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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  
DEAN HEALTH PLAN**

**Report Number 1C-WD-00-15-039**

**March 28, 2016**

**-- CAUTION --**

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# EXECUTIVE SUMMARY

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

Report No. 1C-WD-00-15-039

March 28, 2016

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

The primary objective of the audit was to determine if Dean Health Plan (Plan) was in compliance with the provisions of its contract and the provisions of the laws and regulations governing the Federal Employees Health Benefits Program (FEHBP). We verified whether the Plan met the Medical Loss Ratio (MLR) requirements established by the U.S. Office of Personnel Management (OPM). We also verified whether the Plan developed the FEHBP premium rates using complete, accurate and current data.

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

Under Contract CS 1966, the Office of the Inspector General performed an audit of the FEHBP operations at the Plan. The audit covered the Plan's 2012 and 2013 FEHBP premium rate build-ups and MLR submissions. Our audit fieldwork was conducted from May 11, 2015, through May 22, 2015, at the Plan's office in Madison, Wisconsin.



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

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

We determined that the Plan did not use the correct FEHBP claims data for the 2012 and 2013 MLR calculations. In addition, the Plan did not reduce the incurred claims totals for both years by the change in Health Care Receivables, incorrectly included taxes on investment income, and did not use the correct premium income. As a result, we are questioning \$537,762 for the Plan's overstatement of its 2013 MLR credit. There was no effect on the 2012 MLR.

We also determined that the FEHBP rates were developed in accordance with applicable laws, regulations, and OPM's Rate Instructions to Community-Rated Carriers for contract years 2012 and 2013.

# ABBREVIATIONS

<b>ACA</b>	<b>Affordable Care Act</b>
<b>ACR</b>	<b>Adjusted Community Rating</b>
<b>CFR</b>	<b>Code of Federal Regulations</b>
<b>DHS</b>	<b>Dean Health Systems</b>
<b>FEHBAR</b>	<b>Federal Employees Health Benefits Acquisition Regulations</b>
<b>FEHBP</b>	<b>Federal Employees Health Benefits Program</b>
<b>HHS</b>	<b>U.S. Department of Health and Human Services</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>Dean Health Plan</b>
<b>SSMWI</b>	<b>SSM Health Care of Wisconsin</b>
<b>SSSG</b>	<b>Similarly-Sized Subscriber Group</b>
<b>TCR</b>	<b>Traditional Community Rating</b>

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# I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at Dean Health Plan (Plan). The audit was conducted pursuant to the provisions of Contract CS 1966; 5 United States Code Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract years 2012 and 2013, and was conducted at the Plan's office in Madison, Wisconsin.

The FEHBP was established by the Federal Employees Health Benefits Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for federal employees, annuitants, and dependents, and is administered by the U.S. Office of Personnel Management's (OPM) Healthcare and Insurance Office. The provisions of the Federal Employees Health Benefits Act are implemented by OPM through regulations codified in 5 CFR Chapter 1, Part 890. Health insurance coverage is provided through contracts with health insurance carriers who provide service benefits, indemnity benefits, or comprehensive medical services.

In April 2012, OPM issued a final rule establishing an FEHBP-specific Medical Loss Ratio (MLR) requirement to replace the similarly-sized subscriber group (SSSG) comparison requirement for most community-rated FEHBP carriers (77 FR 19522). MLR is the proportion of FEHBP premiums collected by a carrier that is spent on clinical services and quality health improvements. The MLR for each carrier is calculated by dividing the amount of dollars spent for FEHBP members on clinical services and health care quality improvements by the total amount of FEHBP premiums collected in a calendar year.

The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act (ACA, P.L. 111-148) and defined by the U.S. Department of Health and Human Services (HHS) in 45 CFR Part 158. In 2012, community-rated FEHBP carriers could elect to follow the FEHBP-specific MLR requirements, instead of the SSSG requirements. Beginning in 2013, the MLR methodology was required for all community-rated carriers, except those that are state mandated to use traditional community rating (TCR). State mandated TCR carriers continue to be subject to the SSSG comparison rating methodology.

Starting with the pilot program in 2012 and for all non-TCR FEHBP carriers in 2013, OPM required the carriers to submit an FEHBP-specific MLR. OPM required that the FEHBP-specific MLR threshold calculation take place after the ACA-required MLR calculation, and that any rebate amounts due to the FEHBP as a result of the ACA-required calculation be excluded from the FEHBP-specific MLR threshold calculation. Carriers were required 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.

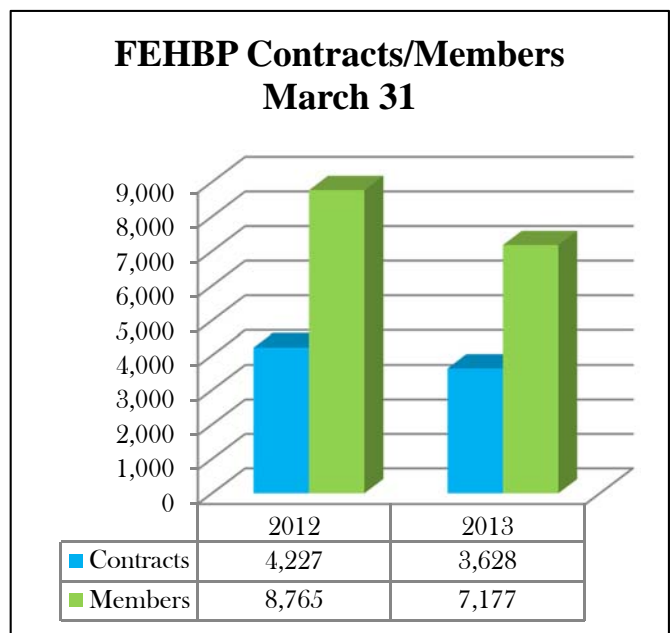
If a carrier fails to meet the FEHBP-specific MLR threshold, it must make a subsidization penalty payment to OPM within 60 days of notification of amounts due.

Community-rated carriers participating in the FEHBP are subject to various Federal, state and local laws, regulations, and ordinances. While most carriers are subject to state jurisdiction, many are further subject to the Health Maintenance Organization Act of 1973 (Public Law 93-222), as amended (i.e., many community-rated carriers are Federally qualified). In addition, participation in the FEHBP subjects the carriers to the Federal Employees Health Benefits Act and implementing regulations promulgated by OPM.

The Plan reported 4,227 contracts and 8,765 members as of March 31, 2012, and 3,628 contracts and 7,177 members as of March 31, 2013, as shown in the chart below.

In contracting with community-rated carriers, OPM relies on carrier compliance with appropriate laws and regulations and, consequently, does not negotiate base rates. OPM negotiations relate primarily to the level of coverage and other unique features of the FEHBP.

The Plan has participated in the FEHBP since 1985 and provides health benefits to FEHBP members in south central Wisconsin. A prior audit of the Plan covered contract year 2011. There were no findings or questioned costs identified.



The preliminary results of this audit were discussed with Plan officials at an exit conference and in subsequent correspondence. A draft report was also provided to the Plan for review and comment. The Plan’s comments were considered in preparation of this report and are included, as appropriate, as an Appendix to the report.

## II. OBJECTIVES, SCOPE, AND METHODOLOGY

### Objectives

The primary objective of this performance audit was to determine whether the Plan was in compliance with the provisions of its contract and the laws and regulations governing the FEHBP. Specifically, we verified whether the Plan met the MLR requirements established by OPM and paid the correct amount to the Subsidization Penalty Account, if applicable. Additional tests were performed to determine whether the Plan was in compliance with the provisions of the laws and regulations governing the FEHBP.

### Scope

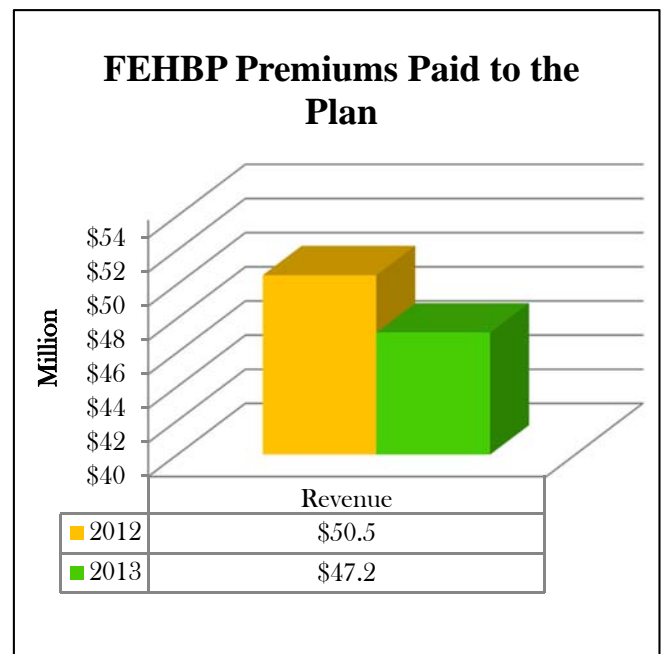
We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. 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 2012 and 2013. For contract years 2012 and 2013, the FEHBP paid approximately \$50.5 million and \$47.2 million in premiums to the Plan, respectively.

The Office of the Inspector General (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. However, the audit included such tests of the Plan's rating system and such other auditing procedures considered necessary under the circumstances. Our review of internal controls was limited to the procedures the Plan has in place to ensure that:

- The rates charged to the FEHBP were developed in accordance with the Plan's standard rating methodology and the claims, factors, trends, and other related adjustments were supported by complete, accurate, and current source documentation; and



- The FEHBP MLR calculation was accurate, complete, and valid; claims were processed accurately; appropriate allocation methods were used; and, that any other costs associated with its MLR calculation were appropriate.

In conducting the audit, we relied to varying degrees on computer-generated billing, enrollment, and claims data provided by the Plan. We did not verify the reliability of the data generated by the various information systems involved. However, nothing came to our attention during our audit utilizing the computer-generated data to cause us to doubt its reliability. We believe that the available data was sufficient to achieve our audit objectives. Except as noted above, the audit was conducted in accordance with generally accepted government auditing standards, issued by the Comptroller General of the United States.

The audit fieldwork was performed from May 11, 2015, through May 22, 2015, at the Plan’s office in Madison, Wisconsin.

**Methodology**

We examined the Plan’s MLR calculation and related documents as a basis for validating the MLR. Further, we examined claim payments and quality health expenses 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 calculation. Finally, we used the contract, the Federal Employees Health Benefits Acquisition Regulations (FEHBAR), and the rate instructions to determine the propriety of the Plan’s MLR calculation.

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

The tests performed, along with the methodology, are detailed below by Medical and Pharmacy claims:

**Medical Claims Sample Selection Criteria/Methodology**

Medical Claims Review Area	Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Coordination of Benefits (COB) – Medicare 2012	All medical claims	██████████	██████████	All claims over \$10,000 for patients age 65+; resulted in 27	Judgmental	No



				claims totaling \$593,064.		
Coordination of Benefits (COB) – Medicare 2013	All medical claims	██████	██████	All claims over \$10,000 for patients age 65+; resulted in 19 claims totaling \$467,356.	Judgmental	No
Non-Covered Benefits (Abortion) 2013	All medical claims	██████	██████	All claim lines with elective abortion CPT codes 59812, 59820, 59821, 59830, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 59866; resulted in 2 claims totaling \$322.	Judgmental	No
Dependent Eligibility 2013	All medical claims	██████	██████	All claims over \$500 for dependent members between age 26 and age 27; resulted in 10 claims totaling \$28,734.	Judgmental	No

**Pharmacy Claims Sample Selection Criteria/Methodology**

Pharmacy Claims Review Area	Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Dependent Eligibility 2013	All pharmacy claims	██████	██████	All claims for members that did not have an employee relationship code listed; resulted in 6 claims totaling \$917.	Judgmental	No

We also examined the rate build-up of the Plan's 2012 and 2013 Federal rate submissions and related documents as a basis for validating the Plan's standard rating methodology. We verified that the factors, trends, and other related adjustments used to determine the FEHBP premium rate(s) were sufficiently supported by source documentation. Further, we examined claim payments to verify that the cost data used to develop the FEHBP rates was accurate, complete and valid. Finally, we used the contract, the FEHBAR, and the rate instructions to determine the propriety of the FEHBP premiums and the reasonableness and acceptability of the Plan's rating system.

In addition, we examined the Plan's financial information and evaluated the Plan's financial condition and ability to continue operations as a viable ongoing business concern.

# III. AUDIT FINDINGS AND RECOMMENDATIONS

## 1. Overstated Medical Loss Ratio Credit

\$537,762

The Plan elected to participate in the 2012 MLR pilot program offered to certain FEHBP carriers. The MLR pilot program replaced the SSSG requirements with an MLR threshold. Simply stated, the MLR is the ratio of FEHBP incurred claims (including expenses for health care quality improvement) to total premium revenue determined by OPM. For contract year 2012, the MLR pilot program carriers must meet the OPM-established MLR threshold of 89 percent. Therefore, 89 cents of every health care premium dollar must be spent on health care expenses. If the carrier's MLR is less than the 89 percent threshold, it will owe a subsidization penalty equal to the difference between the threshold and the carrier's actual MLR.

For contract year 2013, OPM adjusted the MLR threshold to 85 percent and created an MLR corridor. If carriers meet the MLR threshold, no penalty is due. If the MLR is over 89 percent, the carrier receives a credit equal to the difference between the carrier's reported MLR and 89 percent, multiplied by the denominator of the MLR. This credit can be used to offset any future MLR penalty and is available until it is used up by the carrier or the carrier exits the FEHBP.

The Plan calculated an MLR of [REDACTED] percent for contract year 2012, and [REDACTED] percent for contract year 2013. However, during our review of the Plan's MLR submissions, we found the following issues.

### MLR Claims Data

During our review of the Plan's MLR submissions for contract years 2012 and 2013, we determined that the claims included in the MLR calculations did not adhere to OPM instructions, and did not represent the actual cost of the FEHBP's incurred claims.

OPM's 2012 MLR Pilot Instructions state, "FEHB claims *incurred* in calendar year 2012 and paid through March 31, 2013 must be included in the MLR calculation; no other claims will be considered." Similarly, OPM's 2013 Community Rating Guidelines state, "FEHB claims *incurred* in calendar year 2013 and paid through June 30, 2014 must be included in the MLR calculation; no other claims will be considered."

The Plan's 2012 and 2013 MLR claims represented claims *paid* during the respective calendar year, not the claims that were incurred.

Additionally, we determined that the Plan's claims did not accurately represent the actual cost of the FEHBP claims. Instead, the claim costs that were used represent an [REDACTED]

[REDACTED] As described by the Plan, a service agreement was established between the Plan and related companies, Dean Health Systems (DHS) and SSM Health Care

of Wisconsin (SSMWI), [REDACTED]

Consequently, use of this capitation allocation methodology to derive the claims portion of the MLR calculation does not represent the FEHBP's actual incurred claims, and as such, circumvents the purpose of the MLR process. As part of our audit we determined the actual incurred FEHBP claims for contract years 2012 and 2013, which were used in our audited MLR calculation for each year. Our audited 2012 claims amount was \$ [REDACTED], versus the Plan's submitted amount of \$ [REDACTED]. Our audited 2013 claims amount was \$ [REDACTED], versus the Plan's submitted amount of \$ [REDACTED].

**Plan Response:**

*The Plan maintains that it complied with all applicable OPM and HHS MLR requirements and that its agreement with DHS and SSMWI was categorized as a capitated arrangement. The Plan explained that it* [REDACTED]

*In addition, the Plan stated that it obtained pre-approval from OPM's Office of Actuaries for the MLR reporting treatment of its capitation payments.*

**OIG Comment:**

We do not agree with the Plan's position that it complied with all applicable MLR requirements. OPM's Community Rating Guidelines specifically require the use of incurred claims in the MLR calculation. However, the Plan instead [REDACTED] as its claims piece of the MLR calculation, which is a direct violation of the guidance provided by OPM. Furthermore, because of its use of [REDACTED] to represent incurred claims, its MLR calculation can be easily manipulated.

Moreover, the Plan's adjusted community rating (ACR) methodology, used to develop the FEHBP's rates in 2012 and 2013, used group specific claims experience. If claims experience was available to develop the FEHBP's rates, we maintain that a consistent methodology should have been used for its MLR calculation.

Additionally, while the arrangement between the Plan and DHS and SSMWI was categorized by the Plan as a capitated arrangement, the American Medical Association defines capitations as being paid to providers based on membership, rather than per service. Previous audit experience has also shown capitated rates to be agreed-upon rates between a carrier and a provider that are generally developed based on factors such as past utilization, demographics, and other factors. This is not the case with the arrangement between the Plan and DHS and SSMWI, where DHS and SSMWI are actually related companies to the Plan and

Furthermore, it is important to note that even though the Plan had predictable claim expenses

Consequently, this capitated arrangement is not an arm's length transaction and lacks intent to make a profit or even break even. This arrangement also does not meet the expectation of a true capitated arrangement, as the Plan would not, in good faith, enter into a similar arrangement with a non-related third party.

Finally, OPM's Office of Actuaries never confirmed to us or the Plan that it accepted the Plan's claims methodology and its deviation from the FEHBP MLR instructions. We cannot interpret this lack of acknowledgement as acceptance of the methodology.

### **Healthcare Receivables**

The Plan did not include any healthcare receivables on the 2012 and 2013 MLR submissions. Pursuant to HHS instructions, health plans are required to include the impact of any change between prior year healthcare receivables and current year receivables in the MLR numerator. When we inquired why the receivables were not included in the MLR submissions, the Plan responded that it unintentionally excluded them. Our review of the Plan's annual accounting statements showed there was a change in the healthcare receivables balance in both contract years 2012 and 2013. Consequently, we calculated the impact of the change applicable to the FEHBP using claim ratios. Based on our calculations, we included \$58,398 and (\$17,778), in the 2012 and 2013 audited MLR calculations, respectively.

### **Plan Response:**

*The Plan agrees with the healthcare receivables finding and reiterated that it was an unintentional error.*

### **Taxes on Investment Income**

Pursuant to the provision of 45 CFR §158.161(a)(2), health plans are allowed to reduce the premium used in the MLR calculation by taxes and regulatory fees paid, *excluding* Federal income taxes paid on investment income and capital gains. The Plan erroneously included taxes paid on investment income in its Federal income tax calculation. As a result, we removed \$ [REDACTED] and \$ [REDACTED] from the 2012 and 2013 audited MLR calculations, respectively.

### **Plan Response:**

*The Plan agrees with the taxes on investment income finding and stated that it was an unintentional error.*

### **Premium**

The 2012 OPM MLR Pilot Instructions required health plans to use OPM's subscription income amount as the premium portion of the MLR calculation. However, OPM's 2013 Community Rating Guidelines allowed health plans the option of using OPM's subscription income amount or its own premium income amount, if it could be supported. For contract years 2012 and 2013, the Plan elected to use OPM's subscription income amounts for its premium income. However, it made adjustments to these premium amounts in order to reconcile its premium figure to the OPM premium figure. The adjustments were unallowable under the OPM MLR instructions for plans that elected to use OPM's subscription income amount. As a result, we removed the premium adjustments of \$ [REDACTED] and \$ [REDACTED], from the 2012 and 2013 audited MLR calculations, respectively.

### **Plan Response:**

*The Plan agrees with the premium finding for contract year 2012. However, the Plan disagrees with the premium finding for contract year 2013. The Plan stated that the "Total 2013 Premium Income" amount (line 1.11 on the 2013 FEHBP MLR form) equaled its own premium income amount because it elected to use its own premium income instead of OPM's subscription income.*

### **OIG Comment:**

In completing its 2013 FEHBP MLR form, the Plan opted to enter OPM's premium income amount on Line 1.1, which is titled "OPM Provided 2013 Premium from the 2015 Rate Letter." Had it intended to use its own premium income amount the Plan would have filled out Line 1.2, which is titled "Plan Provided 2013 Premium Income." Filling out this line item would have also made that premium income amount subject to audit. However, because the Plan elected to use OPM's provided premium amount, the Plan's premium was not reviewed during our audit. Therefore, we used OPM's provided premium and disallowed any other adjustments made by the Plan in our audited MLR calculation.

## **Conclusion**

We recalculated the Plan's 2012 and 2013 MLR submissions using incurred claims for the calendar year, adding the impact of changes in healthcare receivables, removing taxes paid on investment income, and using OPM's subscription income amounts. Our audited MLR calculation resulted in an overstated MLR credit of \$537,762 in contract year 2013. The audited MLR calculation in 2012 did not result in a penalty or overstated credit.

## **Recommendation 1**

We recommend that the contracting officer instruct OPM's Office of the Actuary to reduce the Plan's 2013 MLR carryover credit by \$537,762.

## **Recommendation 2**

We recommend that the contracting officer require the Plan to follow OPM's Community Rating Guidelines when developing the claims to be included on the MLR submission.

## **2. Program Improvement Area**

## **Procedural**

We determined that the Plan did not maintain documentation for all of its disabled dependent members we reviewed.

Per the FEHBP Handbook, the employing office is responsible for determining if a dependent is incapable of self-support, maintaining necessary records, and notifying the Plan by letter. The Plan may continue coverage for a dependent over the age of 26, if it determines that the dependent had a disability that could cause them to be incapable of self-support during adulthood before reaching the age 26. If the Plan continues the dependent's coverage, it must send an approval notice to the member and advise that member to send a copy of the notice to the employing office.

While the Plan is not required by the FEHBP Handbook to maintain the supporting documentation for disabled dependents, for audit purposes, it is best practice for the Plan to maintain this type of documentation.

We reviewed a sample of six pharmacy claims that did not contain an employee relationship code, which the Plan determined were disabled dependents. For three of the six claims, the Plan provided supporting documentation to verify that the member was a disabled dependent. For the remaining three claims, the Plan did not maintain sufficient supporting documentation.

It is the Plan's position that no purpose is served by retaining the supporting documentation since the employing office made the eligibility determination for the disabled dependents.

However, by not maintaining this documentation, the Plan cannot support the edits within its system that denote the member is a disabled dependent. Consequently, the Plan could have dependent members erroneously marked as disabled dependents whose coverage should have terminated when the member turned 26 years old.

**Recommendation 3**

We recommend that the contracting officer direct the Plan to maintain supporting documentation for disabled dependents.



# IV. MAJOR CONTRIBUTORS TO THIS REPORT

## COMMUNITY-RATED AUDITS GROUP

██████████, Auditor-in-Charge

██████████, Lead Auditor

██████████, Auditor

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██████████, Senior Team Leader

██████████, Group Chief

# EXHIBIT A

## Dean Health Plan Summary of Overstated MLR Credit

### Contract Year 2013

Overstated Medical Loss Ratio Credit	<u>\$537,762</u>
Total Overstated MLR Credit	<u>\$537,762</u>

# EXHIBIT B

## Dean Health Plan Overstated MLR Credit

	Per Audit	Per Plan
2013 FEHBP MLR Lower Corridor	85%	85%
2013 FEHBP MLR Upper Corridor (a)	89%	89%
<b><u>Claims Expense</u></b>		
Incurred Claims (Medical and Pharmacy)	\$ [REDACTED]	\$ [REDACTED]
Less: Prescription Drug – Rebate		
Allowable Fraud Reduction Expense (the smaller of expense or recovery)	\$0	\$0
Less: Change in Healthcare Receivables		\$0
Adjusted Incurred Claims		
Expenses to Improve Health Care Quality		
<b>Total Adjusted Incurred Claims</b>		
<b><u>Premiums</u></b>		
Earned Premium	\$47,162,718	\$47,169,917
Less: Federal and State Taxes and Licensing or Regulatory Fees		
Adjusted Premiums		
Less: Defective Pricing Finding (Due OPM)	\$0	\$0
<b>Total Adjusted Premiums (b)</b>		
Total Adjusted Incurred Claims (MLR Numerator)		
Total Adjusted Premiums less Defective Pricing (MLR Denominator)		
FEHB MLR Calculation (c)	[REDACTED] %	[REDACTED] %
Penalty Calculation	\$0	\$0
Credit Calculation ((c-a)*b)		
<b>Overstated MLR Credit</b>	<b>\$537,762</b>	

<sup>1</sup> This is the MLR credit calculation number that the Plan submitted to OPM. The math from this column will not calculate this credit correctly (\$ [REDACTED] difference) even though we used the exact numbers from the Plan's supporting documentation.

# Appendix

November 16, 2015

██████████  
U.S. Office of Personnel Management  
Office of the Inspector General  
1900 E Street, NW  
Room 6400  
Washington, DC 20415

Re: Draft Audit Report 1C-WD-00-15-039

Dear ██████████:

Dean Health Plan (DHP) has reviewed the draft Audit Report on the Federal Employees Health Benefits Program (FEHBP) operations at DHP for contract years 2012 and 2013 (the Draft Report). We disagree with several of the Draft Report's findings and recommendations. DHP also objects to the phrasing used with respect to certain other findings and recommendations. Both our comments and report phrasing recommendations are to ensure that the final audit report reflects an accurate account and summary of DHP's operations and compliance with Office of Personnel Management (OPM) requirements.

## **I. Overstated Medical Loss Ratio Credit**

The Draft Report indicates that the audited medical loss ratio (MLR) calculation for contract year 2012 did not result in a penalty or overstated credit, although it contains findings with respect to DHP's MLR calculation that are discussed below. For 2013, however, the Draft Report claims that DHP overstated its MLR credit by \$537,762. In addition, the Draft Report contains a recommendation that DHP be directed to follow OPM's community rating guidelines in developing the claims included on the MLR submissions.

### **A. MLR Claims Data**

The Draft Report contains preliminary findings that the claims included in DHP's MLR submissions for 2012 and 2013 did not adhere to OPM instructions and did not represent actual performance of the FEHBP's claims. These findings are simply incorrect. Furthermore, the Draft Report's statement that DHP's capitation methodology "circumvents the purpose of the MLR process" is not correct and reflects a core misunderstanding of capitation vs. fee-reimbursement-based claim liabilities. It also ignores OPM's acceptance of capitation for MLR as well as premium rating purposes,<sup>2</sup> conformity of DHP's MLR calculation process with

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<sup>2</sup> OPM's regulations expressly recognize capitation payments as cost or pricing data for the FEHBP:

Department of Health & Human Services (HHS) MLR reporting guidance, which guidance is applicable to the FEHBP per OPM's own instructions,<sup>3</sup> and DHP's having obtained pre-approval from OPM's Office of the Actuaries for the MLR reporting treatment of its capitation payments.

The issue concerns DHP's reporting for MLR purposes of the capitation payments it makes under its Service Agreement with Dean Health Systems, Inc. (DHS) and SSM HealthCare of Wisconsin, Inc. (SSMWI). [REDACTED]

<sup>4</sup>

**Deleted by OIG  
Not Relevant to the Final Report**

[REDACTED]

Consistent with the above instruction, DHP filed with the OPM Office of the Actuaries our [REDACTED] methodology for valuing the FEHBP MLR numerator (claims) and received approval.<sup>5</sup> The communication between DHP and OPM's Office of the Actuaries including the methodology approval by OPM was provided to the auditors during our meeting on May 18, 2015, but it is not referenced in the Draft Report.

**Deleted by OIG  
Not Relevant to the Final Report**

DHP has complied with all applicable OPM and HHS requirements for the treatment and reporting of capitation payments for MLR purposes. The Draft Report's findings and recommendations under "MLR Claims Data" should not appear in the final audit report.

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(a) *Experience rated carriers.* Cost or pricing data ... includes:

(1) Information such as claims data;

(2) Actual or negotiated benefit payments made to providers of medical services for the provision of healthcare, such as **capitation**...

(b) *Community rated carriers.* Cost or pricing data ... include, but are not limited to, **capitation rates**...48 C.F.R. § 1602.170-5 (emphasis added).

<sup>3</sup> OPM's community rate instructions provide that "HHS MLR guidelines will apply for issues not covered in [the] instructions." 2013 Community Rating Guidelines at p. 9.

<sup>4</sup>

<sup>5</sup> See Exhibit 2 & 3.

## B. Healthcare Receivables

The Draft Report contains findings that DHP did not reduce the incurred claims total by the change in Health Care Receivables. DHP agrees with this finding, but requests that the final audit report reflect that this was an unintentional error.

## C. Taxes on Investment Income

The Draft Report found that DHP did not exclude taxes paid on investment income and capital gains from the reduction to premium for taxes that is allowed under the HHS MLR rules.

**Deleted by OIG  
Not Relevant to the Final Report**

Thus, DHP agrees with this finding, but requests that the final audit report reflect that this was an unintentional error.

**Deleted by OIG  
Not Relevant to the Final Report**

## D. Premium

The Draft Report found that DHP did not use the correct premium income for 2012 and 2013 MLR reporting purposes.

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The “Total 2013 Premium Income” amount (line 1.11) equaled our own premium income amount evidencing our election to use our own premium income vs. OPM’s subscription income.

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DHP acknowledges that the OPM’s 2012 MLR instructions did not allow carriers to use their own premium income.

In light of the foregoing, the audit finding related to use of OPM’s subscription income should be limited to contract year 2012 in the final audit report

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Not Relevant to the Final Report**

## II. **Disabled Dependent Support – Procedural Finding**

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**Not Relevant to the Final Report**

Furthermore, no FEHBP purpose is served by carriers' retaining such documentation since it is the responsibility of the Employing Office to determine employee and family member eligibility.

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Not Relevant to the Final Report**

If you have any questions regarding this document or any of the attachments, please contact me via phone or email.

Sincerely,

Randy Ruplinger  
Chief Financial Officer  
Dean Health Plan

@Deancare.com



## **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:

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