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**U.S. Office of Personnel Management**  
**Office of the Inspector General**  
**Office of Audits**

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# **Final Audit Report**

**Audit of the Federal Employees  
Health Benefits Program Operations  
at Health Alliance Plan**

**Report Number 2022-CRAG-038**

**August 15, 2023**

# Executive Summary

## *Audit of the Federal Employees Health Benefits Program Operations at Health Alliance Plan*

Report No. 2022-CRAG-038

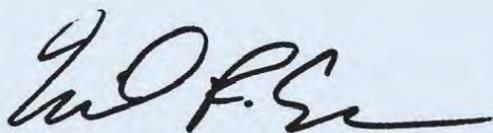
August 15, 2023

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

The primary objective of the audit was to determine if the Health Alliance Plan (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 FEHBP premium rates were developed in accordance with contract regulations and rating instructions established by the U.S. Office of Personnel Management (OPM).

### **What Did We Audit?**

Under Contract CS 1092, the Office of the Inspector General completed a performance audit of the FEHBP premium rate developments for contract years 2019 through 2021. We conducted our audit fieldwork remotely from September 26, 2022, through March 23, 2023.



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

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

We determined that portions of the 2019 through 2021 FEHBP premium rate developments were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM. Specifically, the Plan could not provide sufficient source documentation for several of the rating components. We also identified invoice claims that were erroneously included in the Plan's Adjusted Community Rating claims data for the years 2020 and 2021. However, these issues were classified as procedural as they were immaterial to the overall premium rate calculations and had no related questioned costs.

# Abbreviations

|                 |  |
|-----------------|--|
| <b>ACR</b>      | <b>Adjusted Community Rating</b>                                 |
| <b>CFR</b>      | <b>Code of Federal Regulations</b>                               |
| <b>CL</b>       | <b>Carrier Letter</b>  |
| <b>Contract</b> | <b>OPM Contract CS 1092</b>                                      |
| <b>FEHBAR</b>   | <b>Federal Employees Health Benefits Acquisition Regulations</b> |
| <b>FEHBP</b>    | <b>Federal Employees Health Benefits Program</b>                 |
| <b>HFHS</b>     | <b>Henry Ford Health System</b>                                  |
| <b>IBNR</b>     | <b>Incurred But Not Reported</b>                                 |
| <b>MLR</b>      | <b>Medical Loss Ratio</b>  |
| <b>OIG</b>      | <b>Office of the Inspector General</b>                           |
| <b>OPM</b>      | <b>U.S. Office of Personnel Management</b>                       |
| <b>Plan</b>     | <b>Health Alliance Plan</b>                                      |
| <b>PMPM</b>     | <b>Per Member Per Month</b>                                      |

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# I. Background

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at Health Alliance Plan (Plan), plan codes 52 and GY. The audit was conducted pursuant to the provisions of Contracts CS 1092 (Contract); 5 United States Code Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract years 2019 through 2021 and was conducted remotely by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG) staff.

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 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 comparison requirement for most community-rated FEHBP carriers (77 Federal Register 19522). 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. The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act (Public Law 111-148) and defined by the U.S. Department of Health and Human Services in 45 CFR Part 158.

The premium rates charged to the FEHBP under the MLR methodology should be developed in accordance with OPM Rules and Regulations and the Plan's state-filed standard rating methodology (or if the rating method does not require state filing, the Plan's documented and established rating methodology). All FEHBP pricing data are to be supported by accurate, complete, and current documentation. A rating methodology is defined as a series of well-defined procedures a carrier follows to determine the rates it will charge to its subscriber groups. Further, an independent professional must be able to follow the carriers' procedures and reach the same conclusion. OPM negotiates benefits and rates with each plan annually and all rate agreements between OPM and the carrier are subject to audit by the OPM OIG. The results of such audits may require modifications to previous agreements and subsequent rate adjustments.

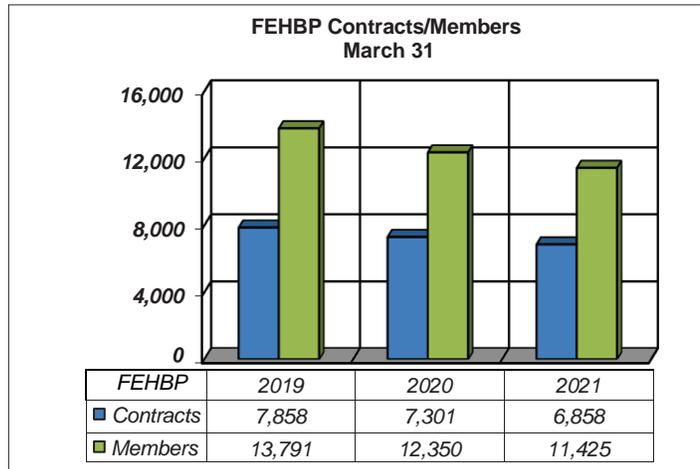
Community-rated carriers participating in the FEHBP are subject to various Federal, state, and local laws, regulations, and ordinances. In addition, participation in the FEHBP subjects the carriers to the Federal Employees Health Benefits Act and implementing regulations promulgated by OPM.

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 1962 and provides health benefits to FEHBP members in Southeastern and East Central Michigan.

The last full scope audit of the Plan conducted by our office covered contract years 2009 through 2011. During that audit, we found that the FEHBP rates were developed in accordance with the applicable laws, regulations, and OPM’s rate instructions.

The preliminary results of this audit were communicated to Plan officials during the Notice of Finding and Recommendations process. The Plan’s comments were considered in the preparation of this report and are included, as appropriate, in the report. Additionally, we discussed the issues outlined in this report with Plan officials during the Exit Conference.



# II. Objectives, Scope, and Methodology

## Objectives

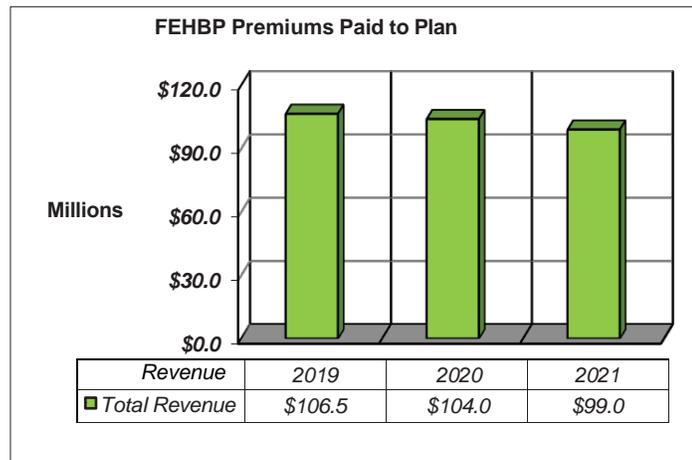
The primary objective of this performance audit was to determine whether the Plan complied with the provisions of its Contract and the laws and regulations governing the FEHBP. Specifically, we verified whether the Plan developed its FEHBP premium rates in accordance with the applicable regulations and rating instructions established by OPM.

## 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 2019 through 2021. For these years, the FEHBP paid approximately \$309.5 million in premiums to the Plan.

The OIG’s 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 premium rate calculations were accurate, complete, and valid;
- appropriate allocation methods were used;
- any other costs associated with its premium rate calculations were appropriate;
- FEHBP medical claims were processed accurately; and
- FEHBP members received the 31-day extension of coverage when coverage was lost, as applicable.

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 remotely conducted our audit fieldwork from September 26, 2022, through March 23, 2023.

## **Methodology**

We examined the Plan's premium rate calculations and related documents as a basis for validating the premium rates. We also examined medical claim payments, pharmacy rebates, completion factors, benefit factors, trends, administrative expenses, and any other applicable expenses considered in the calculation of the premium rates to verify that the cost data used was accurate, complete, and valid. Finally, we used the Contract, the Federal Employees Health Benefits Acquisition Regulations (FEHBAR), the OPM rate instructions, and applicable Federal regulations to determine the propriety of the Plan's premium rate calculations.

To gain an understanding of the internal controls over the Plan's premium rate processes as well as its claims processing system, we reviewed the Plan's premium rate development and claims processing policies and procedures. We also interviewed appropriate Plan officials regarding the controls in place to ensure that the premium rate 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 claims, along with the methodology, are detailed in Exhibit A at the end of this report.

# III. Audit Findings and Recommendations

## Premium Rate Review

FEHBP health carriers proposing rates to OPM are required to submit a Certificate of Accurate Pricing certifying that the cost or pricing data submitted in support of the FEHBP rates were developed in accordance with the requirements of 48 CFR, Chapter 16 and the Contract. We determined that the Plan's 2019 through 2021 Certificates of Accurate Pricing for Plan Codes 52 and GY were defective due to the Plan not providing sufficient source documentation for several of the rating components and due to non-compliance with various sections of the Contract. The monetary findings associated with the record retention issues were immaterial to the overall premium rate calculations for all years of the audit scope; therefore, they are procedural in nature.

### 1. Record Retention and Compliance Issues: Procedural

During our review of the Plan's 2019 through 2021 FEHBP premium rate developments, we determined that the Plan was not in compliance with its Contract in maintaining sufficient documentation for various components of its FEHBP rate developments for all years of the audit scope.

Contract Sections 1.11(b) and 3.4 require that records be maintained for a retention period specified in the FEHBP, 48 CFR 1652.204-70, which is a period of six years for the rate development submissions. Furthermore, the OPM rating instructions state that the Plan "must keep on file all data necessary to justify the [Adjusted Community Rating] ACR rate ... ." Lastly, Contract Section 5.64 specifies that the Plan must establish an internal control system to facilitate timely discovery of contract compliance issues and promptly institute and carry out corrective action.

**The Plan did not maintain sufficient documentation for several components of its FEHBP rate development for the years within the scope.**

We noted that the Plan lacked sufficient documentation for various components in its FEHBP premium rate developments for contract years 2019 through 2021. We have listed each component in order of occurrence in the rate calculation and the applicable rating year(s) below.

#### a. ACR Claims Issue (2019 through 2021)

For 2019, the Plan acknowledged that the incurred claims and large claim amounts were incorrect due to an unstable environment during the calculation of the premium rates. As a result, the Plan was unable to support the estimated incurred claims and large claim totals used at the time of rating. We compared the incurred claims and large claim totals from the Plan's rate development with the documentation that the Plan provided for the

audit. We performed a reasonability test and noted an immaterial variance between the reported claims estimate and the provided supporting documentation.

For 2020 and 2021, we were unable to tie the total incurred claims for the experience periods with the claims data tapes the Plan provided to OPM per Carrier Letters (CL) 2019-07 and 2020-13. Per the Plan, the variances between the claims tape data and the rate development was a result of a system indicator issue. Specifically, the Plan stated that it has a process where some of the drugs covered under its medical benefits are processed by the pharmacy benefit manager and are not in the claims processing system.

The Plan provided the monthly incurred but not reported (IBNR) factors for the experience periods, although we were unable to tie those IBNR factors to the completed monthly claim totals without the raw monthly claims totals. We have ultimately determined that the overall factors appear to be reasonable for the experience periods.

**b. Plan Initiatives (2020 and 2021)**

Per the Plan, the plan initiatives adjustment represents a discretionary managerial discount for plan incentives. The Plan did not provide supporting documentation for the adjustment but applied it in the medical trend calculation for years 2020 and 2021.

**c. Pharmacy Rebate Increase (2020)**

The Plan's pharmacy rebate calculation included an unsupported rebate improvement factor to account for the January 2019 move to Express Scripts. The Plan stated that this specific adjustment was applied to all large groups. The inclusion of this factor ultimately increased the FEHBP's pharmacy rebate.

**d. Population Change Assumption Factors (2019 and 2020)**

The age/gender factor applied in the Plan's rate development included an additional adjustment for a population change assumption. The inclusion of this factor reduced the FEHBP's final demographic factor. However, the Plan was unable to provide support for the final population change assumption factors applied in the 2019 and 2020 rate developments.

**e. Network Adjustment Factors (2019 through 2021)**

Per the Plan, the network adjustment factor "reflects a 2019 reduction in payment rates for Henry Ford Health System's [HFHS] reimbursement schedule." The adjustment took the proportional claims at HFHS relative to the claims paid and applied the anticipated impact of the reimbursement reduction to project forward for future claims. The Plan

provided documentation for the calculation of this adjustment, although the support varied from the final factors applied in the rate developments. This adjustment reduced the FEHBP's premium rates.

**f. Other Fixed Costs PMPM (2019 through 2021)**

The Plan's rate model included an adjustment for capitation (other fixed costs) to account for the non-claims related expenses. The Plan provided a categorical breakout that showed the per member per month (PMPM) cost associated with each line item. The total capitation PMPMs were traced to the applicable annual rate filing. However, the Plan was unable to provide documentation for the individual PMPM line-item cost.

**g. Benefit Factor (2020 and 2021)**

For the 2020 high option, the Plan applied a benefit factor after the unadjusted biweekly rate. The calculation of this factor included two additional factors that were not supported by the Plan. For 2021, benefit and risk adjustment factors were applied to the high and standard option rates after the unadjusted biweekly rates. The inclusion of these factors reduced the FEHBP's final premium rates.

We applied these adjustments to our audited rates, which reduced the FEHBP's overall premium rates for contract years 2019 through 2021. However, these issues were classified as procedural as they were immaterial to the overall premium rate calculations. The Plan's internal controls related to the FEHBP rate development process were insufficient to meet the terms of the Contract. We have determined that the Plan was not in compliance with Contract Sections 1.11(b) and 3.4 or the OPM rating instructions, all of which require the retention of records.

**Recommendation 1:**

We recommend that the Plan maintain supporting documentation for its FEHBP premium rate developments for the specified amount of time in its Contract.

**Recommendation 2:**

We recommend that the Plan strengthen its written policies and procedures related to its FEHBP rate development process.

**Plan Response:**

**The Plan agreed with the finding and recommendations.**

## **2. Claims Pricing Review: Procedural**

We reviewed a judgmental sample of 45 medical claims selected from the contract year 2021 rate development claims data submission, which is required by CL 2020-13. During our review, we identified an invoice claim that was erroneously included in the ACR claims data.

Per OPM's CL 2020-09, "[a] carrier using ACR must use a method based on utilization data or a prospective method based on actual Federal claims data."

**The Plan incorrectly included vendor invoice claims, which were not actual FEHBP member claims, within its ACR claims data.**

The Plan contracted with a vendor to review its processed claims and determine any erroneously paid claims. The vendor identified an erroneously paid claim where the member had Medicare Part A primary coverage when the claim was incurred, but it had not been coordinated correctly. Our sample claim was an invoice claim that was created in the

Plan's system to remit payment to the contracted vendor for a percentage of the savings that was generated by it finding the erroneously paid claim. The fee owed to the contracted vendor became part of the FEHBP's claim experience.

We queried the available 2020 and 2021 ACR medical claims data for all invoice claims. We determined that the invoice claims were less than one percent of the total incurred medical claims for each experience period for both contracted years. Therefore, we determined it to be an immaterial amount. While these invoice claims correlate to cost savings identified by a third-party vendor, the Plan should not have included these claims in the ACR claims experience.

### **Recommendation 3:**

We recommend that the Plan remove all invoice claims from its ACR claims experience in accordance with OPM's Carrier Letters.

**Plan Response:**

**The Plan disagreed with the finding and recommendation. Specifically, the Plan's position is that the invoice claims were appropriately included in the claims experience. The invoice claims are paid to a third-party for savings identified through various pricing reductions. A percentage of the savings realized is calculated for the fees and are directly related to the cost of care.**

**OIG Comment:**

We acknowledge the Plan's position, but we maintain that these fees should not have been included in the FEHBP's ACR experience claims data. OPM's CL explicitly states that the incurred ACR claims data must only consist of the FEHBP's actual claims data and not any additional fees, regardless of the third-party savings attributed to the fees.

# Exhibit

## Health Alliance Plan Medical Claims Sample Selection Criteria and Methodology

| Universe Criteria   | Universe of Unique Claims (Number) | Universe (Dollars) | Sample Criteria and Size  | Sample Number | Sample (Dollars) | Results Projected to the Universe? |
|---|------------------------------------|--------------------|---|---------------|------------------|------------------------------------|
| Incurred Medical Claims from Calendar Year 2018 used in the 2021 FEHBP premium rate development | 317,764 Claims                     | \$84,229,642       | Judgmental – utilized SAS EG <sup>1</sup> to select 15 random inpatient claims greater than \$25,000, 15 random outpatient claims greater than \$10,000 and 15 professional claims greater than \$1,000 | 45            | \$743,064        | No                                 |

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<sup>1</sup> SAS Enterprise Guide is a software used to analyze data allowing users to access and manipulate data quickly.

# Appendix A

**Health Alliance Plan Response to Draft Audit Report Number 2022-CRAG-038**  
Received via e-mail on May 15, 2023

**From:** Deleted by OIG – Not Relevant to the Final  
**To:** Deleted by OIG – Not Relevant to the Final  
**Cc:** Deleted by OIG – Not Relevant to the Final  
**Subject:** RE: Draft Report No. 2022-CRAG-038 Federal Employees Health Benefits Program Operations at Health Alliance Plan  
**Date:** Thursday, May 18, 2023 8:10:52 AM  
**Attachments:** Deleted by OIG – Not Relevant to the Final

Deleted by OIG – Not Relevant to the Final.

HAP is accepting the draft report as provided and does not have any additional information to provide at this time.

Thank you,

Deleted by OIG – Not Relevant to the Final



# Appendix B

Below is the Plan's response to the Notice of Findings and Recommendations related to the Claims Pricing Review issue that was issued during the audit fieldwork, as applicable to the final report.

## **Plan's Response to NFR #2 – Received by the OIG on March 9, 2023**

### **Recommendation:**

We recommend that the Plan remove all invoice claims from its ACR claims experience as specified in OPM's Carrier Letters.

### **Recommendation:**

We recommend that the Plan retain all claims pricing documentation for the ACR claims incurred during the rating experience periods as specified in OPM's CLs.

### **Auditee Response:**

Plan Management disagrees with the factual accuracy of the audit issues.

Plan Management disagrees with Recommendations.

### **Additional Plan Comments:**

It is the position of Health Alliance Plan (HAP) that the invoice claims referenced in Audit Findings above were appropriately included in FEHBP's claim experience. These invoice claims represent the fees that are paid to a third-party on FEHBP's behalf for savings that have been identified through various pricing reductions or other claim savings activity. The fees are calculated based on a percentage of the savings realized and therefore are directly related to the cost of care. For these reasons, HAP respectfully disagrees with Recommendation 1.

Additionally, the reference to missing pricing documentation in the above Audit Findings is in relation to an adjustment of a sample claim. Throughout the course of the audit, HAP fielded multiple questions and documentation requests related to Sample # 27. The pricing documentation that is referenced in the Audit Findings above was not part of those requests related to Sample #27. HAP, however, does have the pricing documentation that is referenced above and is attaching it to this response. Since HAP is able to produce the documentation that is being requested, HAP respectfully disagrees with Recommendation 2.

For the reasons stated above, HAP also respectfully disagrees with the factual accuracy of the audit issues as stated.



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