Comments on the March, 2013 preliminary report by the Segal Company;

and the Dec., 2012 reviews issued by the Dept. of Commerce
Executive Summary

Two Key Messages:

1. The setting of HMO rates from 2002 to 2011 was flawed & rigged. The HMOs probably falsified their information, which the state never verified. Audits are needed to identify and prosecute the fraud.

2. HMOs use a variety of bookkeeping tricks and improper charges to overbill the state, and these must be stopped by tightening the laws.

1. Setting of HMO rates:

A. The March 1, 2013 preliminary report by the Segal Company, commissioned by the MN Dept. of Human Services, shows that the state’s hired actuary, Milliman, failed in its duty to set accurate rates for the public programs, resulting in massive overpayments. This confirms what GMHCC said in its Aug., 2012 report "Who was minding the store?"

B. The Segal report shows that the HMOs took profits far above what was expected from their contracts, and that Milliman used claims and health status data from the HMOs that was never verified. Therefore, the only logical explanation for the consistent, decade-long, extra and unanticipated profits is that the data fed into the rate formula, by the HMOs, was falsified and inflated. Audits are needed to identify and then prosecute the financial fraud.

C. The Segal report repeats what has already been confirmed by statements by UCare and others, that the PMAP (Medical Assistance) rates had extra, unwarranted profit built in for the clear purpose of subsidizing the underfunded GMAC program.

D. This implies that all the HMOs received an extra windfall in 2010, when GAMC (General Assistance Medical Care) ended, yet the built-in subsidy continued. UCare gave $30 million of this excess profit back to the state. The other three HMOs should return that extra, unwarranted profit as well. It would amount to well over $100 million.

2. Tricks to improperly overbill the state:

A. Reports on 2011 expenses of the HMOs, conducted by the Risk & Regulatory Consulting firm on behalf of the MN Dept. of Commerce, and released Dec. 3, 2012, reveal a variety of bookkeeping tricks, supposed mathematical “mistakes,” and unallowable expenses, which overbill the state (and thus the federal government as well).

B. There is evidence of at least one HMO cheating on its state taxes. The MN Dept. of Revenue has begun investigating this. Potentially, there could be other HMOs which are doing this as well, and it might range back for a decade.

C. New, needed legislation has been introduced to outlaw some of the HMOs’ improper uses of state public program funds, such as lobbying, marketing, charitable donations, and excessive administration expenses. The bills are HF 1369 (Leibling) and SF 1219 (Marty).
Part A. Analysis of the Segal Company's preliminary report of March 1, regarding the managed care rate setting of 2002 through 2011.

Last fall, the Dept. of Human Services (DHS) contacted with the Segal Company to review the rate-setting process that occurred from 2002 through mid-2011. To be clear, this was not intended to be a true audit of the financial figures used to set the rates, but instead only an audit of the process which was used to set the rates. This process was conducted each year by the Milliman actuarial firm, under contract to DHS.

The Segal preliminary report does not clearly spell out the multi-step process that was used to set the rates, but it essentially went like this:

1. The HMOs provided aggregate data each year which they asserted represented the actual medical claims they paid. (No detail or documentation was ever provided.) The payment data for all four HMOs was combined together, to arrive at standardized amounts that would apply to the payments to all of them.
2. The rate process conducted during any given year, to set the rates for the coming calendar year, took the payment information from the prior year, and projected it forward to the coming year, using trend estimates of how much the utilization and price would change.
3. Basic demographic factors like age, location, gender were applied to adjust the rates.
4. Health status information on the enrollees, supplied by the HMOs, was also used to make “risk adjustments” based on the expected need for health services by the enrollees.
5. Adjustments were made for changes in utilization caused by legislative changes in approved benefits, if any.
6. After these medical expense estimates were compiled, Milliman added a flat percentage of expense for administrative costs. DHS helped to decide how much the administrative percentage should be.
7. Finally, a “contribution to surplus” (profit) percentage was added on to the rates.

Heavy criticism of every step of Milliman's process

The Segal preliminary report heavily criticizes the way that Milliman compiled the rates, in every step of the rate process, both in terms of making large growth estimates based on inadequate information, and in not using any verified medical claims data or verified enrollee health status data. Here is a summary breakdown of the problems with each step:

1. Base medical expense data

The starting point, which is the actual medical expenses paid for the program enrollees each year, was based only what the HMOs gave the State, in summary form. Neither DHS nor Milliman ever received actual medical claims payment detail. The expense figures used in setting the rates were never reconciled with actual cost data, and the HMOs’ summary figures were never even reconciled with the numbers on the HMOs’ MN Supplement Reports #1 (MSR1). Segal says that the HMOs’ actuaries looked at some financial details, but it amounted to less than 0.1% of the total amounts. Segal states that this percentage is a very low sample. Milliman says that it relied upon assurances it received from the actuaries hired by the HMOs that the data was appropriate, and never tried to check or test any of it on its own.

2. Medical expense trend factors

Milliman’s calculation of expense cost trends resulted in increases of 6% to 9% on average every year. Segal asserts this is a very high rate of increase, and higher than in other states. Segal implies that the HMOs claimed that their payments correlated 75% to the Fee For Service (FFS) reimbursements, but that this does not seem evident in the rates paid to the HMOs. In other words, the payments to the HMOs
seem to reflect provider payments much higher than the FFS reimbursements. The medical expense trend factors are based on the self-reported – but not independently verified – claims information from the HMOs. Segal says that the trend factors needed to be compared, at least once every three years, with actual medical expense information, but they never were.

3. Demographic and regional adjustment factors

Segal questions whether the information and calculations for the demographic adjustment factors accurately reflect the cost variations within each geographic location, and that more detailed data would be needed to do it accurately.

4. Risk (health status) factors

Segal is very critical of how the risk adjustments were calculated and used. Again, Segal found it impossible to connect the rate numbers with data to justify them. All of the adjustments were built on prior year numbers, and so Segal tried to identify numbers from 2003, but couldn’t because they were encrypted, and DHS was not able to provide useable data. Segal found two other important problems: (a) Milliman assigned to all new enrollees the average risk of the current ones. When healthier than average new enrollees are added in, DHS overstated the risk of them for at least a year, and overpaid the HMOs for those people. Segal thinks this added to the overpayments in 2009, 2010 and 2011. (b) When risk adjustments are factored in, there is a clear cut rule that it must be “budget neutral,’ in other words, to not increase the overall payments to the HMOs. However, Segal doubts that this occurred, despite Milliman having certified that the risk adjustments were always budget neutral Segal said that “risk creep” occurred.

A related problem is that when Milliman adjusted the risk factors with a sample from 2004-2006, this resulted in a drop in the overall risk adjustments. That in turn resulted in a corresponding increase in the rates, in order to achieve budget neutrality. However, Segal was unable to find any data that justified this increase in the rates.

5. Change-in-mandated-benefits factors

Whenever the State changes the covered health benefits, Milliman has to make adjustments in the HMO rates to reflect this. Milliman relied on what data the HMOs provided. Segal determined that there is absolutely no way at all to check on the accuracy of this information. Segal points out a potentially very big problem, which is: When State benefit changes are going to reduce the HMOs’ future payments from the State, the HMOs have a vested self interest to give numbers to Milliman that would minimize how much their rates get reduced. If an HMO understates how much a particular benefit is currently being used which is about to be cut, then the HMO would get a windfall in extra net reimbursement in the coming year. Segal warns that if this happens, it can result in very large amounts of overpayment.

6. Administrative cost factor, and lack of efficiency target

Segal says that Milliman applied administrative expenses of about 7% to 9% of revenue each year, and that the annual growth rate in administrative expense was typically 2% to 4%. There wasn’t any diligent review of the administrative expense components, and Segal states that some of the included components should not have been there.

Segal recommends that a different process be used (which is used in some states), which is to set a target for administrative expense, based on what it should be for an efficient HMO, and provide that
amount in the rates. It could be a percentage of revenue, or it could be a fixed cost per contract; and it should not vary much from year to year.

7. Target profit (“contribution to surplus”) factor

The target profit amount, built into the rates, varied from 0% to 1.75%, but was most often at 1%. Yet, Segal points out (as did GMHCC in its (August, 2012 report) that the actual profits, according to the HMOs’ own reports, were much higher. The underwriting profit averaged 1.4% above the targets, generating $162.5 million in extra profit, not including the MSHO program. The investment income from the State’s programs adds another $150 million to this, bringing the excess profit up to $312.5 million, and the overall annual profit to about 3.1% on average, instead of the 1% profit. This means that over three times as much total profit was generated, compared to the target in the contracts.

8. Minnesota Senior Health Options (MSHO) profits

Segal did not add in any figure for MSHO profits on top of this, because the financial reports do not separate out the expenses and profit from the Medical Assistance (DHS) portion of MSHO versus the Medicare (Centers for Medicare & Medicaid Services, or CMS) portion. Segal did not venture any guess, but the DHS and CMS portions of the MSHO revenue are very similar. If it turns out that the rate of profit is also roughly equal between the two (which is not confirmed), then the DHS Medical Assistance portion would add least another $90 to $100 million in excess profit on top of the $312.5 million.

9. The General Assistance Medical Care (GAMC) question

The Segal report re-affirms the nagging question as to whether the Prepaid Medical Assistance Program (PMAP) and MinnesotaCare (MnCare) rates were deliberately inflated in order to subsidize the regular, expected losses of GAMC. About half of that subsidy gets paid, unwillingly and unknowingly, by the federal government, since CMS pays for half of the Medical Assistance revenue. Segal states that there was a clear expectation all along that the profits from PMAP and MnCare would always be more than enough, and would cover the GAMC losses.

This points, unavoidably, to the assumption that there was a deliberate scheme to do so. The big discrepancy between the target profits and the actual profits do not have any good explanation other than the theory that the information used by Milliman to set the HMO rates was inflated, either in the medical claims information provided by the HMOs, and/or the health status information on enrollees, provided by the HMOs, which was used to set the risk adjustments.

Part B. Analysis of Dept. of Commerce reviews of Blue Plus, HealthPartners, Medica, and UCare for 2011

To fulfill part of an Executive Order issued by Gov. Mark Dayton in March of 2011, the MN Dept. of Commerce (DOC) contracted with the Risk & Regulatory Consulting company to conduct limited reviews of the 2011 finances of the four HMOs that the State contracts with for the public low income health care programs. These HMOs are: Blue Plus (owned by Blue Cross/Blue Shield of MN), Medica, HealthPartners, and UCare. The reports included some auditing of administrative expenses.

The set of four reports, issued Dec. 3, 2012, found significant examples of incorrect calculations, questionable expenses, and some expenses that directly violate federal law. The consultant makes clear that their discoveries and reports do not by themselves trigger any corrective actions, and therefore it is up to State regulators or legislators to decide whether or not to do anything about them.

Here are summaries of key points raised in each of the four reports:
B.1. Blue Plus

$5.1 million and $1.3 million errors

The most glaring finding was that in calculating how much money it would need to keep to cover claims yet to be paid, known as a Premium Deficiency Reserve, Blue Plus was off by $5.14 million too much. This might have a bearing on how much profit the company is supposed to return to the state.

Another error was uncovered, which was $1.372 million charged to PMAP and MnCare, for something called: “Additional Allocation for 2012 Strategic Spending.”

The report also noted “unusual fluctuations” in what Blue Plus reported year to year for reserves, expected next-year losses in the public programs, donations, and distribution of capital gains. Plus, at times the official reporting instructions of the Nat’l Assoc. of Insurance Commissioners were not followed, as are required.

$3.6 million in questionable expenses

The report identified 13 expense categories in which amounts charged to PMAP and MnCare have questions as to being proper. The grand total of these is $3.648 million dollars. Items in this total include $1.2 million for marketing and corporate communications; $100,000 in TV ads; and $13,000 for a Twins ballpark sponsorship.

Prohibited costs: $99 K

Very noteworthy is that the report identified certain costs that are absolutely prohibited, by federal law, to be paid by the Medicaid program. These are $88,000 in lobbying expenses, and $10,000 to help pay for an audit of Medicare expenses. While not huge, there are clear-cut unallowable items.

$10 million donation

One more striking expense is a $10 million donation to the Blue Cross/ Blue Shield of MN Foundation. This is not allocated on Blue Plus’ books to the public low income programs. But, the convoluted web of corporate entities raises questions, GMHCC believes, as to which funds are really being used to pay for this huge donation.

Allocation of $10.3 million of realized capital gains

Blue Plus received income of $10.3 million from realized capital gains (sale of some assets). What is odd is that all of this income was assigned to a category of businesses services for Blue Cross programs, and not just in Minnesota, but in six other states as well. None of the money was assigned to either the public programs or the commercial insurance policies. This raises the question as to whether a portion of these capital gains proceeds should have been listed as income for the public programs. In contrast, for example, Medica allocated some of its 2011 realized capital gains to its public programs.

B.2. UCare

Math error of $1.57 million

During the course of the review by Risk & Regulatory Consultants, UCare discovered that there was an error it had built into the mathematical formula in its spreadsheets. The error was in the formula used...
to allocate UCare’s administrative costs among its various coverage programs. The error over-reported its administrative expense for Medical Assistance, resulting in UCare having claimed that it made, in the Medical Assistance program for 2011, $1.57 million less in profit than it actually had made.

This is important, since all the HMOs had agreed to give back to the State any profit off of Medical Assistance and MnCare that exceeded 1%. The report says that UCare has since owned up to the discrepancy and paid the missing $1.57 million to the state of Minnesota. It raises a question: If the consultants hadn’t reviewed UCare’s books, would this error have been found and rectified?

Money for UCare’s ”brand”

The report states that $137,000 was spent by UCare in 2011 for general advertising to promote its image and brand identity to the general public. However, the report quotes from UCare’s contract with the State, which says that only two mailings a year are allowed to existing enrollees, and no ads or promotions to prospective ones.

In its response letter, UCare disagreed, claiming that as long as they weren’t marketing specific policies, it’s permissible for them to pay for general brand advertising as a “general overhead cost of doing business.” This raises a question for DHS to answer, regarding what it allows versus what is written in its contracts regarding these expenses.

Large donations.

The December 3rd report shows that in 2011, UCare gave (besides $30 million to the state of MN) another $1 million to the UCare Fund at the MN Medical Foundation (which is run by the U of M), and over $6 million directly to the U of M medical system.

The report also says that UCare assigned $341,000 of these donations to its Medicare programs, while assigning $7,358,784 to its Medical Assistance programs.

These donations are part of a consistent pattern that Greater MN Health Care Coalition wrote about in its Aug., 2012 report, finding over $70 million in donations over the years, with the vast majority of that going to the U of M medical system. It’s important to remember that UCare’s donations emanate primarily from its overpayments from DHS, and also partly from Medicare Advantage profits.

UCare donating to its parent

There is a problem with UCare giving all this money to the U of M medical system. GMHCC spelled it out in our Aug, 2012 report “Who was minding the store?” The problem is that UCare and the U of M medical system are very closely connected, despite UCare denying that it has a parent entity.

The report issued in December points out that “8 of the 15 UCare Board members have an affiliation with the U of M.” But, the report did not mention that this is not an accident. Rather, the UCare by-laws, filed with the MN Dept. of Health, state that a majority of the Board members -- 8 out of 15 -- have to be U of M medical system employees (physicians and administrators).

The relevant points are that: (1) The U of M holds the controlling votes on UCare’s Board and they should not pretend otherwise; and (2) UCare should not be giving extra advantages to the U of M medical system out of the over-payments from the public programs. If this amounts to a back door method to give higher payments to U of M medical providers than UCare gives to other medical providers, that is improper and likely illegal.

In its response letter, UCare claims that the money to the U of M is to “educate” family physicians. However, the Larson & Allen CPA audit reports over several years, commissioned by UCare itself, indicate otherwise. Those audits say that the payments to the U of M system were also to provide
services for uninsured people – who are not to be served by the DHS contracts; and to make up for shortfalls in other funding for the U of M medical system.

B. 3. Medica

Large donations.

The report on Medica showed very large donations. Identical sums were given in both 2010 and 2011, of $3.5 million to the Medica Foundation, plus $6.5 million to the Medica Research Institute.

Other than this, the report did not discover any irregularities in the expense allocations, although the report noted significant fluctuations in the amounts of some items from 2010 to 2011.

B. 4. HealthPartners

Incorrect method to compute Premium Deficiency Reserves

The Risk & Regulatory Consultant report says that HealthPartners uses an incorrect method to determine whether or not, and how much, of a Premium Deficiency Reserve to post. Another finding was that HealthPartners should change how it calculates reserves for the various public programs to make it more precise.

Deciding to not pay $1.3 million in State taxes?

The most shocking finding in the report is that HealthPartners decided, on its own, to not pay the 1% Minnesota Health Access (MnCare) premium tax on any of its revenue for the MSHO (MN Senior Health Options) program. The report states that HealthPartners made this decision on the basis that “it is a Medicare Advantage program and there should be no taxes allocated to it.” The problem with this statement is that it is only half right. MSHO is a hybrid, consisting of a Medicare Advantage contract with the federal CMS (Centers for Medicare & Medicaid Services), and a Medical Assistance contract with Minnesota DHS. Each of these two contracts provide roughly half of the total MSHO revenue.

In other words, it is illegal for HealthPartners to choose to fail to pay the 1% insurance premium state tax on the DHS portion of the overall MSHO revenue. The Minnesota Dept. of Revenue is currently investigating HealthPartner’s treatment of its State insurance premium tax.

Part C. Are all or most of the HMOs trying to fool the MN Dept. of Revenue?

The MnCare tax issue raises questions about all of the HMOs, since GMHCC has found incorrect postings of MSHO revenue by all four HMOs on their National Association of Insurance Commissioner (NAIC) Annual Statements. These statements are supposed to be the basis from which the HMOs pay their 1% premium tax to the State, but they apparently are not being followed for that purpose. It is unknown just how much the State may have been shortchanged by the HMOs, and this merits a thorough investigation. The MN Dept. of Revenue is starting to look into this issue, and GMHCC has provided the Dept. with relevant information.

Schedule T from the NAIC Annual Statement is what is required by the Dept. of Revenue (DOR) to fill out and attach with the M11H form, which is the DOR form the HMOs must use to compute and file the 1% premium tax. We found that Blue Plus and Medica put all of their MSHO revenue in the Medicare column of Schedule T, while HealthPartners and UCare put all of MSHO in the Medicaid column. Both
methods are incorrect, since about half of MSHO belongs under Medicare, and half under Medicaid. The exact amounts vary somewhat year to year, and from HMO to HMO. In 2011, the Medicaid portions of MSHO revenue for the four HMOs were: Blue Plus 45%, Medica 45.2%, HealthPartners 45.8%, and UCare 50.1%, and the total dollar amount was $466,983,776. The 1% tax amount on this Medicaid MSHO revenue would be $4.6 million, if correctly paid.

Since HealthPartners puts all of MSHO in the Medicaid column, it would be paying tax on all of it, IF it is actually paying the state off of the Schedule T, as required. However, since they are not paying any tax at all on MSHO, this means that they are not following the rules to file the M11H form.

This raises the question as to whether the HMOs are using this Medicare/Medicaid confusion to prevent DOR from figuring out whether the proper amount of tax is being paid or not. Schedule T does not indicate where MSHO revenue is posted. To figure that out, you have to cross reference it with the premiums received that are broken down, program by program, on the MN Supplemental Report #1, which is seen by the Dept. of Commerce, filed with the MN Dept. of Health, and also given to DHS. GMCHC has also looked at HealthPartners’ Consolidated Report which it files with the federal Securities and Exchange Commission (SEC). On this report, it appears as if they are paying a correct amount of 1% premium tax. Like the NAIC report, the SEC report also contradicts what was found in the DOC review. If the information in the DOC report is correct, then HealthPartners is over stating, in its SEC filing, what it is actually paying in state taxes.

The mis-matches in these numbers raise more questions:
(1) Are other elements of the 1% premium tax being computed correctly?
(2) Are the separate payments of 0.6% surcharge for Medical Assistance (which is submitted to DHS) being computed and paid properly as well?
(3) Is HealthPartners paying the proper amount of 2% provider tax for the hospitals and clinics that it operates? The SEC filing indicates that this might not be the case.

GMHCC hopes that the Dept. of Revenue investigation will get to the bottom of these questions, and obtain payment, along with required penalty fees, for any underpaid taxes.

Part D. Additional Points

1. The Dept. of Commerce reviews were not full audits

It’s important to note that the reviews done by Risk & Regulatory Consulting for DOC were not full audits. Although some administrative expenses were audited none of the medical expenses, or their allocation among public programs and commercial policies, were reviewed for documentation.

So, whether some of the HMOs’ numbers are true or not is still an unanswered question. This leads to an additional question:

2. Will the rest of the Governor’s Executive Order be completed?

The Dec. 3 reports were done to fulfill a March, 2011 Executive Order by Governor Dayton. That order directed the DOC to examine several things, only some of which were reviewed in the new reports.

However, the Executive Order also called for examination of additional things, which were not looked at in the reports issued in December -- or any others so far. These missing items include: “Detailed information...on provider payments and reimbursement rates, [and] contributions to reserves...”

These are critical items, especially the question of just what the HMOs really paid the hospitals and doctors (and for medications) compared to what they claimed they paid. That is where, GMHCC believes, there is likely to be found evidence of deliberate, fraudulent inflating and falsifying of the
numbers, which is what the new investigation by the Office of Inspector General is looking into.

3. The Office of Inspector General investigation, and GMHCC’s role

In January, the U.S. Health and Human Services Office of Inspector General (OIG) Audit Services Division began a new investigation, for the express purpose of verifying whether or not the financial and health status data provided by the HMOs in the years 2008 and 2009 was accurate or not. This is, at long last, the kind of auditing that is needed, especially as demonstrated in the Segal report’s remarks of how badly inflated the rates were, and that they were based on data from the HMOs that was never audited.

How did the OIG audit come into being? The OIG has not officially said. GMHCC asserts that we played a major role in making this happen. Anyone can judge for themselves the following facts:

1. After GMHCC issued its report on this issue titled “Who was minding the store?” on August 23, 2012, the Minneapolis office of the U.S. Dept. of Justice (DOJ), Civil Fraud unit, invited GMHCC representatives to show them, in detail, the evidence GMHCC had gathered to support our assertions in “Who was minding the store?”

2. On Friday, Nov. 16, 2012 two GMHCC representatives met at the Minneapolis DOJ office. Present were three DOJ staff, including the head of the Civil Fraud Unit; plus a St. Paul-based Special Agent of OIG, Office of Investigations. Also connected, by teleconference, were six other DOJ and OIG staff, based in other states. The discussion with these ten federal investigators lasted for four and a half hours. The meeting concluded with the federal investigators concurring that a possibility of fraud existed, and that auditing was merited.

3. The following Tues., Nov. 20, Sheri Fulcher, the regional Director for Audit Services of the OIG, based in Chicago, sent a letter to Minnesota DHS Commissioner Jesson, stating that the OIG will commence its investigation to “determine whether information used for capitation rate setting …. was reasonable, allocable, and allowable.”


A new report by the Office of Legislative Auditor (OLA) on Medical Assistance dental payments clearly states that payments to dentists are unrealistically low, leading to little participation by dentists and poor access for enrollees. The OLA report shows how insufficient the Fee For Service (FFS) payments are that DHS pays dentists directly. It also shows that the HMOs pay dentists only slightly more than the FFS rates. Only a small percentage of Medical Assistance enrollees are on the Fee For Service system; the vast majority are enrolled with the HMOs. Most shocking, the report states that DHS repeatedly gave increases in its payments to the HMOs specifically for use in dental care, but never required that the increases be passed onto the dentists. The HMOs kept the dental increases for themselves, padding their profits even further, while they kept the payments to dentists stagnant and even decreased them.

The OLA report did not mention one important point, which is the County Based Purchasing groups Prime West and Itasca Medical Care pay dentists much better than the HMOs do, and as a result obtain good participation from dentists and good access to care for their enrollees. It is one more proof that adequate money for dental services has been provided in the rates to the HMOs, but they have chosen to ignore their obligation, and keep the money for themselves.

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