U.S. Office of Personnel Management
Office of the Inspector General
Office of Audits

Final Audit Report

Audit of the Federal Employee Health Benefit Operations at Independent Health Association, Inc.

Report Number 1C-QA-00-21-003
January 7, 2022

Executive Summary

Audit of the Federal Employees Health Benefits Program Operations at Independent Health Association, Inc.

Report No. 1C-QA-00-21-003 **January 7, 2022**

Why Did We Conduct the Audit?

The primary objective of the audit was to determine if Independent Health Association, Inc. 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 FEHBP premium rates were developed in accordance with contract regulations and rating instructions established by the U.S. Office of Personnel Management OPM) and whether the Plan met the Medical Loss Ratio (MLR) requirements and thresholds established by OPM.

What Did We Audit?

Under Contract CS 1933, the Office of the Inspector General OIG) completed a performance audit of the FEHBP premium rate developments and FEHBP MLR submissions for contract years 2016 through 2018. Our audit fieldwork was conducted remotely from February 8, 2021, through August 2, 2021.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

We determined that portions of the 2016 through 2018 FEHBP premium rate developments and MLR filings were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM. As such, this report questions $1,079,748 for defective pricing in contract years 2016 through 2018. In addition, the FEHBP is due lost investment income of $121,756 on the premium overpayments. The reduction in premium rates, as well as additional reporting errors identified, led to overstated MLR credits, totaling $4,583,592, in contract years 2016 and 2018. Specifically, our audit identified the following:

- Defective pricing of the premium rate developments occurred due to unsupported and unallowable non-claims expenses in 2016 through 2018, as well as an unallowable surcharge and the lack of coordination of claims in the 2016 premium rate.
- The Plan reported incorrect adjusted incurred claims and included unallowable expenses in its 2016 through 2018 FEHBP MLR.
- The Plan included unsupported and unallowable non-claims expenses in the 2016 through 2018 FEHBP MLRs.
- The Plan used erroneous prior year data to calculate portions of its 2016 FEHBP MLR.
- Fraud recoveries were incorrectly reported twice in the Plan's 2016 through 2018 FEHBP MLR submissions.
- The Plan incorrectly calculated its taxes and regulatory fees in the 2016 through 2018 FEHBP MLR submissions.
- The Plan's internal control system did not sufficiently meet the contractual criteria, especially related to dependent terminations, FEHBP MLR calculations, record retention, and complete and timely responses to the OIG.

Abbreviations

ACA	**Affordable Care Act**
CFR	**Code of Federal Regulations**
CMS	**Centers for Medicare and Medicaid Services**
Contract	**Contract CS 1933**
FEHBAR	**Federal Employee Health Benefits Acquisition Regulation**
FEHBP	**Federal Employees Health Benefits Program**
GL	**General Ledger**
HCRA	**Health Care Reform Act**
HDHP	**High Deductible Health Plan**
HRA	**Health Reimbursement Account**
HSA	**Health Savings Account**
IHA	**Independent Health Association, Inc.**
IHBC	**Independent Health Benefits Corporation**
IRS	**Internal Revenue Service**
LII	**Lost Investment Income**
MLR	**Medical Loss Ratio**
NFR	**Notification of Findings and Recommendations**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
PCORI	**Patient Centered Outcome Research Institute**
Plan	**Independent Health Association, Inc.**
PMPM	**Per Member Per Month**
PMPY	**Per Member Per Year**
RAUF	**Risk Adjustment User Fee**
SIU	**Special Investigation Unit**
SSSG	**Similarly-Sized Subscriber Group**
TRF	**Transitional Reinsurance Fee**
U.S.C	**United States Code**

Table of Contents

Exhibit C (Lost Investment Income)

Exhibit D (Summary of Medical Loss Ratio Adjustments)

Exhibit E (Medical Loss Ratio Adjustment by Contract Year)

Exhibit F (Medical Claims Sample Selection Criteria and Methodology)

Appendix (Plan's October 15, 2021, response to the draft report)

Report Fraud, Waste, and Mismanagement

I. Background

This final report details the audit results of the Federal Employees Health Benefits Program FEHBP) operations at Independent Health Association, Inc. (Plan). The audit was conducted pursuant to the provisions of Contract CS 1933 (Contract); 5 United States Code Chapter 89; and 5 Code of Federal Regulations CFR) Chapter 1, Part 890. The audit covered contract years 2016 through 2018 and was conducted remotely by the U.S. Office of Personnel Management's OPM) Office of the Inspector General OIG) staff.

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 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 Federal Register 19522). The MLR is the proportion of FEHBP premiums collected by a carrier that is spent on clinical services and quality health improvements.

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 of the health plan. However, in our opinion the FEHBP MLR is not as transparent as intended and does not provide an assessment of the fairness of the premium paid for benefits received. As this continues to be a significant Program concern for us, we are addressing this issue with OPM through other channels.

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. However, beginning in 2013, 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.

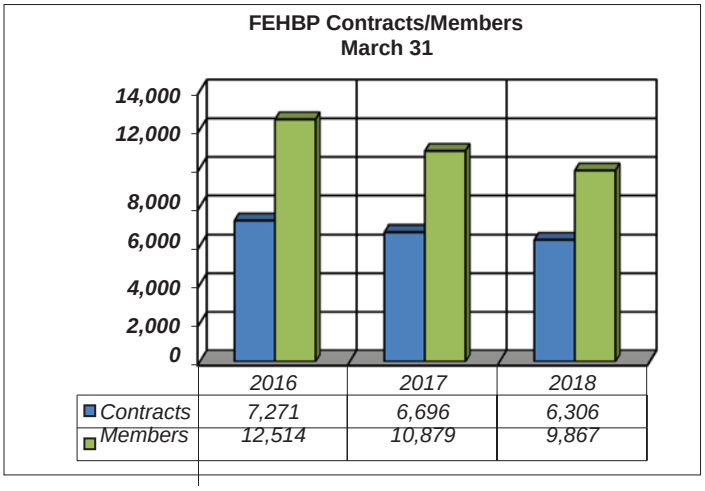
Starting with the pilot program in 2012 and for all non-traditional community-rated FEHBP carriers in 2013, OPM required the carriers to submit an FEHBP-specific MLR. This FEHBP-specific MLR calculation required carriers to report information related to earned premiums and expenditures in various categories, 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.

Furthermore, the premium rates charged to the FEHBP under the MLR methodology are to be developed in accordance with OPM Rules and Regulations and the Plan's state-filed standard rating methodology (or if the rating method does not require state filing, the Plan's documented and established rating methodology . All FEHBP pricing data are to be supported by accurate, complete, and current documentation. A rating methodology is defined as a series of well-defined procedures a carrier follows to determine the rates it will charge to its subscriber groups. Further, an independent professional must be able to follow the carriers' procedures and reach the same conclusion. OPM negotiates benefits and rates with each Plan annually and all rate agreements between OPM and the carrier are subject to audit by the OPM OIG. The results of such audits may require modifications to previous agreements and subsequent rate adjustments.

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 1983 and provides health benefits to FEHBP members in the western New York service area. It is a health maintenance organization that offers FEHBP members a high, standard, and high deductible health plan HDHP) enrollment choice. This is the first audit of the Plan's MLR submissions; however, a previous premium rate audit of contract year 2012 identified inappropriate health benefit charges to the FEHBP. The final audit report was issued in August of 2015, and all issues were resolved by OPM. These issues were considered in the planning and completion of this audit.

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 an Appendix to the report.

II. Objectives, Scope, and Methodology

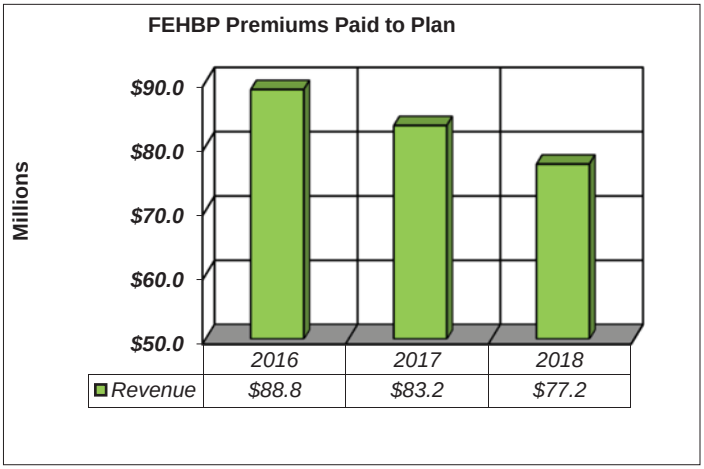
Objectives

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 determined if the Plan developed its FEHBP premium rates in accordance with the applicable regulations and rating instructions established by OPM.

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 2016 through 2018. For these years, the FEHBP paid approximately $249.2 million in premiums to the Plan.



The OIG's 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 and premium rate calculations were accurate, complete, and valid;
- medical claims were processed accurately;
- appropriate allocation methods were used; and
- any other costs associated with its MLR and premium rate 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.

We remotely conducted our audit fieldwork from February 8, 2021, through August 2, 2021.

Methodology

We examined the Plan's MLR, premium rate calculations, and related documents as a basis for validating the MLR and the premium rates. Further, we examined medical claim payments, capitation expenses, pharmacy rebates, completion factors, benefit factors, trends, administrative expenses, and any other applicable expenses considered in the calculation of the MLR and premium rates to verify that the cost data used was accurate, complete, and valid. Finally, we used the Contract, the Federal Employees Health Benefits Acquisition Regulations, the OPM rate instructions, and applicable Federal regulations to determine the propriety of the Plan's MLR and premium rate calculations.

To gain an understanding of the internal controls over the Plan's MLR and premium rate processes as well as its claims processing system, we reviewed the Plan's MLR, premium rate, and claims policies and procedures. We also interviewed appropriate Plan officials regarding the controls in place to ensure that the MLR and premium rate calculations and claims pricing were completed accurately and appropriately. Other auditing procedures were performed as necessary to meet our audit objectives.

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

III. Audit Findings and Recommendations

A. Premium Rate Review

Carriers proposing rates to OPM are required to submit a Certificate of Accurate Pricing certifying that the cost or pricing data submitted in support of the FEHBP rates were developed in accordance with the requirements of 48 CFR, Chapter 16 and the Contract. The Certificates of Accurate Pricing that the Plan signed for contract years 2016 through 2018 were defective. In accordance with Federal regulations, the FEHBP is, therefore, due overpaid premiums of $1,079,748 for contract years 2016 through 2018. In addition, the application of the defective pricing remedy shows that the FEHBP is also due Lost Investment Income LII) of $121,756 on the premium overpayment for a total amount due to OPM of $1,201,504 (see Exhibit A).

1. Defective Pricing: $1,079,748

During our review of the Plan's 2016 through 2018 premium rate developments, we identified issues that resulted in lower audited premium rates than the Plan submitted. This resulted in a reduction of the Plan's premiums, as illustrated in Table I.

Table 1 – Defective Pricing

Year	Plan's Premium	Audited Premium	Defective Pricing
2016	$89,382,343	$88,652,097	$730,246
2017	$84,345,801	$84,121,487	$224,314
2018	$77,723,077	$77,597,889	$125,188
		Total Defective Pricing	**$1,079,748**

The specific issues that led to the overpaid premiums are discussed in paragraphs A.1.a through A.1.d of this report.

a. Unsupported Non-Claims Expenses

The Plan offers a telemedicine[1]/telehealth[2] benefit provided through the Teladoc network of providers. We determined that the Plan included Teladoc in its non-claims per member per month PMPM) calculation for 2016 through 2018. The 2016, 2017, and 2018 FEHBP benefit brochures state that the telehealth or telemedicine program requires a copay.

We required the Plan to provide documentation to demonstrate that the Teladoc PMPMs were adjusted to reflect the members' copays for 2016 through 2018. The Plan stated its Teladoc expenses included payment on a PMPM basis in addition to any claims that were

[1] The telemedicine program is an online video or phone consultation service administered by physicians who participate in the Plan's telemedicine program.
[2] Beginning in 2018, the Plan offered Telehealth services. Telehealth is the use of electronic and communication technologies by a provider to deliver covered services when the member's location is different than the provider's location.

submitted for the general medical service codes outlined in an agreement with the Teladoc provider. Per the Plan, any Teladoc claims that are not under the capitated agreement will process through its claims system and will properly reflect the member copays. However, the Plan was unable to confirm that the Teladoc expenses paid on a PMPM basis were reflective of the member copay, utilization, or varying benefit levels.

Contract Section 2.2(a) states, "The Carrier shall provide the Benefits as described in the agreed upon brochure text . ." Additionally, the Community Rating Guidelines require carriers using an Adjusted Community Rating method to maintain documentation to support all calculations and data used to derive the rates.

Therefore, based upon the supporting documentation provided, we were unable to determine if the Teladoc PMPMs were adjusted for the received copay amounts. As a result, we removed the Teladoc amount from the non-claims PMPM expenses.

b. Unallowable Non-Claims Expenses

The Plan included amounts from its Expense Re-class general ledger account in its 2018 premium rates. Per the 2018 Community Rating Guidelines, premium rates should be developed based on actual FEHBP claims data. The Expense Re-class was not direct paid claims and did not represent compensation for or reimbursement of covered services provided to an enrollee. Therefore, this expense should not have been included in the claims data used in the Plan's rate developments.

The Plan included multiple unallowable expenses within its 2016 through 2018 premium rates.

Within the 2016 through 2018 non-claims PMPMs, the Plan included a vision vendor and two wellness vendors despite the FEHBP benefit brochure stating that these programs were not part of the FEHBP contract or premium. Contract Section 2.2(a) states, "The Carrier shall provide the Benefits as described in the agreed upon brochure text ... ." As a result, these PMPMs were removed from the premium rate developments.

The Plan did not have documented policies and procedures in place to ensure that FEHBP rates were developed for allowable benefits and claims-related costs per OPM's guidance, the Contract, and the FEHBP benefit brochures.

c. Unallowable Surcharge Expenses

The FEHBP was rated under Independent Health Benefits Corporation IHBC) instead of Independent Health Association, Inc. IHA) for contract year 2016. The Plan used nine months of Traditional Community Rating data from IHA and three months of data under IHBC to rate the FEHBP. However, there was an error with the Health Care Reform Act

(HCRA) fee being applied to the last three months of the experience period January through March 2015). HCRA is a fee collected from health plans in the form of a sales tax on certain hospital-based health services. The FEHBP was exempt from this fee per the Community Rating Guidelines since it is a surcharge to the FEHBP. The Plan stated that this total was not reversed out until after the rating was completed and an applied underwriting adjustment was used to mitigate. However, during our review of the 2016 reconciled rates, we noted that the HCRA fee was still present, and the underwriting adjustment was not applied solely to mitigate the HCRA error, but rather to lessen the overall rate increase and keep the Plan's rates competitive. As a result, we removed the amount related to the HCRA from our audited rate development.

d. Coordination of Claims

We reviewed a statistical sample of 75 medical claims from 2016 to determine if the Plan priced and paid the claims for eligible members in accordance with applicable criteria. Based on our review, we identified a coordination of benefits issue.

The Plan overstated its incurred medical claims in 2016 by not coordinating benefits with Medicare.

The Plan improperly processed a member's claim as if it were the primary payor even though it was secondary and Medicare Part A was primary. The Plan stated there was no coordination with Medicare for the claim. The Plan explained that the member's file was updated after the claim was received and auto-adjudicated. Under its coordination of benefits process, the Plan should have completed a claim history review, which is a 10-month look back. This process allows time for the provider to receive notice of the takeback from the Plan via the explanation of payment so it can bill Medicare timely. Per the Plan, it errored by not completing the claim history for this member. The error caused the claim to not be retracted and the provider was not informed to bill Medicare for primary payment, so it remained paid by the Plan.

OPM Contract Section 2.6(a) requires, "The Carrier [to] coordinate the payment of Benefits ... with the payment of Benefits under Medicare ... ." In addition, per the 2016 FEHBP benefit brochure, when Medicare Part A is primary, it processes the claim first and the Plan provides secondary benefits for covered charges.

By paying primary on the claim, the Plan overstated its incurred medical claims in 2016, which consequently misstated the claims used in the rate developments. As a result, we removed the improperly processed claim from the 2016 premium rates calculation.

(This finding is also found under the Medical Loss Ratio Review section, specifically, B.14, as it was removed from both the premium rates and MLR.)

Recommendation 1: We recommend that the Contracting Officer require the Plan to return $1,079,748 to theFEHBP for defective pricing in contract years 2016 through 2018.

Recommendation 2: We recommend that the Plan document its policies and procedures over the FEHBP ratingprocess to assist in detecting and preventing errors, as well as ensure compliance with all applicable criteria when preparing the FEHBP rates.

Recommendation 3: We recommend that the Plan maintain documentation to support all calculations and dataused to derive the FEHBP premium rates.

Recommendation 4: We recommend that the Plan strengthen its system controls to ensure its compliance withthe group-specific benefits and member cost-sharing responsibilities as outlined in the FEHBP benefit brochure.

Plan Response: The Plan disagreed with the findings (A.1.a, A.1.b., and A.1.c. and Recommendation 1but agreed to implement the other recommendations. It stated that it had provided therequested documentation to show the Teladoc PMPMs did reflect the paid copay amounts. Specifically, it pointed out a change in the PMPM amounts due to a copay change during one of the audited contract years. It asserts that the expenses should be included within the calculation of premiums.

Furthermore, it stated the vision benefits were part of the Plan's Community Package that the FEHB agreed to utilize in its benefit package. The Plan also stated that the placement of these benefits within the brochure was at the direction of OPM, though the benefit structure itself was not altered.

The Plan stated that, "In good faith, Independent Health used the budgeted non-claims rather than the actual non-claims for developing the 2016 rates. The actual non-claims are higher than budget, even when HCRA is included." An Excel workbook was provided to demonstrate that the budgeted non-claims used in the rating was less than the actual non-claims.

The Plan agreed with finding A.1.d.

OIG Comment: We acknowledge that the Teladoc expenses included payments on a PMPM basis in additionto any claims that were submitted for the general medical codes outlined in the agreement. Therefore, we understand that the Teladoc claims that are not under the capitated agreement will process through the Plan's claim system and reflect the member copays. However, the Plan was unable to confirm that the Teladoc expenses paid on a PMPM basis were reflective of the member copay, utilization, or varying benefit levels. As a result, we have removed theTeladoc PMPM from the 2016 through 2018 premium rates.

We recognize that the vision vendor benefit may be part of the Plan's Community Package, although that does not limit the Plan from removing specific benefits from the Community Package that are not applicable to the FEHBP. Furthermore, the Plan was unable to provide supporting documents to show that OPM instructed it to place the benefit in the Non - FEHBP section of the FEHBP benefit brochure. Consequently, we have removed the vision vendor PMPMs from the premium rate developments.

We also understand that it was a business decision by the Plan to develop the 2016 rates by applying the budgeted non-claims rather than the actual non-claims. While this was in the favor of the FEHBP, the inclusion of the HCRA fee remains unallowable because the FEHBP is not subject to surcharges, as stated in the Community Rating Guidelines. As a result, the HCRA was removed from our audited rate development.

2. Lost Investment Income: $121,756

In accordance with the FEHBP regulations and the Contract, the FEHBP is entitled to recover LII on the defective pricing findings in contract years 2016 through 2018. We determined that the FEHBP is due $121,756 for LII, calculated through December 31, 2021 (see Exhibit C). In addition, the FEHBP is entitled to LII for the period beginning January 1, 2022, until all defective pricing finding amounts have been returned to the FEHBP.

The FEHBP is due $121,756 for Lost Investment Income resulting from the defective pricing issues.

The Federal Employee Health Benefits Acquisition Regulation FEHBAR) 1652.215-70 provides that if any rate established in connection with the FEHBP contract was increased because the carrier furnished cost or pricing data that was not complete, accurate, or current as certified in its Certificate of Accurate Pricing, the rate shall be reduced by the amount of the overcharge caused by the defective data. In addition, when the rates are reduced due to defective pricing, the regulation states that the government is entitled to a refund and simple interest on the amount of the overcharge from the date the overcharge was paid to the carrier until the overcharge is liquidated. Our calculation of LII is based on the United States Department of the Treasury's semi-annual cost of capital rates.

Recommendation 5: We recommend that the Contracting Officer require the Plan to return $121,756 to the FEHBP for LII, calculated through December 31, 2021. We also recommend that the Contracting Officer recover LII on amounts due for the period beginning January 1, 2022,until all defective pricing amounts have been returned to the FEHBP.

Plan Response: The Plan disagreed with the finding and recommendation. It asserted that based on itsDraft Report responses and additional information provided, the LII should be reduced.

OIG Comment: The Plan provided additional support and documentation, which was reviewed as part of theindividual findings and recommendations that led to the LII finding and are discussed in section A.1. of this report. The results of the defective pricing and LII were updated as a result.

3. Inaccurate PCORI Fees: Procedural

The Plan used an incorrect Patient Centered Outcome Research Institute PCORI) fee in the 2016 through 2018 rate developments.

Per 26 CFR 46.4375, the PCORI fee applies for policies with policy years ending on or after October 1, 2012, and before October 1, 2019. The Internal Revenue Service IRS) issued guidance which lists the PCORI filing due dates and applicable rates for the fees lifespan.

The Plan used a per member per year PMPY) fee of $2.17 for 2016, $2.26 for 2017, and $2.39 for 2018. Since the FEHB plan year ended in December, the appropriate fee that should have been applied was $2.26 PMPY for 2016, $2.39 PMPY for 2017, and $2.45 PMPY for 2018 per the IRS PCORI fee guidance. The Plan did not have documented policies and procedures in place to ensure that the correct PCORI PMPY fees were applied to the 2016 through 2018 premium rates. We updated the PCORI fees in the 2016 through 2018 MLR submissions, which led to an immaterial monetary impact on the premium rates. Although there was no material impact on the premium rates, the Plan was not in compliance with criteria and the PCORI calculation was erroneous.

Recommendation 6: We recommend that the Plan use the applicable PCORI fee from the IRS guidance based onits policy year end date within the Contract.

Recommendation 7: We recommend that the Plan strengthen its policies and procedures over the FEHBP ratingprocess to assist in detecting and preventing errors, as well as ensure compliance with all applicable criteria when preparing the FEHBP rates.

Plan Response: The Plan agreed with this finding and agreed to implement Recommendations 6 and 7.

B. Medical Loss Ratio Review

The Certificates of Accurate MLR signed by the Plan for contract years 2016 through 2018 were defective. The Certificate of Accurate MLR states that the FEHBP-specific MLR is accurate, complete, and consistent with the methodology in Sec. 1615.402(c)(3 ii). In accordance with Federal regulations and the OPM Community Rating Guidelines, our audit identified the following issues:

1. Overstated MLR Credits: $4,583,592

The data in Table II below shows the Plan's calculated unadjusted MLR percentages, and its current MLR credits. Our review of the Plan's FEHBP MLR submissions identified issues that resulted in lower audited MLRs than the Plan's filed MLRs. The audited MLR percentages and credits are also illustrated in Table II.

Table II - Overstated MLR Credits

Year	Plan's MLR Ratio	Audited MLR Ratio	Plan's Current Credit	Audited Credit	Overstated Credit
2016	[redacted]%	[redacted]5%	$775,546	$0	$775,546
2017	[redacted]%	[redacted]%	$1,988,349	$0	$1,988,349
2018	[redacted]%	[redacted]%	$3,886,051	$2,066,354	$1,819,697
				Total Credit Reductions	**$4,583,592**

Although Table II illustrates MLR variances due to the defective pricing findings, these values are specifically related to the amounts documented in this report. All penalty adjustments will be calculated by OPM after the defective pricing findings are resolved and

collected. Any adjustments to the defective pricing findings in this report may also impact the credit reductions. The specific issues that led to the penalty adjustments and defective Certificates of Accurate MLR are discussed throughout the remainder of the report.

Recommendation 8: We recommend that the Contracting Officer adjust the Plan's MLR credits for contract years 2016 through 2018 once the defective pricing findings discussed in this report are resolved.

Plan Response: The Plan disagreed with the finding but agreed that any adjustments to the MLR credits should be done once the premium rate review findings discussed in this report are resolved. It stated that it provided additional information in response to the DraftReport and in response to an Information Request.

OIG Comment: We agree that the Plan did provide additional supporting documentation. We have reviewedthe information and updated the findings in this report accordingly.

2. Inaccurately Reported Adjusted Incurred Claims

The Plan inaccurately reported its MLR adjusted incurred claims in contract years 2016 through 2018.

45 CFR 158.140 states that all components of and adjustments to incurred claims, except for contract reserves, must be calculated based on claims incurred only during the MLR reporting year. Furthermore, OPM Carrier Letters 2017-06, 2018-02, and 2019-07, as well as the 2016, 2017, and 2018 OPM Community Rating Guidelines, state that the acceptable date range is claims incurred during the calendar year and paid through six months of the following year (June 30).

The Plan overstated its adjusted incurred claims by $3,350,684 during contract years 2016 through 2018.

Based on our review of 2016 through 2018 adjusted incurred claims, it was identified that some claims were double counted. The Plan stated that the programs ran to calculate the total amounts paid for each year included both pended claims and paid claims. Once the pended claims were paid between January 1st and June 30th of the following year, it captured those claims as paid a second time. As a result, the Plan's medical claims were overstated. Consequently, the Plan's 2016 through 2018 adjusted incurred claims totals were inaccurate, which caused the MLR numerators to be overstated.

Table III – Overstated Medical Claims	
Year	**Overstatement of Medical Claims**
2016	$1,017,213
2017	$1,125,146
2018	$1,208,325

Recommendation 9: We recommend that the Plan ensure that the data used in the creation of the FEHBP MLR submission to OPM is accurate, complete, and consistent with the methodology stated in 45CFR 158.140, the Community Rating Guidelines, and the Carrier Letters.

Recommendation 10: We recommend that the Plan institute a more stringent review process to identify reportingerrors prior to submitting the FEHBP MLR to OPM.

Plan Response: "The Plan agreed with the finding. It stated that the issue was corrected beginning withthe 2019 MLR filing. Additionally, a more thorough reconciliation process between totals submitted from actuarial and raw data from underwriting will be put in place."

OIG Comment: The updated reconciliation process falls outside the scope of our audit and will be evaluatedfurther during future audits. As such, we cannot comment on its effectiveness.

3. Unallowable Non-Claims Expenses

The Plan included unallowable non-claims expenses within its adjusted incurred claims during contract years 2016 through 2018.

45 CFR 158.140 states that the MLR "must include direct claims paid to or received by providers ... whose services are covered by the policy for clinical services or supplies covered by the policy."

We determined that the general ledger GL) Expense Re-class account and Wellness components of the non-claims adjustments were not direct paid claims and did not represent compensation or reimbursement for covered services provided to an enrollee.

As a result, we removed a total of $604,618, $478,808, and $532,427 for 2016 through 2018, respectively. See Table IV below.

Table IV – Unallowable Non-Claims Expenses			
Expense	**2016**	**2017**	**2018**
Expense Re-Class	$39,434	$58,462	$63,764
Wellness	$565,184	$420,346	$468,663
Total	$604,618	$478,808	$532,427

Recommendation 11: We recommend the Plan ensure direct claims reported on the FEHBP MLR are in accordancewith 45 CFR 158.140.

Plan Response: The Plan agreed with removing the Expense Re-Class and Wellness portions of theclaim expenses, which do not apply to the FEHBP.

4. Unallowable Expenses

a. Non-FEHBP Benefits

In 2016, the Plan included vision expenses for a vision vendor in the "Other" expense category under the non-claims expenses. The FEHBP benefit brochure states that the vision program is not part of the FEHBP contract or member's premium.

Per the Plan, the vision program costs are not captured within its claim system. The Plan also included the vision vendor expenses in 2017 and 2018 MLR calculations but categorized the expenses under its capitations. The 2017 and 2018 FEHBP benefit brochures also note that the vision vendor's vision program was not part of the member's premium or benefits. Therefore, the vision program totals should be excluded from the MLR calculations.

The Plan inflated the 2016 through 2018 MLR numerators by including non-FEHBP benefits in its MLR calculations.

Additionally, the Plan included a separate LASIK expense in its 2017 capitation total. The 2017 FEHBP benefit brochure listed this benefit as a covered benefit under the vision program which is not part of the member's premium or benefits. As a result, this expense should be excluded from the 2017 MLR calculation.

OPM Contract Section 2.2(a) requires the Plan to provide benefits defined in the FEHBP benefit brochure. The Plan did not have documented policies and procedures in place to ensure that the MLR adjusted incurred claims were developed for allowable benefits and

claims-related costs per OPM's guidance, the Contract, and the FEHBP benefit brochures.

The Plan inflated its MLR numerators by $135,412 in 2016, $125,647 in 2017[3], and $115,353 in 2018 due to the vision vendor expenses being included in the non-claims and capitation expenses.

b. Third-Party Vendor Fee

The Plan included an expense related to MRx Case Management under the "Other" expense category in the non-claims expenses for 2016. The Plan stated that the expense represented a utilization management fee, primarily for medical drug injectable management, including chemo drugs and specialty drugs. The Plan mentioned that this expense was not captured in its claims system.

Per 45 CFR 158.140(b)(3)(ii), "Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management" must not be included in incurred claims reported on the MLR submissions.

Our review determined that the MRx Case Management fee represented an amount paid to a third-party vendor for utilization management. Based on the criteria, the MRx Case Management is unallowable and was not representative of actual claims costs. The Plan did not have documented policies and procedures to identify and remove utilization management fees that were incorporated as non-claims expense in its MLR submission. In addition, the Plan was not in compliance with 45 CFR 158.140 b)(3 ii). Consequently, the Plan overstated its adjusted claims reported in the MLR numerator by $67,296 in 2016.

Recommendation 12: We recommend that the Plan create, implement, and document internal control policies andprocedures to ensure that only allowable expenses are included in the FEHBP MLR submissions, in accordance with applicable regulations.

Plan Response: The Plan disagreed with the non-FEHBP benefit finding. It stated that the vision vendor "benefits are part of the Plan's Community Package, which FEHB agreed to utilize in its benefit package. … the placement of this benefit within the brochure was at

[3] The unallowable vision vendor non - claims expense in 2017 included $124,665 reported as non-claims expense and $982 reported as capitation expenses.

the direction of OPM, though the benefit structure itself was not altered." The Plan agreed with the third-party vendor fee finding.

OIG Comment: We acknowledge that the vision vendor benefit may be part of the Plan's Community Package, although that does not limit the Plan from removing specific benefits from the Community Package that are not applicable to the FEHB. Furthermore, the Plan was unableto provide supporting documents to show that OPM instructed it to place the benefit in the Non-FEHBP section of the FEHBP benefit brochure.

5. Non-Claims Expense

During our review of the 2016 MLR calculation, we noted that the Plan included an expense for telemedicine services, Teladoc, in the "Other" category of the non-claims expense. The Plan explained that this expense is the cost of providing telemedicine visits with providers and it is not captured in the claims system. In 2017 and 2018, this expense was moved under the capitation expense.

Contract Section 2.2(a) states, "The Carrier shall provide the Benefits as described in the agreed upon brochure text ... ." The FEHBP benefit brochures showed that the telemedicine program had required copays for telemedicine services in 2016 through 2018.

The Plan did not accurately account for FEHBP utilization, benefit adjustments or varying benefit levels related to its telemedicine benefits.

The Plan calculated the Teladoc GL totals at the commercial large group line of business and then allocated a portion to the FEHBP. Without additional information, we cannot determine the full impact to the affected FEHBP members, nor if the expenses were subsequently adjusted to reflect the member copays. Based upon the available documentation, the Plan did not account for FEHBP utilization, benefit adjustments, or varying benefit levels.

As a result, the Plan overstated its 2016 through 2018 incurred medical claims, which consequently overstated the MLR numerator. Therefore, the Teladoc expenses of $40,036 in 2016, $22,984 in 2017, and $20,945 in 2018 were removed from the non-claims expenses in 2016 and the capitation expenses in 2017 and 2018.

Recommendation 13: We recommend that the Plan strengthen its system controls to ensure its compliance with thegroup-specific benefits and member cost-sharing responsibilities as outlined in the FEHBP benefit brochure.

Plan Response: The Plan disagreed with the finding. The Plan stated that the Teladoc claims were processed through the Plan's claims system and asserts that these expenses should beincluded in the calculation of the MLR. The Plan agreed to implement the associatedrecommendation.

OIG Comment: We reviewed the Teladoc contract and acknowledge that certain procedure codes for Teladocclaims will be processed in the claims system as well as paid on a capitated PMPM basis. However, in this case, we were specifically analyzing the Teladoc claims provided in the "Other" category of the non-claims expense. The Plan explained that this Teladoc expense was the cost of providing telemedicine visits with providers and it was not captured in the claims system. In 2017 and 2018, this expense was moved under the capitation expense. The Plan did not provide any additional documentation in its response to show that these capitated expenses were adjusted to reflective member copays, utilization, or varying benefit levels. As a result, we will continue to remove the Teladoc expenses in the 2016 through 2018 MLR calculations.

6. Inaccurately Reported and Allocated Pharmacy Rebates

The Plan disclosed that it inadvertently used the 2015 pharmacy rebates total to calculate the 2016 pharmacy rebates amount included in the FEHB MLR calculation. We noted it also did not allocate the 2016 pharmacy rebates in a way that would yield the most accurate results.

Per 45 CFR 158.140(a), "All components of and adjustments to incurred claims, with the exception of contract reserves, must be calculated based on claims incurred only during the MLR reporting year and paid through March 31st of the following year." For OPM, the paid through date is extended to six months of the following year. Furthermore, 45 CFR 158.170(b)(1), states that the "Allocation . should be based on a generally accepted accounting method that is expected to yield the most accurate results."

The Plan erroneously used the 2015 pharmacy rebates total to calculate the 2016 pharmacy rebates amount included in the FEHB MLR calculation. Therefore, we recalculated the FEHBP 2016 pharmacy rebates using the correct GL pharmacy rebate totals. The Plan allocated its 2016 pharmacy rebates based on a claims ratio that included both medical and

pharmacy claims. In 2017 and 2018, the Plan allocated the pharmacy rebates to the FEHB based solely on the pharmacy claim ratio. Since the pharmacy rebates are directly related to pharmacy claims, an allocation based solely on the pharmacy claims would have been more accurate for 2016.

Lastly, we determined that the Plan inaccurately included its 2016 pharmacy rebates in the "Other" expense category as a part of the non-claims expense captured in its FEHBP MLR. However, in 2017 and 2018, the Plan corrected the issue and recorded its pharmacy rebates as healthcare receivables. In our audited 2016 MLR calculation, we recorded the 2016 pharmacy rebates as healthcare receivables.

Consequently, the Plan understated its pharmacy rebate reported in the MLR numerator by $793,902 for the 2016 MLR calculation.

Recommendation 14: We recommend that the Plan create, implement, and document internal control policies andprocedures to ensure that pharmacy rebates are allocated to the FEHBP MLR based on a methodology that yields the most accurate results, as required by 45 CFR 158.170(b)(1).

Recommendation 15: We recommend that the Plan institute a more stringent MLR review process to better identifyreporting errors prior to submitting the MLR to OPM.

Plan Response: The Plan agreed with the 2016 pharmacy rebates allocation part of the finding andagreed to Recommendation 15.

OIG Comment: The Plan did not comment on the pharmacy rebate allocation part of the finding orRecommendation 14.

7. Fraud Reduction Expenses and Recoveries

Our review determined that the Plan reported the fraud recoveries twice, which reduced the paid claims amount in the 2016 through 2018 FEHBP MLR calculations. Furthermore, the Plan inaccurately allocated the fraud recoveries in its 2016 through 2018 FEHBP MLR calculations.

The MLR fraud reduction expenses and recoveries are regulated by 45 CFR 158.140(b)(2)(iv), which allows incurred claims adjustments, part of the MLR numerator,

from claims payments recovered through fraud reduction efforts no greater than fraud reduction expenses.

The Plan erroneously double counted its fraud recoveries and used an inaccurate allocation methodology to calculate them.

Specifically, the fraud recoveries were included on the MLR form as total fraud recoveries that reduced paid claims as well as captured in the "Other" expense category under the non-claims expenses as Special Investigation Unit SIU). The Plan acknowledged that the fraud recoveries were double counted, and it should have been either reported as a non-claims expense or fraud recoveries, but not both. As a result, we removed the SIU expense from the "Other" expense category under the non-claim expense in the MLR numerators in the amounts of $29,391 for 2016, $14,294 for 2017 and $5,473 for 2018.

Per 45 CFR 158.170(b)(1), the "Allocation . should be based on a generally accepted accounting method that is expected to yield the most accurate results."

In 2016, the plan allocated the fraud recoveries to the large group and then a portion of that amount was allocated to the FEHB using a total claims ratio, which included both medical and pharmacy claims. However, in 2017 and 2018, the Plan allocated the fraud recoveries to the large group using only the pharmacy claims ratio and then a portion of that amount was allocated to the FEHBP using a total claims ratio. The Plan explained that for the 2017 MLR filing and thereafter, it determined that using only pharmacy claim totals was a more equitable basis for allocating fraud recoveries. The Plan also noted that the 2017 and 2018 allocations would have varied by less than three percent had it included both medical and pharmacy claims in the calculation.

The Plan should have applied the total claims ratios since the fraud recoveries included services for both medical and pharmacy benefits. As a result, the Plan was not in compliance with the applicable criteria. We reallocated the fraud recoveries using the total claims ratios. However, the impacts on the 2016 through 2018 MLR calculations were immaterial.

Recommendation 16: We recommend that the Plan strengthen its internal controls surrounding the review and reporting of the fraud reduction expenses and recoveries for the FEHBP MLR calculation toensure its compliance with applicable criteria.

Plan Response: The Plan agreed that the Fraud Reduction Expenses and Recoveries expense was reported twice in error. The Plan agreed to implement the associated recommendation.

8. Inaccurately Reported Capitations

We determined that the Plan used an incorrect allocation ratio in its 2017 and 2018 capitation expense totals within its MLR calculations.

Per 45 CFR 158.170(b)(1), the "Allocation . should be based on a generally accepted accounting method that is expected to yield the most accurate results."

The Plan should have applied the total claims ratios since the capitations included services for both medical and pharmacy benefits. As a result, the Plan was not in compliance with the applicable criteria.

We recalculated the capitations attributable to the large group, less the unallowable expenses or portion of expenses previously mentioned in finding B.4.a. and B.5., based on the 2017 and 2018 total claims ratios. Consequently, the Plan inflated the capitation expenses by $120,535 for 2017 and $74,727 for 2018 MLR calculations.

Recommendation 17: We recommend that the Plan create, implement, and document internal control policies and procedures to ensure that expenses are allocated to the FEHBP MLR based on a methodologythat yields the most accurate results, as required by 45 CFR 158.170(b)(1).

Plan Response: The Plan agreed with the finding and to implement the associated recommendations.

9. Other Non-Claims Expenses

The Plan could not support its 2016 "Medical and Rx Claims Adjustments" amount. We also determined that it incorrectly allocated the "Medical and Rx Claims Adjustments" and "Claims Settlements" expenses in 2017 and 2018.

Contract Section 1.11(b) requires insurance carriers to maintain all records relating to the contract and to make these records available for a period of time specified by the FEHBAR 1652.204-70.

The Plan noted that the amount used in the 2016 FEHBP MLR calculation was $183,338 but provided GL detail that showed a total of $165,611. The Plan stated that it was searching its older GL records for the difference but if the difference could not be identified, the $165,611 should be used in the calculation. The Plan is not in compliance with Contract Section 1.11(b), because it did not maintain the GL information to support the original "Medical and Rx Claims Adjustment" amount.

Additionally, per 45 CFR 158.170(b)(1), the "Allocation . should be based on a generally accepted accounting method that is expected to yield the most accurate results." During our review of the Plan's provided documentation, we noted that the Plan applied the pharmacy claims ratios to allocate the Medical and Rx Claims Adjustment, Claims Settlements, Care Coordination, and Software/Licensing Fees for 2017 and 2018. The Plan should have applied the total claims ratios since these claims included services for both medical and pharmacy benefits. As a result, the Plan was not in compliance with the applicable criteria.

The Plan could not support its 2016 Medical and Rx Claims Adjustments and Claims Settlement amounts and it incorrectly allocated its other non-claims expenses in 2017 and 2018.

Therefore, we recalculated the expenses above and determined that the Plan inflated the MLR numerator by $2,763 for 2016 and understated the MLR numerator by $10,255 for 2017 and $15,993 for 2018.

Recommendation 18: We recommend that the Plan maintain all records and MLR documentation for the time period specified in its Contract.

Recommendation 19: We recommend that the Plan ensure that expenses are allocated to the FEHBP MLR based ona methodology that yields the most accurate results, as required by 45 CFR 158.170(b)(1).

Plan Response: The Plan disagreed with finding but agreed to implement the associated recommendation in response to other findings herein.

10. Inaccurate Allocation of Medical Incentives

We determined that the Plan did not accurately allocate its 2016 medical incentives.

Per 45 CFR 158.170(b)(1), the "Allocation . should be based on a generally accepted accounting method that is expected to yield the most accurate results."

The plan discovered that it inadvertently used the 2015 claims ratio to allocate its 2016 medical incentives in its MLR calculation. As a result, the Plan was not in compliance with applicable criteria, which resulted in an overstated medical incentive amount by $99,377.

Further, based on the documentation provided by the Plan, we determined that in 2017 and 2018 the Plan changed its allocation methodology. In 2017 and 2018, the Plan allocated the medical incentives to the large group using only the pharmacy claims ratio and then a portion of that amount was allocated to the FEHBP using a total claims ratio. The Plan should have applied the total claims ratios since medical incentives cover services for both medical and pharmacy benefits. As a result, the Plan was not in compliance with the applicable criteria. Therefore, we reallocated the medical incentives using the total claims ratio. Consequently, the Plan understated its medical incentives in the MLR numerator by $27,033 for 2017 and $20,568 for 2018 MLR calculations.

Recommendation 20: We recommend that the Plan allocate the medical incentive expenses to the FEHBP MLRbased on a methodology that yields the most accurate results, as required by 45 CFR 158.170(b)(1).

Plan Response: The Plan agreed with the medical incentive finding as it relates to 2016 and toimplement the associated recommendation.

OIG Comment: The Plan did not comment on the medical incentive allocations for 2017 or 2018.

11. Inaccurate High Deductible Health Plan Pass-Throughs

The Plan incorrectly accounted for the high deductible health plan HDHP) pass-through amounts in its 2016 through 2018 MLR calculations.

The 2016 through 2018 Community Rating Guidelines state, "The pass-through amount [that is] put into a Health Savings Account HSA) will be included in the numerator and the denominator of the FEHBP MLR calculation. Only the portion of a Health Reimbursement Account HRA) that is used for claims incurred during an MLR Calculation Year [should be] included in the numerator of the FEHBP MLR calculation."

The Plan inaccurately calculated the HDHP pass-through amounts, which inflated the 2016 through 2018 MLR numerators.

The Plan included the HSA, HRA, and dental pass-through amounts less the HRA incurred claims amount within the numerator for the 2016 through 2018 MLR calculations. The Plan stated that full HSA and dental amounts were included in the numerator because they were liabilities. The net of the HRA pass-through amount less the HRA claims were also

included in the numerator as liabilities. However, per the Community Rating Guidelines, the HRA pass-through should have been excluded from the numerator as only the HRA claims were allowed to be included in the MLR numerator.

Per OPM's Office of Actuaries, the dental pass-through should have been handled the same as the HRA pass-through. The dental pass-through should have been included in the denominator, but only the dental claim amount used for dental benefits should be included in the numerator. Therefore, the dental pass-through should have been excluded from the MLR numerator for all scope years. As a result, the numerators of the 2016 through 2018 MLRs were misstated.

Consequently, we removed the HRA and dental pass-through amounts and the additional HRA liabilities amount included in the MLR numerator totaling $87,172, $103,969, and $157,669 for 2016 through 2018, respectively.

Recommendation 21

We recommend that the Plan ensure it follows the Community Rating Guidelines when calculating the HDHP pass-through amounts used in its FEHBP MLR submissions.

Plan Response:

The Plan agreed with the calculation logic in respect to the numerator and denominator of the MLR. The plan agreed to implement the associated recommendation.

12. Coordination of Claims

This finding was first mentioned under the Premium Rate Review section, specifically, A.1.d. The claim, totaling $86,073, which was referenced in the above Section has been removed from the MLR submission as well.

Recommendation 22

We recommend that the Plan strengthen its controls to properly coordinate benefits as required by Contract Section 2.6(a).

Plan Response:

The Plan agreed with the finding and to implement the associated recommendation.

13. Regulatory Fee Calculation Errors

a. Regulatory Authority Licenses and Fees

The Plan did not accurately report its regulatory authority licenses and fees in contract year 2017.

The 2017 Community Rating Guidelines provide detailed instruction on how the Plan should develop each MLR calculation component stated on the MLR form. Specifically, the Community Rating Guidelines state that "5 [United States Code (U.S.C.)] 8909(f)(1) prohibits the imposition of taxes, fees, or other monetary payment, directly or indirectly, on FEHBP premiums by any State, the District of Columbia, or the Commonwealth of Puerto Rico or by any political subdivision or other governmental authority" thereof, with respect to any payment made from the fund. Further, the instructions state that OPM does not accept surcharges.

Our review determined that the Plan applied a New York Section 206 Assessment fee in its 2017 FEHBP MLR calculation. Based on the supporting documentation provided, we determined that the New York Section 206 Assessment fee for 2017 totaled $521,241, which was removed from the MLR denominator.

Recommendation 23: We recommend that the Plan develop policies and procedures over the MLR calculation process to ensure tax expenses are calculated in accordance with federal regulations 5 U.S.C. 8909 f)(1) and OPM guidance.

Plan Response: "The plan agreed with the finding and stated that the issue will be corrected goingforward."

OIG Comment: We will verify the New York Section 206 Assessment fee is not included in additionalMLR calculations during future audits.

b. Risk Adjustment User Fee

The Plan overstated its 2016 and 2017 FEHBP MLR denominators by including a Risk Adjustment User Fee (RAUF).

The Plan inflated its 2016 and 2017 MLR denominators by including an unallowable RAUF.

The Patient Protection and Affordable Care Act (ACA), specifically Section 1343, established a permanent risk adjustment program to provide payments to health insurance issuers that cover higher-cost and higher-risk populations to more evenly spread the financial risk borne by issuers and help stabilize premiums. The risk adjustment program applies to non-grandfathered plans in the individual and small group insurance markets, both inside and outside of the exchanges. Since the FEHBP is not included in the individual or small group insurance

market, but rather the large group insurance market, this fee was not applicable and should have been excluded from the 2016 and 2017 MLR denominators.

As a result of including the RAUF and inflating the MLR denominator, the Plan's 2016 and 2017 submitted FEHBP MLR percentage calculations were inaccurate. We removed the RAUF totaling $12,451 for 2016 and $7,245 for 2017 from the MLR denominators.

Recommendation 24: We recommend that the Plan develop policies and procedures over the MLR calculationprocess to ensure tax expenses are calculated in accordance with federal regulations andOPM guidance.

Plan Response: "The plan agreed with the finding and stated that the issue will be corrected goingforward."

OIG Comment: We will verify the RAUF is not included in future additional MLR calculations duringfuture audits.

c. Transitional Reinsurance Fee

i. Inaccurate Transitional Reinsurance Fee

The Plan overcharged the FEHBP for the transitional reinsurance fee (TRF) in 2016.

Section 1341 of the ACA established a transitional reinsurance program to help stabilize premiums in the individual market inside and outside of the Marketplaces during 2014 through 2016. The TRF generally applies to major medical coverage, although certain types of coverage are specifically excluded from the fee, including Medicare.

Carrier Letter 2013-15 states that Carriers are not required to make fee payments for individuals who are enrolled in any part of Medicare if Medicare is the primary payer of services for those individuals. A carrier's loading must be adjusted to recognize that the fee is not applicable for those FEHBP members where Medicare coverage is primary.

According to 45 CFR 153.400(a)(1)(iv) members covered as Primary under Medicare Secondary Payor rules are excluded.

The Plan disclosed that it did not adjust the 2016 FEHBP membership for Medicare primary members. The Plan also disclosed that it inadvertently applied the 2014 Reinsurance Contribution Rate of $5.25 PMPM instead of the appropriate 2016 Reinsurance Contribution Rate of $2.25 PMPM as the TRF in the 2016 FEHB MLR calculation.

The Plan overstated its TRF, which caused its 2016 MLR denominator to be understated and therefore increasing the Plan's overall MLR ratio. We recalculated the TRF fee using the correct PMPM and membership. We determined it was overstated by $531,864 in the 2016 MLR calculation.

ii. Unallowable Transitional Reinsurance Fee

During our review of the 2017 MLR calculation, we noted the Plan included a TRF, although the TRF program expired in 2016.

The Plan stated that the 2017 TRF amount included in its 2017 MLR calculation was due to run out from the program and it was allocated to the FEHBP. The Plan provided documentation to show there was an error in accruing the 2016 TRF fee to the appropriate GL accounts. As a result, the 2016 TRF GL account had an under-accrual, which was not accounted for in the 2016 allocation process. The Plan included a TRF expense in the 2017 FEHBP MLR calculation to cover the under-accrual from the previous year.

Although the TRF expired in 2016, the Plan erroneously included it in its 2017 MLR calculation.

Per 45 CFR 153.405, the TRF is calculated by multiplying the contribution rate for the applicable benefit year by the number of covered lives during the benefit year for all the entity's plans and coverage that must pay contributions. Therefore, it is inappropriate to allocate the 2016 under-accrual to the 2017 MLR calculation. We removed the TRF of $11,999 from the 2017 MLR denominator.

iii. Transitional Reinsurance Fee Covered Lives Calculation

The Plan did not follow an approved counting method to determine its membership that was used in the 2016 TRF calculation.

The Plan used the subscriber and dependent counts for each month of the 2016 calendar year through June 30 of the following year 2017) to calculate its TRF. This was not an acceptable counting method to calculate the TRF. The Plan was required to use one of the Centers for Medicare and Medicaid Services' CMS) approved counting methods for the FEHBP TRF calculations for 2016.

Section 1341 of the ACA established a TRF, and CMS uses the annual enrollment count to calculate a Contributing Entity's reinsurance contribution amount due for the applicable benefit year. "In order to calculate the number of covered lives of reinsurance contribution enrollees for a benefit year, CMS set forth certain permitted counting methods in 45 CFR 153.405. These counting methods are: 1) the actual count method; 2) the snapshot count method; 3) the snapshot factor method; 4) the Member Months or State Form method; and 5) the Form 5500 method. The permitted counting method depends on whether the Contributing Entity is a health insurance issuer or a self-insured group health plan, and whether, in the case of a group health plan that is a Contributing Entity, the plan offers more than one coverage option."

The Plan overstated its 2016 membership for the TRF calculation by not following one of the CMS approved counting methods. The overall impact on the TRF in the MLR calculation was immaterial for the year under review.

Recommendation 25: We recommend that Plan develop policies and procedures over the MLR calculationprocess to ensure tax expenses input on the FEHBP MLR are calculated in accordance with Federal regulations and OPM guidance.

Recommendation 26: We recommend that the Plan institute a more stringent FEHBP MLR review processto identify reporting errors prior to submitting the FEHBP MLR to OPM.

Recommendation 27: We recommend that the Contracting Officer verify that the Plan implemented enhanced processes, including policies and procedures to govern the collection andallocation of FEHBP expenses to ensure compliance with MLR regulations.

Plan Response: The Plan agreed with finding B.13.c.i., but disagreed with findings B.13.c.ii. and B.13.c.iii. They asserted, "that the inclusion of the 'true up' in 2017 for the 2016TRF calculation was appropriate." They also stated that they used the snapshot counting method as of January 2017 for the year 2016, although the FEHB MLRcalculation was not developed until August of 2017. The Plan indicated that the membership was stated accurately and appropriately. The Plan agreed to implement the associated recommendations.

OIG Comment: We acknowledge the Plan's response. However, there is no provision for a ""true up," carryover, or run-out under 45 CFR 153.405 related to the TRF. Additionally,the TRF was not applicable in 2017 as the program expired in 2016.

Furthermore, under 45 CFR 153.405, the snapshot counting method requires a Contributing Entity to add the total number of covered lives of reinsurance contribution enrollees on any date (or more dates, if an equal number of dates are used for each quarter) during the same corresponding month in each of the first three quarters (e.g., March, June and September) of the benefit year, and divide that total by the number of dates on which a count was made. The date(s) used for the second and third quarters must fall within the same week of the quarter as the corresponding date(s) used for the first quarter [see 45 CFR 153.405(d)(2)].

Based on the snapshot counting method, the Plan would use member month information from the first nine months, or three quarters, of the benefit year. The Plan stated it used the member months as of January 2017 for 2016 multiplied by the applicable fee. However, this is not the how the snapshot counting method is described in the applicable criteria. Therefore, the Plan did not use an approved counting method for computing the number of covered lives. Consequently, the FEHBP TRF expense included in the FEHBP MLR for 2016 was not in compliance with applicable criteria.

d. PCORI Covered Lives Calculation and Fees

For the 2016 through 2018 FEHBP MLR calculations, the Plan calculated the PCORI by allocating the GL PCORI totals to each market segment using a member months ratio. The PCORI totals for the large group market segment were then allocated to the FEHBP using the FEHBP member months over the large group member months.

26 CFR 46.4375-1 paragraph c) provides rules for calculating the PCORI fee, which is the average covered lives under the policy for the policy year multiplied by the applicable dollar amount. Determining the average covered lives must follow one of the four methodologies listed in the regulation.

The Plan stated it used the "member month method" to calculate its GL PCORI. Per 26 CFR 46.4375-1 (c)(2)(v), the "member month method" is described as "the average number of lives covered under all policies in effect for a calendar year based on the member months (an amount that equals the sum of the totals of lives covered on pre-specified days in each month of the reporting period) reported on the National

The Plan did not follow the specific rules to accurately calculate its PCORI fees.

Association of Insurance Commissioners . Supplemental Healthcare Exhibit filed for that calendar year. Under this method, the average number of lives covered under the policies in effect for the calendar year equals the member months divided by 12."

Based on our review of the GL PCORI calculation, we determined that the Plan used the member months for each month multiplied by the applicable fee. However, this is not how the "member month method" is described in the criteria. Therefore, the Plan did not use an approved counting method for computing covered lives at the GL reporting level. Consequently, the FEHBP PCORI expense included in the FEHBP MLR for 2016 through 2018 was not in compliance with applicable criteria.

We also noted the GL PCORI was calculated using the incorrect PCORI fees. Per 26 CFR 46.4375, the fee applies for policies with policy years ending on or after October 1, 2012, and before October 1, 2019. The IRS issued guidance which listed the PCORI filing due dates and applicable rates for each year of the fees' lifespan. The FEHBP plan year ended in December, so the Plan should have applied a $2.45 PMPY fee per the IRS PCORI Fee for Policy or Plan Year ending December 2018, $2.39 PMPY for Policy or Plan Year ending December 2017, and $2.26 PMPY per the IRS PCORI Fee for Policy or Plan Year ending December 2016. The Plan did not have documented policies and procedures in place to ensure that the correct PCORI PMPY fee was applied to the 2016 through 2018 MLR calculations.

As a result, the allocated PCORI totals calculated within the 2016, 2017 and 2018 FEHBP MLR calculations were erroneous. The overall impacts of the recalculated PCORI amounts to be included in the MLR calculation based on the provided membership reports and applicable criteria were immaterial.

Recommendation 28: We recommend that the Plan ensure its FEHBP MLR PCORI expenses are calculated inaccordance with Federal regulations.

Recommendation 29: We recommend that the Plan use the applicable PCORI fee from the IRS guidance basedon its policy year end date within the contract.

Plan Response: The Plan agreed with the finding and agreed to implement the associatedrecommendations.

14. Premium Findings

As discussed in Section A of this draft report, our audit identified defective pricing findings related to the Plan's premium rates in contract years 2016 through 2018, totaling $1,079,748. The Community Rating Guidelines state that the denominator of the FEHBP MLR calculation will be equal to the OPM supplied premium income or carrier supplied premium income less any amount recovered from the carrier due to an audit. Therefore, we have removed from the 2016 through 2018 premiums the amounts of $730,246; $224,314; and $125,188, respectively. This, in turn, reduced the MLR denominators, as illustrated in the variance column in Table I on page 1 of this report.

Recommendation 30: We recommend the Contracting Officer reduce the 2016 through 2018 MLR premiums by $730,246 in 2016, $224,314 in 2017, and $125,188 in 2018 for the questioned premium costsidentified in this audit.

Plan Response: The Plan disagreed with this finding and requested that the additional documentationprovided in response to the Draft Report be reviewed by the OIG. It agreed that adjustments to the MLR should be made once the final pricing findings are resolved.

OIG Comment: The Plan provided additional support and documentation, which was reviewed as part of the individual findings and recommendations that led to Recommendation 1 (see Section A.1 of this report). The premium reductions in Recommendation 1 were updated in accordance withour review in Section A.1 of this report.

Conclusion – MLR Review

Per the issues discussed above, adjustments were made to the FEHBP MLR submissions. These adjustments resulted in credit reductions of $775,546 for contract year 2016, $1,988,349 for contract year 2017, and $1,819,697 in contract year 2018.

C. Internal Control Review

Per Contract Section 5.64, Contractor Code of Business Ethics and Conduct, "(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

The Plan did not terminate dependent coverage timely, retain all required documentation, nor did it respond to OIG requests timely or completely.

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."

We determined that the Plan's internal control systems over the FEHBP in the following areas did not sufficiently meet the contractual criteria. Specifically, we found the issues noted below.

1. Untimely Dependent Termination

The Plan did not timely terminate coverage for dependent members who had become ineligible for coverage during contract years 2016 through 2018.

The FEHBP benefit brochure states that a dependent is covered until their 26th birthday, unless they are incapable of self-support. An additional 31 days of extended coverage begins when a family member is no longer eligible, which in this case, begins the day of their 26th birthday.

During the scope of our audit, the Plan had a manual process in place to terminate dependents using the day after, instead of the day of, the dependent's 26th birthday. The Plan provided an extension of coverage to the dependent member for 31 days beginning the day of termination. The Plan therefore provided an extra day of coverage to the dependent members, which resulted in untimely FEHBP dependent terminations during the scope of the audit.

Recommendation 31: We recommend that the Plan ensure that ineligible dependents are accurately terminated inaccordance with the guidance in the FEHBP benefit brochure.

Plan Response: “The plan agreed with the finding. The Plan stated it will monitor and update anybusiness process to ensure all dependents are terminated in accordance with the guidance in the FEHBP benefit brochure.”

2. MLR Calculation Internal Controls and Record Retention

The Plan did not have adequate written policies and procedures to govern its MLR process and did not maintain documentation in accordance with its Contract.

Section 5.64(c)(2)(ii)(A) of the Contract states that the Contractor's internal control system will at a minimum provide for "Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the ... internal control system." The contract

further states at Section 5.64(c)(2)(ii)(C)(1), 2) and 3) that the Contractor's internal control system should provide "Periodic reviews of company business practices, procedures, policies, and internal controls for compliance with. the special requirements of government contracting _ ."

Additionally, Contract Section 1.11 b) requires insurance carriers to maintain all records relating to the contract and to make these records available for a period of time specified by the FEHBAR 1652.204-70. The referenced clause is incorporated into the contracts at Section 3.4, which requires the carrier to maintain "all records applicable to a contract term ... for a period of six years after the end of the contract term to which the records relate."

The Plan did not comply with the Contract's records retention requirements and was unable to provide all of the necessary supporting documentation during the audit, as evidenced by a number of findings in this report. A lack of internal controls over the MLR review process resulted in discrepancies in the MLR filings reviewed for contract years 2016 through 2018.

Recommendation 32: We recommend that the Plan maintain all records and MLR documentation for the time period specified in its Contract.

Plan Response: "The Plan stated that it retains records for a period of six years after the end of the contract term to which the claim records relate. In some cases, additional time was needed to respond to a request due to coordination across departments/systems and thescope/volume of requests – not because the records have not been retained."

OIG Comment: We acknowledge that the Plan disagrees with the finding, but it agreed with the recommendation. The Plan has provided responses to several information requests, but therewere items that were either not provided or were unavailable. For example, the Plan was unable to provide documentation to show that the capitated Teladoc expenses accounts for member copays. Additionally, the Plan was unable to provide documentation to confirm that OPM determined the vision vendor benefit brochure placement, or the original medical and pharmacy claims adjustments GL totals for 2016. Lastly, the Plan was unable to provide the original MRx Case Management GL totals for 2016.

3. Complete and Timely Responses to OIG Document Requests

The Plan did not provide complete and/or timely responses to several of our information request or Notification of Findings and Recommendations NFRs).

The Plan did not provide its full cooperation during the audit.

Contract section 5.64(c)(2)(ii)(G) states that at a minimum, the Plan's internal control system shall provide for full cooperation with Government agencies responsible for audits. Additionally, Contract section 5.64(a) defines "full cooperation" as providing timely and complete responses to the OIG's request for documents.

During the audit, we issued several information requests and NFRs with due dates included. Early in the audit, we held a meeting with a Plan representative to discuss the information request process and the importance of timely responses to our information requests and NFRs. There have been several information request responses that were not provided or provided after the due dates without a request for an extension. As one example, there was an information request that was due on March 26, 2021. The Plan completed its response to the information request on April 28, 2021, 33 days after the due date. As a result, we created NFRs to disallow several MLR components due to the lack of complete and timely documentation, which caused an inability to properly evaluate the various components.

Recommendation 33: We recommend that the Plan provide its full cooperation to the OIG in all future audits andensure it provides complete and accurate documentation, as requested, in a timely manner.

Plan Response: The Plan disagreed with the finding but agreed to implement the associated recommendation. "The Plan stated that it has cooperated with the OIG auditors overthe course of the audit period, submitting requested documentation according to the requested timeframes and regularly communicating with the audit team when additional time is needed."

OIG Comment: We recognize that some Plan personnel were communicative, responsive, and helpful, although we maintain that the Plan overall did not provide timely and/or full responses to ourinformation requests and/or NFRs. Based upon our records, the Plan missed the deadline for11 out of 22 information requests. Therefore, we continue to assert that the Plan did not provide complete, accurate and timely responses to our information requests and NFRs. We understand that the COVID-19 circumstances have presented challenges for everyone, and we were willing to work with all of our partners throughout the process to ensure that appropriate information was provided in a timely manner. We would like the Plan to make improvements in its process of providing documentation to the auditors as well as being moreaccurate with appropriate deadlines for providing the information.

Exhibit A

Independent Health Association, Inc.
Summary of Defective Pricing Questioned Costs

Contract Year 2016	$730,246
Contract Year 2017	$224,314
Contract Year 2018	$125,188
Total Defective Pricing Questioned Costs	**$1,079,748**
Lost Investment Income	$121,756
Total Amount Due to OPM	**$1,201,504**

Exhibit B

Independent Health Association, Inc.
Defective Pricing Questioned Costs by Contract Year

Contract Year 2016 – High Option

	Self	Self+1	Family	Total
FEHBP Line 5 - Reconciled Rate	$ [redacted]	$ [redacted]	$ [redacted]	
FEHBP Line 5 - Audited Rate	$ [redacted]	$ [redacted]	$ [redacted]	
Bi-weekly Overcharge	$ [redacted]	$ [redacted]	$ [redacted]	
To Annualize Overcharge:				
March 31, 2016 Enrollment	[redacted]	[redacted]	[redacted]	
Pay Periods				
2016 High Option Defective Pricing	**$258,224**	**$148,389**	**$280,056**	**$686.668**

Contract Year 2016 – Standard Option

	Self	Self+1	Family	Total
FEHBP Line 5 - Reconciled Rate	$ [redacted]	$ [redacted]	$ [redacted]	
FEHBP Line 5 - Audited Rate	$ [redacted]	$ [redacted]	$ [redacted]	
Bi-weekly Overcharge	$ [redacted]	$ [redacted]	$ [redacted]	
To Annualize Overcharge:				
March 31, 2016 Enrollment	[redacted]	[redacted]	[redacted]	
Pay Periods				
2016 Standard Option Defective Pricing	**$6,748**	**$11,985**	**$8,993**	**$27,725**

Contract Year 2016 – HDHP Option

	Self	Self+1	Family	Total
FEHBP Line 5 - Reconciled Rate	$ [redacted]	$ [redacted]	$ [redacted]	
FEHBP Line 5 - Audited Rate	$ [redacted]	$ [redacted]	$ [redacted]	
Bi-weekly Overcharge	$ [redacted]	$ [redacted]	$ [redacted]	
To Annualize Overcharge:				
March 31, 2016 Enrollment	[redacted]	[redacted]	[redacted]	
Pay Periods				
2016 HDHP Option Defective Pricing	**$4,172**	**$2,271**	**$9,409**	**$15,853**
Total 2016 Combined Defective Pricing	**$269,143**	**$162,645**	**$298,458**	**$730,246**

Exhibit B (continued)

Independent Health Association, Inc.
Defective Pricing Questioned Costs by Contract Year continued)

Contract Year 2017 – High Option

	Self	Self+1	Family	Total
FEHBP Line 5 - Reconciled Rate	$ [redacted]	$ [redacted]	$ [redacted]	
FEHBP Line 5 - Audited Rate	$ [redacted]	$ [redacted]	$ [redacted]	
Bi-weekly Overcharge	$0.85	$2.19	$2.31	
To Annualize Overcharge:				
March 31, 2017 Enrollment	[redacted]	[redacted]	[redacted]	
Pay Periods				
2017 High Option Defective Pricing	**$86,455**	**$44,983**	**$69,730**	**$201,167**

Contract Year 2017 – Standard Option

	Self	Self+1	Family	Total
FEHBP Line 5 - Reconciled Rate	$ [redacted]	$ [redacted]	$ [redacted]	
FEHBP Line 5 - Audited Rate	$ [redacted]	$ [redacted]	$ [redacted]	
Bi-weekly Overcharge	$ [redacted]	$ [redacted]	$ [redacted]	
To Annualize Overcharge:				
March 31, 2017 Enrollment	[redacted]	[redacted]	[redacted]	
Pay Periods				
2017 Standard Option Defective Pricing	**$4,786**	**$8,246**	**$4,507**	**$17,538**

Contract Year 2017 – HDHP Option

	Self	Self+1	Family	Total
FEHBP Line 5 - Reconciled Rate	$ [redacted]	$ [redacted]	$ [redacted]	
FEHBP Line 5 - Audited Rate	$ [redacted]	$ [redacted]	$ [redacted]	
Bi-weekly Overcharge	$ [redacted]	$ [redacted]	$ [redacted]	
To Annualize Overcharge:				
March 31, 2017 Enrollment	[redacted]	[redacted]	[redacted]	
Pay Periods				
2017 HDHP Option Defective Pricing	**$1,590**	**$1,234**	**$2,785**	**$5,609**
Total 2017 Combined Defective Pricing	**$92,831**	**$54,462**	**$77,021**	**$224,314**

Exhibit B (continued)

Independent Health Association, Inc.
Defective Pricing Questioned Costs by Contract Year continued)

Contract Year 2018 – High Option

	Self	Self+1	Family	Total
FEHBP Line 5 - Reconciled Rate	$ [redacted]	$ [redacted]	$ [redacted]	
FEHBP Line 5 - Audited Rate	$ [redacted]	$ [redacted]	$ [redacted]	
Bi-weekly Overcharge	$ [redacted]	$ [redacted]	$ [redacted]	
To Annualize Overcharge:				
March 31, 2018 Enrollment	[redacted]	[redacted]	[redacted]	
Pay Periods				
2018 High Option Defective Pricing	**$51,052**	**$25,658**	**$32,637**	**$109,347**

Contract Year 2018 – Standard Option

	Self	Self+1	Family	Total
FEHBP Line 5 - Reconciled Rate	$ [redacted]	$ [redacted]	$ [redacted]	
FEHBP Line 5 - Audited Rate	$ [redacted]	$ [redacted]	$ [redacted]	
Bi-weekly Overcharge	$ [redacted]	$ [redacted]	$ [redacted]	
To Annualize Overcharge:				
March 31, 2018 Enrollment	[redacted]	[redacted]	[redacted]	
Pay Periods				
2018 Standard Option Defective Pricing	**$3,469**	**$5,117**	**$2,603**	**$11,189**

Contract Year 2018 – HDHP Option

	Self	Self+1	Family	Total
FEHBP Line 5 - Reconciled Rate	$ [redacted]	$ [redacted]	$ [redacted]	
FEHBP Line 5 - Audited Rate	$ [redacted]	$ [redacted]	$ [redacted]	
Bi-weekly Overcharge	$ [redacted]	$ [redacted]	$ [redacted]	
To Annualize Overcharge:				
March 31, 2018 Enrollment	[redacted]	[redacted]	[redacted]	
Pay Periods				
2018 High Option Defective Pricing	**$1,233**	**$1,253**	**$2,166**	**$4,652**
Total 2018 Combined Defective Pricing	**$55,754**	**$32,028**	**$37,406**	**$125,188**

Exhibit C

Independent Health Association, Inc.

Lost Investment Income

	2016	2017	2018	2019	2020	2021	Total
Defective Pricing:	$730,246	$224,314	$125,188	$0	$0	$0	$1,079,748
Cumulative Totals:	$730,246	$954,561	$1,079,748	$1,079,748	$1,079,748	$1,079,748	$1,079,748
Average Interest Rate (per year):	2.1875%	2.4375%	3.0625%	3.1250%	1.6250%	1.0000%	
Interest on Prior Year Findings	$0	$17,800	$29,233	$33,742	$17,546	$10,797	$109,118
Current Year Interest	$7,987	$2,734	$1,917	$0	$0	$0	$12,638
Total Cumulative Interest Calculated through December 31, 2021:	$7,987	$20,534	$31,150	$33,742	$17,546	$10,797	**$121,756**

Exhibit D

Independent Health Association, Inc.

Summary of Medical Loss Ratio Adjustments

Contract Year 2016	
Credit Calculated	$0
Credit Received	$775,546
Total 2016 Credit Reduction	**$775,546**
Contract Year 2017	
Credit Calculated	$0
Credit Received	$1,988,349
Total 2017 Credit Reduction	**$1,988,349**
Contract Year 2018	
Credit Calculated	$2,066,354
Credit Received	$3,886,051
Total 2018 Credit Reduction	**$1,819,697**

Exhibit E

Independent Health Association, Inc.

2016 Medical Loss Ratio Adjustment

	Plan	Audited
2016 FEHBP MLR Lower Threshold a)	[redacted]%	[redacted]%
2016 FEHBP MLR Upper Threshold b)	[redacted]%	[redacted]%
Claims Expense		
Adjusted Incurred Medical and Pharmacy Claims	$[redacted]	$[redacted]
Less: Inaccurately Reported Adjusted Incurred Claims		$1,017,213)
Less: Uncoordinated Medical Claim		$86,073)
Less: Non-Claims Expenses[4]		$604,618)
Plus: Fraud Recoveries (SIU Expenses)		$29,391
Plus: Overstated Other Non-Claims Expenses[5]		$2,763
Less: Non-FEHBP Benefits		$135,412)
Less: Non-Claims Expense - Teladoc not Adjusted for Copay		$40,036)
Less: Capitated Third-Party Vendor Fee		$67,296)
Less: High Deductible Health Plan HDHP) Pass-throughs		$87,172)
Less: Medical Incentives Allocation Methodology		$99,377)
Less: Pharmacy Rebates		$793,902)
Plus: Quality Health Improvement Expenses	$1,533,604	$1,533,604
Total MLR Numerator	**$77,732,491**	**$74,833,546**
Premium Income	$[redacted]	$[redacted]
Less: Premium Rate Defective Pricing Questioned Costs		$730,246)
Less: Taxes and Regulatory Filing Fees[6]	$2,322,427)	$1,796,112)
Total MLR Denominator c)	**$86,468,478**	**$86,264,546**
FEHBP Medical Loss Ratio d)	[redacted]%	[redacted]%
Penalty Calculation If d) is less than a), a-d) c)	$0	$0
Credit Calculation If d) is greater than b), d-b c)	$775,546	$0
Total MLR Credit Reduction		**$775,546**

[4] This total includes Expense Re-Class $39,434) and Wellness ($565,184).
[5] Other non-claims expenses include Medical and Rx Claims Adjustments, Class Settlements, Care Coordination, and Software/Licensing Fees.
[6] This total is comprised of TRF $267,415), PCORI $26,564), and the HIT ($1,502,133).

Exhibit E (continued)

Independent Health Association, Inc.

2017 Medical Loss Ratio Adjustment

	Plan	Audited
2017 FEHBP MLR Lower Threshold a)	[redacted]%	[redacted]%
2017 FEHBP MLR Upper Threshold b)	[redacted]%	[redacted]%
Claims Expense		
Adjusted Incurred Medical and Pharmacy Claims	$[redacted]	$[redacted]
Less: Inaccurately Reported Adjusted Incurred Claims		$1,125,146)
Less: Non-Claims Expenses[7]		$478,808)
Plus: Fraud Recoveries (SIU Expenses)		$14,294
Plus: Overstated Other Non-Claims Expenses[8]		$10,255
Less: Inaccurately Reported Capitations		$120,535)
Less: Inaccurate High Deductible Health Plan (HDHP) Pass-throughs		$103,969)
Plus: Medical Incentives Allocation Methodology		$27,033
Plus: Quality Health Improvement Expenses	$1,991,137	$1,991,137
Total MLR Numerator	**$75,568,627**	**$73,791,751**
Premium Income	$[redacted]	$[redacted]
Less: Premium Rate Defective Pricing Questioned Costs		$244,314)
Less: Taxes and Regulatory Filing Fees	$566,289)	$25,804)
Total MLR Denominator c)	**$82,674,470**	**$82,990,641**
FEHBP Medical Loss Ratio d)	[redacted]%	[redacted]%
Penalty Calculation If d) is less than a), a-d) c)	$0	$0
Credit Calculation If d) is greater than b), d-b c)	$1,988,349	$0
Total MLR Credit Reduction		**$1,988,349**

[7] This total includes Expense Re-Class $58,462) and Wellness ($420,346).
[8] Other non-claims expenses include Medical and Rx Claims Adjustments, Class Settlements, Care Coordination, and Software/Licensing Fees.

Exhibit E (continued)

Independent Health Association, Inc.

2018 Medical Loss Ratio Adjustment

	Plan	Audited
2018 FEHBP MLR Lower Threshold a)	[redacted]%	[redacted]%
2018 FEHBP MLR Upper Threshold b)	[redacted]%	[redacted]%
Claims Expense		
Adjusted Incurred Medical and Pharmacy Claims	$[redacted]	$[redacted]
Less: Inaccurately Reported Adjusted Incurred Claims		$1,208,325)
Less: Non-Claims Expenses[9]		$532,427)
Plus: Fraud Recoveries (SIU Expenses)		$5,473
Plus: Understated Other Non-Claims Expenses[10]		$15,993
Less: Inaccurately Reported Capitations		$74,727)
Less: Inaccurate High Deductible Health Plan (HDHP) Pass-throughs		$157,669)
Plus: Medical Incentives Allocation Methodology		$20,568
Plus: Quality Health Improvement Expenses	$1,402,146	$1,402,146
Total MLR Numerator	**$71,258,112**	**$69,326,998**
Premium Income	$[redacted]	$[redacted]
Less: Premium Rate Defective Pricing Questioned Costs		$125,188)
Less: Taxes and Regulatory Filing Fees	$1,515,156)	$1,515,156)
Total MLR Denominator c)	**$75,698,945**	**$75,573,757**
FEHBP Medical Loss Ratio d)	[redacted]%	[redacted]%
Penalty Calculation If d) is less than a), a-d) c)	$0	$0
Credit Calculation If d) is greater than b), d-b c)	$3,886,051	$2,066,354
Total MLR Credit Reduction		**$1,819,697**

[9] This total includes Expense Re-Class $63,764) and Wellness ($468,663).

[10] Other non-claims expenses include Medical and Rx Claims Adjustments, Class Settlements, Care Coordination, and Software/Licensing Fees.

Exhibit F

Independent Health Plan, Inc.

Medical Claims Sample Selection Criteria and Methodology

Universe Criteria	Universe Number)	Universe Dollars	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Medical claims incurred from 1/1/2016 through 12/31/2016	224,276 Claims	$[redacted]	Utilized RAT-STATS[11] 90% Confidence Level/50% Anticipated Rate of Occurrence/20% Desired Precision Range), which generated a statistical sample size of 75. Then utilized SAS[12] to randomly select 75 incurred, unadjusted medical claims.	Statistical	No

[11] RAT-STATS is a statistical software designed by the U.S. Department of Health and Human Services OIG to assist in selecting random samples.
[12] SAS Enterprise Guide is a software used to analyze data allowing users to access and manipulate data quickly.

Appendix

OPM OIG Draft Audit Report Response – Received October 15, 2021

I. Audit Findings and Recommendations

A. Premium Rate Review

Deleted by the OIG – Not Relevant to the Final

Recommendation 1

We recommend that the contracting officer require the Plan to return $**Deleted by the OIG – Not Relevant to the Final** to the FEHBP for defective pricing in contract years 2016, 2017, and 2018.

Recommendation 2

We recommend that the Plan document its policies and procedures over the FEHBP rating process that will assist in detecting and preventing errors, as well as ensure compliance with all applicable criteria when preparing the FEHBP rates.

Recommendation 3

We recommend that the Plan maintain documentation to support all calculations and data used to derive the FEHBP premium rates**.**

Recommendation 4

We recommend that the Plan strengthen its system controls to ensure its compliance with the group-specific benefits and member cost-sharing responsibilities as outlined in the FEHBP benefit brochure.

Plan Response

The Plan disagrees with finding A.1.a. The Plan has provided the requested documentation Deleted by the OIG – Not Relevant to the Final and asserts that these expenses should be included in the calculation of premiums. Deleted by the OIG – Not Relevant to the Final the Plan has provided supporting documentation to demonstrate that the Teledoc PMPMs were adjusted for the paid copay amounts Deleted by the OIG – Not Relevant to the Final

The Plan disagrees with finding A.1.b. Deleted by the OIG – Not Relevant to the Final benefits are part of the Plan's Community Package, which FEHB agrees to utilize in its benefit package. Deleted by the OIG – Not Relevant to the Final the placement of these benefits within the brochure was at the direction of FEHB, though the benefit structure itself was not altered Deleted by the OIG – Not Relevant to the Final

The Plan disagrees with finding A.1.c. In good faith, Independent Health used the budgeted non-claims rather than the actual non-claims for developing the 2016 rates. The actual non-claims are higher than budget, even when HCRA is included. The excel file Deleted by the OIG – Not Relevant to the Final demonstrates what the rates would have been had the Plan used its standard practice of applying actual non-claims. Deleted by the OIG – Not Relevant to the Final

The Plan agreed with finding A.1.d. and agrees to implement Recommendations 2-4. The plan does not agree with Recommendation 1.

Deleted by the OIG – Not Relevant to the Final

Recommendation 5

We recommend that the contracting officer require the Plan to return $**Deleted by the OIG – Not Relevant to the Final** to the FEHBP for LII, calculated through July 31, 2021. We also recommend that the contracting officer recover LII on amounts due for the period beginning August 1, 2021, until all defective pricing amounts are returned to the FEHBP.

Plan Response

The Plan disagrees with the finding and recommendation, asserting that the LII should be reduced based on responses provided herein and in response to IR Deleted by the OIG – Not Relevant to the Final.

Deleted by the OIG – Not Relevant to the Final

Recommendation 6

We recommend that the Plan use the applicable PCORI fee from the IRS guidance based on its policy year end date within the Contract.

Recommendation 7

We recommend that the Plan strengthen its policies and procedures over the FEHBP rating process to assist in detecting and preventing errors, as well as ensure compliance with all applicable criteria when preparing the FEHBP rates.

Plan Response

The Plan agreed with this finding and agrees to implement Recommendations 6 and 7.

B. Medical Loss Ratio Review

Deleted by the OIG – Not Relevant to the Final

Recommendation 8

We recommend that the Contracting Officer adjust the Plan's MLR credits for contract years 2016 through 2018 once the defective pricing findings discussed in this report are resolved.

Plan Response

The Plan disagrees with the finding, based on the supporting information provided herein and in response to IR Deleted by the OIG – Not Relevant to the Final

, and agrees that any adjustment of MLR credits should be made once the pricing findings discussed in the report are resolved.

Deleted by the OIG – Not Relevant to the Final

Recommendation 9

We recommend that the Plan ensure that the data used in the creation of the FEHBP MLR submission to OPM is accurate, complete, and consistent with the methodology stated in 45 CFR 158.140, the Community Rating Guidelines, and the Carrier Letters.

Recommendation 10

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

Plan Response

The Plan agreed with the finding. It stated that the issue was corrected beginning with the 2019 MLR filing. Additionally, a more thorough reconciliation process between totals submitted from actuarial and raw data from underwriting will be put in place.

Deleted by the OIG – Not Relevant to the Final

Recommendation 11

We recommend the Plan ensure direct claims reported on the FEHBP MLR are in accordance with 45 CFR 158.140.

Plan Response

Deleted by the OIG – Not Relevant to the Final

The Plan agreed with removing the Wellness and Expense Re-class portions of the claims expenses, which do not apply to FEHBP.

Deleted by the OIG – Not Relevant to the Final

Recommendation 12

We recommend the Plan create, implement, and document internal control policies and

procedures to ensure that only allowable and allocable expenses are included in the FEHBP MLR submissions, in accordance with applicable regulations.

Plan Response

The Plan disagrees with finding Deleted by the OIG – Not Relevant to the Final

benefits are part of the Plan's Community Package, which FEHB agrees to utilize in its benefit package. As articulated in response to IR Deleted by the OIG – Not Relevant to the Final the placement of this benefit within the brochure was at the direction of FEHB, though the benefit structure itself was not altered.

The Plan agrees with finding B.4.b. and agrees to implement Recommendation 12.

Deleted by the OIG – Not Relevant to the Final

Recommendation 13

We recommend that the Plan strengthen its system controls to ensure its compliance with the group-specific benefits and member cost-sharing responsibilities as outlined in the FEHBP benefit brochures.

Plan Response

The Plan disagrees with the finding B.5. As clarified in the response to IR Deleted by the OIG – Not Relevant to the Final Teledoc claims were processed through the Plan's HealthRules system Deleted by the OIG – Not Relevant to the Final The Plan asserts that these expenses should be included in the calculation of the MLR. The Plan has agreed to implement the recommendation within Recommendation 13 in response to other findings herein.

Deleted by the OIG – Not Relevant to the Final

Recommendation 14

We recommend that the Plan create, implement, and document internal control policies and procedures to ensure that pharmacy rebates are allocated to the FEHBP MLR based on a methodology that yields the most accurate results, as required by 45 CFR 158.170(b)(1).

Recommendation 15

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

Deleted by the OIG – Not Relevant to the Final

Plan Response

The Plan agrees with the finding as it relates to the 2016 pharmacy rebates allocation Deleted by the OIG – Not Relevant to the Final The Plan agrees to implement Recommendation 15.

Deleted by the OIG – Not Relevant to the Final

Recommendation 17

We recommend that the Plan strengthen its internal controls surrounding the review and reporting of the fraud reduction expenses and recoveries for the FEHBP MLR calculation to ensure its compliance with applicable criteria.

Deleted by the OIG – Not Relevant to the Final

Plan Response

The Plan agrees that the Fraud Reduction Expenses and Recoveries expense was reported twice in error. The Plan agrees to implement Recommendation 17 Deleted by the OIG – Not Relevant to the Final

Deleted by the OIG – Not Relevant to the Final

Recommendation 22

We recommend that the Plan create, implement, and document internal control policies and procedures to ensure that expenses are allocated to the FEHBP MLR based on a methodology that yields the most accurate results, as required by 45 CFR 158.170(b)(1).

Plan Response

The Plan agrees with the finding as it relates to using the total claims ratio and asserts that the capitation ratios should be re-calculated based on supporting documentation submitted in response to IR 24. The Plan agrees to implement Recommendations Deleted by the OIG – Not Relevant to the Final.

Deleted by the OIG – Not Relevant to the Final

Recommendation 24

We recommend that the Plan maintain all records and MLR documentation for the time period specified in its Contract.

Plan Response

The Plan disagrees with finding B.10. Deleted by the OIG – Not Relevant to the FinalThe Plan has agreed to implement the recommendations identified in Recommendation 24 in response to other findings herein.

Deleted by the OIG – Not Relevant to the Final

Recommendation 26

We recommend that the Plan allocate the medical incentive expenses to the FEHBP MLR based on a methodology that yields the most accurate results, as required by 45 CFR 158.170(b)(1).

Plan Response

The Plan agrees with the finding as it relates to the 2016 allocation of medical incentives. Deleted by the OIG – Not Relevant to the Final and agrees to implement Recommendation 26.

Deleted by the OIG – Not Relevant to the Final

Recommendation 30

We recommend that the Plan ensure it follows the Community Rating Guidelines when calculating the HDHP pass-through amounts used in it FEHBP MLR submissions.

Plan Response

The Plan agrees with the calculation logic in respect to the numerator and denominator of the MLR. Deleted by the OIG – Not Relevant to the Final The plan agrees to implement Recommendation 30.

Deleted by the OIG – Not Relevant to the Final

Recommendation 31

We recommend that the Plan strengthen its controls to properly coordinate benefits as required by Contract Section 2.6(a).

Plan Response

The Plan agreed with the finding and agrees to implement Recommendation 31.

Deleted by the OIG – Not Relevant to the Final

Recommendation 32

We recommend that the Plan develop policies and procedures over the MLR calculation process to ensure tax expenses are calculated in accordance with federal regulations 5 U.S.C. 8909(f)(1) and OPM guidance.

Plan Response

The plan agreed with the finding and stated that the issue will be corrected going forward.

Deleted by the OIG – Not Relevant to the Final

Recommendation 33

We recommend that the Plan develop policies and procedures over the MLR calculation process to ensure tax expenses are calculated in accordance with federal regulations and applicable guidance.

Plan Response

The plan agreed with the finding and stated that the issue will be corrected going forward.

Deleted by the OIG – Not Relevant to the Final

Plan Response

The Plan acknowledged and agreed Deleted by the OIG – Not Relevant to the Final

Deleted by the OIG – Not Relevant to the Final

Plan Response

The Plan disagrees with finding B.15.c.i., asserting that the inclusion of the "true up" in 2017 for the 2016 TRF calculation was appropriate.

Deleted by the OIG – Not Relevant to the Final

Plan Response

The Plan disagreed with the finding. The Plan stated it used the snapshot counting method as of Jan 2017 for 2016, even though the FEHB MLR calculation was not undertaken until August of 2017. The Plan indicated that the membership was

stated accurately and appropriately. The Plan agrees to implement recommendations 34-36.

Deleted by the OIG – Not Relevant to the Final

Recommendation 34

We recommend that Plan develop policies and procedures over the MLR calculation process to ensure tax expenses input on the FEHBP MLR are calculated in accordance with Federal regulations and OPM guidance.

Recommendation 35

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 36

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 expenses to ensure compliance with MLR regulations.

Deleted by the OIG – Not Relevant to the Final

Recommendation 37

We recommend that the Plan ensure its FEHBP MLR PCORI expenses are calculated in accordance with Federal regulations.

Recommendation 38

We recommend that the Plan use the applicable PCORI fee from the IRS guidance based on its policy year end date within the contract.

Plan Response

The plan agreed with the finding related to the calculation of the PCORI expenses Deleted by the OIG – Not Relevant to the Final The plan agrees to implement recommendations 37 and 38.

Deleted by the OIG – Not Relevant to the Final

Recommendation 41

We recommend the Contracting Officer reduce the 2016 through 2018 MLR premiums by $**Deleted by the OIG – Not Relevant to the Final**, in 2016, $**Deleted by the OIG – Not Relevant to the Final** in 2017, and $**Deleted by the OIG – Not Relevant to the Final** in 2018 for the questioned premium costs identified in this audit.

Plan Response

The Plan disagrees with this finding and asserts that 2016-2018 MLRs should be re-calculated using the supporting documentation that has been provided in response to IR 22-24, and all other documentation submitted through the course of the audit.

Deleted by the OIG – Not Relevant to the Final

Recommendation 42

We recommend that the Plan ensure that ineligible dependents are accurately terminated in accordance with the guidance in the FEHBP benefit brochure.

Plan Response

The plan agreed with the finding. The Plan stated it will monitor and update any business process to ensure all dependents are terminated in accordance with the guidance in the FEHBP benefit brochure.

Deleted by the OIG – Not Relevant to the Final

Recommendation 43

We recommend that the Plan maintain all records and MLR documentation for the time period specified in its Contract.

Plan Response

The Plan stated that it retains records for a period of six years after the end of the contract term to which the claim records relate. In some cases, additional time was needed to respond to a request due to coordination across departments/systems and the scope/volume of requests – not because the records have not been retained. The Plan agrees to Recommendation 43.

Deleted by the OIG – Not Relevant to the Final

Recommendation 44

We recommend that the Plan provide its full cooperation to the OIG in all future audits and ensure it provides complete and accurate documentation, as requested, in a timely manner.

Plan Response

The Plan disagreed with the finding. The Plan stated that it has cooperated with the OIG auditors over the course of the audit period, submitting requested documentation according to the requested timeframes and regularly communicating with the audit team when additional time is needed. The Plan agrees with Recommendation 44.

Deleted by the OIG – Not Relevant to the Final

Report Fraud, Waste, and Mismanagement

Fraud, waste, and mismanagement in Government concerns everyone: Office of the Inspector General staff, agency employees, and the general public. We actively solicit allegations of any inefficient and wasteful practices, fraud, and mismanagement related to OPM programs and operations. You can report allegations to us in several ways:

By Internet: http://www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse

By Phone: Toll Free Number: 877-499-7295
Washington Metro Area 202-606-2423

By Mail: Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, NW
Room 6400
Washington, DC 20415-1100