implemented oversight activities, including updated procedures to disallow lifetime authorizations as well as audit processes over new authorizations that are entered with a lifetime end date or copayment override. In addition, the Plan stated that it completed a review of all copayment override authorizations in 2015 to validate their appropriateness and add end dates, as necessary. The Plan stated that it will do an additional review to ensure there are no inappropriate copayment override authorizations remaining.

OIG Comment:

Without additional supporting documentation, we cannot verify the improvements that the Plan described to its processes and procedures. In addition, if the Plan performed its original review in 2015 as stated, and the error for our sampled drug was not identified or corrected until the end of 2017, we do not have confidence that the review was effective in identifying all inappropriate copayment overrides.

Draft Report Plan Response to Recommendations 16 and 17

Humana updated all procedures in 2015 to no longer allow lifetime authorizations unless required by law. Humana also implemented a new Rx Auth Oversight audit process that audits for any new authorization entered with a lifetime end date or copay override in error. This work began in 2015 to clean-up all active lifetime authorizations. Clinically based drug authorizations required additional time and care when the member was actively using the approved drug. The review for the

clinically based drug authorization in question was completed in 2017, and the authorization was termed as of 12/31/2017. This review is a continuous process.

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