



---

**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 UPMC HEALTH PLAN**

Report Number 1C-8W-00-16-041

May 3, 2017

-- CAUTION --

This report has been distributed to Federal officials who are responsible for the administration of the subject program. This non-public version may contain confidential and/or proprietary information, including information protected by the Trade Secrets Act, 18 U.S.C. § 1905, and the Privacy Act, 5 U.S.C. § 552a. Therefore, while a redacted version of this report is available under the Freedom of Information Act and made publicly available on the OIG webpage (<http://www.opm.gov/our-inspector-general>), this non-public version should not be further released unless authorized by the OIG.

# EXECUTIVE SUMMARY

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

Report No. 1C-8W-00-16-041

May 3, 2017

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

The primary objective of the audit was to determine if UPMC 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).

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

Under Contract CS 2856-A and 2856-B, the Office of the Inspector General (OIG) performed an audit of the FEHBP operations at the Plan. We verified whether the Plan met the Medical Loss Ratio (MLR) requirements established by the U.S. Office of Personnel Management (OPM) in contract years 2012 and 2013. We also verified whether the Plan developed the FEHBP premium rates using complete, accurate, and current data in contract years 2012 and 2013. Our audit fieldwork was conducted from June 6, 2016, through January 12, 2017, at the Plan's office in Pittsburgh, Pennsylvania and in our OIG offices.



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

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

This report identifies an overstated OPM MLR credit of \$68,885 for contract year 2013.

Our review of the 2012 and 2013 MLR submissions showed that the Plan erroneously excluded the High-Deductible Health Plan allocations for Rx rebates, health care receivables, quality health improvement expenses, and fraud reduction expenses. We also determined that portions of the MLR calculation were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM. Specifically, our audit identified the following errors in the 2013 submission:

- The Plan included medical claims not allowed by the FEHBP and included claims for ineligible dependents in the incurred claims data used to calculate the 2013 MLR.
- The Plan did not correctly coordinate the payment of a medical claim with the Centers for Medicare and Medicaid Services and included the inaccurately paid claim in the incurred claims data used to calculate the 2013 MLR.
- The documentation provided by the Plan did not support the tax and fraud reduction expenses reported in the 2013 MLR submission.

Although these findings also affected the 2012 MLR calculation, the findings did not result in a penalty for this contract year. Additionally, the audit showed that the rating documentation provided was sufficient to support the 2012 and 2013 FEHBP premium rates.

# ABBREVIATIONS

<b>CFR</b>	<b>Code of Federal Regulations</b>
<b>COB</b>	<b>Coordination of Benefits</b>
<b>FEHBAR</b>	<b>Federal Employees Health Benefits Acquisition Regulations</b>
<b>FEHBP</b>	<b>Federal Employees Health Benefits Program</b>
<b>HDHP</b>	<b>High-Deductible Health Plan</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>UPMC Health Plan</b>
<b>SSSG</b>	<b>Similarly-Sized Subscriber Group</b>

# TABLE OF CONTENTS

	<u>Page</u>
<b>EXECUTIVE SUMMARY</b> .....	i
<b>ABBREVIATIONS</b> .....	ii
<b>I. BACKGROUND</b> .....	1
<b>II. OBJECTIVES, SCOPE, AND METHODOLOGY</b> .....	3
<b>III. AUDIT FINDINGS AND RECOMMENDATIONS</b> .....	7
A. 2013 Overstated Medical Loss Ratio Credit.....	7
<b>EXHIBIT A</b> (Summary of Overstated Medical Loss Ratio Credit)	
<b>EXHIBIT B</b> (2012 and 2013 Medical Loss Ratio)	
<b>APPENDIX</b> (UPMC Health Plan’s March 6, 2017, response to the Draft Report)	
<b>REPORT FRAUD, WASTE, AND MISMANAGEMENT</b>	

# I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at UPMC Health Plan (Plan). The audit was conducted pursuant to the provisions of Contract CS 2856-A and CS 2856-B; 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 Pittsburgh, Pennsylvania.

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, or claims, and quality health improvements. The MLR for each carrier is calculated by dividing the amount of dollars spent for FEHBP members on clinical services and health care quality improvements by the total amount of FEHBP premiums collected in a calendar year. The MLR is important because it requires health insurers to provide consumers with value for their premium payments by limiting the percentage of premium dollars that can be spent on administrative expenses and profit. For example, an MLR threshold of 85 percent requires carriers to spend 85 cents of every premium dollar on claims and quality health improvements and limits the amount that can be spent on administrative expenses and profit to 15 cents of every dollar.

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

Starting with the pilot program in 2012 and for all non-traditional community-rated FEHBP carriers in 2013, OPM required the carriers to submit an FEHBP-specific MLR. This

FEHBP-specific MLR calculation required carriers to report information related to earned premiums and expenditures in various categories, including reimbursement for clinical services provided to enrollees and activities that improve health care quality. 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.

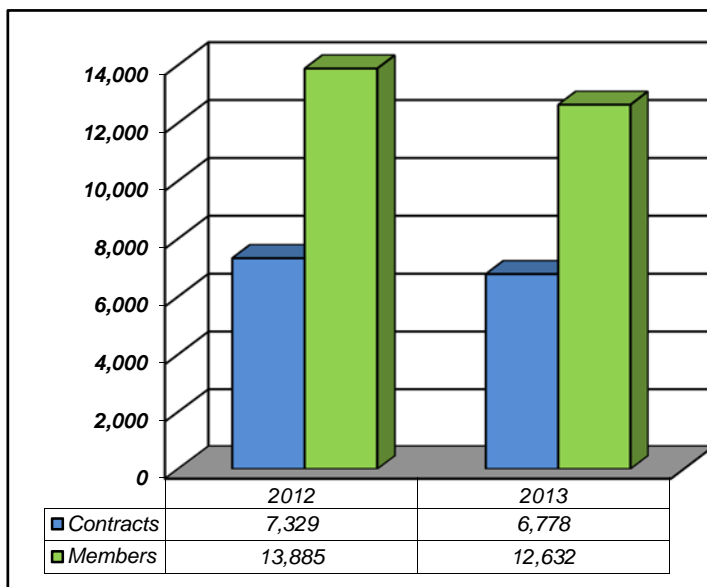
Community-rated carriers participating in the FEHBP are subject to various Federal, state and local laws, regulations, and ordinances. In addition, participation in the FEHBP subjects the carriers to the Federal Employees Health Benefits Act and implementing regulations promulgated by OPM.

The number of FEHBP contracts and members reported by the Plan as of March 31 for each contract year audited are 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 2000, and provides health benefits to FEHBP members in a 28-County area in Western Pennsylvania. A prior audit of the Plan covered contract year 2011. There were no findings or questioned costs identified in that audit.

**FEHBP Contracts/Members  
March 31**



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 also performed to determine whether the Plan was in compliance with the provisions of other applicable laws and regulations.

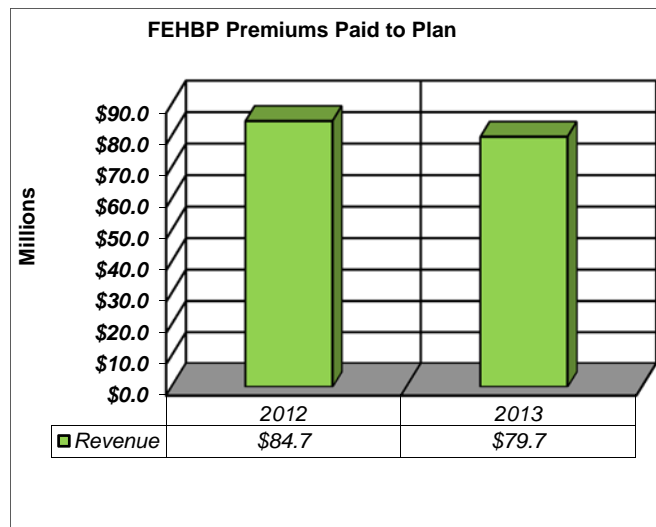
## SCOPE

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 these years, the FEHBP paid approximately \$164.4 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. 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 calculations were 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 June 6, 2016, through June 17, 2016, at the Plan’s office in Pittsburgh, Pennsylvania. Additional fieldwork was completed through January 12, 2017, at our offices in Jacksonville, Florida; Cranberry Township, Pennsylvania; and Washington, D.C.

## **METHODOLOGY**

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

To gain an understanding of the internal controls 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 with Medicare 2013	All Medical claims for members greater than or equal to age 65.	█ claims	\$ █	Selected all members in the universe with claims greater than or equal to \$20,000. A total of 18 claims were selected with duplicate members removed.	Judgmental	No
Deceased Member 2013	All members greater than or equal to age 90.	█ members	\$ █	Selected all members from the universe with claims paid after the date of death. A total of 1 member and 1 claim totaling \$1,177 was selected.	Judgmental	No
Dependent Eligibility 2013	Members greater than or equal to age 26 designated as dependent.	█ members	N/A	Randomly selected 20 members from the universe utilizing SAS EG software.	Random	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?
High Dollar Scripts 2013	All pharmacy claims greater than or equal to \$8,000.	█ claims	\$ █	Selected the highest paid claim for each of the members in the universe. Total sample included 14 claims for 14 members with a total amount paid of \$238,129.	Judgmental	N/A
Dependent Eligibility 2013	Members greater than or equal to age 26 designated as dependent.	█ members	N/A	Selected all members in the universe that were not included in the medical claims sample. Total pharmacy sample includes 25 members.	Judgmental	N/A

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 rates were sufficiently supported by source documentation. We also 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.

Finally, 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

## A. 2013 Overstated Medical Loss Ratio Credit

**\$68,885**

The UPMC Health Plan (Plan) elected to participate in the 2012 Medical Loss Ratio (MLR) pilot program offered to certain Federal Employees Health Benefits Program (FEHBP) carriers. In order to assess the appropriateness of the Plan's premium rates in 2012 and 2013, it was required to file an MLR ratio submission under OPM's MLR program. The MLR 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 have met the OPM-established MLR threshold of 89 percent. Therefore, at least 89 cents of every health care premium dollar must have been spent on health care expenses. If the amount spent on health care expenses was less than 89 percent, a carrier owed a subsidization penalty equal to the difference between the threshold and the carrier's actual MLR.

For contract year 2013, OPM changed the MLR threshold to 85 percent and created an MLR corridor. If carriers met the MLR threshold, no penalty was due. If the MLR was over 89 percent, the carrier received 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 Plan or the Plan 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.

### 1) 2012 and 2013 Allocation of Expenses

In contract years 2012 and 2013, the Plan offered FEHBP members three benefit options; a High Option Plan, a Standard Option Plan and a High-Deductible Health Plan (HDHP). Based on the Plan's legal entity structure, the high and standard option members are included under the Plan's Health Plan, Inc. legal entity. The HDHP members are included under the Plan's Health Network Inc. legal entity. Since many of the FEHB MLR components are allocated from the U.S. Department of Health and Human Services (HHS) MLR submissions, which are filed by legal entity, the Plan should include allocations from both the Health Plan, Inc. and Health Network, Inc. legal entities to capture all FEHB benefit options in the FEHB MLR calculation.

**The Plan excluded HDHP allocations from the 2012 and 2013 MLR calculations.**

However, during our review of contract years 2012 and 2013, we found that the Plan opted to exclude the HDHP allocations (under Health Network Inc.) for Rx rebates, health care receivables, quality health improvement expenses, and fraud reduction expenses due to the low FEHBP membership in the HDHP option. Although we agree that the overall impact of excluding these MLR components is nominal, it is a best practice to include all MLR components related to all benefit options, including the HDHP option, since the claims and premium used in calculating the MLR include the HDHP option.

Consequently, our audited MLR calculations for contract years 2012 and 2013 included allocations for the HDHP benefit option under the categories of Rx rebates, health care receivables, quality health improvement expenses, and fraud reduction expenses as applicable.

**Plan Response:**

***The Plan agrees with the HDHP allocation finding in 2012 and 2013 and agrees it is a best practice to include all MLR components in future FEHB MLR submissions.***

**2) 2013 MLR Claims Data**

Our review of the Plan's 2013 MLR submission disclosed that the incurred claims amount included in the Plan's 2013 MLR calculation was incorrect. Specifically, the Plan included claims amounts not allowed by the FEHBP.

During our coordination of benefits (COB) review, we reviewed a sample of 18 claims for 18 members age 65 or over to determine whether the sampled claims were properly paid and coordinated with Medicare. We identified one claim improperly paid for a member, totaling \$33,902, who had primary coverage under Medicare. Per the 2013 contract, section 2.13, "the Carrier shall limit its payment to an amount that supplements the Benefits payable by Medicare (regardless of whether or not Medicare Benefits are paid)".

Furthermore, the FEHBP's certificate of coverage states that dependent coverage ends once dependents turn 26 years of age, unless they are incapable of self-support. To determine whether the Plan had adequate controls in place to prevent payments to ineligible dependents, we reviewed a sample of 45 members (20 members from the medical claims data and 25 members from the pharmacy claims data) age 26 and older that were designated as dependents in the claims data submitted to OPM. Our review disclosed that the Plan did

**The Plan did not have sufficient controls in place to exclude unallowable claims from the FEHBP's MLR calculation.**

not have sufficient support for two overage members. The results of our query and review of claims that the Plan paid on behalf of the ineligible dependents disclosed total improper payments of \$ [REDACTED].

In conclusion, our review of the 2013 claims data disclosed total improper payments of \$ [REDACTED]. Therefore, we removed \$ [REDACTED] from the 2013 MLR numerator in our audited calculation (See Exhibit B).

**Plan Response:**

*The Plan agrees with the claims findings for contract year 2013. Furthermore, the Plan states, "To promote correct payment of claims..., internal controls and proper system edits will be reviewed and modified as necessary by April 30, 2017."*

**3) 2013 Tax Expense**

Pursuant to the provisions of HHS 45 CFR § 158, 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 reported a total tax expense adjustment of \$ [REDACTED] in its 2013 MLR submission. However, the documentation provided by the Plan did not support this tax expense total. As a result, utilizing the documentation provided, we adjusted the tax expense amount to reflect a total of \$ [REDACTED], and used this amount in our audited 2013 MLR calculation (Exhibit B).

**Plan Response:**

*The Plan did not specifically mention the tax expense adjustment finding. However, in response to our recommendation for this finding, the Plan agreed "to implement internal controls to effectively reduce the risk of including incorrect and unsupported data in the MLR calculation."*

**4) 2013 Fraud Reduction Expense**

The Plan reported a fraud reduction expense of \$ [REDACTED] in their 2013 MLR calculation. However, in responding to our requests for supporting documentation, the Plan identified that this expense was incorrectly allocated from the Individual product line instead of the Large Group product line, under which the FEHB is included. Consequently, we calculated the fraud reduction expense based on the Large Group product line and determined the allocated

**The Plan utilized incorrect and unsupported data in the 2013 MLR calculation for the tax and fraud reduction expenses.**

fraud reduction expense to be \$ [REDACTED] for contract year 2013. We adjusted for this change in the audited 2013 MLR calculation.

**Plan Response:**

*The Plan did not specifically mention the fraud reduction expense finding. However, in response to our recommendation for this finding, the Plan agreed “to implement internal controls to effectively reduce the risk of including incorrect and unsupported data in the MLR calculation.”*

**Conclusion**

We recalculated the Plan’s 2012 and 2013 MLR submissions based upon the issues outlined above. Our audited 2013 MLR calculation resulted in an overstated MLR credit of \$68,885. Our audited 2012 MLR calculation did not result in a penalty (See Exhibit B).

**Plan Response:**

*The Plan agrees that the 2013 MLR carryover credit should be reduced by \$68,885.*

**Recommendation 1**

We recommend that the contracting officer require the Plan to allocate all MLR components for the offered FEHB benefit options in future FEHB MLR submissions.

**Recommendation 2**

We recommend that the contracting officer require the Plan to implement internal controls and proper system edits to promote the correct payment of claims coordinated with Medicare.

**Recommendation 3**

We recommend that the contracting officer require the Plan to implement internal controls and proper system edits to prevent the payment of claims for ineligible dependents.

**Recommendation 4**

We recommend that the contracting officer require the Plan to institute internal controls to mitigate the use of incorrect and unsupported data in the MLR calculation prior to filing it with OPM.

**Recommendation 5**

We recommend that the contracting officer instruct OPM's Office of the Actuary to reduce the Plan's 2013 MLR carryover credit by \$68,885.

# EXHIBIT A

## UPMC Health Plan Summary of Overstated Medical Loss Ratio Credit

### Contract Year 2013

UPMC's Filed 2013 Credit	\$141,207
Less: Audited 2013 Credit	<u>\$72,322</u>
Total Overstated MLR Credit	<u>\$68,885</u>

Report No. 1C-8W-00-16-041



# EXHIBIT B

## UPMC Health Plan 2012 Medical Loss Ratio

	Plan	Audited
2012 FEHBP MLR Threshold (a)	89%	89%
<b><u>Claims Expense</u></b>		
Incurred Claims (Medical and Pharmacy)	[REDACTED]	[REDACTED]
Dental Claims	[REDACTED]	[REDACTED]
Less: Prescription Drug Rebate	[REDACTED]	[REDACTED]
<b>Adjusted Incurred Claims</b>	[REDACTED]	[REDACTED]
Allowable Fraud Reduction Expenses	[REDACTED]	[REDACTED]
Less: Healthcare Receivables	[REDACTED]	[REDACTED]
Expenses to Improve Health Care Quality	[REDACTED]	[REDACTED]
<b>Total Adjusted Incurred Claims</b>	[REDACTED]	[REDACTED]
<b><u>Premium Expense</u></b>		
Premium Income	\$83,843,079	\$83,843,079
Less: Federal and State Taxes and Regulatory Fees	[REDACTED]	[REDACTED]
<b>Adjusted Premium</b>	[REDACTED]	[REDACTED]
Less: Defective Pricing Finding (Due OPM)	[REDACTED]	[REDACTED]
<b>Total Adjusted Premium (c)</b>	[REDACTED]	[REDACTED]
Total Adjusted Incurred Claims (MLR Numerator)	[REDACTED]	[REDACTED]
Total Adjusted Premium less Defective Pricing (MLR Denominator)	[REDACTED]	[REDACTED]
FEHBP MLR Calculation (d)	[REDACTED] %	[REDACTED] %
Penalty Calculation (If (d) is less than (a), ((a-d)*c)	\$0	\$0
<b>Total Penalty Due OPM</b>		<b>\$0</b>

Report No. 1C-8W-00-16-041

# EXHIBIT B

## UPMC Health Plan 2013 Medical Loss Ratio

	Plan	Audited
2013 FEHBP MLR Lower Corridor (a)	85%	85%
2013 FEHBP MLR Upper Corridor (b)	89%	89%
<b><u>Claims Expense</u></b>		
Incurred Claims (Medical and Pharmacy)		
Less: Incorrectly Paid COB Claims Finding		
Less: Incorrectly Paid Dependent Eligibility Claims Finding		
Less: Prescription Drug Rebate		
Dental Claims		
<b>Adjusted Incurred Claims</b>		
Allowable Fraud Reduction Expenses		
Less: Healthcare Receivables		
Expenses to Improve Health Care Quality		
<b>Total Adjusted Incurred Claims</b>		
<b><u>Premium Expense</u></b>		
Premium Income	\$79,699,538	\$79,699,539
Less: Federal and State Taxes and Regulatory Fees		
<b>Adjusted Premium</b>		
Less: Defective Pricing Finding (Due OPM)		
<b>Total Adjusted Premium (c)</b>		
Total Adjusted Incurred Claims (MLR Numerator)		
Total Adjusted Premium less Defective Pricing (MLR Denominator)		
FEHBP MLR Calculation (d)	%	%
Penalty Calculation (If (d) is less than (a), ((a-d)*c)	\$0	\$0
Credit Calculation (If (d) is greater than (b), ((d-b)*c)	\$141,207	\$72,322
<b>Overstated Credit Amount</b>		<b>(\$68,885)</b>

Report No. 1C-8W-00-16-041

# APPENDIX



UPMC Health Plan  
Gordon Gebbens  
Senior Vice President  
Finance – Insurance  
Services and CFO  
UPMC Insurance  
Services Operating  
Companies

600 Grant Street  
55<sup>th</sup> Floor  
Pittsburgh, PA 15219  
T 412-454-5675

██████████@upmc.edu

March 6, 2017

██████████  
Chief, Community-  
Rated Audits Group  
U.S. Office of Personnel Management  
Office of the Inspector General

Report Number 1C-8W-00-16-041

Enclosed are the management responses for the audit report which detailed the results of the Federal Employees Health Benefits Program (FEHBP) operations at UPMC Health Plan. The audit covered contract years 2012 and 2013.

#### 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 \$68,885.

#### Management Response:

UPMC Health Plan agrees that the 2013 OPM MLR credit was overstated by \$68,885 and will instruct the OPM's Office of the Actuary to reduce the 2013 MLR carryover credit by this amount.

#### Recommendation 2

We recommend that the contracting officer require the Plan to allocate all MLR components for the offered FEHB benefit options in future FEHB MLR submissions.

#### Management Response:

UPMC Health Plan did exclude the High-Deductible Health Plan allocations (under Health Network, Inc.) for Rx rebates, health care receivables, quality health improvement, and fraud reduction expenses. Even though these amounts are nominal, we agree that it is a best practice to include all MLR components and will allocate all MLR components in future FEHB MLR submissions.

Report No. 1C-8W-00-16-041

### Recommendation 3

We recommend that the contracting officer require the Plan to implement internal controls and proper system edits to promote the correct payment of claims coordinated with Medicare.

#### Management Response:

UPMC Health Plan agrees with findings that a claim in the amount of \$33,902 was paid for a member that had primary coverage under Medicare. To promote correct payment of claims coordinated with Medicare, internal controls and proper system edits will be reviewed and modified as necessary by April 30, 2017

### Recommendation 4

We recommend that the contracting officer require the Plan to implement internal controls and proper system edits to prevent the payment of claims for ineligible dependents.

#### Management Response:

UPMC Health Plan agrees with findings that 2 of the 50 members (4%) tested that were age 26 and older did not have sufficient support to validate that they were eligible. To prevent the payment of claims for ineligible dependents, internal controls and proper system edits will be reviewed and modified as necessary by April 30, 2017.

### Recommendation 5

We recommend that the contracting officer require the Plan to institute internal controls to mitigate the use of incorrect and unsupported data in the MLR calculation prior to filing it with OPM.

#### Management Response:

UPMC Health Plan agrees to implement internal controls to effectively reduce the risk of including incorrect and unsupported data in the MLR calculation. As it relates to medical expenses included in the MLR, the internal controls identified in the management response to Recommendation 3 and Recommendation 4 will mitigate the risk of having incorrect claims paid, which would impact reporting incorrect medical expenses. Regarding administrative expenses that are included in the MLR calculation, expenses that are coded to this line of business will be routed to a reviewer from the accounting team. Before these expenses are posted to the

Report No. 1C-8W-00-16-041

accounting system, they will be reviewed for accuracy and appropriate support as it relates to being a valid FEHBP expense.

Please contact me with questions or if you require additional information.

Thank you.

A handwritten signature in black ink, appearing to read 'G. Gebbens', with a stylized flourish at the end.

Gordon Gebbens

Senior Vice President Finance – Insurance Services and CFO  
UPMC Insurance Services Operating Companies  
UPMC Health Plan

Report No. 1C-8W-00-16-041



## **Report Fraud, Waste, and Mismanagement**

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

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

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

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

Report No. 1C-8W-00-16-041

-- CAUTION --

This report has been distributed to Federal officials who are responsible for the administration of the subject program. This non-public version may contain confidential and/or proprietary information, including information protected by the Trade Secrets Act, 18 U.S.C. § 1905, and the Privacy Act, 5 U.S.C. § 552a. Therefore, while a redacted version of this report is available under the Freedom of Information Act and made publicly available on the OIG webpage (<http://www.opm.gov/our-inspector-general>), this non-public version should not be further released unless authorized by the OIG.