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

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# Final Audit Report

**AUDIT OF THE FEDERAL EMPLOYEES HEALTH  
BENEFITS PROGRAM OPERATIONS  
AT PRESBYTERIAN HEALTH PLAN**

**Report Number 1C-P2-00-18-014  
March 7, 2019**



# EXECUTIVE SUMMARY

## *Audit of the Federal Employees Health Benefits Program Operations at Presbyterian Health Plan*

Report No. 1C-P2-00-18-014

March 7, 2019

### **Why Did We Conduct The Audit?**

The primary objective of the audit was to determine if Presbyterian Health Plan (Plan) complied with the provisions of its contract and the laws and regulations governing the Federal Employees Health Benefits Program (FEHBP). To accomplish this objective, we verified whether the Plan met the Medical Loss Ratio (MLR) requirements and thresholds established by the U.S. Office of Personnel Management (OPM).

Because of Program changes resulting from OPM's rollout of its MLR methodology, we are no longer performing a review of the FEHBP's rates. Consequently, this change to our audit process only allows us to verify whether the calculated percentage of the premium paid is spent on patient-related health care expenses. It does not allow us to assess the fairness of the premium paid for benefits received, which is a concern we intend to address with OPM in a separate report.

### **What Did We Audit?**

Under Contract CS 2627, the Office of the Inspector General (OIG) completed a performance audit of the FEHBP MLR submissions to OPM for contract years 2014 and 2015. Our audit fieldwork was conducted from March 12, 2018, through August 16, 2018, at the Plan's offices in Albuquerque, New Mexico, and in our OIG offices.



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**Michael R. Esser**  
*Assistant Inspector General  
for Audits*

### **What Did We Find?**

We determined that portions of the MLR calculations were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM. This resulted in an MLR penalty underpayment due OPM of \$530,688 for 2015, and an additional \$30,017 of lost investment income on the unpaid penalty calculated through December 31, 2018, for a total of \$560,705 due OPM. Although the Plan met the MLR threshold in 2014, our audit also identified errors in that year's MLR calculation. Specifically, our audit identified the following:

- The Plan included medical and pharmacy claims not allowed by the FEHBP in the incurred claims total.
- The Plan incorrectly reported claims adjustments and healthcare receivables.
- The Plan could not support that it allocated Quality Health Improvement expenses accurately and appropriately in compliance with applicable Federal regulations.
- The Plan's tax expense was incorrectly reported and unreasonably allocated.
- The Plan does not have sufficient internal controls over the FEHBP MLR process.

# ABBREVIATIONS

<b>ACA</b>	<b>Affordable Care Act</b>
<b>CFR</b>	<b>Code of Federal Regulation</b>
<b>Contract</b>	<b>U.S. Office of Personnel Management Contract CS 2627</b>
<b>FAR</b>	<b>Federal Acquisition Regulation</b>
<b>FEHBAR</b>	<b>Federal Employees Health Benefits Acquisition Regulations</b>
<b>FEHBP</b>	<b>Federal Employees Health Benefits Program</b>
<b>FFS</b>	<b>Fee for Service</b>
<b>FIT</b>	<b>Federal Income Tax</b>
<b>FWA</b>	<b>Fraud, Waste, and Abuse</b>
<b>HIF</b>	<b>Health Insurer Fee</b>
<b>MLR</b>	<b>Medical Loss Ratio</b>
<b>OIG</b>	<b>Office of the Inspector General</b>
<b>OPM</b>	<b>U.S. Office of Personnel Management</b>
<b>PCORI</b>	<b>Patient Centered Outcome Research Institute</b>
<b>Plan</b>	<b>Presbyterian Health Plan</b>
<b>PMPM</b>	<b>Per Member Per Month</b>
<b>QHI</b>	<b>Quality Health Improvements</b>
<b>SSSG</b>	<b>Similarly-Sized Subscriber Group</b>
<b>TRF</b>	<b>Transitional Reinsurance Fee</b>

# TABLE OF CONTENTS

	<u>Page</u>
<b>EXECUTIVE SUMMARY</b> .....	i
<b>ABBREVIATIONS</b> .....	ii
<b>I. BACKGROUND</b> .....	1
<b>II. OBJECTIVES, SCOPE, AND METHODOLOGY</b> .....	3
<b>III. AUDIT FINDINGS AND RECOMMENDATIONS</b> .....	6
<b>A. MEDICAL LOSS RATIO REVIEW</b> .....	6
1. Penalty Underpayments Due OPM.....	6
Table I – MLR Penalty Underpayments .....	6
2. No Penalty or Credit Due.....	6
Table II – No Monetary Adjustment.....	6
3. MLR Claims Data .....	7
a. Claims Paid for Capitated Members .....	7
b. Claims Not Properly Coordinated with Medicare .....	8
Table III – Coordination of Benefits Finding Summary.....	9
c. Claims Paid for Ineligible Dependents .....	10
Table IV – Dependent Eligibility Finding Summary.....	11
d. Claims Paid for Members after Effective Date of Termination.....	11
e. Deceased Members .....	12
f. Incorrect Adjustments to Claims .....	12
i. Dental Claims.....	13
ii. Subrogation Recoveries .....	13
iii. Provider Refunds .....	14
iv. Vendor Payments.....	15
Table V – Claims Adjustments Finding Summary .....	16
v. Unidentified Claims Adjustments.....	17
Table VI – 2015 Adjusted Incurred Claims Variance .....	17
4. Healthcare Receivables .....	18
5. Quality Health Improvements (QHI).....	19
a. Unsupported QHI Expenses.....	20

b.	Unallowable Expenses .....	21
c.	Reasonableness of QHI Allocation Methodology .....	22
6.	Premium Review.....	23
7.	Federal and State Taxes and Licensing or Regulatory Fees .....	23
a.	Federal Income Tax (FIT).....	23
b.	Health Insurer Fee (HIF).....	24
c.	Transitional Reinsurance Fee (TRF).....	25
d.	Patient Centered Outcomes Research Institute (PCORI) Fee .....	26
	Table VII – Tax Expense Finding Summary .....	27
	Conclusion - MLR Review .....	28
B.	LOST INVESTMENT INCOME .....	30
C.	INTERNAL CONTROLS REVIEW .....	30
1.	Inaccurate MLR Reporting .....	31
a.	Claims .....	31
b.	Healthcare Receivables.....	31
c.	QHI .....	31
d.	Taxes and Regulatory Fees .....	31
2.	Inappropriate Expense Allocations .....	32
3.	Reporting of Fraud Reduction Expenses .....	32
4.	Capitation Rates Not Adjusted for Benefits.....	32
	Conclusion – Internal Controls Review .....	33
D.	OTHER AREAS REVIEWED .....	34
1.	Fraud, Waste and Abuse Review .....	34
2.	Debarment Review.....	34
	<b>Exhibit A</b> (Summary of Amounts Due OPM)	
	<b>Exhibit B</b> (2014 Medical Loss Ratio Calculation)	
	<b>Exhibit C</b> (2015 Medical Loss Ratio Calculation)	
	<b>Exhibit D</b> (Lost Investment Income Calculation)	
	<b>Exhibit E</b> (Claims and Capitation Sample Selection Criteria/Methodology)	
	<b>APPENDIX A</b> (Plan’s October 12, 2018, Response to the Draft Report)	
	<b>APPENDIX B</b> (Plan’s November 8, 2018, Supplemental Response – Dependent Eligibility)	

**APPENDIX C** (Plan's November 8, 2018, Supplemental Response – Healthcare  
Receivables)

**REPORT FRAUD, WASTE, AND MISMANAGEMENT**



# I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at Presbyterian Health Plan (Plan). The audit was conducted pursuant to the provisions of Contract CS 2627 (Contract); 5 United States Code Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract years 2014 and 2015, and was conducted at the Plan's offices in Albuquerque, New Mexico.

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, and is administered by the U.S. Office of Personnel Management's (OPM) Healthcare and Insurance Office. The provisions of the Federal Employees Health Benefits Act are implemented by OPM through regulations codified in 5 CFR Chapter 1, Part 890. Health insurance coverage is provided through contracts with health insurance carriers who provide service benefits, indemnity benefits, or comprehensive medical services.

In April 2012, OPM issued a final rule establishing an FEHBP-specific Medical Loss Ratio (MLR) requirement to replace the similarly-sized subscriber group (SSSG) comparison requirement for most community-rated FEHBP carriers (77 FR 19522). MLR is the proportion of FEHBP premiums collected by a carrier that is spent on clinical services and quality health improvements. The MLR for each carrier is calculated by dividing the amount of dollars spent for FEHBP members on clinical services and health care quality improvements by the total amount of FEHBP premiums collected in a calendar year.

The MLR was established to ensure that health plans are meeting specified thresholds for spending on medical care and health care quality improvement measures, and thus limiting spending on administrative costs, such as executive salaries, overhead, and marketing. For example, the threshold of 85 percent requires carriers to spend 85 cents of every premium dollar on patient care and limits the amount that can go to administrative expenses and profit to 15 cents of every dollar. However, the MLR does not provide an assessment of the fairness of the premium paid for benefits received, only that the calculated percentage of the premium paid is spent on patient-related health care expenses. As this continues to be a significant Program concern for us, we will be addressing this issue with OPM in a separate report.

The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act (P.L. 111-148) and defined by the U.S. Department of Health and Human Services in 45 CFR Part 158. In 2012, community-rated FEHBP carriers could elect to follow the FEHBP-specific MLR requirements, instead of the SSSG requirements. Beginning in 2013, however, the

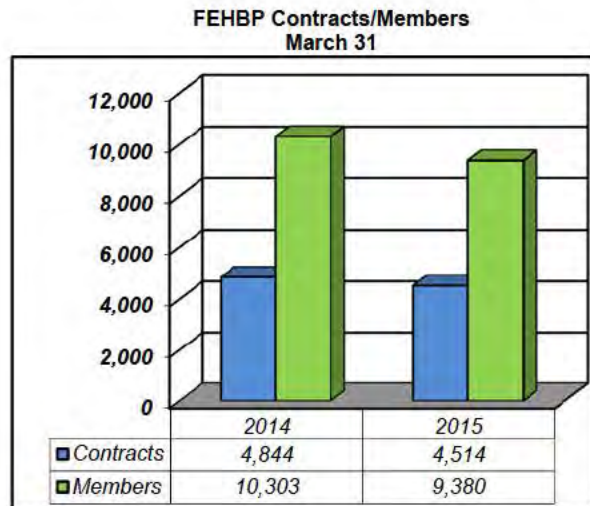
MLR methodology was required for all community-rated carriers, except those that are state-mandated to use traditional community rating. State-mandated traditional community-rated carriers continue to be subject to the SSSG comparison rating methodology.

Starting with the pilot program in 2012 and for all non-traditional community-rated FEHBP carriers in 2013, OPM required the carriers to submit an FEHBP-specific MLR. This FEHBP-specific MLR calculation required carriers to report information related to earned premiums and expenditures in various categories, including reimbursement for clinical services provided to enrollees, activities that improve health care quality, and all other non-claims costs. If a carrier fails to meet the FEHBP-specific MLR threshold, it must make a subsidization penalty payment to OPM within 60 days of notification of amounts due.

Community-rated carriers participating in the FEHBP are subject to various Federal, state and local laws, regulations, and ordinances. In addition, participation in the FEHBP subjects the carriers to the Federal Employees Health Benefits Act and implementing regulations promulgated by OPM.

The number of FEHBP contracts and members reported by the Plan as of March 31 for each contract year audited is shown in the chart to the right.

The Plan has participated in the FEHBP since 1991 and provides health benefits to FEHBP members in New Mexico.



A prior audit of the Plan covered contract year 2013. The audit did not identify any findings or questioned costs, and no corrective action was necessary.

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



## II. OBJECTIVES, SCOPE, AND METHODOLOGY

### **OBJECTIVES**

The primary objective of this performance audit was to determine whether the Plan complied with the provisions of its Contract and the laws and regulations governing the FEHBP. Specifically, we verified whether the Plan met the MLR requirements and thresholds established by OPM and paid the correct amount to the Subsidization Penalty Account, if applicable. We also performed additional testing to determine whether the Plan complied with the provisions of other applicable laws and regulations. Further, we reviewed the Plan's internal controls; compliance with fraud, waste, and abuse (FWA) requirements; debarment from the FEHBP; and offshore contracting program areas to ensure that the Plan had adequate policies and procedures covering these areas.

Our audits of the MLR submission filed with OPM are completed in accordance with the criteria expressed in OPM's rating instructions. The MLR audit evaluation includes an assessment of key components of the MLR calculation, including allowable claims, capitations, health care expenses, and quality health improvements (numerator), and the premium received, excluding applicable tax expenses (denominator). The result of the MLR calculation must meet OPM's prescribed thresholds. If the calculation falls below the threshold, the health plan must pay a penalty determined by the variance between the actual MLR ratio and the established threshold.

Although the FEHBP premiums used in the MLR calculation are ultimately determined by the premium rates proposed by the Plan and certified and paid by OPM, the OPM rating instructions no longer provide sufficient criteria to evaluate the fairness of those rates against the standard market value of similarly-sized groups. Furthermore, per the OPM rating instructions, health plans can utilize OPM's total reported premium, as the denominator in the MLR calculation, which when utilized is not subject to audit. Since the majority of health plans choose this option, the premiums utilized in the MLR calculation are very frequently not available for audit and the fairness of the FEHBP premium rates cannot be evaluated. As this continues to be a significant Program concern for us, we will be addressing this issue with OPM in a separate report.

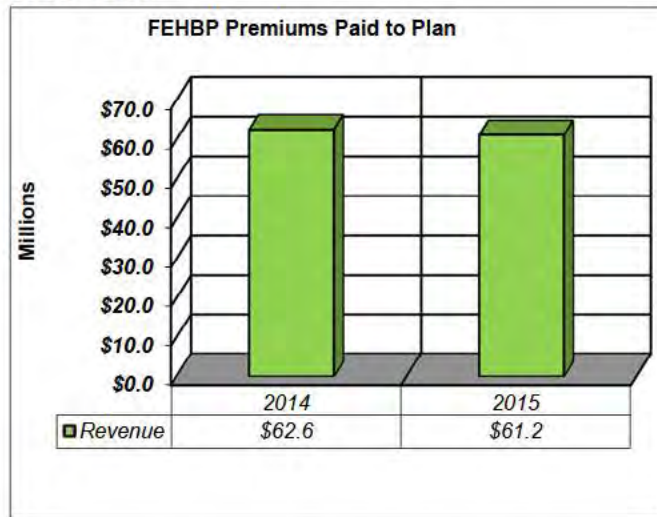
### **SCOPE**

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 2014 and 2015. For these years, the FEHBP paid approximately \$123.8 million in premiums to the Plan.

The Office of the Inspector General's (OIG) audits of community-rated carriers are designed to test carrier compliance with the FEHBP contract, applicable laws and regulations, and the 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. Our review of internal controls was limited to the procedures the Plan has in place to ensure that:



- the FEHBP MLR calculations were accurate, complete, and valid;
- claims were processed accurately;
- appropriate allocation methods were used; and
- any other costs associated with its MLR calculations were appropriate.

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 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 from March 12, 2018, through August 16, 2018, at the Plan's offices in Albuquerque, New Mexico, as well as in our offices in Cranberry Township, Pennsylvania, and Washington, D.C.

## **METHODOLOGY**

We examined the Plan's MLR calculations and related documents as a basis for validating the MLR. Further, we examined claim payments, quality health expenses, taxes and regulatory fees,

and any other applicable costs to verify that the cost data used to develop the MLR was accurate, complete, and valid. We also examined the methodology used by the Plan in determining the premium in the MLR calculations. Finally, we used the Contract, the Federal Employees Health Benefits Acquisition Regulations (FEHBAR), and the rate instructions to determine the propriety of the Plan's MLR calculations.

To gain an understanding of the internal controls over the Plan's MLR process, we reviewed the Plan's MLR policies and procedures and interviewed appropriate Plan officials regarding the controls in place to ensure that MLR calculations were completed accurately and appropriately. Other auditing procedures were performed as necessary to meet our audit objectives.

We also interviewed Plan officials and reviewed the Plan's policies and procedures associated with its internal controls over the claims processing system, FWA, debarment, and offshore contracting programs.

The tests performed for the medical and pharmacy claims and capitations, along with the methodology, are detailed in Exhibit E at the end of this report.



# III. AUDIT FINDINGS AND RECOMMENDATIONS

## A. MEDICAL LOSS RATIO REVIEW

The Certificates of Accurate Medical Loss Ratio (MLR) that the Plan signed for contract years 2014 and 2015 were defective. In accordance with Federal regulations and the OPM Community Rating Guidelines, our audit identified the following issues:

### 1. **Penalty Underpayments Due OPM** **\$530,688**

During the 2015 MLR filing period, the Plan calculated MLR ratios that met the OPM prescribed lower threshold of 85 percent, but did not exceed the upper threshold of 89 percent, resulting in no penalty or credit due. However, during our review of the FEHBP MLR submission, we identified issues that resulted in a lower audited MLR than the Plan's calculated MLR, resulting in a penalty of \$530,688 due to OPM. Table I illustrates the variances that generated the penalty due to OPM. The specific issues that led to the additional penalties, listed in Table I below, are discussed beginning in section A.3. on page 7.

Table I - MLR Penalty Underpayments					
Year	Plan's MLR Ratio	Audited MLR Ratio	Plan's Current Penalty/Credit	Audited Penalty	Penalty Due OPM
2015	86.18%	84.09%	\$0	\$530,688	\$530,688

### 2. **No Penalty or Credit Due** **\$0**

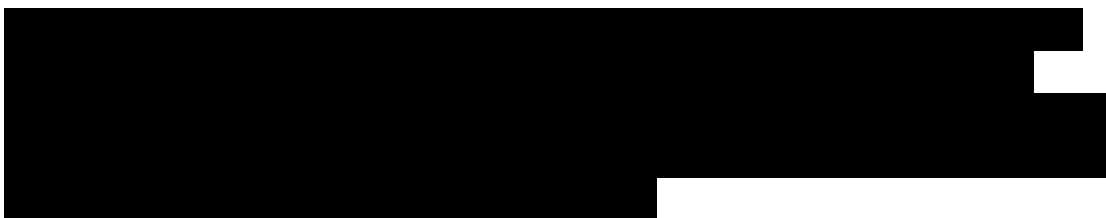
During the 2014 MLR filing period, the Plan calculated an MLR ratio that met the OPM prescribed lower threshold of 85 percent, but did not exceed the upper threshold of 89 percent (see Table II on page 7). However, our review of the Plan's MLR submission disclosed issues within the MLR calculation, as discussed beginning in section A.3. These adjustments, while reportable, were not significant enough to result in a penalty due to OPM or a credit due the Plan, as seen in Table II.

Table II - No Monetary Adjustment					
Year	Plan's MLR Ratio	Audited MLR Ratio	Plan's Current Penalty/Credit	Audited Penalty/Credit	Additional Amount Due
2014	87.79%	87.18%	\$0	\$0	\$0

### 3. MLR Claims Data

#### a. Claims Paid for Capitated Members

The Plan paid unallowable Fee-for-Service (FFS) claims in 2015 for FEHBP members who were covered under an active capitation agreement. Therefore, we removed \$130,463 from the 2015 MLR numerator.



We queried the Plan's 2014 and 2015 FFS claims and identified capitated members who incurred FFS claims in both years. We then selected a judgmental sample of 15 capitated members from each year who incurred the highest amount of FFS claims to determine if the claims were incurred during a month in which the member was covered by the PMPM paid under the capitation agreement. Specifically, our sample included 15 members who incurred 711 claims, totaling \$1,232,949, in 2014 and 15 members who incurred 455 claims, totaling \$503,242, in 2015.

Based on our review, we determined that the 2014 FFS claims for capitated members were allowable because these claims were incurred during months in which the members were not actively covered under the capitation agreement. However, in 2015, 229 FFS claims, totaling \$130,463, were paid for 83 members who were actively covered under the capitation agreement. As a result, the Plan inflated the 2015 MLR numerator because it included capitation payments for the FEHBP members as well as the unallowable claims. The erroneous payments are attributable to an apparent lack of internal controls over the coordination of capitation coverage and the payment of FFS claims.

**In contract years 2014 and 2015, the Plan included improperly paid claims in its MLR calculations.**

We removed the total value of these claims, or \$130,463, from the 2015 MLR numerator.

#### Plan Response:

*The Plan agreed that it paid \$130,463.46 FFS claims for capitated FEHBP members in 2015. The Plan stated that these claims were paid for capitated members "who were*

*originally identified as the Plan’s FFS responsibility” but were subsequently changed to capitation “due to retroactive or mid-month PCP [Preferred Care Provider] changes.” The Plan further noted that there is no overpayment as a result of these claims payments because “all FFS claims for capitated members are deducted from the capitation paid to the provider group.” The Plan suggested that the root cause of FFS claims being paid for capitated members may be the result of timing differences related to claims that are recouped subsequent to the cutoff date for MLR reporting. The Plan concluded that it “is refining the claims pull for purposes of the MLR cut off to accurately exclude the FFS claims paid for capitated members in the future.”*

**OIG Comment:**

The Plan stated that the payment of FFS claims for capitated members did not result in overpayment; however, no support was provided to substantiate this position. In addition, while the Plan stated that it was adjusting its future MLR claims data pulls to exclude the FFS claims paid for capitated members, this does not appear to address the problem of claims being inappropriately paid for capitated members in the first place.

**b. Claims Not Properly Coordinated with Medicare**

The Plan did not properly coordinate the payment of 113 Medicare claims, totaling \$139,765, in 2014 and 2015.

OPM Contract CS 2627 Sections 2.6(a) and (b) (Contract) require the Plan to coordinate Federal employee health benefit payments with the payment of Medicare benefits. The Contract directs the Plan not to pay contracted benefits “until it has determined whether it is the primary Carrier or unless permitted to do so by the Contracting Officer.” Contract Section 2.6(c) directs the Plan to “follow the order of precedence established by the [National Association of Insurance Carriers] Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits.”

The National Association of Insurance Carriers Coordination of Benefits Model Regulation, dated October 2013, states, “The plan that covers a person as an active employee ... is the primary plan. The plan covering that same person as a retired or laid-off employee ... is the secondary plan.”

The Center for Medicare and Medicaid Services’ Handbook entitled, “Medicare & Other Health Benefits: Your Guide to Who Pays First,” states that when a retiree over the age of 65 incurs healthcare costs, Medicare is the primary payor and the retiree health plan is



secondary. If the employee is still working, then the group health plan is the primary payor and Medicare is secondary.

Based on our review of a judgmental sample of 18 claims for members aged 65 and older in 2014, we determined that the Plan paid claims for 5 members as the primary payor when it should have paid secondary to Medicare. Claims for two of these members were not properly coordinated as the result of errors made by manual claims processors. Claims for the remaining three members were not properly coordinated because the Plan's system was not updated to reflect the correct order of benefits or class code. However, in each circumstance, the root cause of the errors appears to stem from a lack of controls over the coordination of benefits process. Specifically, the Plan did not have documented policies and procedures governing the process for updating the order of benefits and class codes in its system when a member retires.

As a result of these errors, we expanded our sample to review an additional 25 claims in 2014 and 2015, totaling \$23,687, for the 3 members whose order of benefits had been incorrect. We did not find any additional errors as a result of the expanded sample. However, we questioned the two claims processed incorrectly due to manual errors and all claims incurred for the remaining three members for the time period during which the Plan's system was not updated to appropriately coordinate their benefits. In total, we removed \$139,765 of claims expense in 2014 and 2015 from the claims costs used in the MLR calculation, as illustrated in Table III below.

<b>Table III: Coordination of Benefits Finding Summary</b>			
<b>Year</b>	<b>Member Count*</b>	<b>Medical Claims Count</b>	<b>Medical Claims Value</b>
2014	4	74	\$134,888
2015	2	39	\$4,877
<b>Total</b>	<b>5</b>	<b>113</b>	<b>\$139,765</b>

*\* One member identified in 2015 also had 2014 questioned claims.*

**Plan Response:**

*The Plan concurred with the finding and stated that it is actively working to improve this process.*

**OIG Comment:**

We were unable to verify the type of improvements that the Plan is making over the coordination of benefits process.

**c. Claims Paid for Ineligible Dependents**

The Plan could not support the eligibility of two dependent members aged 26 and older in 2014 and 2015. As a result, the Plan paid \$23,507 in medical and pharmacy claims for these members who may not be eligible for coverage.

According to the FEHBP benefit brochures, an FEHBP member's dependents are only eligible to be covered after age 26 if the dependent is disabled or incapable of self-support. In these cases, the FEHBP Handbook indicates that the subscriber's employing office will provide the insurance carrier with its decision about the dependent's eligibility. Contract Section 1.11(b) also requires insurance carriers to maintain all records relating to the contract and to make these records available for a period of time specified by Federal Employee Health Benefit Acquisition Regulation 1652.204-70. The referenced clause is incorporated into the contract at Section 3.4, which requires the carrier to maintain individual enrollee and/or patient claim records "for six years after the end of the contract term to which the claim records relate." Since the member's employing office certifies via letter a disabled child's status as a dependent, the letter should be maintained in accordance with the contract to ensure that claims for dependents aged 26 and older are allowable.

Based on our review of a judgmental sample of 40 dependent members who were aged 26 or older in 2014 and 2015, we determined that the Plan did not maintain appropriate documentation to support eligibility for 2 of the dependent members. By not maintaining eligibility documentation, which is necessary to ensure that claims for dependents aged 26 and older are allowable, the Plan did not comply with contractual and regulatory requirements for the maintenance of records. Since we cannot verify that the 140 medical claims, totaling \$22,596, and 46 pharmacy claims, totaling \$911, incurred by these members were allowable, the Plan may be overstating the claims used in its 2014 and 2015 MLR calculations. Therefore, we removed the incorrectly paid dependent eligibility claims from the numerator of the MLR, as illustrated in Table IV below.



Table IV: Dependent Eligibility Finding Summary							
Year	Mbr. Count	Med. Claim Count	Pharm. Claims Count	Med. Claim Value	Pharm. Claim Value	Total Claim Count	Total Claim Value
2014	2	67	34	\$3,982	\$559	101	\$4,541
2015		73	12	\$18,614	\$352	85	\$18,966
<b>Total</b>	<b>2</b>	<b>140</b>	<b>46</b>	<b>\$22,596</b>	<b>\$911</b>	<b>186</b>	<b>\$23,507</b>

**Plan Response:**

*The Plan disagreed with the finding, citing the OPM dependent eligibility requirements that are presented in the finding as well as CMS Medicare eligibility rules that state a person under 65 is eligible for Medicare Benefits once they have received Medicare Disability benefits for 24 months. The Plan stated that the members, all of whom were the natural children of the FEHB enrollee, were classified as disabled by OPM prior to age 26 and had Medicare eligibility. Further, the Plan stated, “The Medicare status of the members supports the Plan’s stance that the members are permanently disabled.”*

**OIG Comment:**

While we agree that the members' Medicare eligibility would support that the members were permanently disabled, the documentation provided by the Plan did not support that the questioned members were eligible for Medicare during our audit scope. Specifically, the eligibility start date for one member was in 2018, and the eligibility for another member appears to have ended in 2000. Because we cannot verify that the members either had Medicare in 2014 and 2015, or had been certified as disabled or incapable of self-support by the employing office, we are continuing to question the eligibility and claims for these members.

**d. Claims Paid for Members after Effective Date of Termination**

The Plan paid \$3,952 for medical claims in 2015 after the effective date for termination of coverage.

Contract Section 2.2(a) requires the Plan to “provide the Benefits as described in the agreed upon brochure text found in Appendix A.” The referenced benefit brochure states that members will receive an additional 31 days of coverage after the member is no longer eligible for coverage.



The Plan provided additional support in response to the draft report, specifically related to FFS claims paid for members under a capitation agreement. During its review of the 2015 medical claims, the Plan identified four members whose coverage had been retroactively terminated. Although we confirmed that these members were not assigned to a capitated Preferred Care Provider at the time of the FFS claims, we determined that the Plan paid \$3,952 for 12 FFS claims associated with these members beyond the allowable 31 day run-out period. The cause of the erroneous claims payments is unclear based on the support provided but may be attributed to insufficient internal controls. The Plan noted that while claims for one of the members were not adjusted, claims for the remaining three members were subsequently adjusted. However, the Plan did not provide support for these adjustments. Moreover, the adjustments occurred starting in August of 2016, and as such, would not have been reflected in the claims data used for the 2015 MLR calculation. Therefore, we removed \$3,952 from the numerator of the 2015 MLR calculation.

**OIG Comment:**

This finding was identified as a result of the Plan's response to the draft report finding related to FFS claims paid for capitated members. As such, the Plan did not have an opportunity to review this finding prior to the final report.

e. **Deceased Members**

Based on our review, we concluded that the Plan did not improperly pay medical benefits for members after the member's date of death.

**Plan Response:**

*The Plan agreed.*

f. **Incorrect Adjustments to Claims**

The Plan did not accurately adjust incurred claims used in the numerator of the 2014 and 2015 MLR submissions. We removed a total of \$320,015 in claims adjustments from incurred claims, as demonstrated in Table V on page 16.

Per 45 CFR 158.140(b), the Plan is directed to adjust the reported incurred claims, including adjustments for provider refunds and subrogation recoveries as well as removal of vendor payments. However, allocations of these adjustments must be documented and

based on a generally accepted accounting method that yields the most accurate results, per 45 CFR 158.170(b).

Based on our review of the Plan's paid claims and applicable adjustments, we identified the following:

**i. Dental Claims**

The Plan did not accurately allocate FEHBP dental claims in 2014. Specifically, the Plan allocated dental claims to the FEBHP based on a paid claims ratio of 16.66 percent. However, we found that the ratio was insufficiently supported and did not match the paid claims ratio of 17.67 percent, which the Plan calculated and utilized for other FEHBP allocations. We found the 17.67 percent paid claims ratio to be supported by data in the general ledger and consistent with the criteria outlined in 45 CFR 158.170(b). Therefore, we utilized the 17.67 percent paid claims ratio to allocate dental claims expense to the FEHBP. The result was \$8,314 of dental claims attributed to the FEHBP in 2014. This was a \$475 increase to the Plan's reported dental claims.

**Plan Response:**

*The Plan agreed with the finding and stated that it will ensure its FEHBP allocation processes are applied consistently in future.*

**OIG Comment:**

We continue to encourage the Plan to develop process improvements and policies and procedures to ensure accurate and consistent MLR reporting.

**ii. Subrogation Recoveries**

The Plan did not appropriately reduce incurred claims by subrogation recoveries in 2014 and 2015, as required by 45 CFR 158.140(a)(2). Similar to provider refunds, the Plan inaccurately allocated 2014 subrogation recoveries using an unsupported paid claims ratio. Furthermore, the Plan mistakenly omitted the adjustment altogether in 2015. Therefore, we used the general ledger detail and associated allocation percentages to identify and remove subrogation recoveries of \$162,074 and \$144,603 from incurred claims in 2014 and 2015, respectively.

**Plan Response:**

*The Plan agreed with the finding and stated that the incurred claims were reduced by subrogation recoveries on its most recent MLR submission. Further, the Plan stated that it put a process in place to ensure accuracy on future MLR submissions.*

**OIG Comment:**

We did not verify the accuracy of the most recent MLR submission. In addition, we cannot verify what, if any, additional processes the Plan has implemented to address this issue. We will evaluate the effectiveness of any updated processes during future audits.

**iii. Provider Refunds**

The Plan did not appropriately reduce incurred claims by provider refunds in 2014 and 2015, as required by 45 CFR 158.140(b)(1)(ii). Specifically, the Plan understated the provider refund in 2014 and excluded the provider refund entirely in 2015.

In 2014, the Plan removed \$5,440 of provider refunds from paid claims as part of its claims adjustments. However, similar to the dental claims, the refunds were allocated using an unsupported paid claims ratio. As such, we applied the 17.67 percent paid claims ratio, supported by general ledger data, to our audited calculation. The resulting total of \$5,770 was removed from the incurred claims.

As mentioned above, in 2015, the Plan did not include an adjustment for provider refunds. Therefore, we used the general ledger detail and associated allocation percentages to identify and remove \$20,577 from the incurred claims.

**Plan Response:**

*The Plan concurred with the identified discrepancies and stated that the incurred claims were reduced by provider refunds on its most recent MLR submission. Further, the Plan stated that it put a process in place to ensure accuracy on future MLR submissions.*

**OIG Comment:**

We did not verify the accuracy of the most recent MLR submission. In addition, we cannot verify what, if any, additional processes the Plan has implemented to address



this issue. We will evaluate the effectiveness of any updated processes during future audits.

#### **iv. Vendor Payments**

The Plan reported \$106,279 as other claims adjustments deductible from the 2014 FEHBP MLR claims expense. This total included the above-mentioned adjustment for provider refunds of \$5,440 as discussed in (A)(3)(f)(iii). The remaining amount of \$100,839 was attributable to vendor payments. While vendor payments are required to be removed per 45 CFR 158.140(b)(3), the Plan's reported 2014 claims data did not originally include these expenses. Therefore, we removed the adjustment for vendor payments, net of the adjusted provider refunds, as illustrated in Table V on page 16.

**Table V - Claims Adjustments Finding Summary**

Claims Adjustment Category	2014			2015			Total (Both Years)		
	Plan's Claims Adjustment	Audited Claims Adjustment	Variance (\$)	Plan's Claims Adjustment	Audited Claims Adjustment	Variance (\$)	Plan's Claims Adjustment	Audited Claims Adjustment	Total Variance (\$)
<b>Dental Claims</b>	\$7,840	\$8,314	\$474	\$4,695	\$4,695	\$0	\$12,535	\$13,009	
<b>Less: Subrogation Recoveries</b>	\$152,814	\$162,074	\$9,260	\$0	\$144,603	\$144,603	\$152,814	\$306,677	
Provider Refunds	\$5,440	\$5,770	\$330	\$0	\$20,577	\$20,577	\$5,440	\$26,347	
<u>Vendor Payments</u>	<u>\$100,839</u>	<u>\$0</u>	<u>(\$100,839)</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$100,839</u>	<u>\$0</u>	
<b>Less: Total Other Adjustments</b>	\$106,279	\$5,770	(\$100,509)	\$0	\$20,577	\$20,577	\$106,279	\$26,347	
<b>Total Claims Adjustments</b>	<b>(\$251,253)</b>	<b>(\$159,530)</b>	<b>\$91,723</b>	<b>\$4,695</b>	<b>(\$160,485)</b>	<b>(\$165,180)</b>	<b>(\$246,558)</b>	<b>(\$320,015)</b>	<b>(\$73,457)</b>

**Plan Response:**

*The Plan concurred that its treatment of vendor payments was incorrect and notes that it was corrected in the most recent MLR submission. Further, the Plan stated that it put a process in place to ensure accuracy on future MLR submissions.*

**OIG Comment:**

We did not verify the accuracy of the most recent MLR submission. In addition, we cannot verify what, if any, additional processes the Plan has implemented to address this issue. We will evaluate the effectiveness of any updated processes during future audits.

**v. Unidentified Claims Adjustments**

The Plan could not sufficiently explain a paid claims variance of \$145,945 between what it filed with OPM in 2015 and what it could support. Specifically, the documentation provided by the Plan supported \$49,884,261 in medical and pharmacy claims, capitations, and dental claims reportable to Line 2.1b of the MLR Form. However, the MLR Form itself reported the total Line 2.1b claims as \$49,738,316. Although multiple attempts were made to verify the 2015 MLR form Line 2.1b amount, the Plan could not provide sufficient support for the variance. Therefore, we utilized the supported claims data amount of \$49,884,261 as the starting point for the 2015 audited incurred claims calculation as demonstrated in Table VI below.

<b>Table VI: 2015 Adjusted Incurred Claims Variance</b>					
<b>Claims</b>	<b>Plan's Summary - 2015 MLR Submission (Adjusted Incurred Claims)</b>	<b>Audited - 2015 MLR Submission (Adjusted Incurred Claims)</b>	<b>2015 MLR Submission (Adjusted Incurred Claims)</b>	<b>Variance (Dollars) From Plan Summary</b>	<b>Variance (Dollars) From Audited Support</b>
Medical and Hospital Claims	\$14,963,024	\$14,963,024			
Pharmacy Claims	\$3,831,186	\$3,831,186			
Capitation	\$31,085,356	\$31,085,356			
Dental Claims	\$4,695	\$4,695			
Provider Refunds		(\$20,577)			
Subrogation Recoveries		(\$144,603)			
<b>Total Adj. Claims</b>	<b>\$49,884,261</b>	<b>\$49,719,081</b>	<b>\$49,738,316</b>	<b>\$145,945</b>	<b>\$19,235</b>

**Plan Response:**

*The Plan concurred with the finding and intends to put controls in place to review for accuracy in future MLR submissions.*



**OIG Comment:**

We continue to encourage the Plan to develop process improvements and policies and procedures to ensure accurate and consistent MLR reporting.

**4. Healthcare Receivables**

The Plan did not reduce paid claims by all pharmacy rebates received for 2014 and 2015 incurred pharmacy claims. Moreover, the Plan could not adequately support the amount of pharmacy rebates received for either year. Finally, the Plan did not reduce the FEHBP's incurred claims by the allocable portion of a claims settlement received in 2015. As a result, the Plan overstated incurred claims reported on its FEHBP MLR Form by \$247,013 in 2014 and \$543,528 in 2015.

45 CFR 158.140(b)(1)(i) and (ii) require that prescription drug rebates and overpayment recoveries should be deducted from incurred claims.

**The Plan overstated incurred claims in 2014 and 2015 by inaccurately reporting pharmacy rebates, categorized as healthcare receivables.**

The Plan included pharmacy rebates in the Healthcare Receivables Line 2.12a of each year's FEHBP MLR Form, which reduces paid claims. However, in 2014, the Plan only reported the pharmacy rebates for 2014 claims that were received from January through June 2015, and did not incorporate pharmacy rebates received during 2014. In 2015, the Plan reported only the pharmacy rebates receivables balance, not the pharmacy rebates actually received.

Although the Plan attempted to provide support for the pharmacy rebates received, the support included hardcoded spreadsheets that were not easily verifiable to other independent sources. Therefore, we used the Plan's audited 2014 through 2016 financial statements to identify the total pharmacy rebates received for 2014 and 2015. We then multiplied the total rebates by a pharmacy paid claims ratio to determine the FEHBP's allocable share of pharmacy rebates. As a result, we included allocable pharmacy rebates of \$488,086 in 2014 and \$515,218 in 2015 on Line 2.12a of each year's FEHBP MLR Form to reduce paid claims.

In addition to the pharmacy rebates issues, the Plan also noted that it had not allocated a claims settlement from Presbyterian Health Services to the FEHBP in 2015. The FEHBP's allocation of this settlement was \$32,516, which we included in Line 2.12a of the 2015 FEHBP MLR Form to reduce paid claims. Therefore, we reported the total healthcare receivables for 2015 as \$547,734.

**Plan Response:**

*The Plan acknowledged that its reporting of pharmacy rebates was inconsistent in 2014 and 2015 but added that “there are no explicit instructions provided to the Plan when completing the MLR.” Although the Plan stated that it could not verify the auditors’ pharmacy rebate calculations, a subsequent response sent with additional commentary and supporting documentation noted that “the pharmacy rebates calculated by the OPM auditors are not drastically different when compared to the Plan numbers and are acceptable to the Plan.” Finally, the Plan agreed that it did not allocate a Presbyterian Health Services claims settlement to the FEHBP in 2015, explaining that it was “missed during completion of the MLR.”*

**OIG Comment:**

Although the Plan attributed inconsistencies in its reporting of pharmacy rebates to a lack of instruction, 45 CFR 158.140(b)(1)(i) and (ii) clearly require prescription drug rebates and overpayment recoveries to be deducted from incurred claims. We reviewed additional support for what the Plan believes to reasonably represent allocable FEHBP pharmacy rebates. However, the information did not adequately support rebate adjustments. As such, and in consideration of the fact that the Plan ultimately found our questioned costs to be acceptable, we continue to consider the allocation of rebates reported in the audited financial statements as the most reliable source of data in 2014 and 2015.

**5. Quality Health Improvements (QHI)**

The Plan’s QHI expenses were not allocated accurately and appropriately. Specifically, the allocation methodology was not in compliance with applicable federal regulations, resulting in unsupported and unallowable expenses allocated to the FEHBP. As such, we removed the QHI expenses from the MLR numerator in 2014 and 2015.

**QHI expenses were removed from the MLR numerator in 2014 and 2015 due to the Plan’s non-compliance with applicable regulations.**

Per 45 CFR 158.221(b), the numerator of the MLR submission can include Plan expenses for activities that improve health care quality, which are defined in 45 CFR 158.150 and 158.151. The definition covers activities such as those that improve health outcomes, prevent hospital readmissions, improve patient safety, promote health and wellness activities, and the information technology expenses required to accomplish such activities.



To determine its applicable QHI costs, the Plan identified cost centers that performed QHI activities and the percentage of costs related to QHI within those cost centers. The Plan then allocated the costs to its product groups at the account level, based on two different methodologies: member months and paid claims ratios. Based on our review of the documentation provided in support of this process, we identified the following issues:

**a. Unsupported QHI Expenses**

We could not verify that all of the QHI expenses, reported on the FEHBP MLR Forms for 2014 and 2015, met the definition of qualifying QHI per 45 CFR 158.150.

In 2014, the Plan did not have supporting documentation for the process by which it identified and allocated cost centers that contained QHI-related expenses. Also, the majority of expenses allocated for QHI in both 2014 and 2015 related to general ledger accounts for salaries and benefits. Because the expenses were allocated at the account level, we were unable to tie these costs directly to personnel who may be working in cost centers that are performing QHI activities. Similarly, we could not determine how the other accounts included in the total QHI expenses related to quality improvement activities defined by regulation.

By not maintaining sufficient documentation to support that the reported costs meet the definitions in 45 CFR 158.150, the Plan is also not in compliance with 45 CFR 158.502(a), which requires Plans to maintain all documentation and evidence necessary to verify that the reported information meets the regulatory criteria.

**Plan Response:**

*The Plan agreed that it did not have documentation to support how it identified QHI costs for 2014 and noted that it is documented and maintained for 2015 and future years. However, the Plan argued that the methodology for identifying QHI expenses was the same in both years, and the methodology is designed to identify cost centers that perform activities that meet the definitions of qualifying QHI per 45 CFR 158.150. The Plan noted that once the percentage to which the cost centers engage in QHI is determined, that percentage is applied to the entire general ledger amount for that cost center. The Plan stated that personnel information and support for expenses were available.*

**OIG Comment:**

Regardless of whether or not the Plan's methodology for identifying QHI expenses was the same in both years, the Plan is still not in compliance in 2014 with requirements for maintaining documentation and support, per 45 CFR 158.502(a). In addition, while we understand that the Plan's methodology identifies QHI activities at the cost center level, the Plan did not attach the relevant supporting documentation to its response that would tie the account level detail for the 2014 and 2015 salaries and benefits that were allocated to the FEHBP to personnel in costs centers performing QHI.

**b. Unallowable Expenses**

We identified some general ledger accounts that should not have been included in the QHI allocation in 2014 and 2015. Specifically, general ledger accounts that were included in the allocation to the FEHBP, such as entertainment and employee celebration, do not meet the definition of QHI as defined in 45 CFR 158.150 and 158.151. Moreover, these costs are expressly unallowable per Federal Acquisition Regulation 31.205-14.

In addition, one of the general ledger accounts that was included in the 2014 QHI allocation captured costs for administrative services performed by Presbyterian Health Services that are allocated to the Plan. However, the Plan stated that this account was not used in the FEHBP MLR calculation. Therefore, it should not have been included in the QHI allocation.

**Plan Response:**

*The Plan agreed that entertainment and employee celebration should be excluded and considered this in its most recent MLR submission. However, it noted that the amounts of these items were immaterial to total QHI expenses. In addition, it could not address the issue related to the administrative work performed by Presbyterian Health Services without more information.*

**OIG Comment:**

We did not verify the accuracy of the most recent MLR submission. We will evaluate the effectiveness of any updated processes during future audits.

**c. Reasonableness of QHI Allocation Methodology**

We could not verify that the allocations of QHI costs yielded the most accurate results, as required by 45 CFR 158.170(b)(1).

45 CFR 158.170(b)(1) states that allocations “should be based on a generally accepted accounting method that is expected to yield the most accurate results” and goes on to require an explanation of the reasoning behind why the Plan believes its allocation yields the most accurate results. In addition, 45 CFR 158.170(c) requires Plans to identify “the specific basis used to allocate expenses reported” in its MLR report.

In 2014 and 2015, the Plan reported its allocation methodology in Part 4 of the FEHBP MLR Form, as required by 45 CFR 158.170(c). Specifically, the Plan stated that a member months ratio was used to allocate to its product groups, including the FEHBP. However, we observed that at least two general ledger accounts in 2015 were allocated using a paid claims ratio instead. The Plan’s rationale in choosing these two different methodologies is not clear, particularly given that QHI expenses are added to the claims expense in the MLR numerator. Therefore, a claims paid ratio is more relevant. Finally, the inputs for the paid claims ratio were not supported by actual FEHBP claims data.

**Plan Response:**

*The Plan maintained, “that it selects the allocation methodology that is most appropriate given the cost driver for each specific account” and noted that there is no explicit guidance that it must use only one method of allocation.*

**OIG Comment:**

While the regulations do not necessarily preclude use of more than one allocation methodology, the Plan did not accurately communicate its methodology in Part 4 of the FEHBP MLR form, as it did not identify that it was using any methodology other than member months. In addition, we are still not certain that the overall allocation methodology is the most reasonable method, as stated in the finding.

Because these combined issues prevent us from determining whether the FEHB received an equitable and accurate allocation of applicable QHI expenses, we removed the QHI expenses from the MLR numerator in 2014 and 2015.

## 6. Premium Review

Per OPM's Community Rating Guidelines, "OPM will provide to carriers the incurred premium to be used in the MLR calculation from the OPM subscription income reports. The OPM supplied subscription income is not subject to audit. If the carrier believes the OPM subscription income is incorrect, the carrier may use its own premium income amount. The carriers' supplied premium income is subject to audit and must be justified with supporting documentation at the time of audit."

The Plan opted to use OPM's subscription income in each year's FEHBP MLR calculation. We confirmed that the Plan accurately reported OPM's subscription income in the 2014 and 2015 FEHBP MLR submissions. Per the OPM Community Rating Guidelines, we did not perform any further review.

### Plan Response:

*The Plan agreed.*

## 7. Federal and State Taxes and Licensing or Regulatory Fees

The Plan did not reasonably or accurately allocate certain tax expenses to the FEHBP resulting in an increase of reported tax expenses in 2014, totaling \$1,353,758, and a net decrease of tax expenses in 2015, totaling \$1,352, as demonstrated in Table VII on page 27.

45 CFR 158.161 and 162 require that taxes and regulatory fees be broken out and excluded from the total amount of premium revenue when calculating an issuer's MLR. In addition, 45 CFR 158.170 requires methods used to allocate costs be based on generally accepted accounting principles that generate the most accurate results.

**The Plan did not reasonably or accurately allocate certain tax expenses to the FEHBP in 2014 and 2015.**

Based on our review of the Plan's support for federal income tax and other tax-related expenses, we identified the following issues:

### **a. Federal Income Tax (FIT)**

The Plan under-reported FEHBP FIT by \$1,117,060 in 2014. Specifically, our review of the initial support provided by the Plan revealed errors in its allocation. Because the Plan used a net income methodology to determine the applicable FIT to be allocated to the



FEHBP, we traced the elements of the Plan's calculation to general ledger detail. Ultimately, we determined that the total FIT allocable to the FEHBP using the Plan's methodology was \$1,289,641, which is an increase from what the Plan originally reported. We used these results to increase Line 3.1 on the FEHBP MLR Form in 2014.

**Plan Response:**

*The Plan concurred with the finding, stating that the error resulted from the use of an incorrect FIT amount from an original filing of the statutory financial statements when completing the MLR, which did not include amendments to the statutory financial statements. The Plan stated that it has put processes in place at the time amendments are submitted to address the issue.*

**OIG Comment:**

We cannot verify what, if any, additional processes the Plan has implemented to address this issue. We will evaluate the effectiveness of any updated processes during future audits.

**b. Health Insurer Fee (HIF)**

The Plan under-allocated HIF expenses to the FEHBP in 2014. The HIF is imposed on an issuer of fully insured health plans with at least \$25 million in net premiums in proportion to the issuer's market share, per Affordable Care Act (ACA) Provision 9010. The Plan explained that a formula error in the Plan's allocation calculation caused the allocation to be incorrect. Based on the corrected data, we added \$231,423 to the Plan's federal taxes reported on Line 3.1 for allocable HIF expenses.

**Plan Response:**

*The Plan agreed with the finding and stated that it has put additional controls in place to prevent the issue on future MLR submissions.*

**OIG Comment:**

We cannot verify what, if any, additional controls were implemented to address this issue. We will evaluate the effectiveness of any updated controls during future audits.

**c. Transitional Reinsurance Fee (TRF)**

The Plan over-allocated TRF expenses to the FEHBP in 2014.

The TRF is required by ACA Section 1341 to support the transitional reinsurance program, which was established in the same section to help stabilize premiums for coverage in the individual market. The Plan allocates this fee to the FEHBP based on FEHBP Member Months as a percentage of total Commercial Group Member Months. We tested the reasonableness of this methodology by recalculating the allocable TRF using the annual fee multiplied by FEHBP covered lives in 2014.

As a result, we determined that the Plan allocated 2 percent more than our calculated allocable TRF. Although only 2 percent, the dollar value was \$15,274. Therefore, we determined that the Plan's allocation for TRF did not yield the most accurate results as required by 45 CFR 158.170(b). Using our audited numbers, we removed \$15,274 from Line 3.3 of the FEHBP MLR Form in 2014.

**Plan Response:**

*The Plan disagreed with the finding and believes that member months is a reasonable allocation method. The Plan cited 26 CFR 46.4375-1(c)(2), which considers the member months method as allowable when determining the average covered lives. It also argued, "This method of allocation is not explicitly stated as incorrect" based on its review of 45 CFR 158.170(b).*

**OIG Comment:**

The Plan cited 26 CFR 46.4375 in support of its position; however, this CFR provides guidance over the Patient Centered Outcomes Research Institute fee, not the TRF. CMS posts guidance on its website regarding the TRF, which is pursuant to 45 CFR 153.20. CMS specifically identifies the applicable rate for the year and notes that this rate is to be paid "per covered life." While we agree with the Plan that member months could reasonably be used to identify average covered lives for this purpose, that is not precisely the methodology used by the Plan. The Plan does not identify the FEHBP portion of the TRF using FEHBP covered lives but rather allocates the TRF based on a member months ratio, as noted in the finding. When we compared the results of our recalculated FEHBP TRF, which directly applied the annual TRF rate to the FEHBP's average covered lives, the variance indicated that the Plan's member months allocation methodology did not yield the most accurate results in 2014. Again, as stated in the finding, this does not comply with 45 CFR 158.170. Specifically, 45 CFR 158.170(b)(1)

states, “Allocation to each category should be based on a generally accepted accounting methodology which is expected to yield the most accurate results. Specific identification of an expense ... will generally be the most accurate method.” Therefore, we will continue to question the Plan's FEHBP TRF expenses in 2014.

**d. Patient Centered Outcomes Research Institute (PCORI) Fee**

The Plan did not report any PCORI expenses in 2014 and over-allocated PCORI expenses in 2015.

The PCORI fee is imposed on applicable issuers per ACA Provision 6301. 26 CFR 46.4375-1(c) states that this fee is calculated as the product of average covered lives for the policy year and the applicable annual rate. The Plan allocates this fee to the FEHBP based on FEHBP Member Months as a percentage of total Commercial Group Member Months. We tested the reasonableness of this methodology by recalculating the allocable PCORI fee in 2014 and 2015, using the member month methodology set forth in 26 CFR 46.4395(c)(2)(v)(a) with the effective rate for each year defined by the Internal Revenue Service guidelines.

As a result, we determined that the Plan allocated 6 percent more for PCORI fees than we calculated as allocable per the regulation in 2015. In addition, the Plan did not include any allocation for the PCORI fee in the taxes reported on its 2014 FEHB MLR Form due to an oversight. Because of these variances, we determined that the Plan's allocation for PCORI did not yield the most accurate results, as required by 45 CFR 158.170(b). Therefore, we used our audited PCORI fees in the FEHBP MLR calculation, resulting in a \$20,549 increase in Line 3.1 for 2014 and a \$1,352 decrease in 2015.

**Plan Response:**

*The Plan disagreed with the finding, again stating that its use of member months is a reasonable allocation method per 26 CFR 46.4375-1(c)(2) and is not “explicitly stated as incorrect” by 45 CRF 158.170(b).*

**OIG Comment:**

Although the Plan states that the finding was unsupported by the CFRs, the fact that the Plan did not report any PCORI in 2014 is supported by its own data and admission during the course of the audit. In terms of the allocation methodology, 26 CFR 46.4375(c)(1) indicates that the PCORI fee is to be calculated by multiplying average covered lives by the applicable dollar value. 26 CFR 46.4375(c)(2) goes on to require calculation of the

average covered lives by one of several methods, which includes the member months method as defined by 26 CFR 46.4395(c)(2)(v)(a). As with the TRF, the Plan is allocating PCORI to the FEHBP based on a member months ratio, not using average covered lives. This methodology did not yield the most accurate results when compared to our recalculation of the FEHBP's allocable portion of the fee using FEHBP's average covered lives. Again, 45 CFR 158.170(b)(1) requires allocation methods to yield the most accurate results. Therefore, we will continue to question the Plan's FEHBP PCORI expenses in 2014 and 2015 using our audited numbers.

The effect of these tax expense and regulatory fee findings is summarized in Table VII, below:

<b>Table VII - Tax Expense Finding Summary</b>					
<b>Year</b>	<b>Tax Expense</b>	<b>Plan's Reported Tax Expense</b>	<b>Audited Tax Expense</b>	<b>Variance (\$)</b>	<b>Variance (%)</b>
<b>2014</b>	FIT	\$172,581	\$1,289,641	\$1,117,060	647%
	PCORI	\$0	\$20,549	\$20,549	n/a
	HIF	\$711,904	\$943,327	\$231,423	33%
	<b>Federal Taxes (Line 3.1)</b>	<b>\$884,485</b>	<b>\$2,253,517</b>	<b>\$1,369,032</b>	<b>155%</b>
	<b>State Taxes (Line 3.2)</b>	<b>\$11,128</b>	<b>\$11,128</b>	<b>\$0</b>	<b>0%</b>
	TRF	\$637,672	\$622,398	(\$15,274)	-2%
	Risk Adjustment User Fees	\$1,568	\$1,568	\$0	0%
	<b>Reg. Auth. Lic./Fees (Line 3.3)</b>	<b>\$639,240</b>	<b>\$623,966</b>	<b>(\$15,274)</b>	<b>-2%</b>
	<b>Total Taxes (Line 3.4)</b>	<b>\$1,534,853</b>	<b>\$2,888,611</b>	<b>\$1,353,758</b>	<b>88%</b>
	<b>2015</b>	FIT	\$1,439,993	\$1,439,993	\$0
PCORI		\$21,725	\$20,373	(\$1,352)	-6%
HIF		\$1,277,745	\$1,277,745	\$0	0%
<b>Federal Taxes (Line 3.1)</b>		<b>\$2,739,463</b>	<b>\$2,738,111</b>	<b>(\$1,352)</b>	<b>0%</b>
<b>State Taxes (Line 3.2)</b>		<b>\$4,479</b>	<b>\$4,479</b>	<b>\$0</b>	<b>0%</b>
<b>Reg. Auth. Lic./Fees (Line 3.3)</b>		<b>\$113,328</b>	<b>\$113,328</b>	<b>\$0</b>	<b>0%</b>
<b>Total Taxes (Line 3.4)</b>		<b>\$2,857,270</b>	<b>\$2,855,918</b>	<b>(\$1,352)</b>	<b>0%</b>



## **Conclusion – MLR Review**

We made adjustments to the Plan's FEHBP MLRs as indicated above. The results of these adjustments indicated that a penalty payment, in the amount of \$530,688, is due to OPM for the 2015 MLR submission. Even though the 2014 MLR submission required adjustments due to the above-mentioned audit issues, there was no financial impact to the MLR that was submitted to OPM.

In general, the errors identified above were related to oversights, human error, or deficiencies in the Plan's allocation methodologies. However, the root cause of these issues is a lack of internal controls over the MLR calculation and reporting process to ensure compliance with applicable federal and contractual requirements. Without detailed, written policies and procedures to govern and oversee MLR data collection, allocation, and reporting, the Plan is at risk for continued reporting inconsistencies and errors that may have material impacts on the MLR calculation.

### **Recommendation 1**

We recommend that the contracting officer require the Plan to return \$530,688 to the MLR subsidization penalty account for contract year 2015.

### **Recommendation 2**

We recommend that the Plan institute internal controls to identify FFS claims paid for members who are actively enrolled and charged under a capitated arrangement.

### **Recommendation 3**

We recommend that the Plan enhance its controls to ensure that its systems are correctly updated with proper order of benefits information, including the development of documented policies and procedures, additional system controls, and training for its claims processors.

### **Recommendation 4**

We recommend that the Contracting Officer verify that the Plan has put corrective measures in place over the coordination of benefits process.

### **Recommendation 5**

We recommend that the Plan maintain supporting documentation for FEHBP dependents that have been designated as disabled.

### **Recommendation 6**

We recommend that the Plan enhance its internal controls over claims processing to ensure that claims are appropriately and timely adjusted when members' coverage is retroactively terminated.

### **Recommendation 7**

We recommend that the Plan develop detailed policies and procedures to govern the collection and allocation of FEHBP MLR expenses, including QHI, healthcare receivables, and taxes, to ensure compliance with MLR regulations.

### **Recommendation 8**

We recommend that the Contracting Officer verify that the Plan implemented enhanced processes, including policies and procedures to govern the collection and allocation of FEHBP MLR claims expenses to ensure compliance with MLR regulations.

### **Recommendation 9**

We recommend that the Plan develop policies and procedures for additional oversight of the MLR reporting process as well as record retention for MLR supporting data.

### **Recommendation 10**

We recommend that the Plan institute a more stringent FEHBP MLR review process to identify reporting errors prior to submitting the FEHBP MLR to OPM.

### **Recommendation 11**

We recommend that the Plan review its allocation process and update as necessary to yield the most accurate reporting of QHI costs as defined by regulation.

### **Recommendation 12**

We recommend that the Plan review its methodology for allocating TRF and PCORI fees and make updates as necessary to yield the most accurate reporting of tax expenses as defined by regulation.

## **B. LOST INVESTMENT INCOME**

**\$30,017**

In accordance with FEHBP regulations and the contract between OPM and the Plan, the FEHBP is entitled to recover lost investment income on MLR penalties due in contract year 2015. We determined the FEHBP is due \$30,017 for lost investment income, calculated through December 31, 2018 (see Exhibit D). In addition, the FEHBP is entitled to lost investment income for the period beginning January 1, 2019, until all defective pricing amounts have been returned to the FEHBP.

FEHBAR 1652.215-70 provides that “When the [OPM] Contracting Officer determines that the rates shall be reduced and the Government is entitled to an MLR penalty, the Carrier shall be liable to and shall pay the FEHB Fund at the time the MLR penalty is paid . . . .” In addition, the Government is entitled to a refund and simple interest on the amount of “the MLR penalty from the date on which the penalty should have been paid to the FEHB Fund to the date on which the penalty was or will be actually paid to the FEHB Fund.”

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

### **OIG Comment:**

Lost Investment Income was calculated on the MLR penalty after the review and inclusion of the Plan's Response. As such, the Plan did not have an opportunity to review this finding prior to the final report.

### **Recommendation 13**

We recommend that the Plan return \$30,017 to the FEHBP for lost investment income calculated through December 31, 2018. We also recommend that the Plan return lost investment income on amounts due for the period beginning January 1, 2019, until the entire MLR penalty has been returned to the FEHBP.

## **C. INTERNAL CONTROLS REVIEW**

**Procedural**

The Plan did not maintain an adequate system of internal controls to govern the MLR process or the capitation rate build-up process.

Per Contract Section 5.64, “(c)...The Contractor shall establish the following within 90 days after the contract award.... (2) An internal controls system. (i) The Contractor's internal control system shall--(A) Establish standards and procedures to facilitate timely discovery of improper

conduct in connection with Government contracts; and (B) Ensure corrective measures are promptly instituted and carried out. (ii) At a minimum, the Contractor's internal control system shall provide for...(A) Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the business ethics awareness and compliance program and internal control system.”

However, we found that the Plan’s internal controls system did not sufficiently meet the contract criteria in the following ways:

**Inadequate internal controls over the MLR process resulted in numerous errors in the 2014 and 2015 MLR calculations and pose a significant risk for continued MLR reporting errors.**

**1. Inaccurate MLR Reporting**

We identified numerous errors caused by a lack of documented policies and procedures and insufficient oversight related to the FEHBP MLR processes. Ultimately, these errors resulted in defective Certificates of Accurate MLR in 2014 and 2015 and a penalty due to OPM in 2015. The errors included:

**a. Claims**

Inaccurate adjustments to incurred claims were used in Line 2.1b as well as improper payment of claims related to capitated members, coordination of benefits, and ineligible dependents. See Section A.3.

**b. Healthcare Receivables**

Incorrect pharmacy rebates were reported and other applicable receivables were omitted. See Section A.4.

**c. QHI**

QHI expenses were not adequately supported. Furthermore, unreasonable allocation methodologies were utilized and unallowable expenses were included in QHI. See Section A.5.

**d. Taxes and Regulatory Fees**

The Plan incorrectly allocated FIT, HIF, TRF, and PCORI expenses. See Section A.7.



## **2. Inappropriate Expense Allocations**

As previously noted, the Plan's QHI allocation methodology included unallowable accounts. Similarly, the Plan's 2014 and 2015 net income calculations also included accounts for expenses considered unallowable per OPM guidance and Federal Acquisition Regulation (FAR) 31.205, including late fees, meals, entertainment, employee celebration, and political contributions. Moreover, 45 CFR 158.170(b)(1) states that the most accurate result of an allocation is typically direct identification of an expense. However, the Plan allocated claims and capitation costs used in its net income calculation instead of using direct costs. Finally, the 2015 calculation mistakenly excluded allocation of an allowable account. Although these errors did not result in questioned dollars for purposes of the MLR calculation, the Plan did not have adequate policies and procedures in place to ensure that the FEHBP is receiving appropriate expense allocations per federal regulations.

## **3. Reporting of Fraud Reduction Expenses**

The Plan adjusted claims on its 2015 MLR Form by \$12,565 in fraud reduction expenses but did not report any fraud recoveries on the form. 45 CFR 158.140(b)(2)(iv) requires that incurred claims must be adjusted by the amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. According to the Plan personnel responsible for preparing the MLR form, they were not aware that recoveries were supposed to be reported on the MLR form. Subsequently, we obtained and reviewed data that supported the Plan's 2015 fraud recoveries and verified that the amount of fraud reduction expenses reported on the 2015 MLR form was less than the recoveries, in accordance with the regulation. Although this error did not result in a monetary impact to the MLR, the Plan did not have adequate policies and procedures over the process of gathering and reporting allowable fraud reduction expenses that complied with regulations.

## **4. Capitation Rates Not Adjusted for Benefits**

The FEHBP capitation rate does not accurately represent the benefits as listed in the 2014 and 2015 benefit brochures. Contract Section 2.2(a) states, "The Carrier shall provide the benefits as described in the agreed upon brochure text found in Appendix A." However, during our review of the 2014 and 2015 FEHBP capitated rates, we found that the Plan did not account for the FEHBP benefits, as illustrated in the benefit brochure, in the claims experience used in the capitated rate calculation. Furthermore, the Plan utilizes claims experience from the entire capitated community to derive the necessary rate increase for all groups. At no point in the community capitation rate calculation did the Plan account for the difference in benefits between groups or adjust the capitated community claims experience to the same benefit level. For this reason, the basis for the necessary rate increase, determined by the capitated

community claims experience, is skewed and does not accurately account for future costs of the capitated benefits. This is a direct result of a lack of internal controls over the coordination of capitation coverage and insufficient policies and procedures over the capitation rate build-up process.

### **Conclusion – Internal Controls Review**

Based on the expansiveness of these errors across multiple Federally regulated filing requirements, it is evident that the Plan did not have the contractually required oversight at a sufficiently high level. Furthermore, the Plan does not have adequate resources to ensure the effectiveness of the internal control system as it relates to the oversight of the FEHBP MLR submissions.

#### **Plan Response:**

*The Plan did not respond to this finding.*

#### **OIG Comment:**

Some of the Plan's responses to the findings in Section A – MLR Review did note that it was making process improvements and commented on its allocation procedures, which relate to some of the issues identified in this finding. However, it did not provide commentary directly regarding additional concerns presented in this finding, including fraud and abuse expense reporting and benefit adjustments to capitation rates.

### **Recommendation 14**

We recommend that the Plan develop documented policies and procedures to govern the collection and reporting of MLR data that comply with laws, regulations, and the OPM contract, including: appropriate FEHBP expense allocations; adjustments to incurred claims for the lesser of fraud recoveries or fraud reduction expenses; and capitation rate development inclusive of benefit adjustments.

### **Recommendation 15**

We recommend that the Plan adjust all capitated group experience to one benefit level prior to determining the community capitation rate and necessary capitation rate increase.

## **Recommendation 16**

We recommend that the Plan adjust the FEHBP capitated claims experience to account for all benefit changes between the experience period and the renewal period when calculating the FEHBP capitated renewal rate.

## **D. OTHER AREAS REVIEWED**

## **Procedural**

During the course of our audit, we reviewed the following areas, in which no audit findings were identified.

### **1. Fraud, Waste and Abuse Review**

OPM Carrier Letter 2014-29 provided fraud and abuse industry standards and requirements for Plans contracting with OPM and providing health benefits to Federal employees. Based on our review, we concluded the Plan has processes and procedures in place to meet the requirements outlined in OPM's Fraud and Abuse carrier letter.

### **2. Debarment Review**

Per Contract Sections 2.7 and 5.47, the Plan must meet contractual requirements related to providers debarred by OPM. Based on our review, we concluded the Plan has processes and procedures in place to meet the requirements outlined in the contract.

#### **Plan Response:**

*The Plan did not respond to this section of the report.*

# EXHIBIT A

## Presbyterian Health Plan - Plan Code P2 Summary of Amounts Due OPM

### Contract Year 2014 - No Penalty or Credit

Medical Loss Ratio Penalty/Credit	\$0
Amount Paid/Credited	\$0
Total Penalty/Credit Due	<u>\$0</u>

### Contract Year 2015 - Penalty Underpayments

Medical Loss Ratio Penalty	\$530,688
Amount Paid	\$0
Total Penalty Due OPM	<u>\$530,688</u>

### Lost Investment Income

Lost Investment Income on Contract Year 2015 Penalty	\$30,017
<b>Total Due OPM</b>	<u><u>\$560,705</u></u>



# EXHIBIT B

## Presbyterian Health Plan - Plan Code P2 2014 Medical Loss Ratio Calculation

	<b>Plan</b>	<b>Audited</b>
<b>2014 FEHBP MLR Lower Threshold (a)</b>	85%	85%
<b>2014 FEHBP MLR Upper Threshold (b)</b>	89%	89%
 <b><u>Claims Expense</u></b>		
Medical Incurred Claims	\$17,781,569	\$17,781,569
Pharmacy Incurred Claims	\$4,104,811	\$4,104,811
Less: Incorrectly Paid Medical COB Claims		\$134,888
Less: Incorrectly Paid Medical Dependents Claims		\$3,982
Less: Incorrectly Paid Pharmacy Dependent Claims		\$559
Capitation	\$30,940,883	\$30,940,883
Dental Rider	\$7,840	\$8,314
Less: Subrogation	\$152,814	\$162,074
Less: Other (Provider Refunds*)	\$106,279	\$5,770
<b>Adjusted Incurred Claims</b>	<b>\$52,576,010</b>	<b>\$52,528,304</b>
 Paid Medical Incentive Pools and Bonuses	 \$4,954	 \$4,954
Less: Healthcare Receivables	\$241,073	\$488,086
Expenses to Improve Health Care Quality	\$1,260,550	\$0
<b>Total MLR Numerator</b>	<b>\$53,600,441</b>	<b>\$52,045,172</b>
 <b><u>Premium Expense</u></b>		
Premium Income	\$62,587,423	\$62,587,423
Less: Federal and State Taxes and Licensing or Regulatory Fees	\$1,534,853	\$2,888,611
<b>Total MLR Denominator (c)</b>	<b>\$61,052,570</b>	<b>\$59,698,812</b>
 <b>FEHBP MLR Calculation (d)</b>	 87.79%	 87.18%
Penalty Calculation (If (d) is less than (a), ((a-d)*c)	\$0	\$0
Credit Calculation (If (d) is greater than (b), ((d-b)*c)	\$0	\$0
<b>Total Penalty Due OPM (inclusive of penalty previously paid)</b>	<b>\$0</b>	<b>\$0</b>

\*PHP reduced the numerator of their 2014 MLR calculation for both vendor payments and provider refunds. However, only the provider refund deduction is valid here. See FINDING for more information.

# EXHIBIT C

## Presbyterian Health Plan - Plan Code P2 2015 Medical Loss Ratio Calculation

	Plan	Audited
<b>2015 FEHBP MLR Lower Threshold (a)</b>	85%	85%
<b>2015 FEHBP MLR Upper Threshold (b)</b>	89%	89%
<b><u>Claims Expense</u></b>		
Medical Incurred Claims	\$14,963,024	\$14,963,024
Pharmacy Incurred Claims	\$3,831,186	\$3,831,186
Less: Incorrectly Paid Medical COB Claims		\$4,877
Less: Incorrectly Paid Medical Dependents Claims		\$18,614
Less: Incorrectly Paid Medical Claims after Termination of Coverage		\$3,952
Less: Incorrectly Paid Pharmacy Dependent Claims		\$352
Capitation	\$31,085,356	\$31,085,356
Less: Incorrectly Paid Capitated Member Claims		\$130,463
Dental Rider	\$4,695	\$4,695
Less: Subrogation		\$144,603
Less: Other (Provider Refunds)		\$20,577
Less: Unsupported Incurred Claims Adjustment	\$145,945	
<b>Adjusted Incurred Claims</b>	<b>\$49,738,316</b>	<b>\$49,560,823</b>
Paid Medical Incentive Pools and Bonuses	\$7,084	\$7,084
Less: Healthcare Receivables	\$4,206	\$547,734
Allowable Fraud Reduction Expenses	\$12,565	\$12,565
Expenses to Improve Health Care Quality	\$498,699	\$0
<b>Total MLR Numerator</b>	<b>\$50,252,458</b>	<b>\$49,032,738</b>
<b><u>Premium Expense</u></b>		
Premium Income	\$61,165,831	\$61,165,831
Less: Federal and State Taxes and Licensing or Regulatory Fees	\$2,857,270	\$2,855,918
<b>Total MLR Denominator (c)</b>	<b>\$58,308,561</b>	<b>\$58,309,913</b>
<b>FEHBP MLR Calculation (d)</b>	86.18%	84.09%
Penalty Calculation (If (d) is less than (a), ((a-d)*c)	\$0	\$530,688
Credit Calculation (If (d) is greater than (b), ((d-b)*c)	\$0.00	\$0.00
<b>Total Penalty Due OPM (inclusive of penalty previously paid)</b>		<b>\$530,688</b>

# EXHIBIT D

## Presbyterian Health Plan Lost Investment Income Calculation

Years:	2016	2017	2018	Total
<b>MLR Penalty Due OPM</b>				
2015 MLR Penalty Due	\$530,688			\$530,688
Total:	\$530,688	\$0	\$0	\$530,688
Cumulative Totals:	\$530,688	\$530,688	\$530,688	\$530,688
Average Interest Rate (per year):	1.875% <sup>[1]</sup>	2.440%	3.060%	-
Interest on Prior Years Findings:	\$0	\$12,949	\$16,239	\$29,188
Interest as of December 1st of the current year: <span style="padding-left: 40px;"><sup>[2]</sup></span>	\$829	\$0	\$0	\$829
Total Cumulative Interest Calculated Through December 31, 2018: <sup>[3]</sup>	\$829	\$12,949	\$16,239	<b>\$30,017</b>

<sup>[1]</sup> The interest rate of 1.875% was the applicable interest rate for December 2016 and does not reflect the average interest rate for the entire year.

<sup>[2]</sup> MLR submissions are due to OPM on September 30th the year after the MLR contract year. All penalties are due to OPM no later than November 30th following the submission date. Therefore, lost investment income is calculated starting on December 1st of the submission year.

<sup>[3]</sup> We recommend that the Plan return lost investment income on amounts due for the period beginning January 1, 2019 until the entire MLR penalty has been returned to the FEHBP.

# EXHIBIT E

## Claims and Capitation Sample Selection Criteria/Methodology

### Medical Claims Sample

Medical Claims Review Area	Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Coordination of Benefits with Medicare 2014	Queried high dollar medical claims for members greater than or equal to age 65 in 2014	15,377 claims	\$3,423,187	Selected incurred, unadjusted medical claims greater than or equal to \$10,000, totaling \$405,649 for 17 members	Judgmental	No
Dependent Eligibility 2014	Queried dependent members greater than or equal to age 26 who incurred medical claims in 2014	40 members	N/A	Selected the entire universe	N/A	No
Deceased Members 2014	Queried members greater than or equal to age 90 and older who incurred medical claims in 2014	21 members	N/A	Selected the entire universe	N/A	No

# EXHIBIT E Continued

## Pharmacy Claims Sample

Pharmacy Claims Review Area	Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Dependent Eligibility 2014	Queried dependent members greater than or equal to age 26 who incurred pharmacy claims in 2014	43 members	N/A	Selected all members in the universe who were not included in the medical dependent eligibility review, resulting in 3 additional members sampled	Judgmental	No



# EXHIBIT E Continued

## Capitations Sample

Capitations Review Area	Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
FFS Claims Paid for Capitated Members 2014	Queried capitated members who incurred FFS claims in 2014	822 members	N/A	Selected the top 15 members under a capitated arrangement that generated the highest total FFS claims amount paid in 2014	Judgmental	No
FFS Claims Paid for Capitated Members 2015	Queried capitated members who incurred FFS claims in 2015	792 members	N/A	Selected the top 15 members under a capitated arrangement that generated the highest total FFS claims amount paid in 2015	Judgmental	No

# APPENDIX A

Ms. [REDACTED]  
Senior Team Leader  
Community-Rated Audits Group  
Office of Personnel Management  
Washington, DC 20415

October 12, 2018

RE: Draft 2014 and 2015 MLR Audit Report Federal Employees Health Benefits Program Operations, Presbyterian Health Plan, plan code P2 issued August 16, 2018.

Dear [REDACTED]:

Presbyterian Health Plan is in receipt of your August 16, 2018 Draft report covering the audit of Presbyterian Health Plan, plan code P2, Medical Loss Ratio (MLR) calculation for contract years 2014 and 2015. We appreciate the opportunity to respond to the audit findings.

Enclosed please find the Presbyterian rebuttal response to the draft audit report. We have begun changes and corrections of items identified in the draft report and will rely on OPM's direction and continued update of MLR calculation instructions and clarification documentation.

Please let me know if you have questions regarding our rebuttal information.

Sincerely,

[REDACTED], CHC, CCEP, CHP  
Director of Compliance  
Presbyterian Health Plan, Inc.

CC: [REDACTED], FEHB Account Manager  
[REDACTED], CFO Presbyterian Health Plan

Enclosures: As Stated

Report No. 1C-P2-00-18-014

Attachment: Rebuttal, 2014 – 2015 Audit Report Federal Employees Health Benefits Program Operations, Presbyterian Health Plan, plan code P2.

**OPM Findings:**

**1. Penalty Underpayments Due OPM**

**Deleted by the OIG Not Relevant to the Final Report**

**PHP Response:**

Plan does not agree with penalty due. Plan has calculated amount based on our concurred and contested responses to findings.

**Deleted by the OIG Not Relevant to the Final Report**

**PHP Response:**

See PHP's response to items identified in our response to 3 below.

**3. MLR Claims Data**

**a. Claims Paid for Capitated Members**

**Deleted by the OIG Not Relevant to the Final Report**

**PHP Response:**

The Plan concurs that it paid FFS claims in 2015 for FEHBP members who were covered under an active capitation agreement at the time. However, the plan attests that the total actual FFS paid claims amount is \$130,463.46, Deleted by the OIG Not Relevant to the Final Report

This can be seen easily in the claims file and relates to members who were originally identified as the Plan's FFS responsibility. At a later date, due to retroactive or mid-month PCP changes, these members were switched to capitation. The current claims system does not maintain the original risk assignment, only the most current. In addition, there are six claims Deleted by the OIG Not Relevant to the Final Report

that are not identified as either capitated or FFS, but all were the Plan's responsibility and not capitated as they were subject to the wash method and were termed prior to the 15<sup>th</sup> of the month, or they were retro-terminated and the claims were adjusted after the June cutoff date. All of these claims are appropriately FFS.

The payment of FFS claims for capitated members may be attributable to timing differences as there is no identification of fee for service claims that were recouped subsequent to the MLR cutoff date.

Operationally, the payment of FFS claims for capitated members does not create an issue of overpayment because all FFS claims for capitated members are deducted from the capitation paid to the provider group. The root of the issue lies only in the FFS claims pull used to create the MLR calculation.

The plan is refining the claims pull for purposes of the MLR cut off to accurately exclude the FFS claims paid for capitated members in the future.

The Plan requests that the substantiated amount of \$130,463.46 be excluded from the 2015 MLR numerator **Deleted by the OIG – Not Relevant to the Final Report**

**b. Claims Not Properly Coordinated with Medicare**

The Plan did not properly coordinate the payment of 113 Medicare claims totaling \$139,765 in 2014 and Attachment: Rebuttal, 2014 – 2015 Audit Report Federal Employees Health Benefits Program Operations, Presbyterian Health Plan, plan code P2.

2015.

**PHP Response:**

**The Plan concurs with the finding. PHP is actively working to improve this process.**

**c. Claims Paid for Ineligible Dependents**

The Plan could not support three dependent members aged 26 and older in 2014 and 2015. As a result, the Plan paid \$27,248 in medical and pharmacy claims for members who may not be eligible for coverage.

**PHP Response:**

**PHP disagrees that with the auditor finding that the three (3) members identified over 26 years of age are not eligible for FEHB coverage on their parent's policy. We provide the following to support our position:**

**Medicare eligibility: Per CMS rules a person under 65 is eligible for Medicare Benefits once they have received Medicare Disability benefits for 24 months.**

**OPM eligibility: According FEHB OPM a child age 26 or over who is incapable of self-support because of a mental or physical disability that existed before age 26 is also an eligible family member. In determining whether the child is a covered family member, the employing office will look at the child's relationship to the enrollee. In all of the cases the dependents are the natural child of the enrollee.**

In the cases listed in the draft report each of the members have been listed as disabled by OPM prior to age 26 and have Medicare eligibility. In all of the cases the dependents are the natural child of the enrollee. The Medicare status of the members supports the Plan's stance that the members are permanently disabled. We request the findings be removed from the final report.

**d. Deceased Members**

Based on our review, OPM concluded that the Plan did not improperly pay medical benefits for members after the member's date of death.

**PHP Response: The Plan concurs.**

**e. Incorrect Adjustments to Claims**

The Plan did not accurately adjust incurred claims used in the numerator of the 2014 and 2015 MLR submissions. **Deleted by the OIG Not Relevant to the Final Report**

**i. Dental Claims**

The Plan did not accurately allocate FEHBP dental claims in 2014.

**PHP Response:**

**Dental Claims – no rebuttal. This discrepancy is noted and we will assure our processes for allocation to FEHBP are consistent in future submissions.**

**ii. Subrogation Recoveries**

The Plan did not appropriately reduce incurred claims by subrogation recoveries in 2014 and 2015, as required by 45 CFR 158.140(a)(2). Similar to provider refunds, the Plan inaccurately allocated 2014 subrogation recoveries using an unsupported paid claims ratio. Furthermore, the Plan mistakenly omitted the adjustment altogether in 2015. Therefore, we used the general ledger detail and associated allocation percentages to identify and remove subrogation recoveries of \$162,074 and \$144,603 from incurred claims in 2014 and 2015, respectively.

**PHP Response:**

**Subrogation Recoveries – The Plan concurs with the inconsistencies noted in 2014 and 2015. The reduction of incurred claims by subrogation recoveries has been included in the most recent MLR submission and a process has been put in place to correct on future MLR submissions.**

**iii. Provider Refunds**

The Plan did not appropriately reduce incurred claims by provider refunds in 2014 and 2015, as required by 45 CFR 158.140(b)(1)(ii). Specifically, the Plan understated the provider refund in 2014 and excluded the provider refund entirely in 2015.

**PHP Response:**

**Provider Refunds – The plan concurs with the inconsistencies noted in 2014 and 2015. The reduction of incurred claims by provider refunds has been included in the most recent MLR submission and a process has been put in place to correct on future MLR submissions.**

**iv. Vendor Payments**

The Plan reported \$106,279 as other claims adjustments deductible from the 2014 FEHBP MLR claims expense. This total included an adjustment for provider refunds of \$5,440 as discussed in (A)(3)(e)(iii). The remaining amount of \$100,839 was attributable to vendor payments. While vendor payments are required to be removed per 45 CFR158.140(b)(3), the Plan's reported 2014 claims data did not originally



Attachment: Rebuttal, 2014 – 2015 Audit Report Federal Employees Health Benefits Program Operations, Presbyterian Health Plan, plan code P2.

include these expenses. Therefore, we removed the adjustment for vendor payments, net of the adjusted provider refunds, as illustrated in Table V below.

**PHP Response:**

**Vendor Payments – The plan concurs that the treatment of vendor payments was incorrect. This requirement has been included in the most recent MLR submission and a process has been put in place to correct on future MLR submissions.**

**v. Unidentified Claims Adjustments**

The Plan could not sufficiently support the \$145,945 variance between the supporting documentation and its 2015 FEHBP MLR Form.

**PHP Response:**

**Unidentified Claims Adjustments – The plan concurs with this finding and will put controls in place to review for accuracy in future MLR submissions**

**4. Healthcare Receivables**

The Plan did not reduce paid claims by all pharmacy rebates received for 2014 and 2015 incurred pharmacy claims. Moreover, the Plan could not adequately support the amount of pharmacy rebates received for either year. Finally the Plan did not reduce FEHBP incurred claims by the allocable portion of a claims settlement received in 2015. As a result, the Plan overstated incurred claims reported on this FEHBP MLR Form by \$247,013 in 2014 and \$543,528 in 2015.

**PHP Response:**

**Healthcare Receivables – The Plan does acknowledge inconsistent reporting of pharmacy rebates between 2014 and 2015, however, there are no explicit instructions provided to the Plan when completing the MLR. In response to the statement that the support for actual pharmacy rebates received included hardcoded spreadsheets that could not be verified by any other independent source, the Plan would like to offer explanation that the hardcoded spreadsheets were provided as opposed to linked spreadsheets, as the linked spreadsheets would not be readable to the auditors. The Plan responded to the original request with support and tieout information to both the HIOS MLR and the statutory Supplement. We were not made aware that there needed to be any further verification of the information with another independent source during the audit. The Plan welcomes the opportunity to provide additional information about the support provided such as verification of amounts received per the bank statements and support from the Pharmacy department and pharmaceutical companies. The Plan was not able to substantiate the rebate calculations provided by the auditors the draft memo. Lastly, the Plan concurs that it did not allocate a claims settlement from Presbyterian Health Services to the FEHBP in 2015. This settlement was simply missed during completion of the MLR.**

## **5. Quality Health Improvements (QHI)**

The Plan's Quality Health Improvement (QHI) expenses were not allocated accurately and appropriately. To determine its applicable QHI costs, the Plan identified cost centers that performed QHI activities and the percentage of costs related to QHI within those cost centers. The Plan then allocated the costs to its product groups at the account level, based on two different methodologies: member months and paid claims ratios. Based on our review of the documentation provided in support of this process, we identified the following issues:

### **a. Unsupported QHI Expenses**

We could not verify that all of the QHI expenses, reported on the FEHBP MLR Forms for 2014 and 2015, met the definition of qualifying QHI per 45 CFR 158.150.

#### **PHP Response:**

**Unsupported QHI Expenses – The Plan concurs that it did not have supporting documentation of the identification of qualifying QHI for 2014. However the methodology was the same in 2014 as for 2015. The process for identifying QHI expenses includes the Plan sending a survey/interview to the department/cost center Directors on an annual basis to determine the percentage of their department's time that is spent on QHI related activities. The survey/interview contains the definitions of qualifying QHI as stated in 45 CFR 158.150. The Plan contends that there are some departments that are entirely dedicated to QHI activities, therefore the expenses associated with those departments, other than those specifically disallowed, should be considered part of the QHI costs. Other departments' activities are only partially considered QHI, so the appropriate percentage of their total costs is applied. Once the percentages are determined, they are applied to the entire GL amount for that cost center as QHI. Sample surveys/interviews, personnel information, and support for actual expenses are available, but were not requested by the OPM auditors during the on-site portion of the audit. The support for the QHI determination is available and documented for 2015 and forward. We welcome the opportunity to provide this support for further review.**

### **b. Unallowable Expenses**

We identified some general ledger accounts that should not have been included in the QHI allocation in 2014 and 2015. Specifically, general ledger accounts that were included in the allocation to the FEHB, such as entertainment and employee celebration, do not meet the definition of QHI as defined in 45 CFR 158.150 and 158.151. Moreover, these costs are expressly unallowable per FAR 31.205-14.

In addition, one of the general ledger accounts, which was included in the 2014 QHI allocation, captured costs for administrative services performed by Presbyterian Health Services that are allocated to the Plan. However, the Plan stated that this account was not used in the FEHBP MLR calculation. Therefore, it should not have been included in the QHI allocation.

Attachment: Rebuttal, 2014 – 2015 Audit Report Federal Employees Health Benefits Program Operations, Presbyterian Health Plan, plan code P2.

**PHP Response:**

**Unallowable Expenses – For 2014, entertainment and employee celebration, which the Plan concurs should have been excluded, Deleted by the OIG – Not Relevant to the Final Report.** The Plan has taken these unallowed expenses into consideration in the most recent MLR submission. Lastly, we are unsure which account OPM is referring to that should not have been included in the QHI allocation. An account name was not provided in order to answer to the second portion of this draft finding. We would welcome further information in order to understand the issue and provide an appropriate response.

**c. Reasonableness of QHI Allocation Methodology**

We could not verify that the allocations of QHI costs yielded the most accurate results, as required by 45 CFR 158.170(b)(1).

**PHP Response:**

**Reasonableness of QHI Allocation Methodology – The Plan contends that it selects the allocation methodology that is most appropriate given the cost driver for each specific account. We are unaware of guidance that explicitly states we must only select one method of allocation and the appropriateness of the allocation methodology used was not addressed during the audit. We would welcome the opportunity to discuss this further. In conjunction with our responses in a. and b. above, we do not understand the removal of the entire QHI balance. Total QHI, less the specifically unallowed amounts for entertainment and employee celebration, seems more appropriate. Deleted by the OIG – Not Relevant to the Final Report**

**6. Premium Review**

The Plan opted to use OPM's subscription income in the FEHBP MLR calculation. We confirmed that the Plan accurately reported OPM's subscription income in the FEHB

**PHP Response: The Plan concurs.**

**7. Federal and State Taxes and Licensing or Regulatory Fees**

The Plan did not reasonably or accurately allocate certain tax expenses to the FEHBP resulting in an increase of reported tax expenses in 2014, totaling \$1,353,758, and a net decrease of tax expenses in 2015, totaling \$1,352, as demonstrated in Table VII on page 14.

Based on our review of the Plan's support for federal income tax and other tax-related expenses, Attachment: Rebuttal, 2014 – 2015 Audit Report Federal Employees Health Benefits Program Operations, Presbyterian Health Plan, plan code P2.

we identified the following issues:

**a. Federal Income Tax (FIT)**

The Plan under-reported FEHBP FIT by \$1,117,060 in 2014. Specifically, our review of the initial support provided by the Plan revealed errors in its allocation.

**PHP Response:**

**Federal Income Tax (FIT) – The Plan concurs that it under-reported FEHBP FIT in 2014 as a result of using the FIT amount from an original filing of the statutory financial statements when completing the MLR. The FEHBP MLR was not amended for the amendment of the statutory financial statements. The Plan has put processes in place to address this issue each time an amendment is submitted**

**b. Health Insurer Fee (HIF)**

The Plan under-allocated HIF expensed to the FEHBP in 2014. The Plan explained that a formula error in the Plans' allocation calculation caused the allocation to be incorrect.

**PHP Response:**

**Health Insurer Fee (HIF) – The Plan agrees that a formula error caused none of the HIF to be allocated to FEHBP in 2014. We have added more controls to ensure this is not an issue in subsequent submissions.**

**c. Transitional Reinsurance Fee (TRF)**

The Plan over allocated TRF expenses to the FEHBP in 2014.

**PHP Response:**

**Transitional Reinsurance Fee (TRF) – The Plan contends its use of member months as an allocation basis is not unreasonable. This method of allocation is not explicitly stated as incorrect upon the Plan's review of the 45 CFR 158.170(b). Furthermore, the Plan notes that upon review of 26 CFR 46.4375-1(c)(2), the member months method is acceptable in determining the average number of lives covered under a specified health insurance policy during a policy year. Therefore, this finding is inconsistent per review of the referenced CFR's.**

**d. Patient Centered Outcomes Research Institute (PCORI) Fee**

The Plan did not report any PCORI expenses in 2014 and over-allocated PCORI expenses in 2015.

**PHP Response:**

**Patient Centered Outcomes Research Institute (PCORI) Fee – Consistent with the Plan's response to**

Attachment: Rebuttal, 2014 – 2015 Audit Report Federal Employees Health Benefits Program Operations, Presbyterian Health Plan, plan code P2.

the finding regarding TRF, the Plan's use of member months as an allocation basis is not unreasonable. This method of allocation is not explicitly stated as incorrect upon the Plan's review of the 45 CFR 158.170(b). Furthermore, the Plan notes that upon review of 26 CFR 46.4375-1(c)(2), the member months method is acceptable in determining the average number of lives covered under a specified health insurance policy during a policy year. Therefore, this finding is unsupported per review of the referenced CFR's.



# APPENDIX B

November 8, 2018

OPM FEHB Audit

Section: 3 Subsection: C: Claims for Ineligible Dependents:

Plan's Response: Per CMS rules a person under 65 is eligible for Medicare Benefits once they have received Medicare Disability benefits for 24 months. In the cases listed in the draft report each of the members have Medicare eligibility, this provides proof that they have been deemed disabled. *According FEHB OPM A child age 26 or over who is incapable of self-support because of a mental or physical disability that existed before age 26 is also an eligible family member. In determining whether the child is a covered family member, the employing office will look at the child's relationship to the enrollee.* In all of the cases the dependents are the natural child of the enrollee. This plan disagrees with the findings and request that they be removed from the final report.

Documentation:

Dependent: 

[IMAGE]

This shows the Dependent had a Medicare Advantage plan through Presbyterian Health Plan.

Dependent: 

[IMAGE]

This shows the Dependent has a Medicare Advantage Plan through Presbyterian Health Plan.

Dependent: 

[Image]

This shows the dependent had a Medicare Advantage Plan outside of Presbyterian Health Plan.

# APPENDIX C

November 8, 2018

Office of Personnel Management

Audit of Presbyterian Health Plan (Plan Code P2) for contract years 2014 and 2015.

Section: IR

Sub-Category: **Follow-Up Request for Fieldwork Support related to Plan rebuttal – Finding 4**

Request #: IR#15 resubmitted

Question 2 -

- a. Pharmacy Rebates – Support for the total Pharmacy Rebate receipts that should have been reported on the 2014 and 2015 FEHBP MLR Filing as well as a tie out of these numbers to HIOS.

Original Answer with additional grid:

PHP has always included pharmacy rebates earned in all of our reporting, MLR's, etc., not cash received for rebates. The numbers used come straight from the general ledger. At the Statutory financial level, the rebates are allocated to FEHBP, along with the other Commercial products, and tie-out to HIOS MLR and the Statutory Supplement.

**Deleted by the OIG – Not Relevant to the Final Report**

See all screenshots below for financial statement tie-outs to HIOS MLR and Statutory Supplement, as well as general ledger detail for subsequent activity through 6/30 of each year.

Rebuttal Followup:

Additional detailed support for pharmacy rebate monthly calculations, receipts, and contracts is available as stated in the rebuttal, but the amount of information, file sizes, and links utilized over two years make it very difficult to provide and walk through with an off-site auditor. A sampling process would be effective for auditing these documents if needed. To strengthen our position on the numbers calculated in the original answer above, we have included GL detail for each year's total pharmacy rebates, which ties to audited financials, as a reduction to Pharmacy expense. The pharmacy rebates calculated by the OPM auditors are not drastically different when compared to the Plan numbers and are acceptable to the Plan. However, we were

unable to validate them ourselves without further information. Therefore, we are resubmitting our original information along with the additional documentation to further support what we believe to be a reasonable allocation of pharmacy rebates to the FEHBP for 2014 and 2015. We believe the auditors already have the Plan's audited financial statements, Statutory Supplement, and HIOS MLR filings and are not including them in this submission. However, they are available upon request.

[IMAGES]



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