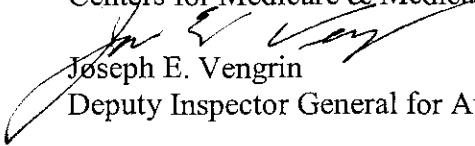




JUL - 5 2005

TO: Leslie V. Norwalk, Esq.
Acting Director, Center for Beneficiary Choices
Centers for Medicare & Medicaid Services

FROM: 
Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of Humana Health Plan of Texas, Inc.'s Modifications to Its 2001 Adjusted Community Rate Proposal Under the Benefits Improvement and Protection Act of 2000 (A-06-03-00027)

Attached is an advance copy of our final report on Humana Health Plan of Texas, Inc.'s (Humana) modifications to its 2001 adjusted community rate proposal (proposal) under the Benefits Improvement and Protection Act (BIPA) of 2000. We will issue this report to Humana within 5 business days. This is one of a series of reports on Medicare+Choice organizations' (MCO) use of the additional funding provided by BIPA.

Under Part C (Medicare+Choice) of the Medicare program, MCOs are responsible for providing all Medicare-covered services, except hospice care, in return for a predetermined capitated payment. BIPA provided an estimated \$11 billion in increased capitation payments to MCOs effective March 1, 2001. BIPA required MCOs with plans for which payment rates increased to submit revised proposals to show how they would use the increase during 2001. According to section 604(c) of BIPA, MCOs were required to use the additional amounts to reduce beneficiary premiums or cost-sharing, enhance benefits, contribute to a stabilization fund for benefits in future years, or stabilize or enhance beneficiary access to providers.

Humana submitted a revised proposal that reflected an overall increase of \$14.4 million in estimated direct medical care costs. About \$7.8 million of the \$14.4 million reflected the increase in Medicare capitation payments provided by the BIPA legislation. The remaining \$6.6 million, which was not related to the BIPA funding increase, resulted from Humana updating its original medical cost assumptions and decreasing its estimate for additional revenues.

Our objectives were to determine whether Humana (1) supported the \$7.8 million of additional capitation payments and used the funds in a manner consistent with BIPA requirements and (2) supported the \$6.6 million cost increase that was not related to the BIPA funding increase.

Of the \$7.8 million BIPA capitation payment increase in Humana's revised proposal, \$2.6 million was properly supported and was used in a manner consistent with BIPA requirements. However, the remaining \$5.2 million was unsupported; therefore, we could not determine whether it was used in a manner consistent with BIPA requirements.

Additionally, of the \$6.6 million increase in direct medical care costs that was not related to the BIPA funding increase, \$1.3 million was supported. The remaining \$5.3 million was unsupported.

We recommend that Humana:

- work with the Centers for Medicare & Medicaid Services (CMS) to determine how much of the \$5.2 million BIPA capitation payment increase was used in a manner consistent with BIPA requirements and refund any amount not used in such a manner,
- work with CMS to determine what remedies are needed to address the \$5.3 million of unsupported increases unrelated to the BIPA funding increase, and
- ensure that estimated costs in future proposals are properly supported.

In response to our draft report, Humana did not address our recommendations. Humana stated that the base cost did not change from its initial 2001 proposal and that it had actually paid \$713,200 more than estimated to providers. Humana also provided additional documents to support its revised proposal.

We made changes to the draft report to address the additional items provided by Humana. However, even with the additional items, we could not determine whether the unsupported \$5.2 million associated with the increase in BIPA funding was used in accordance with BIPA requirements. In addition, the \$5.3 million of cost increases not related to the BIPA funding increase remains unsupported.

If you have any questions or comments about this report, please do not hesitate to call me, or have your staff contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Gordon L. Sato, Regional Inspector General for Audit Services, at (214) 767-8414. Please refer to report number A-06-03-00027 in all correspondence.

Attachment



JUL - 8 2005

Report Number: A-06-03-00027

Mr. Michael McCallister
CEO, Humana Health Plan
500 West Main Street
Louisville, Kentucky 40201-1438

Dear Mr. McCallister:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Humana Health Plan of Texas, Inc.'s Modifications to Its 2001 Adjusted Community Rate Proposal Under the Benefits Improvement and Protection Act of 2000." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

The HHS action official named below will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent the information contained therein is not subject to exemptions in the Act which the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-06-03-00027 in all correspondence.

Sincerely,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:
James R. Farris, M.D.
Regional Administrator
Centers for Medicare & Medicaid Services
1301 Young Street, Room 714
Dallas, Texas 75202

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF HUMANA HEALTH PLAN
OF TEXAS, INC.'S MODIFICATIONS
TO ITS 2001 ADJUSTED COMMUNITY
RATE PROPOSAL UNDER THE
BENEFITS IMPROVEMENT AND
PROTECTION ACT OF 2000**



**Daniel R. Levinson
Inspector General**

**JULY 2005
A-06-03-00027**

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.



EXECUTIVE SUMMARY

BACKGROUND

Under Part C (Medicare+Choice) of the Medicare program, Medicare+Choice organizations (MCOs) are responsible for providing all Medicare-covered services, except hospice care, in return for a predetermined capitated payment. The Benefits Improvement and Protection Act (BIPA) of 2000 provided an estimated \$11 billion in increased capitation payments to MCOs effective March 1, 2001.

BIPA required MCOs with plans for which payment rates increased to submit revised adjusted community rate proposals (proposals) to show how they would use the increase during contract year 2001. Humana Health Plan of Texas, Inc. (Humana) submitted a revised proposal for contract year 2001 that reflected an overall increase of \$14.4 million in estimated direct medical care costs. About \$7.8 million of the \$14.4 million reflected the increase in Medicare capitation payments provided by the BIPA legislation. The remaining \$6.6 million, which was not related to the BIPA funding increase, resulted from Humana updating its original medical cost assumptions and decreasing its estimate for additional revenues.

OBJECTIVES

Our objectives were to determine whether Humana (1) supported the \$7.8 million of additional capitation payments and used the funds in a manner consistent with BIPA requirements and (2) supported the \$6.6 million cost increase that was not related to the BIPA funding increase.

SUMMARY OF FINDINGS

According to section 604(c) of BIPA, MCOs were required to use the additional amounts to reduce beneficiary premiums or cost-sharing, enhance benefits, contribute to a stabilization fund for benefits in future years, or stabilize or enhance beneficiary access to providers. In addition, the Centers for Medicare & Medicaid Services (CMS) instructions required MCOs to support proposal revisions.

Of the \$7.8 million BIPA capitation payment increase in Humana's revised proposal, \$2.6 million was properly supported and was used in a manner consistent with BIPA requirements. However, the remaining \$5.2 million increase was unsupported. Specifically, Humana could not demonstrate that:

- \$4.3 million of increased medical cost estimates was associated with stabilizing or enhancing access to providers and
- \$866,899 of increased medical cost estimates was to be used to increase payments to entities in the provider network.

Because the \$5.2 million increase was unsupported, we could not determine whether it was used in a manner consistent with BIPA requirements.

Additionally, of the \$6.6 million increase in direct medical care costs that was not related to the BIPA funding increase, \$1.3 million was supported. The remaining \$5.3 million was unsupported.

RECOMMENDATIONS

We recommend that Humana:

- work with CMS to determine how much of the \$5.2 million BIPA capitation payment increase was used in a manner consistent with BIPA requirements and refund any amount not used in such a manner,
- work with CMS to determine what remedies are needed to address the \$5.3 million of unsupported increases unrelated to the BIPA funding increase, and
- ensure that estimated costs in future proposals are properly supported.

HUMANA COMMENTS

Humana did not address our recommendations. Humana stated that the base cost did not change from its initial 2001 proposal and that it had actually paid \$713,200 more than estimated to providers. Humana also provided additional documents to support the trend of 11.4 percent that was adjusted to 9 percent for proposal purposes and the demographic factor of 1.0164 percent.

Humana's response to our draft report is included as the appendix to this report. We excluded the attachments to Humana's comments because they contained proprietary data.

OFFICE OF INSPECTOR GENERAL RESPONSE

We made changes to the draft report to address the additional items provided by Humana. However, even with the additional items, we could not determine whether the unsupported \$5.2 million associated with the increase in BIPA funding was used in accordance with BIPA requirements. In addition, the \$5.3 million of cost increases not related to the BIPA funding increase remains unsupported.

BIPA Funds

With regard to the \$5.2 million BIPA funding increase, we agree that Humana did not change the base year direct medical care costs from its initial 2001 proposal. Humana modified estimated direct medical care costs to reflect changes in payments to providers but did not demonstrate whether the resulting \$4.3 million increase was associated with stabilizing or enhancing the provider network as required by BIPA. Additionally, Humana did not support \$866,899 of

increased medical cost estimates associated with terminated providers and incorrect contract payment terms.

Humana did not provide sufficient documentation to support that it had actually paid \$713,200 more than estimated to providers.

Non-BIPA Funds

Regarding the unsupported \$5.3 million increase in direct medical care costs that was not related to the BIPA funding increase, the additional documents that Humana provided to support the trend and the demographic factor were not adequate. In addition, Humana's use of a single trend factor for all cost categories does not comply with the proposal instructions for reporting expected variations. Humana merely adjusted each line item of base year costs by a single, unsupported trend factor in determining the expected variations.

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INTRODUCTION

BACKGROUND

Medicare+Choice

Under Title XVIII of the Social Security Act, the Medicare program provides health insurance to Americans aged 65 and over, those who have permanent kidney failure, and certain people with disabilities. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

The Balanced Budget Act of 1997 (Public Law 105-33) established Part C (Medicare+Choice) of the Medicare program, which offers Medicare beneficiaries a variety of health delivery models, including Medicare+Choice organizations (MCOs), such as health maintenance organizations; preferred provider organizations; and provider-sponsored organizations. MCOs are responsible for providing all Medicare-covered services, except hospice care, in return for a predetermined capitated payment.

Proposal Requirements

At the time of our review, Medicare regulations required each MCO participating in the Medicare+Choice program to complete, for each plan, an annual adjusted community rate proposal (proposal) that contains specific information about benefits and cost sharing. The MCO had to submit the proposal to CMS before the beginning of each contract period. CMS used the proposal to determine if the estimated capitation paid to the MCO exceeded what the MCO would charge in the commercial market for Medicare-covered services, adjusted for the utilization patterns of the Medicare population. MCOs had to use any excess as prescribed by law, including offering additional benefits, reducing members' premiums, accepting a capitation payment reduction for the excess amount, or depositing funds in a stabilization fund administered by CMS. The proposal process was designed to ensure that Medicare beneficiaries were not overcharged for the benefit package being offered.

BIPA Requirements

The Benefits Improvement and Protection Act (BIPA) provided for an estimated \$11 billion in increased capitation payments to MCOs effective March 1, 2001. BIPA required MCOs with plans whose payment rates increased to submit revised proposals by January 18, 2001, to show how they would use the increase during contract year 2001. The CMS instructions for the revised proposals, dated January 9, 2001, required MCOs to (1) submit a cover letter summarizing how they would use the increased payments and (2) support entries that changed from the original filing.

Humana's Revised Proposal

For contract year 2001, Humana Health Plan of Texas, Inc. (Humana) submitted the required proposal for contract number H 4510-006. The proposal reflected an overall increase of \$14.4 million in estimated direct medical care costs. About \$7.8 million of the \$14.4 million reflected the increase in Medicare capitation payments provided by BIPA. The remaining \$6.6 million, which was not related to the BIPA funding increase, resulted from Humana updating its original medical cost assumptions and decreasing its estimate for additional revenues.

The revised proposal stated that Humana would (1) update base period direct medical care costs to reflect increased payments to providers above the costs originally estimated, which were based on incomplete 1999 and 2000 data; (2) cover increased costs due to demographic changes; and (3) increase payments to providers with payment terms set as a percentage of Medicare premiums. The initial proposal increased estimated costs by 8.67 percent, whereas the revised proposal increased estimated costs by 26.42 percent.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether Humana (1) supported the \$7.8 million of additional capitation payments and used the funds in a manner consistent with BIPA requirements and (2) supported the \$6.6 million cost increase that was not related to the BIPA funding increase.

Scope

Our review covered the \$14.4 million in direct medical care cost increases consisting of \$7.8 million related to BIPA modifications and \$6.6 million unrelated to BIPA.

Our audit objectives did not require us to review the internal control structure of Humana.

We conducted our audit work at Humana's central office in Louisville, KY.

Methodology

To accomplish our objectives, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed the cover letter Humana submitted with its revised proposal, in which it stated how it would use the \$7.8 million of additional funds in the contract year;
- compared the initial proposal with the revised proposal to determine the modifications;

- reviewed support for changes in membership projections indicated in the revised proposal;
- reviewed support for the revised direct medical care cost projections;
- compared the proposed contract rates with the actual contract rates in effect for contract year 2001 for percentage of premium providers;
- reviewed the supporting documentation for the revised average payment rate;
- verified the mathematical accuracy of the plan's direct medical care cost projections;
- interviewed Humana officials; and
- calculated the increase in 2001 Medicare capitation payments using actual membership data obtained from CMS.

We performed our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Humana's revised proposal reflected an overall increase of \$14.4 million in estimated direct medical care costs. About \$7.8 million of the \$14.4 million reflected the increase in Medicare capitation payments provided by BIPA. The remaining \$6.6 million, which was not related to the BIPA funding increase, resulted from Humana updating its original medical cost assumptions and decreasing its estimate for additional revenues.

Of the \$7.8 million BIPA capitation payment increase in Humana's revised proposal, \$2.6 million was properly supported and was used in a manner consistent with BIPA requirements. However, the remaining \$5.2 million increase was unsupported. Specifically, Humana could not demonstrate that:

- \$4.3 million of increased medical cost estimates was associated with stabilizing or enhancing access to providers and
- \$866,899 of increased medical cost estimates was to be used to increase payments to entities in the provider network.

Because the \$5.2 million increase was not adequately supported, we could not determine whether it was used in a manner consistent with BIPA requirements.

Additionally, of the \$6.6 million increase in direct medical care costs that was not related to the BIPA funding increase, \$1.3 million was supported. The remaining \$5.3 million was unsupported.

COMPLIANCE WITH BIPA REQUIREMENTS

Under section 604(c) of BIPA, MCOs were required to use the additional amounts under sections 601 and 602 to reduce beneficiary premiums, reduce beneficiary cost-sharing, enhance benefits, contribute to a benefits stabilization fund for use in future years, or stabilize or enhance beneficiary access to providers.

Of the \$7.8 million capitation payment increase in Humana's revised proposal, \$2.6 million was used in a manner consistent with BIPA requirements and was properly supported. Because the remaining \$5.2 million increase was unsupported, we could not determine whether it was used in a manner consistent with BIPA requirements. This increase resulted from Humana updating its estimated direct medical care costs (\$4.3 million) and increasing payments to providers with contractual payment terms set as a percentage of Medicare premiums (\$866,899), as explained below.

Updated Direct Medical Care Costs

Of the \$5.2 million previously mentioned, we could not determine whether Humana used about \$4.3 million for any of the purposes permitted by BIPA. Humana updated direct medical care costs to reflect increased payments to providers above the costs originally estimated.

According to CMS's instructions for the revised proposal, updates to cost assumptions and projections were allowed only to the extent they would enhance or stabilize the provider network. The instructions required that the proposal include "a summary list detailing how the increased payment will be used" and "explain how each change stabilizes and/or enhances access to providers." However, Humana's proposal did not include any details explaining how the increased payment would enhance or stabilize the provider network. A Humana official acknowledged that Humana had not reviewed the revised proposal instructions in detail.

Increased Payments to Percentage of Premium Providers

Humana increased direct medical care cost estimates for two providers with contractual payment terms set as a percentage of Medicare premiums. Humana's formula for estimating this increase showed 100 percent of this increase in Medicare premiums passing to these two providers for calendar year 2001. However, one contract terminated prior to 2001, and the other terminated June 30, 2001. In addition, according to the contract terms of the provider that was in operation only through June 2001, the percentage of the increase in Medicare premiums passed through should have been 80 percent rather than the 100 percent applied. As a result, \$866,899 of costs on the revised proposal was unsupported. The CMS instructions for the revised proposals required that the

cost modifications be justified. Further, Humana could not demonstrate that this amount was used in accordance with BIPA requirements.

During our audit fieldwork, Humana stated that it believed the pass-through cost estimate was a good estimate at the time the proposal was prepared and that it was based on a simple methodology used to meet the submission deadline. However, Humana did not review contract terms before estimating pass-through costs. According to Humana officials, they did not have time to review provider contracts for all their plans and meet the submission deadline.

UNSUPPORTED COST ASSUMPTIONS NOT RELATED TO BIPA FUNDING INCREASE

The CMS instructions for the revised proposals, dated January 9, 2001, required MCOs to support entries that changed from the original filing.

Of the \$6.6 million increase in direct medical care costs that was not related to BIPA funding, \$1.3 million was supported. However, Humana increased costs by a net adjustment of \$5.3 million associated with a 9 percent trend and an estimated demographic factor but did not provide any information to support this increase. Humana applied an estimated (1) trend of 9 percent to the updated base costs as of November 2000, resulting in a cost increase of \$7.7 million; (2) 1.0164 percent demographic factor, resulting in a cost increase of \$912,630; and (3) benefit reduction of \$3.3 million. According to Humana's cover letter, the trend was based on actual 1999 to 2000 claim cost trends, expected provider contract changes in 2001, and expected changes in 2000 to 2001 claim cost trends.

The documents provided to support the trend development and the demographic factor were not adequate. Humana did not document its rationale or methodology showing how the trend assumption was derived. Further, the trend adjusted each line item of base year costs by a single factor but did not provide, as required by the proposal instructions, discrete and measurable estimates of expected variations.

CONCLUSION

Humana did not support the \$5.2 million of BIPA cost increases, and we could not determine whether these funds were used for authorized BIPA activities. In addition, Humana did not provide adequate support for its \$5.3 million increase in estimated direct medical care costs that was not related to the BIPA funding increase.

RECOMMENDATIONS

We recommend that Humana:

- work with CMS to determine how much of the \$5.2 million BIPA capitation payment increase was used in a manner consistent with BIPA requirements and refund any amount not used in such a manner,

- work with CMS to determine what remedies are needed to address the \$5.3 million of unsupported increases unrelated to the BIPA funding increase, and
- ensure that estimated costs in future proposals are properly supported.

HUMANA COMMENTS

Humana did not address our recommendations. Humana stated that the base cost did not change from its initial 2001 proposal and that it had actually paid \$713,200 more than estimated to providers. Humana also provided additional documents to support the trend of 11.4 percent that was adjusted to 9 percent for proposal purposes and the demographic factor of 1.0164 percent.

Humana's response to our draft report is included as the appendix to this report. We excluded the attachments to Humana's comments because they contained proprietary data.

OFFICE OF INSPECTOR GENERAL RESPONSE

We made changes to the draft report to address the additional items that Humana provided. However, even with the additional items, we could not determine whether the unsupported \$5.2 million associated with the increase in BIPA funding was used in accordance with BIPA requirements. In addition, \$5.3 million of cost increases not related to the BIPA funding increase was not supported.

BIPA Funds

With regard to the \$5.2 million BIPA funding increase, we agree that Humana did not change the base year direct medical care costs from its initial 2001 proposal. However, Humana used updated claims data through November 2000 in estimating contract year 2001 direct medical care costs in the revised proposal. Humana modified estimated direct medical care costs to reflect changes in payments to providers. Humana did not demonstrate whether the resulting \$4.3 million increase was associated with stabilizing or enhancing the provider network as required by BIPA. Additionally, Humana did not support \$866,899 of increased medical cost estimates associated with terminated providers and incorrect contract payment terms.

Humana did not provide sufficient documentation to support that it had actually paid \$713,200 more than estimated to providers.

Non-BIPA Funds

Regarding the unsupported \$5.3 million increase in direct medical care costs that was not related to the BIPA funding increase, the additional documents Humana provided to support the trend development and the demographic factor were not adequate.

Humana did not document its rationale or methodology showing how the trend was derived or how the increase was associated with provider network enhancement or stabilization. In

addition, Humana failed to follow the proposal instructions regarding expected variation entries. According to the proposal instructions, expected variations were intended to adjust costs so that they more closely approximated the costs expected to be incurred during the contract year. For example, if Medicare added another benefit to Medicare-covered benefits, the cost of the benefit would not have been reflected in base year costs and an expected variation entry would have been required to adjust for that. Similarly, if the MCO planned to drop a benefit in the contract year, the MCO should have removed the cost of the benefit from base year costs using an expected variation adjustment. Other examples included changes in benefit design and expected changes in utilization patterns. Humana's use of a single trend factor for all cost categories did not comply with the proposal instructions for reporting expected variations. Humana merely adjusted each line item of base year costs by a single, unsupported trend factor in determining the expected variations.

Therefore, we continue to believe that the \$5.3 million increase that was not related to BIPA funding is unsupported.

APPENDIX

Humana Inc.
500 West Main Street
P.O. Box 1438
Louisville, KY 40201-1438
502 580 1000 Tel

August 26, 2004



Gordon L. Sato
Regional Inspector General for Audit Services, OIG
Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

Dear Mr. Sato:

The purpose of this letter is to respond to issues raised in your recent letter regarding Humana's BIPA ACR for H4510, Plan 006 including undocumented actuarial assumptions, non-compliant change in base costs, and insufficient allocation of additional BIPA revenue to providers.

With regard to the actuarial assumptions, after investigation, we have located two documents supporting the actuarial secular trend development (11.4%) and demographic factor development (1.0164%) we used. (See Attachments A and B.) A third document, Exhibit 3a, shows that after the actuaries conferred with Corporate Finance and Market Leaders in early January 2001, the team concluded that a secular trend of 9.0% was more appropriate. Please note that Exhibit 3a was previously released to the auditors.

With regard to the base cost for H4510, Plan 006, the base cost of \$407.76 PMPM did not change from our initial 2001 ACR to our 2001 BIPA ACR. With regard to the issue of allocating additional BIPA revenue to providers, we believe that paying providers the correct amount (i.e., with sufficient trend) was consistent with the intent of BIPA to improve beneficiary access to and stabilize the financial position of our providers—both of which, we believe, were in the best interest of our members. Based on the BIPA ACR, the estimated allocation of additional BIPA revenue to providers was \$1.38M. As shown in Attachment C, the actual amount allocated to providers from March 1, 2001 through December 31, 2001 was \$2.45M.

Please call me should you have any questions or concerns.

Sincerely,

A handwritten signature in black ink that reads "Harry Hotchkiss".

Harry Hotchkiss, ASA, MAAA
Senior Products Actuarial Director
(800) 664-4140, ext. 2047
hhotchkiss@humana.com

cc: John Bertko, Vice President and Corporate Actuary
Tony Hammond, Vice President and Chief Actuary, Senior Products
Heidi Margulis, Senior Vice President – Government Relations
Gene Shields, Senior Vice President – Senior Products

Attachments