

**HEALTH NET, INC.  
TENN CARE OPERATIONS**

**FOR THE PERIOD  
JANUARY 1, 1994, THROUGH JUNE 30, 1995**

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July 16, 1996

The Honorable Don Sundquist, Governor  
and  
Members of the General Assembly  
and  
The Honorable Bob Corker, Commissioner  
Department of Finance and Administration  
and  
Members of the State Insurance Committee  
State Capitol  
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the report on the compliance audit of the managed care organization (MCO) Health Net, Inc., for the period January 1, 1994, through June 30, 1995.

The review of the operations disclosed certain deficiencies, which are detailed in the Findings and Recommendations section of this report. This report is intended to aid the Bureau of TennCare in its review to determine whether the MCO has adhered to the terms of the preferred provider organization contract. The Department of Commerce and Insurance should take whatever action it deems appropriate regarding the findings contained in this report.

Very truly yours,

W. R. Snodgrass  
Comptroller of the Treasury

cc: Bill Young  
Theresa Clarke

State of Tennessee

# Audit Highlights

Comptroller of the Treasury

Division of State Audit

Compliance Audit

**Health Net, Inc.**

**TennCare Operations**

For the Period January 1, 1994, through June 30, 1995

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## AUDIT OBJECTIVES

The objectives of the audit were to determine if the managed care organization (MCO) is meeting its contractual obligations, including, but not limited to, proper claims payment, proper accounting for payments from the TennCare Bureau, proper enrollment counts, maintenance of sufficient financial reserves, and recordkeeping sufficient to meet program requirements.

## AUDIT FINDINGS

### **Insolvency and Deficiency in Financial Reporting**

Health Net, Inc., is considered insolvent as of June 30, 1995, with an audit-adjusted equity of (\$8,137,611). Health Net, Inc., asserts that its parent company has pledged its financial support and that the company's deficit will be cleared by the end of 1996. (page 6).

### **Deficiency in Claims Processing**

For certain TennCare claims paid, Health Net, Inc., incorrectly calculated deductibles and copayments. The overstatement of these items resulted in underpayments to medical providers. The calculations were based on percent of charges rather than on negotiated rates (page 8).

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"Audit Highlights" is a summary of the report. To obtain the complete audit report which contains all findings, recommendations, and management comments, please contact

Comptroller of the Treasury, Division of State Audit  
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COMPLIANCE AUDIT  
HEALTH NET, INC.  
TENNCARE OPERATIONS  
FOR THE PERIOD JANUARY 1, 1994, THROUGH JUNE 30, 1995

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COMPLIANCE AUDIT  
HEALTH NET, INC.  
TENNCARE OPERATIONS  
FOR THE PERIOD JANUARY 1, 1994, THROUGH JUNE 30, 1995

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INTRODUCTION

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**PURPOSE OF THE AUDIT**

This report details the results of a compliance audit of the transactions, books, and accounts of Health Net, Inc. The purpose of this audit was to evaluate the programmatic operations of the managed care organization (MCO) in accordance with generally accepted government auditing standards and to determine if Health Net, Inc., was administered in accordance with the requirements of *Tennessee Code Annotated* and the contracts between the state and the MCO. The objectives of the audit were

1. to determine whether the MCO is meeting its contractual obligations under the TennCare agreement with the state;
2. to determine whether the MCO has properly adjudicated claims from service providers and has made payments in a timely manner;
3. to determine whether enrollment counts and categories are accurate and whether monthly payments and withhold amounts from TennCare to the MCO are accurate;
4. to determine if the MCO has sufficient financial capital to ensure uninterrupted delivery of health care;
5. to determine if records maintained by the MCO are adequate to determine compliance with the rules and contract requirements of the Bureau of TennCare; and
6. to recommend appropriate actions to correct any deficiencies.

**POST-AUDIT AUTHORITY**

This audit was conducted pursuant to Section 4-3-304, *Tennessee Code Annotated*, which authorizes the Department of Audit to “perform a post-audit of all accounts and other financial records of the state government and of any department, institution, office, or agency thereof in accordance with generally accepted auditing standards and in accordance with such procedures as may be established by the comptroller.”

Section 8-4-109, *Tennessee Code Annotated*, authorizes the Comptroller of the Treasury to audit any books and records of any government entity that handles public funds when the Comptroller considers an audit to be necessary or appropriate. In addition, Section 2-14 of the Contractor Risk Agreement between Health Net, Inc., and the State of Tennessee provides that the books and records “shall be available for review by authorized federal, state, and Comptroller personnel.”

## **SCOPE OF THE AUDIT**

The audit examined the records, transactions, and contract provisions of Health Net, Inc., for the period January 1, 1994, through June 30, 1995. The audit included tests of insurance claims, review of accounting records, and other auditing procedures considered necessary.

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## **BACKGROUND INFORMATION**

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Effective January 1, 1994, the State of Tennessee received approval from the U.S. Department of Health and Human Services to begin a five-year Medicaid waiver project which changed most services covered under the Medicaid program to a managed care capitated system. Under the waiver program, known as TennCare, the state contracts with 12 managed care organizations that manage and provide care for enrollees for a stated monthly capitation fee. In addition to recipients eligible under Medicaid criteria, certain uninsured or uninsurable persons may enroll in the TennCare Program. The managed care organizations in turn arrange for a network of hospitals, doctors, and other health care providers to furnish health care services for persons enrolled in the plan.

The Tennessee Department of Finance and Administration is the state agency responsible for administration of the managed care program in Tennessee. The department is authorized to contract with MCOs to provide specified services to people who are or would have been eligible for Medicaid as it was administered during fiscal year 1992-93 and to other Tennesseans who are eligible for and are enrolled in the TennCare system. The managed care organization must

1. be appropriately licensed to operate within the State of Tennessee;
2. demonstrate the existence of a network of health care providers capable of providing comprehensive health care services throughout the community where the plan is offered;
3. clearly demonstrate the capability and intent to provide case management services;

4. assure the availability of service providers outside the community service network for covered services that are not commonly provided in that particular community area;
5. demonstrate sufficient financial capital to ensure uninterrupted delivery of health care on an ongoing basis;
6. demonstrate sufficient financial capital, network capability, and a willingness to accept a reasonable number of enrollees from any failed health plan operating in the community;
7. agree to move to electronic billing for all of its TennCare plans within three years of the effective date of the agreement;
8. unanimously agree with other MCOs in the TennCare system for the provision of pharmacy services to TennCare enrollees who reside in long-term care facilities so that only one pharmacy shall be responsible for the their pharmacy services;
9. agree not to require service providers to accept TennCare reimbursement amounts for services provided under any non-TennCare plan operated or administered by the managed care organization; and
10. mutually agree to such other requirements as may be reasonably established by TennCare.

Health Net, Inc., is a not-for-profit corporation. Effective January 1, 1994, Health Net, Inc., contracted with the State of Tennessee as a preferred provider organization (PPO) to provide medical services under the newly established TennCare program. At June 30, 1995, the enrollment for Health Net, Inc., was approximately 75,000 members.

As a PPO, Health Net, Inc., must establish risk reserves in an amount equal to what would have been required by the Tennessee Department of Commerce and Insurance if Health Net, Inc., had been a health maintenance organization licensed by the State of Tennessee. Also, Health Net, Inc., is allowed to retain up to 10 percent of the monthly capitation amount paid by TennCare as a management fee, with the remainder of the monthly capitation payment available for the payment of covered benefits. TennCare shall not be liable for any excess benefit costs. Any and all excess administrative costs will be borne by Health Net, Inc. In the event of savings, Health Net, Inc., as provided for in Section 2-10(e)(2) of the TennCare contract, is required to share with TennCare a portion of such savings after medical benefits and allowable administrative expenses are paid. The contractor shall be permitted to share 5 percent of the savings with the providers and retain 5 percent for its efficiency. The remainder of the savings shall be returned to TennCare.

This is the first audit of the provisions of the preferred provider organization contract between the State of Tennessee and Health Net, Inc.

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## RESULTS OF THE AUDIT

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Our review of the plan's claims processing system and accounting and financial data revealed discrepancies which are further discussed in the Findings and Recommendations section of the report.

Based on our audit, the capitation payments by TennCare, and the payments by Health Net, Inc., for covered benefits, we have computed a plan loss of (\$5,962,503.84) for the year ended December 31, 1994. Schedule 1 exhibits the tentative settlement calculation according to the Division of State Audit. A final settlement will be determined when all transactions for the period under audit have been completed.

The loss calculation as computed includes cash payments through November 30, 1995, for calendar year 1994 services. Some payments may still be outstanding for calendar year 1994.

The company's audited financial statements include as an asset deferred medical costs of \$8,644,744. The deferred medical expenses represent the excess of medical expenses over premium revenue received. Health Net, Inc., also decreased its medical expenses by the same amount since as a preferred provider organization (PPO) it is not at risk for medical costs in excess of premiums received. The risk is assumed by its network providers. As of June 30, 1995, the likelihood of collection of excess benefits expenses from providers is uncertain. If the financial statements were adjusted to remove the deferred medical cost asset and increase medical expenses by \$8,644,744, total assets of Health Net, Inc., would be \$7,141,252; total liabilities would be \$15,278,863; and equity would be (\$8,137,611). Health Net, Inc., is considered insolvent as of June 30, 1995.

LOSS CALCULATION  
FOR THE PERIOD JANUARY 1 THROUGH DECEMBER 31, 1994  
PREPARED BY THE DIVISION OF STATE AUDIT

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Capitation Amounts Paid by TennCare for 1994 Dates of Eligibility:

Payable by TennCare in 1994	\$76,471,731.94	
Adverse Selection Capitation for 1994	2,496,610.00	
Retroactive Capitation Adjustment for 1994	<u>3,333,400.75</u>	
Total Capitation Adjustment for 1994 Dates of Eligibility		\$82,301,742.69
Management Fee (10%)	<u>8,230,174.27</u>	
Available for Payment of Covered Services		74,071,568.42

Payments by Health Net, Inc., for Covered Benefits:

Cash Payments January 1, 1994, through November 30, 1995, for Calendar Year 1994 Services	\$80,842,273.26	
Reimbursement by TennCare for First 30 Days of Uninsured Coverage	<u>(808,201.00)</u>	
Total Medical Expense		<u>80,034,072.26</u>
Total Loss		<u><u>(\$5,962,503.84)</u></u>

## FINDINGS AND RECOMMENDATIONS

### INSOLVENCY AND DEFICIENCY IN FINANCIAL REPORTING

#### 1. FINDING:

Health Net, Inc., is considered insolvent as of June 30, 1995, with an audit-adjusted equity of (\$8,137,611). The plan does not meet the minimum financial reserve requirement specified in the TennCare contract and in *Tennessee Code Annotated*.

Section 2-10(e)(4) of the preferred provider TennCare contract states, "The Contractor shall establish risk reserves in an amount equal to the amount that would have been required by Tennessee Department of Commerce and Insurance if the Contractor had been a health maintenance organization licensed by the State of Tennessee."

Section 56-32-201 et seq. of *Tennessee Code Annotated* addresses the statutory requirements for health maintenance organizations.

#### RECOMMENDATION:

Health Net, Inc., should take the appropriate action to achieve positive equity and meet the minimum risk reserve requirements. The Tennessee Department of Commerce and Insurance should take whatever action deemed necessary to ensure that Health Net, Inc., meets the minimum equity requirements.

#### MANAGEMENT'S COMMENT:

The primary issue as to HNI's solvency relates to the recording of certain health benefits expenses as deferred medical costs. Due to the nature of this asset, a brief explanation of the accounting rationale is appropriate.

Since its incorporation in 1984, HNI has operated as a not-for-profit preferred provider organization (PPO) which primarily offers its network of hospitals, physicians, and other providers to commercial insurers and third party administrators in exchange for an administrative fee. Accordingly, HNI does not assume financial risk for the costs associated with the provision of health care services to employers and their employees which select the HNI provider network in conjunction with a health insurance program. Due to the nature of its operations, HNI has not been required to obtain an insurance license or a license to operate as a health maintenance organization.

At the inception of the TennCare program, HNI was deemed by the Bureau of TennCare to be a qualifying organization capable of providing or arranging for health care services for TennCare enrollees. The initial Provider Risk Agreement with TennCare, as well as subsequent amendments and contracts, recognized HNI's PPO status in several provisions including:

Section 2-10(e)(1), which says in part "any and all benefit costs in excess of the amounts allowed pursuant to this Agreement shall be the responsibility of the contract providers who provided the services." This section also states in part "any and all excess administrative costs will be borne by the Contractor. . . ." This concept is further reaffirmed in the Background Information section of your draft audit report.

Section 2-10(e)(2), which says in part "the Contractor shall be liable for any excess administrative costs and the service providers shall be liable for excess benefits costs."

Based upon these provisions, HNI determined the amount of available funding for health services by deducting administrative fees, which in total were less than the 10% allowed in the Provider Risk Agreement, from the capitation amounts paid to HNI by the Bureau of TennCare. Any excess of estimated incurred health services expenses over the related funding was recorded as a deferred medical cost. In August 1995 HNI amended reimbursement methodologies with its various providers to assure that ongoing incurred medical costs would not exceed available funding and that the deferred medical costs balance would be recovered over time. As of May 31, 1996, funding for health services costs during the eleven month period then ended has exceeded incurred claims, and the deferred medical costs have been reduced by approximately \$2.267 million to a balance of \$6.376 million. Furthermore, it is management's opinion that the deferred medical costs will be substantially reduced, or eliminated, by December 31, 1996, based on medical management action plans and reimbursement methodologies which have been initiated.

Notwithstanding the above, HNI recognizes its obligations under Section 2-10(e)(4) of the TennCare contract regarding compliance with risk reserve requirements. HNI has maintained a good working relationship with the Bureau of TennCare and the Department of Commerce and Insurance, TennCare Division, since the program's inception. Through periodic meetings and discussions with appropriate personnel, HNI has kept these departments aware of its TennCare operating results. Furthermore, we have worked closely with Deputy Commissioner William Young to address concerns over risk reserve requirements. Based on discussions with Deputy Commissioner Young, Baptist Hospital, Inc., which is the parent company for HNI, has agreed to the following:

- Issuance of an Irrevocable Standby Letter of Credit in the favor of HNI up to the aggregate amount of \$2.1 million.

- Issuance of a Capital Infusion Agreement which provides for an additional capital contribution, should it be required, for the express purpose of funding the uncertainty of collection of the deferred medical costs recorded on HNI's financial statements at the time the Provider Risk Agreement terminates. It is expected the Provider Risk Agreement will terminate as of December 31, 1996, and at that time HNI, or a related corporation, will obtain a license to operate as a health maintenance organization and enter into a Contractor Risk Agreement with TennCare.

Both the Irrevocable Standby Letter of Credit and the Capital Infusion Agreement have been executed in a form which is believed to be acceptable to Deputy Commissioner Young. These documents have been submitted for his approval.

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### DEFICIENCY IN CLAIMS PROCESSING

#### 2. FINDING:

For certain TennCare claims paid, Health Net, Inc., incorrectly calculated deductibles and copayments. The deductibles and copayments were computed based on percent of charges for medical services instead of the negotiated rate between the providers and Health Net, Inc.

Section 2-3(h) of the TennCare contract with Health Net, Inc., states, "Deductibles and copayments charged the enrollee shall be based upon the negotiated rate between the MCO and the provider."

As a result of the incorrect calculations, deductibles and copayments were overstated, and medical providers were underpaid.

#### RECOMMENDATION:

Health Net, Inc., should correctly calculate deductibles and copayments based on the rate negotiated with providers. Health Net, Inc., should correct previously filed claims containing incorrect deductible and copayment calculations. Also, Health Net, Inc., should notify the affected providers and ensure they properly adjust patient accounts for the overstated deductibles and copayments.

## MANAGEMENT'S COMMENT:

During the State's audit, it was brought to our attention that the claims system did not calculate the coinsurance amounts according to contract. After review we have determined the required revision only affects outpatient and emergency room claim types for subgroups 005-010 of the uninsured population, which represents 6,351 members or approximately 9% of our total membership. We immediately began working to change this system calculation. After extensive programming and testing, the system change was implemented on February 12, 1996. All claims processed on or after February 12, 1996, are calculating coinsurance amounts in accordance with the contract's terms.

We have produced preliminary reports comparing the differences in claim amounts payable under the revised methodology to actual claims paid during 1994. This report indicates approximately \$61,000 was overcharged to the uninsured members, which represents 1.2% of the \$4,944,242 of paid claims for these members. The report also indicates the vast majority of affected members have an immaterial variance. It will take us approximately two weeks to complete the remainder of the report and analysis needed to determine an appropriate course of action. By August 31, 1996, we will produce a written summary to the Bureau of TennCare on our findings and recommendations and will include a proposed plan of correction. You will be copied on all pertinent correspondence.