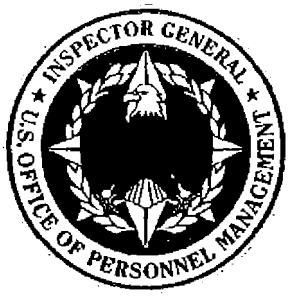


U.S. OFFICE OF PERSONNEL MANAGEMENT
OFFICE OF THE INSPECTOR GENERAL
OFFICE OF AUDITS

Final Audit Report

Subject:

Audit of the Federal Employees Health Benefits Program Operations of TakeCare Insurance Company, Inc.

Report No. 1C-JK-00-09-045

Date: February 22, 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
TakeCare Insurance Company, Inc.
Contract Number CS 2825-A - Plan Code JK
Tamuning, Guam

Report No. 1C-JK-00-09-045 **Date:** February 22, 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
TakeCare Insurance Company, Inc.
Contract Number CS 2825-A - Plan Code JK
Tamuning, Guam

Report No. 1C-JK-00-09-045 **Date:** February 22, 2010

The Office of the Inspector General (OIG) performed an audit of the Federal Employees Health Benefits Program (FEHBP) operations at TakeCare Insurance Company, Inc. (Plan). The audit covered contract years 2005 through 2008 and was conducted at the Plan's office in Tamuning, Guam. During the years covered by the audit, the Plan did not implement five of the FEHB industry standards for Fraud and Abuse programs as listed in FEHB Program Carrier Letter 2003-23. We found that the FEHBP rates were developed in accordance with the Office of Personnel Management's rules and regulations in contract years 2005 through 2008.

CONTENTS

I. INTRODUCTION AND BACKGROUND

Introduction

We completed an audit of the Federal Employees Health Benefits Program (FEHBP) operations at TakeCare Insurance Company, Inc. (Plan). The audit covered contract years 2005 through 2008 and was conducted at the Plan's office in Tamuning, Guam. The audit was conducted pursuant to the provisions of Contract CS 2825-A; 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.

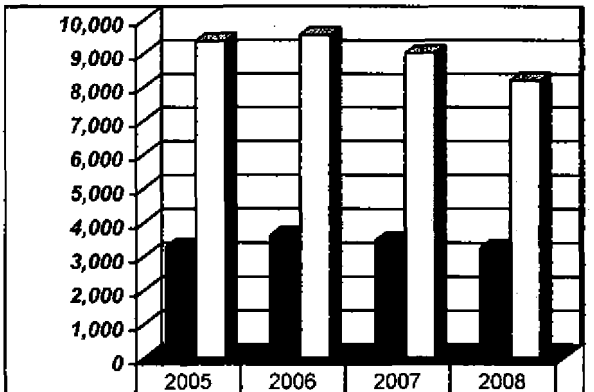
Background

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 Retirement and Benefits Office. 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.

FEHBP Contracts/Members
March 31



	2005	2006	2007	2008
■ Contracts	3,293	3,631	3,478	3,246
□ Members	9,382	9,563	9,020	8,204

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.

The Plan has participated in the FEHBP since 1998 and provides health benefits to FEHBP members on the island of Guam. The last full-scope audit covered contract years 1999 through 2003. All questioned costs associated with that audit have been resolved.

The preliminary results of this audit were discussed with Plan officials at an exit conference and through 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 final report and are included, as appropriate, as the Appendix.

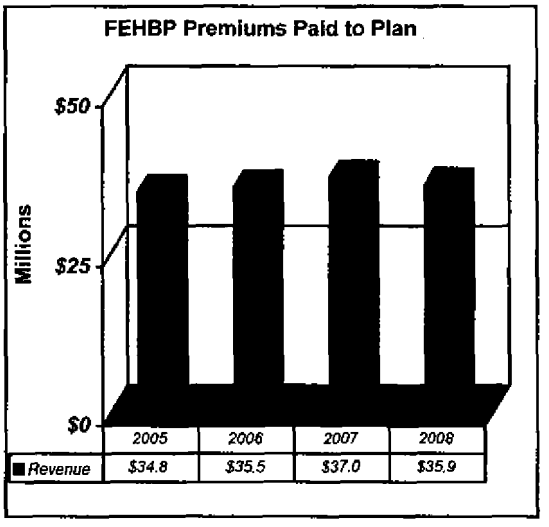
II. OBJECTIVES, SCOPE, AND METHODOLOGY

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 2005 through 2008. For these years, the FEHBP paid approximately $143.2 million in premiums to the Plan. The premiums paid for each contract year audited are shown on the chart to the right.

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 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 Tamuning, Guam, during April 2009. Additional audit work was completed at our office in Cranberry Township, Pennsylvania.

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 were 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, 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

1. Premium Rate Review

Our audit showed that the Plan's rating of the FEHBP was in accordance with the applicable laws, regulations, and OPM's rating instructions to carriers for contract years 2005 through 2008. Consequently, the audit did not identify any questioned costs.

2. Fraud and Abuse Program Review

We reviewed the Plan's Fraud and Abuse (F&A) Program and interviewed Plan personnel to determine compliance with FEHB Program Carrier Letter # 2003-23 (CL 2003-23). CL 2003-23 lists eight industry standards that OPM expects all FEHB plans to have in place to help address health care F&A within their organization (for both in-house and subcontracted work). During 2005 through 2008, the following five industry standards were not implemented by the Plan:

1. Anti-Fraud Policy Statement: Publish a policy statement providing the corporate strategy to address F&A and make it available to employees, enrollees, providers, and subcontractors.

2. Written Plan and Procedures: Establish written policies and procedures to be followed by all personnel for the deterrence and detection of fraud.

3. Formal Training: Conduct fraud awareness training for all employees, underwriting departments, and subcontractors. Training should consist of an overview of specific F&A reporting requirements and debarment policies and procedures to enable personnel to identify and handle potentially fraudulent claims submitted.

4. Education: Inform enrollees about fraudulent and abusive practices via newsletters, web sites, or other means.

5. Technology: Use fraud protection software to analyze claims data. Software should evaluate on a prospective claim-by-claim basis and through the retrospective analysis of claim trends from either providers and/or members.

Prior to 2005, the Plan was owned by PacifiCare Health Plan and operated under the name PacifiCare Asia Pacific. In 2005, TakeCare became an independent company and did not maintain PacifiCare Health Plan's formal F&A program.

Failure to implement all eight industry standards increases the risks of fraudulent activities and potential abuse resulting in unnecessary costs.

Plan's Comments (See Appendix):

The Plan does not agree with the OIG's opinion that its F&A program was insufficient to meet the requirements set by CL 2003-23. The Plan feels that it attempted to meet the "spirit" of the regulations. The Plan feels that it made a good faith effort to implement F&A protocols that were consistent with an organization of their size, based upon the circumstances at the time.

The Plan is in the process of implementing an Anti-Fraud Program in cooperation with Total Claims Capture and Control Health, Inc. (TC3). The Plan has provided an Anti-Fraud Program implementation timeline that lists a completion date of July 11, 2010. The Plan is also in the process of reviewing their provider contract agreement to ensure that no legal issues will result from any retrospective cost recovery due to F&A. The Plan is currently in discussion with TC3 to implement post-F&A recoveries.

OIG's Response to the Plan's Comments:

While we recognize that the Anti-Fraud Program developed in conjunction with TC3 is a positive step in meeting the FEHB industry standards established in CL 2003-23, this program was not in place during the scope of the audit.

Recommendation 1

We recommend that the contracting officer require the Plan to report on its Anti-Fraud Program implementation every three months until such time that the contracting officer feels the Plan is fully compliant with CL 2003-23. The Plan's Anti-Fraud Program will be reviewed during future audits scheduled by the OIG.

Recommendation 2

We recommend that the Plan use fraud detection software to determine if there were any fraudulent claims paid on FEHBP members during the experience periods used to develop the FEHBP's rates in contract years 2005 through 2008. Any fraud recoveries should be credited in the FEHBP rate development. The Plan's fraud detection software efforts will be reviewed during future audits scheduled by the OIG.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Community-Rated Audits Group

[redacted] Auditor-In-Charge

[redacted] Auditor

[redacted] Auditor

[redacted] Chief

[redacted] Senior Team Leader

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Appendix

2009 NOV 13 AM 10: 30

November 11, 2009

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

Re: TakeCare Insurance Company Response to Office of the Inspector General Draft Audit Report (Audit Report No. 1C-JK-00-09-045)

Dear[redacted]

Thank you for extending the deadline to respond to the Office of the Inspector General (OIG) Draft audit report for TakeCare Insurance Company (Audit Report No. 1C-JK-00-09-045) to November 12, 2009 instead of the original October 29, 2009 deadline. This allowed our organization sufficient time to present a comprehensive response to the Draft audit report.

The following responds to the audit findings stated in the OIG Draft report:

1. TakeCare appreciates the Office of the Inspector General's opinion that the interim fraud and abuse program was insufficient to meet the requirements set forth by the FEHBP Carrier Letter 2003-23. While we do not necessarily share the same opinion, we do hope you understand that TakeCare attempted to meet the spirit of the regulations. We made every effort to implement, in good faith, protocols albeit less formalized than the OIG would have preferred, but consistent with an organization of our size and based upon the circumstances at the time.

   Moving forward, the implementation of the enterprise wide fraud and abuse program through the assistance of our vendor partner, Total Claims Capture and Control Health Inc (TC3) will be effective (based on timeline from TC3). We have attached a detailed timeline for the fraud and abuse program implementation for your reference.

It was also noted in the draft report that initial Special Investigative Unit (SIU) team members did not have any law enforcement experience. We have asked TC3 to provide us with additional team members profile to deal with this issue. We have attached the profile of these additional SIU team members. Furthermore, we do not have any Guam contacts with law enforcement experience but the program implementation will be managed and monitored by the Underwriting Department through the Corporate Compliance Officer, [redacted]

It was also initially mentioned by TakeCare personnel that no retro recovery will occur during the program implementation for fraud and abuse. We acknowledge that it's important that retro cost recovery should occur. We are in the process of reviewing our provider contract agreement to ensure that no legal issues will result from these recoveries. Also, we have engaged TC3 in discussions to implement post recoveries.

Lastly, we have attached TakeCare's anti-fraud manual that will be a significant part of the program implementation for this program.

Deleted by OIG – Not relevant to the Final Report

We anticipate that our responses are sufficient to address all procedural findings in this Draft report and these issues will be deemed resolved in the Final audit report for TakeCare Insurance Company.

Please do not hesitate to contact me with any concerns or questions.

Respectfully,

[redacted]