U.S. OFFICE OF PERSONNEL MANAGEMENT
OFFICE OF THE INSPECTOR GENERAL
OFFICE OF AUDITS

Final Audit Report

Subject:

Audit of the Federal Employees Health Benefits Program Operations at Group Health Cooperative

Report No. 1C-54-00-09-048

Date: September 8, 2010

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

AUDIT REPORT

Federal Employees Health Benefits Program
Community-Rated Health Maintenance Organization
Group Health Cooperative
Contract Number CS 1043 - Plan Code 54
Seattle, Washington

Report No. 1C-54-00-09-048 **Date:** September 8, 2010

Michael R. Esser
Assistant Inspector General
for Audits

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

EXECUTIVE SUMMARY

Federal Employees Health Benefits Program
Community-Rated Health Maintenance Organization
Group Health Cooperative
Contract Number CS 1043 - Plan Code 54
Seattle, Washington

Report No. 1C-54-00-09-048 **Date:** September 8, 2010

The Office of the Inspector General performed an audit of the Federal Employees Health Benefits Program (FEHBP) operations at Group Health Cooperative (Plan). The audit covered contract years 2006 through 2008 and was conducted at the Plan's office in Seattle, Washington.

This report questions $37,816,559 for defective pricing in contract years 2007 and 2008. The questioned amount includes $33,122,807 for inappropriate health benefit charges and $4,693,752 due the FEHBP for lost investment income, calculated through June 30, 2010. We found that the FEHBP rates were developed in accordance with the Office of Personnel Management's rules and regulations in 2006.

For contract years 2007 and 2008, we determined that the FEHBP's rates were overstated by $30,636,448 in 2007 and $2,486,359 in 2008 due to defective pricing. More specifically, the Plan did not select the correct similarly sized subscriber group (SSSG) for comparison to the FEHBP and did not apply that SSSG discount appropriately at line 5 of the FEHBP's rates in 2007. Additionally, the Plan did not appropriately apply an SSSG discount in 2008 at line 5 of the FEHBP's rates.

Consistent with the FEHBP regulations and the contract, the FEHBP is due $4,693,752 for lost investment income, calculated through June 30, 2010, on the defective pricing findings. In

addition, the contracting officer should recover lost investment income on amounts due for the period beginning July 1, 2010, until all defective pricing amounts have been returned to the FEHBP.

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I. INTRODUCTION AND BACKGROUND

Introduction

We completed an audit of the Federal Employees Health Benefits Program (FEHBP) operations at Group Health Cooperative (Plan) in Seattle, Washington. The audit covered contract years 2006 through 2008. The audit was conducted pursuant to the provisions of Contract CS 1043; 5 U.S.C. Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit was performed by the Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

Background

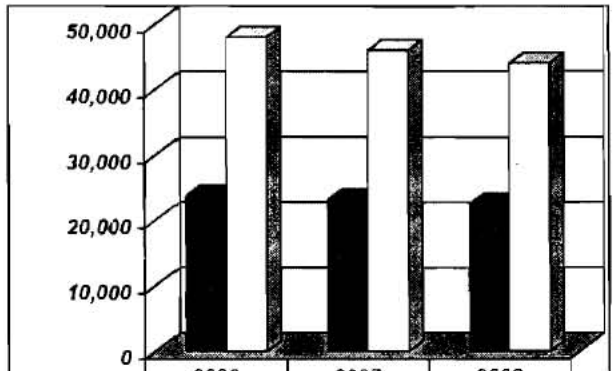
The FEHBP was established by the Federal Employees Health Benefits Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for federal employees, annuitants, and dependents. The FEHBP is administered by OPM's Center for Retirement and Insurance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

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 FEHBP should pay a market price rate, which is defined as the best rate offered to either of the two groups closest in size to the FEHBP. 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 chart to the right shows the number of FEHBP contracts and members reported by the Plan as of March 31 for each contract year audited.

FEHBP Contracts/Members
March 31



	2006	2007	2008
Contracts	23,920	23,318	22,639
Members	48,117	46,095	44,152

The Plan has participated in the FEHBP since 1960 and provides health benefits to FEHBP members in most of Washington State and Northern Idaho. The last audit conducted by our office was a full scope audit and covered contract years 2000, 2001, 2003 and 2005. All matters related to that audit have been resolved.

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 the preparation of this report and are included, as appropriate, as the Appendix.

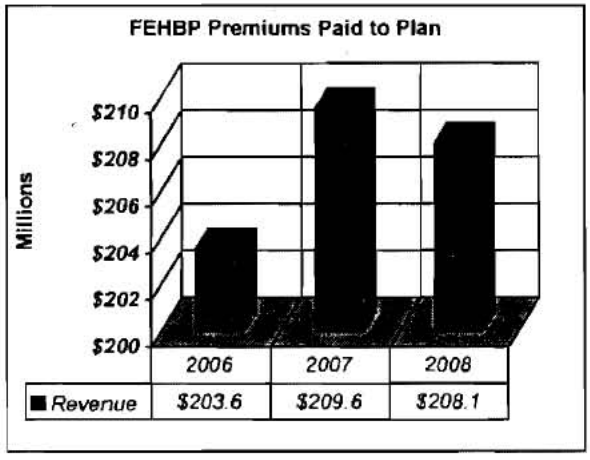
II. OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The primary objectives of the audit were to verify that the Plan offered market price rates to the FEHBP and to verify that the loadings to the FEHBP rates were reasonable and equitable. 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 2006 through 2008. For these contract years, the FEHBP paid approximately $621.3 million in premiums to the Plan. The premiums paid for each contract year audited are shown on the chart above.

OIG audits of community-rated carriers are designed to test carrier compliance with the FEHBP contract, applicable laws and regulations, and OPM 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 appropriate similarly sized subscriber groups (SSSG) were selected;
- the rates charged to the FEHBP were the market price rates (i.e., equivalent to the best rate offered to the SSSGs); and
- the loadings to the FEHBP rates were reasonable and equitable.

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 testing 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 at the Plan's office in Seattle, Washington, during May 2009. Additional audit work was completed at our field offices in Cranberry Township, Pennsylvania, and Jacksonville, Florida.

Methodology

We examined the Plan's federal rate submissions and related documents as a basis for validating the market price rates. Further, we examined claim payments to verify that the cost data used to develop the FEHBP rates was accurate, complete and valid. In addition, we examined the rate development documentation and billings to other groups, such as the SSSGs, to determine if the market price was actually charged to the FEHBP. Finally, we used the contract, the Federal Employees Health Benefits Acquisition Regulations (FEHBAR), and OPM's Rate Instructions to Community-Rated Carriers to determine the propriety of the FEHBP premiums and the reasonableness and acceptability of the Plan's rating system.

To gain an understanding of the internal controls in the Plan's rating system, we reviewed the Plan's rating system's policies and procedures, interviewed appropriate Plan officials, and performed other auditing procedures necessary to meet our audit objectives.

III. AUDIT FINDINGS AND RECOMMENDATIONS

Premium Rates

1. Defective Pricing — $33,122,807

The Certificates of Accurate Pricing the Plan signed for contract years 2007 and 2008 were defective. In accordance with federal regulations, the FEHBP is therefore due a price adjustment for these years. Application of the defective pricing remedies shows that the FEHBP is entitled to premium adjustments totaling $33,122,807 (see Exhibit A). We found that the FEHBP rates were developed in accordance with OPM's rules and regulations for contract year 2006.

FEHBAR 1652.215-70 provides that carriers proposing rates to OPM are required to submit a Certificate of Accurate Pricing certifying that the proposed subscription rates, subject to adjustments recognized by OPM, are market price rates. OPM regulations refer to a market price rate in conjunction with the rates offered to an SSSG. If it is found that the FEHBP was charged higher than a market price (i.e., the best rate offered to an SSSG), a condition of defective pricing exists, requiring a downward adjustment of the FEHBP premiums to the equivalent market price.

2007

The Plan selected the [redacted] and [redacted] as SSSGs for contract year 2007. We agree with the selection of the [redacted] but disagree with the selection of [redacted] should have been selected as an SSSG since it was closer in enrollment size to the FEHBP and because it met SSSG requirements.

Our analysis of the rates charged to the SSSGs shows that [redacted] received a [redacted] percent discount. The Plan applied a [redacted] percent discount to the FEHBP rates. The [redacted] did not receive a discount.

Since OPM requires the FEHBP rates to be at least equivalent to the best rates given to an SSSG and that the discount be applied at line 5, we recalculated the FEHBP rates by applying the factors, trends, and the [redacted] percent discount given to [redacted] A comparison of our audited line 5 rates to the Plan's reconciled line 5 rates shows that the FEHBP was overcharged $30,636,448 in 2007 (see Exhibit B).

Plan's Comments (See Appendix):

I. (a) [redacted] cannot be an SSSG because [redacted] is not a customer group of Group Health Cooperative (GHC) but is a customer of Group Health Options, Inc. (GHO), which is a wholly-owned subsidiary of GHC.

(b) Only groups that contract with GHC "the Carrier" are eligible for SSSG consideration.

(c) The Plan asserts that the definition of "Carrier" is the entity contracting with the FEHBP and does not include the subsidiaries and affiliates of the entity.

II. Even if [redacted] were a customer group of GHC, [redacted] is comprised of individuals and groups coming together to purchase insurance and qualifies for exclusion as a purchasing alliance.

III. The discount given to an SSSG should be applied only to the non-Medicare portion of the FEHBP's rates, which is the per member per month line 1 portion of the rate, before the Medicare rates are blended in.

IV. [redacted] factors and trends should not be used in the calculation of the FEHBP's rates; however, if [redacted] factors and trends are used to re-rate the FEHBP, then [redacted] commission and tax factors should be applied to the FEHBP as well.

OIG's Response to the Plan's Comments:

I. (a) GHO does not meet the criteria to be a separate line of business. According to the 2007 rate instructions, "Groups covered under a separate line of business of a carrier that offers an FEHBP product are excluded from consideration as an SSSG. To be considered a separate line of business all of the following criteria must be satisfied:

- It must be a separate organizational unit, such as a division;
- It must have separate financial accounting with 'books and records that provide separate revenue and expense information'; and
- It must have a separate work force and separate management involved in the design and rating of the healthcare product."

GHO does not have separate financial accounting with books and records that provide separate revenue and expense information, nor does it have a separate work force and separate management involved in the design and rating of the healthcare product. Therefore, GHO groups are not excluded under the separate line of business criteria above and can be SSSGs.

(b) Any group that contracts with GHC and its subsidiaries (excluding separate lines of business as established in the 2007 Rate Reconciliation Instructions above) can be selected as an SSSG.

According to the 2007 rate instructions, "any group with which an FEHB carrier enters into an agreement to provide health care services may be an SSSG (including government entities, groups that have multi-year contracts, and groups having point of service products)."

Since GHO is not a separate line of business (as defined above) from GHC and since GHO provides all of the POS and PPO products for GHC, groups under GHO can be selected as SSSGs.

(c) The interpretation that the term "Carrier", as established in Carrier Letter 2005-11, excludes subsidiaries and affiliates is inaccurate. The rewording of 'parent company' to 'carrier' and the addition of 'subsidiary' to the first disqualifying point does not negate the second and third disqualifying points. To be a separate line of business, GHO must have separate financial accounting with "books and records that provide separate revenue and expense information," and GHO must have a "separate work force and separate management involved in the design and rating of the healthcare product."

OPM clearly establishes that all three disqualifying points must be met to exclude an entity (including separate and distinct legal entities) and their contracted groups from SSSG qualification. As discussed above, GHO does not meet the qualifications to be considered a separate line of business. Therefore, [redacted] and all other GHO groups, if meeting the SSSG criteria, can be selected as SSSGs.

II. [redacted] is a purchasing alliance made up of groups only (not individuals) and does not meet OPM's qualification to be excluded from SSSG consideration as a purchasing alliance. According to the 2007 rate instructions, "Purchasing Alliances are any groups bonding together to purchase health insurance. Purchasing Alliances are considered employee groups and may be SSSGs." The rate instructions further state that, "Exceptions to the general rule (and the following groups must be excluded from SSSG consideration)...(9) A purchasing alliance (as defined above) in which every employer in the alliance has less than 100 enrollees."

[redacted] meets the 'Purchasing Alliance' definition. It is unclear what information the Plan used to state that this purchasing alliance included individual enrollees. However, our review of the Plan's supporting enrollment report showed that [redacted] was made up of groups only (not individuals). Each of the three groups in the [redacted] purchasing alliance ([redacted]) have 100 enrollees or more. Therefore, [redacted] cannot be excluded as an SSSG in 2007 under the purchasing alliance disqualifications.

III. As stated in the 2007 Proposal Instructions, "unless OPM agrees in writing, all discounts must be applied at line 5." We recognize that there should be consistency related to the application of discounts from SSSGs. Since the FEHBP's rate includes a blend of non-Medicare and Medicare enrollees, it is our practice to blend SSSG non-Medicare and Medicare rates to determine the overall discount. We then apply that blended discount to the FEHBP rates.

Furthermore, past proposal and reconciliation instructions clearly state that all discounts should be applied to the FEHBP line 5 rates. There was not a written agreement between OPM and GHC stating that SSSG discounts could be applied using a different

methodology. Therefore, the discount given to [redacted] in 2007 will be applied to the FEHBP line 5 rates.

IV. It is our practice to use the discounted SSSG's factors and trends in the FEHBP rate development to determine the true amount of a given discount. However, this practice does not supersede 5 U.S.C 8909(f)(1), which prohibits the imposition of taxes, fees, or other monetary payment, directly or indirectly, on FEHBP premiums by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority of those entities. Based on this statute, the FEHBP rate cannot include [redacted] tax charges.

Furthermore, broker fees are specifically disallowed under 48 C.F.R. 1631.205-75(a) which states, "to eliminate from allowable costs those costs related to sales promotion and the payment of sales commissions fees or salaries to employees or outside commercial or selling agencies for enrolling Federal subscribers in a particular FEHB plan." Based on this statute, the FEHBP rates cannot include [redacted] broker fees.

2008

We agree with the Plan's selection of the [redacted] and [redacted] as SSSGs for contract year 2008. Our analysis of the rates charged to the SSSGs shows that [redacted] received a [redacted] percent discount, which was not applied to the FEHBP. The [redacted] did not receive a discount.

For [redacted] the Plan did not disclose a discount to OPM at the time of the FEHBP reconciliation. During our review, we found that the enrollment used to determine the current per member per month (PMPM) calculation for [redacted] was overstated for subgroup number [redacted] by 99 contracts. When the additional contracts were removed, the current PMPM of $[redacted] was reduced to [redacted], resulting in a greater renewal rate action. Overall, we determined that [redacted] received a [redacted] percent discount due to this error.

Since OPM requires the FEHBP rates to be at least equivalent to the best rates offered to an SSSG, we recalculated the FEHBP rates by applying the factors, trends, and the [redacted] percent discount given to [redacted] A comparison of our audited line 5 rates to the Plan's reconciled line 5 rates shows that the FEHBP was overcharged $2,486,359 in 2008 (see Exhibit B).

Plan's Comments (See Appendix):

I. The Plan agrees that an unintentional numerical error resulted in a discount for [redacted] however, the Plan does not agree that said discount should be applied to the FEHBP line 5 rates. Instead, the Plan believes that the discount should be applied to the FEHBP's non-Medicare PMPM rate, which is the line 1 rate before Medicare is blended in the rate.

II. The Plan asserts that the OIG auditors did not use GHC's benefit adjustment methodology to adjust both the [redacted] and FEHBP benefits from the 2006 experience period to the 2008 contract year.

OIG's Response to the Plan's Comments:

I. As stated in the 2008 Proposal Instructions, "unless OPM agrees in writing, all discounts must be applied at line 5." We recognize that there should be consistency related to the application of discounts from SSSGs. Since the FEHBP's rate includes a blend of non-Medicare and Medicare enrollees, it is our practice to blend SSSG non-Medicare and Medicare rates to determine the overall discount. We then apply that blended discount to the FEHBP rates.

Furthermore, past proposal and reconciliation instructions clearly state that all discounts should be applied to the FEHBP line 5 rates. There was not a written agreement between OPM and GHC stating that SSSG discounts could be applied using a different methodology. Therefore, the discount given to [redacted] in 2008 will be applied to the FEHBP line 5 rates.

II. The benefit change factors were consistently developed for [redacted] and the FEHBP and our audited analysis resulted in the same benefit change factors as those developed by the Plan.

Recommendation 1

We recommend that the contracting officer require the Plan to return $33,122,807 to the FEHBP for defective pricing in contract years 2007 and 2008.

2. Lost Investment Income **$4,693,752**

In accordance with the FEHBP regulations and the contract between OPM and the Plan, the FEHBP is entitled to recover lost investment income on the defective pricing findings due the FEHBP in contract years 2007 and 2008. We determined that the FEHBP is due $4,693,752 for lost investment income, calculated through June 30, 2010 (see Exhibit C). In addition, the FEHBP is entitled to lost investment income for the period beginning July 1, 2010, until all defective pricing finding amounts have been returned to the FEHBP.

FEHBAR 1652.215-70 provides that, if any rate established in connection with the FEHBP contract was increased because the carrier furnished cost or pricing data that were not complete, accurate, or current as certified in its Certificate of Accurate Pricing, the rate shall be reduced by the amount of the overcharge caused by the defective data. In addition, when the rates are reduced due to defective pricing, the regulation states that the government is entitled to a refund and simple interest on the amount of the overcharge from the date the overcharge was paid to the carrier until the overcharge is liquidated.

Our calculation of lost investment income is based on the United States Department of the Treasury's semiannual cost of capital rates.

Plan's Comments (See Appendix):

The lost investment income calculation must be based on the amounts ultimately due the FEHBP.

OIG's Response to the Plan's Comments:

We agree and our calculation of lost investment income is based on the amounts due the FEHBP.

Recommendation 2

We recommend that the contracting officer require the Plan to return $4,693,752 to the FEHBP for lost investment income for the period January 1, 2007 through June 30, 2010. In addition, we recommend that the contracting officer recover lost investment income on amounts due for the period beginning July 1, 2010, until all defective pricing amounts have been returned to the FEHBP.

3. Claims Review

Non-Covered Abortion-Related Claims

The Plan used FEHBP claims experience from calendar years 2005 and 2006 to develop premium rates for contract years 2007 and 2008. We found that from January 1, 2005 through December 31, 2006, the Plan paid 18 abortion-related claims for FEHBP members that should not have been paid, or the supporting documentation was not adequate to justify the claim payment.

Beginning January 1, 1996, Public Law 104-52 requires that FEHBP plans not be permitted to pay or provide benefits for an abortion except, "where the life of the mother would be endangered if the fetus were carried to term, or that the pregnancy is the result of an act of rape or incest."

The Plan's claim processing and information systems did not have adequate controls in place to detect, document and deny payment for non-covered abortion-related claims. Failure to adjudicate abortion-related claims correctly increases the risk that the Plan will pay for non-covered services and inflate the FEHBP premiums.

Plan's Comments (See Appendix):

The Plan agrees that it paid 18 abortion-related claims for the FEHBP that should not have been paid or for which the supporting documentation was not adequate to justify the claim

payment. The Plan will create and implement policies and procedures documenting these internal controls and accountabilities. To confirm the effectiveness of these measures, the Plan will perform an audit and the outcomes will be documented and reviewed six-months after the submission of this response.

OIG's Response to the Plan's Comments:

We acknowledge the Plan's proposed corrective action and will evaluate its effectiveness during our next audit of the Plan.

Recommendation 3

We recommend that the contracting officer require the Plan to submit the results of its internal audit to our office by December 31, 2010.

4. Gender-Specific Identifiers

The Plan did not comply with FEHBP Carrier Letter 2007-09 (CL 2007-09), Attachment 1 related to gender-specific identifiers in its claim data submission. CL 2007-09 requires certain plans to submit its FEHBP claims data to the OIG annually. Attachment 1 further explains the specific data field requirements that plans are to follow.

The Plan's claim data submission to the OIG in 2007 (to support the 2008 rates) was incomplete because it did not include gender-specific identifiers in the data fields. Failure to comply with CL 2007-09 restricts our ability to meet the audit objective and increases the risk that payment for non-covered services will remain undetected.

Plan's Comments (See Appendix):

The Plan agrees that the claims data it submitted did not include gender-specific identifiers in the data fields. In response, this field will be included in the program used to create the FEHBP data.

OIG's Response to the Plan's Comments:

We acknowledge the Plan's agreement and will verify that the Plan's next claim data submission to the OIG contains gender-specific identifiers.

Recommendation 4

We recommend that the contracting officer remind the Plan to ensure that future claim data submissions contain all of the required fields.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Community-Rated Audits Group

[redacted], Auditor-In-Charge

[redacted], Staff Auditor

[redacted], Staff Auditor

[redacted], Staff Auditor

[redacted], Staff Auditor

[redacted], Chief

[redacted] Senior Team Leader

Exhibit A

Group Health Cooperative
Summary of Questioned Costs

Defective Pricing Questioned Costs:

Contract Year 2007	$30,636,448
Contract Year 2008	$2,486,359
Total Defective Pricing Questioned Costs	**$33,122,807**
Lost Investment Income	**$4,693,752**
Total Questioned Costs	**$37,816,559**

Exhibit B

Group Health Cooperative
Defective Pricing Questioned Costs

2007 Contract Year - High Option

	Single	Family	
Plan's Reconciled Rates	[redacted]	[redacted]	
Audited Rates	[redacted]	[redacted]	
Biweekly Overcharge	[redacted]	[redacted]	
To Annualize:			
x March 31, 2007 Headcount	[redacted]	[redacted]	
x Pay Periods	26	26	
Subtotal	[redacted]	[redacted]	
Total 2007 High Option Defective Pricing Questioned Costs			**$30,122,090**

2007 Contract Year - Standard Option

	Single	Family	
Plan's Reconciled Rates	[redacted]	[redacted]	
Audited Rates	[redacted]	[redacted]	
Biweekly Overcharge	[redacted]	[redacted]	
To Annualize:			
x March 31, 2007 Headcount	[redacted]	[redacted]	
x Pay Periods	26	26	
Subtotal	[redacted]	[redacted]	
Total 2007 Standard Option Defective Pricing Questioned Costs			**$514,358**

Total 2007 Total Defective Pricing Questioned Costs **$30,636,448**

2008 Contract Year - High Option

	Single	Family	
Plan's Reconciled Rates	[redacted]	[redacted]	
Audited Rates	[redacted]	[redacted]	
Biweekly Overcharge	[redacted]	[redacted]	
To Annualize:			
x March 31, 2008 Headcount	[redacted]	[redacted]	
x Pay Periods	26	26	
Subtotal	[redacted]	[redacted]	
Total 2008 High Option Defective Pricing Questioned Costs			**$2,337,507**

2008 Contract Year - Standard Option

	Single	Family	
Plan's Reconciled Rates	[redacted]	[redacted]	
Audited Rates	[redacted]	[redacted]	
Biweekly Overcharge	[redacted]	[redacted]	
To Annualize:			
x March 31, 2008 Headcount	[redacted]	[redacted]	
x Pay Periods	26	26	
Subtotal	[redacted]	[redacted]	
Total 2008 Standard Option Defective Pricing Questioned Costs			**$148,852**

Total 2008 Total Defective Pricing Questioned Costs **$2,486,359**

Total Defective Pricing Questioned Costs **$33,122,807**

Exhibit C

Group Health Cooperative
Lost Investment Income

Year **Audit Findings:**	2007	2008	2009	2010	Total
Defective Pricing	**$30,636,448**	**$2,486,359**	**$0**	**$0**	**$33,122,807**
Totals (per year):	$30,636,448	$2,486,359	$0	$0	$33,122,807
Cumulative Totals:	$30,636,448	$33,122,807	$33,122,807	$33,122,807	$33,122,807
Average Annual Interest Rate:	5.5000%	4.9375%	5.2500%	3.2500%	
Interest on Prior Years Findings:	$0	$1,512,675	$1,738,947	$538,246	$3,789,868
Current Years Interest:	$842,502	$61,382	$0	$0	$903,884
Total Cumulative Interest Through June 30, 2010	$842,502	$1,574,057	$1,738,947	$538,246	**$4,693,752**

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GroupHealth.

Group Health Cooperative
320 Westlake Avenue N, Suite 100
Seattle, WA 98109

www.ghc.org

May 28, 2010

[redacted]
Chief, Community-Rated Audits Group
United States Office of Personnel Management
Office of the Inspector General
1900 E Street, NW
Room 6400
Washington, DC 20415-1100

Re: Group Health Cooperative
Draft Audit Report No. 1C-54-00-09-048

Dear [redacted]:

Group Health Cooperative ("GHC") submits this response to the Office of Inspector General, Office of Audits, Draft Report No. 1C-54-00-09-048, dated March 2, 2010 ("Draft Report") on the Federal Employees Health Benefits Program ("FEHBP") operations at GHC for contract years 2006 through 2008. The Draft Report includes preliminary findings of defective pricing in contract years 2007 and 2008, and a preliminary recommendation that GHC return $44,133,179 to the FEHBP, exclusive of lost investment income.

As discussed below, GHC disagrees with the Draft Report's findings and recommendation regarding defective pricing for contract year 2007. The Draft Report's finding is not supported by law or OPM instructions. GHC acknowledges that an adjustment is due the FEHBP related to contract year 2008, but disagrees with the amount asserted in the Draft Report's findings.

I. Premium Rate Review

A. Contract Year 2007

The Draft Report disagrees with GHC's selection of the similarly sized subscriber groups ("SSSGs") for 2007. The Draft Report asserts that GHC should have selected [redacted] as one of two SSSGs since it was closer in size to the FEHBP and [redacted] meets the SSSG criteria. Based on the rating of

[redacted], the Draft Report alleges that GHC engaged in defective pricing and that the FEHBP is entitled to an adjustment of $37,710,669, exclusive of lost investment income.

GHC disagrees with the Draft Report's preliminary finding that [redacted] meets the SSSG criteria. [redacted] does not qualify as an SSSG for two reasons. The first reason that [redacted] is not an eligible group for SSSG purposes is that [redacted] is not a customer group of GHC. [redacted] is a customer group of Group Health Options, Inc. ("GHO, INC."), a wholly-owned subsidiary of GHC. See Organizational Chart attached hereto as Exhibit A. See also Group Contracts between GHO, INC. and [redacted] attached hereto as Exhibit B. Since [redacted] is not a customer group of the FEHBP carrier – GHC, [redacted] cannot be an SSSG under GHC's contract with the Office of Personnel Management ("OPM"). GHC's inadvertent inclusion of [redacted] in GHC's 2007 rate proposal does not change the fact that [redacted] is not an eligible group for SSSG purposes.

The second reason that [redacted] is not an SSSG is that, even if [redacted] were a customer group of GHC, [redacted] is comprised of individuals and groups coming together to purchase insurance. Therefore, [redacted] does not qualify as a purchasing alliance, based on OPM guidance, and is not eligible to be an SSSG.

1. Only Groups that Contract with GHC Are Eligible for SSSG Consideration

OPM's rating requirements for the FEHBP, including instructions for identifying the SSSGs, are governed by the FEHB Act, the FEHB Acquisition Regulation ("FEHBAR"), OPM's Standard Contract for Community-Rated Health Maintenance Organization Carriers (the "Standard Contract") and OPM's annual rate instructions.

The FEHBAR defines the SSSGs as follows:

> (a) Similarly sized subscriber groups (SSSGs) are a comprehensive medical plan carrier's two employer groups that: (1) As of the date specified by OPM in the rate instructions, have a subscriber enrollment closest to the FEHBP subscriber enrollment; and, (2) Use any rating method other than retrospective experience rating; and, (3) Meet the criteria specified in the rate instructions issued by OPM.
>
> (b) Any group with which an FEHBP carrier enters into an agreement to provide health care services is a potential SSSG (including separate lines of business, government entities, groups that have multi-year contracts, and groups having point-of-service products).
>
> (c) Exceptions to the general rule stated in paragraph (b) of this section are (and the following groups must be excluded from SSSG consideration): (1) Groups the carrier rates by the method of retrospective experience rating; (2) Groups consisting of the carrier's

> own employees; (3) Medicaid groups, Medicare groups, and groups that have only a stand alone benefit (such as dental only); and (4) A purchasing alliance whose rate-setting is mandated by the State or local government.
>
> (d) OPM shall determine the FEHBP rate by selecting the lower of the two rates derived by using rating methods consistent with those used to derive the SSSG rates.

48 C.F.R. § 1602.170-13 (emphasis added).

Under OPM's regulations for the FEHBP, the SSSGs are the "carrier's" two groups. The term "carrier" is defined in the FEHB Act as follows:

> "[C]arrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization and an association of organizations or other entities described in this paragraph sponsoring a health benefits plan[.]

5 U.S.C. § 8901(7) (emphasis added). See also 48 C.F.R. § 1602.170-1.

The definition of carrier in the Standard Contract incorporates the statutory definition and further provides that the term "may be used interchangeably with the term Contractor." See Standard Contract at § 1.1.

Finally, the term "health benefits plan," which is used in the definition of carrier, is defined as follows:

> Health benefits plan means a group insurance policy, contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangements provided by a carrier for the purpose of providing, arranging for, delivering, paying for, or reimbursing any of the costs of health care services.

48 C.F.R. § 1602.170-9 (emphasis added).

Based on the foregoing definitions, the term "carrier" as used in the definition of SSSGs refers to the legal entity that contracts with OPM to offer a health benefits plan

under the FEHBP. The definition of carrier does not include subsidiaries or other corporate affiliates of the carrier.

OPM's rating instructions regarding SSSGs are consistent with the definitions discussed above. This consistent approach is highlighted by revisions OPM made to its rate instructions regarding the circumstances under which groups covered under a separate line of business of a carrier that offers an FEHBP product can be excluded from SSSG consideration. Specifically, in 2005, OPM proposed to define a separate line of business as follows:

> Groups covered under a separate line of business of a **parent company** that offers an FEHBP product are excluded from consideration as an SSSG. To be considered a separate line of business all of the following criteria must be satisfied:
> - It must be a separate organizational unit, such as a division or **subsidiary**,
> - It must have separate financial accountability with "books and records that provide separate revenue and expense information that is used for internal planning and control,
> - It must have a separate work force and separate management involved in the design and rating of the healthcare product.

See OPM letter dated February 23, 2005 attached hereto as Exhibit C.

In response to comments that OPM's use of the terms "parent company" and "subsidiary" would cause confusion regarding whether groups that are not customers of the carrier could be considered SSSGs, OPM modified the language, changing "parent company" to "carrier" and deleted the word "subsidiary".[1] Specifically, OPM noted

> Some of the carriers had problems with the term "parent company" since they thought this implied groups could be SSSGs even though a legal entity other than the FEHBP carrier provides the coverage. They said the use of the words "parent company" and "subsidiary" creates confusion about intent of the proposed policy.
>
> One respondent said the word "subsidiary" presented a problem because it typically refers to a separate and distinct legal entity. They said the wording would create uncertainty about whether groups who are not customers of the carrier could in some instances be considered SSSGs. They propose amending the language by changing "parent company" to "carrier" and striking out the word "subsidiary."

[1] See e.g. Comment letter dated March 3, 2005 attached hereto as Exhibit D.

> One carrier said that our description appears to encompass a carrier's sister corporations which are separate legal entities and, potentially, not contracted with OPM as approved carriers. They do not believe it is the intent to cross into separate legal entities even between commonly owned corporations to select potential SSSGs.
>
> We agree to change "Parent Company" to "Carrier" and strike out the word "subsidiary."

See OPM Carrier Letter No. 2005-11 attached hereto as Exhibit E.

OPM's revisions in response to comments demonstrate the agency's clear intent to exclude from consideration as an SSSG those groups that are not customers of the carrier that contracts with OPM. The clarified instructions remain to address situations where a group customer of a separate line of business, operated as a division within a single carrier, could be excluded from SSSG eligibility. They do not seek to expand the contractual and regulatory definition of SSSGs. The instructions make clear that a determination as to whether a program is a separate line of business is made as with respect to the operations "of a carrier."

Therefore, the "separate line of business" instruction cannot be applied to a subsidiary of the carrier that contracts with OPM. The fact that the carrier that contracts with OPM also performs administrative services for the subsidiary does not create a different result. The provision of administrative services by a corporate parent to an affiliate is very common in the health plan and other industries. Such arrangements do not affect the legal separateness of the related parties.

Based on the foregoing, OPM recognizes that the carrier with which it contracts under the FEHBP and the carrier's affiliate(s) are separate legal entities and only group customers of the FEHBP carrier are eligible for SSSG consideration. Thus, contrary to the Draft Report's preliminary finding, [redacted] cannot be an SSSG since it does not contract with GHC for health benefits coverage.

2. Group Health Cooperative and Group Health Options Inc. Are Separate and Distinct Legal Entities

GHC and GHO, INC. are separate and distinct legal entities. GHC was formed in 1945. It is a Washington nonprofit, tax-exempt organization. GHC has been registered with the Washington State Office of the Insurance Commissioner ("OIC") as a health maintenance organization since 1976. See OIC Certificate of Registration attached hereto as Exhibit F. GHC's total enrollment as of April 2010 is approximately 375,000. It has contracted with OPM as an FEHBP contractor since 1985.

GHO, INC. was formed in 1990. It is a Washington for-profit corporation. GHO, INC. has been registered with the OIC as a health care service contractor since 1990. See

OIC Certificate of Registration attached hereto as Exhibit G. GHO, INC. was established primarily to offer health plan products, such as point-of-service benefits, that would be inconsistent with GHC's registration as a health maintenance organization. GHO, INC.'s total enrollment as of April 2010 is 228,000. GHO, INC. is not an FEHBP contractor.

As separately registered carriers, GHC and GHO, INC. are each subject to separate chapters of the Washington State Insurance Code. GHC is primarily governed by RCW Ch. 48.46 and GHO, INC. is primarily governed by RCW Ch. 48.44. Each entity submits all necessary filings with the OIC. Each entity is also appropriately capitalized in accordance with Washington State insurance law.

Pursuant to an Administrative Services Agreement, GHC performs administrative functions for GHO, INC., including claims processing, underwriting, and appeals. There is also a Medical Service Agreement between GHO, INC. and GHC through which GHC provides medical services to GHO, INC. enrollees. Both agreements are filed with the OIC and provide that GHC is compensated for all activities performed on behalf of GHO, INC.

3. [redacted] Does not Satisfy OPM Criteria for Purchasing Alliances

As noted above, there are two reasons why [redacted] does not satisfy OPM's SSSG criteria. With respect to the second reason, even if we assume that groups that do not contract with the FEHBP carrier can be potential SSSGs, [redacted] does not satisfy OPM's criteria for purchasing alliances as potential SSSGs. The definition of a purchasing alliance in the 2007 Rate Instructions provides that "Purchasing Alliances are any groups bonding together to purchase health insurance." (emphasis added) [redacted] does not meet the definition of a Purchasing Alliance because it is comprised of both individuals and groups. A combination of individuals and groups is not the type of bonding together to purchase insurance that OPM intended to include in the Rate Instruction definition. Even the OIG's Audit Guidance supports the conclusion that a combination of individuals and groups such as [redacted] is not a potential SSSG. Per Audit Guidance Community-Rated Carriers Bulletin #97-02 (effective 05/05/97), a "coalition is formed when **several subscriber groups** come together to form one unit and negotiate with the plan as a united front." (emphasis added)

4. Calculation of Alleged [redacted] Discount

GHC continues to assert that [redacted] does not meet the requirements of an SSSG and therefore cannot be the basis for a defective pricing finding or pricing adjustment against GHC. However, in order to preserve all rights, GHC also has identified the following errors in the Draft Report's application of the [redacted] rating methodology to the FEHBP for contract year 2007.

The fundamental purpose of the SSSGs is to ensure that OPM's rates are determined in a matter consistent with the SSSGs. See 48 C.F.R. § 1602.170-13(d).

"OPM shall determine the FEHBP rate by selecting the lower of the two rates derived by using rating methods consistent with those used to derive the SSSG rates." (emphasis added). When a discount is provided to an SSSG, OPM's rating requirements dictate that an equivalent discount be applied to the FEHBP. See 48 C.F.R. § 1652.216-70(b)(2).

In that regard, when only a specific segment of an SSSG receives a discount, then only the comparable segment of the FEHBP enrollment should receive the discount in order for the FEHBP to be rated using a methodology consistent with that used to rate the SSSG as required by OPM's regulations. See 48 C.F.R. § 1652.215-70. It is a standard industry practice for carriers to rate non-Medicare and Medicare components of a group health plan separately. GHC follows this standard industry practice. In the case of [redacted] the non-Medicare segment of the group received a discount of [redacted] while the Medicare portion of the group did not receive any discount. However, the Draft Report applies the discount to GHC's entire FEHBP enrollment. Applying the discount to the entire FEHBP enrollment, both Medicare and non-Medicare, disregards OPM's regulations and applies a rating methodology to the FEHBP that is not consistent with the applicable SSSG's methodology. In essence, the FEHBP receives more than the benefit of the bargain provided to the SSSG and pays less than what it is legally and contractually required to pay GHC. An example calculation demonstrating the foregoing is attached hereto as Exhibit H.

In addition, blending the discounts between the SSSG's Medicare and non-Medicare rates does not result in the application of a consistent rating methodology between the SSSG and FEHBP if the SSSG was not rated with the same blending methodology. Moreover, the SSSG's mix between Medicare and non-Medicare will rarely, if ever, match the FEHBP group mix between Medicare and non-Medicare. Thus the application of a blended SSSG rate (combining Medicare and non-Medicare) to the FEHBP group will result in the FEHBP receiving more of a discount than the SSSG received or less of a discount than the SSSG received depending upon the FEHBP's Medicare/non-Medicare mix in comparison to that of the SSSG. See Exhibit H for an example calculation demonstrating the foregoing. Such a result is contrary to the rating requirements governing the FEHBP.

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Not Relevant to the Final Report

Finally, the FEHBP rates for the High Option Benefits and Standard Plan Benefits did not include taxes and commissions related to [redacted] before determining the discount due to the FEHBP, which inappropriately lowers the FEHBP rate and inappropriately inflates the discount due to the FEHBP.

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Not Relevant to the Final Report

5. **Adjustment Due FEHBP for Contract Year 2007**

Based on the foregoing, no adjustment is due the FEHBP in connection with [redacted] as [redacted] does not satisfy the SSSG criteria for 2007.

B. **Contract Year 2008**

For contract year 2008, the Draft Report agrees with GHC's SSSG selections. However, the Draft Report contains preliminary findings that one of the SSSGs, [redacted] received a [redacted] discount, a portion of which was not applied to the FEHBP. GHC acknowledges that [redacted] received a discount and that the FEHBP did not receive the entire amount of that discount. The [redacted] discount was the result of an unintentional transposition of numbers when entering the group's enrollment data in the rating model. However, GHC disagrees with the Draft Report's analysis of the [redacted] and FEHBP rating.

First, as explained above, when only a specific segment of an SSSG receives a discount then only the comparable segment of the FEHBP enrollment should receive that discount in order for the FEHBP to be rated using a methodology consistent with that used to rate the SSSG as required by OPM's regulations. See 48 C.F.R. § 1652.215-70. As with [redacted], [redacted] has separate ratings for its Medicare and non-Medicare population. [redacted] discount in 2008 applied only to the group's non-Medicare population. Therefore, that discount should only be applied to the non-Medicare

members of the FEHBP. Application of a non-Medicare population discount to the entire FEHBP disregards OPM's regulations and rating requirements and applies a rating methodology to the FEHBP that is not consistent with the applicable SSSG's methodology.

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Not Relevant to the Final Report

C. **Lost Investment Income**

Any lost investment income due the FEHBP must be based on the amounts ultimately due the FEHBP and not the inflated amounts set forth in the Draft Report

II. **Claims Review**

A. **Non-Covered Abortion-Related Claims**

The Draft Report contains preliminary findings that during the period of January 1, 2005 through December 31, 2006, the experience period for the 2006 and 2007 contract years, GHC paid 18 abortion-related claims for the FEHBP that should not have been paid or for which the supporting documentation was not adequate to justify the claim payment.

Management agrees to the above finding. As a result of the FEHBP audit, two issues were identified and are being addressed. One issue concerns a lack of an internal control to stop internal claims (claims for procedures provided in facilities owned and operated by GHC) from paying since a medical necessity review process is not in place to distinguish between claims that are for covered services and should be paid and those that are for non-covered services according to the FEHBP contract and should not be paid. Work is underway to enable GHC practitioners to use the medical necessity review process to ensure that claims are paid according to applicable contract terms.

The second issue that resulted in claims being paid when they should have been denied occurred in a very isolated number of cases and relates to laboratory services provided in GHC's contracted network. The control in place to prevent this involves the ordering physician knowing these services are non-covered by requesting and being denied pre-authorization. It is the provider's responsibility to identify these services as non-covered and to ensure related claims are not submitted for reimbursement.

In response to these two identified process gaps GHC will create and implement a specific policy and procedure documenting these internal controls and accountabilities. This policy will help to more clearly communicate FEHBP standards and how these are met. In addition, training in the form of a written process summary will be provided to employed practitioners identified through this audit process and a formal communication regarding this standard will be added to GHC's Contracted Provider Manual. To confirm the effectiveness of these measures, an audit will be performed and audit outcomes documented and reviewed six-months after the submission of this response.

B. Gender-Specific Identifiers

The Draft Report contains preliminary findings that GHC's claims data submission to the OIG in 2007 pursuant to Carrier Letter 2007-09 was incomplete because it did not include gender-specific identifiers in the data fields.

It is agreed that GHC claims data did not include gender-specific identifiers in the data fields. In response, this field will be included in the program used to create the FEHBP data. We are resubmitting the data to support rates for 2008 and a CD containing that information is hereto included as Exhibit O. We have also created a new process to check the data fields required to ensure all requested data is submitted. Going forward, when GHC assembles the data requested by the OIG, a reference document will be created to identify the components of the text document that correspond to the data

requested from the OIG. Through this process, GHC will be able to ensure that the text document with the claims data contains all of the requested elements.

III. Conclusion

Based on the foregoing and attached supporting documentation, FEHBP is due $0 for 2007 and is due $1,445,362 for 2008 as noted on Exhibit J – 2008 Audited FEHBP Workbook adjusted, Sheet *Exhibit-A High Option*, Cell P47. .

If you have any questions regarding our response, please contact [redacted]

[redacted]
Director, Complex Accounts