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

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# **Final Audit Report**

**AUDIT OF THE FEDERAL EMPLOYEES HEALTH  
BENEFITS PROGRAM OPERATIONS  
AT AETNA OPEN ACCESS**

**Report Number 1C-99-00-17-007  
December 17, 2019**

# EXECUTIVE SUMMARY

## *Audit of the Federal Employees Health Benefits Program Operations at Aetna Open Access*

Report No. 1C-99-00-17-007

December 17, 2019

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

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

Due to changes to our audit scope resulting from OPM's implementation of its MLR methodology, we cannot express an opinion on the fairness of the premium paid for benefits received. Our audit process was limited to an assessment of the Plan's MLR, which is representative of the Plan's cost of doing business with the FEHBP. In our opinion, the MLR calculation is neither transparent nor a fair assessment of the FEHBP rates, which are concerns that we are addressing with OPM through other channels.

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

Under Contracts CS 2867 and CS 2914, the Office of the Inspector General (OIG) completed a performance audit of the FEHBP MLR submission to OPM for contract year 2013. We conducted our audit fieldwork from January 23, 2017, through June 26, 2018, at the Plan's office in Blue Bell, Pennsylvania and in our OIG offices.



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

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

We determined that portions of the MLR calculations, reviewed for nine Aetna Open Access plan codes, were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM. Specifically in contract year 2013, our audit identified that the Plan did not have sufficient internal controls over the FEHBP MLR reporting process. This control environment resulted in numerous MLR calculation errors in the following areas: Quality Health Improvement expenses, pharmacy claims adjustments, capitation payments, vendor payments, non-income tax expenses, membership, and dual contract data from Aetna Health Insurance Company. In addition, the Plan paid claims for unsupported dependent members over age 26 and for non-covered benefits. Furthermore, the Plan did not submit its pharmacy claims in accordance with Carrier Letter 2014-18.

The materiality of these issues could not be determined, due to a lack of criteria surrounding the FEHBP MLR. Specifically, OPM's Community-Rating Guidelines do not sufficiently address the impact of corporate structure on the reporting of FEHBP MLR tax expenses. Since Federal and State income tax, which are material adjustments to the denominator of the MLR, cannot be determined, we cannot provide an opinion on the MLR as a whole.

# ABBREVIATIONS

<b>AHIC</b>	<b>Aetna Health Insurance Company</b>
<b>AHI NJ</b>	<b>Aetna Health Inc. (a New Jersey corporation)</b>
<b>AHM</b>	<b>Aetna Health Management</b>
<b>AI</b>	<b>Aetna Inc.</b>
<b>ALIC</b>	<b>Aetna Life Insurance Company</b>
<b>CFR</b>	<b>Code of Federal Regulation</b>
<b>FEHBP</b>	<b>Federal Employees Health Benefits Program</b>
<b>FIT</b>	<b>Federal Income Tax</b>
<b>HHS</b>	<b>U.S. Department of Health and Human Services</b>
<b>ICD-10</b>	<b>International Classification of Diseases, Tenth Revision</b>
<b>MLR</b>	<b>Medical Loss Ratio</b>
<b>NAIC</b>	<b>National Association of Insurance Commissioners</b>
<b>OIG</b>	<b>Office of the Inspector General</b>
<b>OPM</b>	<b>U.S. Office of Personnel Management</b>
<b>QHI</b>	<b>Quality Health Improvements</b>
<b>Plan</b>	<b>Aetna Open Access</b>
<b>SG&amp;A</b>	<b>Selling, General, and Administrative Expenses</b>
<b>SHCE</b>	<b>Supplemental Health Care Exhibit</b>
<b>SSSG</b>	<b>Similarly-Sized Subscriber Group</b>
<b>U.S.C.</b>	<b>United States Code</b>

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**Exhibit E** (Aetna Inc. Consolidated Entities: Excerpt from 2013 Financial Statements)

**APPENDIX** (Plan’s Response to the Draft Report, dated October 1, 2018)

**REPORT FRAUD, WASTE, AND MISMANAGEMENT**

# I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at Aetna Open Access (Plan). The audit was conducted pursuant to the provisions of Contracts CS 2867 and CS 2914 (Contracts); 5 United States Code Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract year 2013, and was conducted at the Plan's offices in Blue Bell, Pennsylvania.

The FEHBP was established by the Federal Employees Health Benefits Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for Federal employees, annuitants, and dependents, and is administered by the U.S. Office of Personnel Management's (OPM) Healthcare and Insurance Office. The provisions of the Federal Employees Health Benefits Act are implemented by OPM through regulations codified in 5 CFR Chapter 1, Part 890. Health insurance coverage is provided through contracts with health insurance carriers who provide service benefits, indemnity benefits, or comprehensive medical services.

In April 2012, OPM issued a final rule establishing an FEHBP-specific Medical Loss Ratio (MLR) requirement to replace the similarly-sized subscriber group (SSSG) comparison requirement for most community-rated FEHBP carriers (77 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 (HHS) 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.

The Plan provides health benefits to FEHBP members in the following locations:

<b>Table I – Coverage Areas</b>		
<b>FEHBP Plan Name</b>	<b>Plan Code</b>	<b>Coverage Area</b>
Aetna Open Access	2X	Los Angeles, California and San Diego, California
	HF	Las Vegas, Nevada
	HY	Kansas City, Kansas and Kansas City, Missouri
	JC	New York City and Upstate New York
	P1	Austin, Texas and San Antonio, Texas
	P3	“Mid-Atlantic”: Delaware, Southern New Jersey, Philadelphia, Pennsylvania and Southeastern Pennsylvania
	UB	Memphis, Tennessee
	WQ	Phoenix, Arizona and Tucson, Arizona
	YE	Pittsburgh, Pennsylvania and Western Pennsylvania

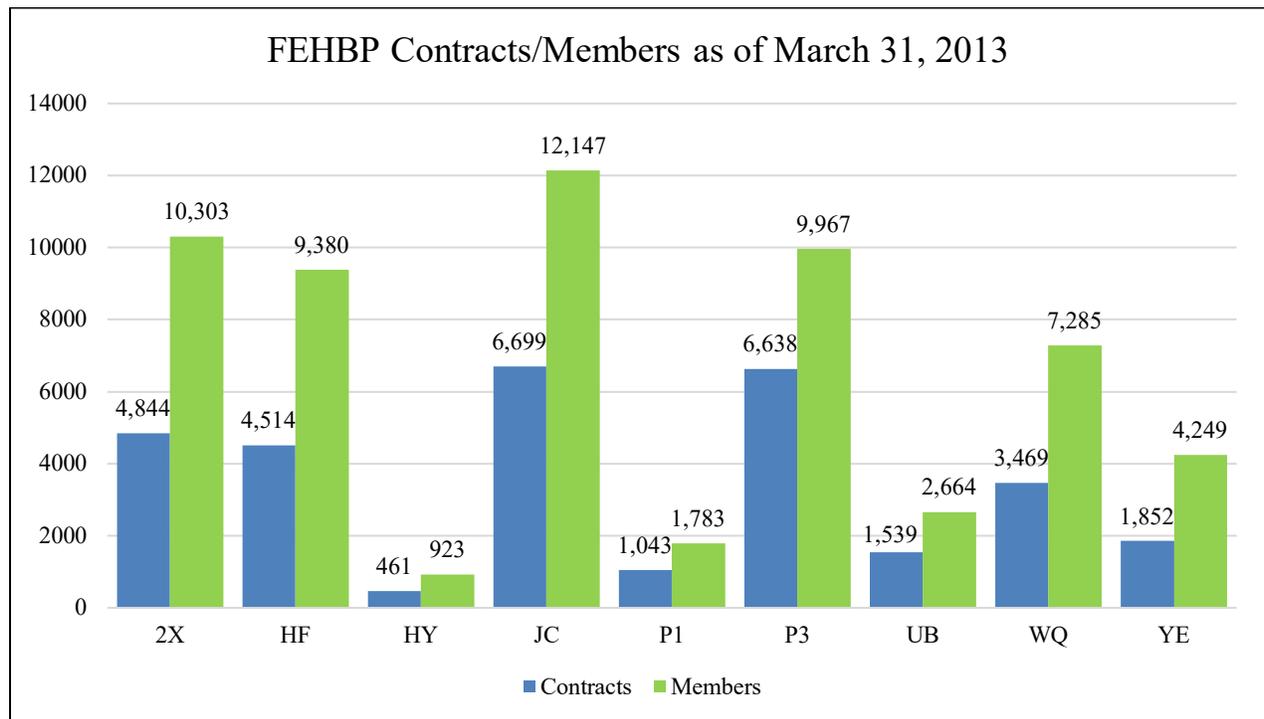
The Plan Codes are licensed under multiple legal entities:

<b>Table II – Plan Legal Entities</b>	
<b>FEHBP Plan Code</b>	<b>Legal Entities – Consolidated Under Aetna Health Inc.</b>
2X	Aetna Health Inc. California
HF	Aetna Health Inc. (a Pennsylvania corporation)
HY	Aetna Health Inc. (a Pennsylvania corporation)
JC	Aetna Health Inc. (a New York corporation)
P1	Aetna Health Inc. (a Texas corporation)
P3	Aetna Health Inc. (a Pennsylvania corporation) – Pennsylvania members Aetna Health Inc. (a New Jersey corporation) – New Jersey members Aetna Health Inc. (a Pennsylvania corporation) – Delaware members
UB	Aetna Health Inc. (a Pennsylvania corporation)
WQ	Aetna Health Inc. (a Pennsylvania corporation)
YE	Aetna Health Inc. (a Pennsylvania corporation)

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.

This is the first MLR audit of the plan codes listed in Table I above. Furthermore, this is the first Aetna Open Access MLR audit that includes multiple plan codes (Global audit).

The number of FEHBP contracts and members reported by the Plan as of March 31 for each plan code audited is shown in the chart below.



The preliminary results of this audit were discussed with Plan officials at an exit conference. 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

### **OBJECTIVE**

The primary objective of this performance audit was to determine whether the Plan complied with the provisions of its Contracts and the laws and regulations governing the FEHBP. Specifically, we verified whether the Plan met the MLR requirements and thresholds established by OPM and paid the correct amount to the Subsidization Penalty Account, if applicable.

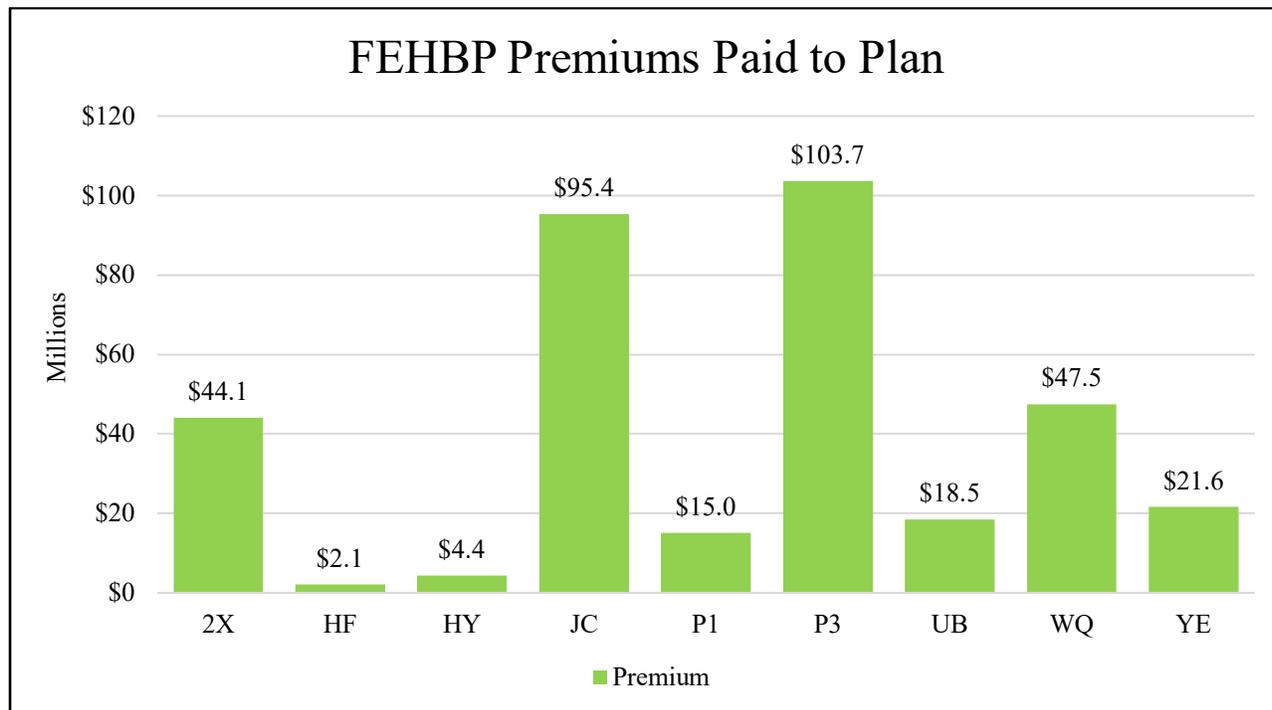
Our audits of the MLR submission filed with OPM are completed in accordance with the criteria expressed in OPM's rating instructions. The MLR audit evaluation includes an assessment of key components of the MLR calculation, including allowable claims, capitations, health care expenses, and quality health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

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

### **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 year 2013 and 9 FEHBP plan codes. For the scope of our audit, the FEHBP paid approximately \$352.3 million in premiums to the Plan.



The Office of the Inspector General’s (OIG) audits of community-rated carriers are designed to test carrier compliance with the FEHBP contract, applicable laws and regulations, and the rate instructions. These audits are also designed to provide reasonable assurance of detecting errors, irregularities, and illegal acts.

We obtained an understanding of the Plan’s internal control structure, but we did not use this information to determine the nature, timing, and extent of our audit procedures. Our review of internal controls was limited to the procedures the Plan has in place to ensure that:

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

In conducting the audit, we relied to varying degrees on computer-generated billing, enrollment, and claims data provided by the Plan. We did not verify the reliability of the data generated by the various information systems involved. However, nothing came to our attention during our audit utilizing the computer-generated data to cause us to doubt its reliability. We believe that the available data was sufficient to achieve our audit objectives. Except as noted above, the audit

was conducted in accordance with generally accepted government auditing standards, issued by the Comptroller General of the United States.

We conducted our audit fieldwork from January 23, 2017, through June 6, 2018, at the Plan's offices in Blue Bell, Pennsylvania, as well as in our offices in Cranberry Township, Pennsylvania; Jacksonville, Florida; and Washington, D.C.

## **METHODOLOGY**

We examined the Plan's MLR calculations and related documents as a basis for validating the MLR. Further, we examined claim payments, quality health expenses, taxes and regulatory fees, and any other applicable costs to verify that the cost data used to develop the MLR was accurate, complete, and valid. We also examined the methodology used by the Plan in determining the premium in the MLR calculations. Finally, we used the Contract, the Federal Employees Health Benefits Acquisition Regulations (FEHBAR), and applicable Federal regulations to determine the propriety of the Plan's MLR calculations.

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

The tests performed for the medical and pharmacy claims, along with the methodology, are detailed in Exhibits A through D at the end of this report.

# III. AUDIT FINDINGS AND RECOMMENDATIONS

## A. INTERNAL CONTROLS REVIEW

Per contracts 2867 and 2914, 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 facilitate timely discovery of improper conduct in connection with Government contracts; and (B) Ensure corrective measures are promptly instituted and carried out. (ii) At a minimum, the Contractor's internal control system shall provide for ... (A) Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the business ethics awareness and compliance program and internal control system.” However, we found that the Plan’s internal controls system did not sufficiently meet the criteria in the contract in the following ways.

### 1. Lack of Written Policies and Procedures

During the pre-audit phase, the Plan stated that it implements a variety of mitigating internal control activities to ensure the completeness and accuracy of the data used in the FEHBP MLR reporting, and analyzes the process each year to identify and implement improvements. However, the Plan did not have any documented policies and procedures to govern how information reported in the 2013 FEHBP MLR filing was gathered and how the yearly analysis process was conducted. Moreover, the lack of documented policies is not in compliance with 45 CFR 158.170(b), which specifies how allocation methodologies used in the calculation of the MLR should be developed, applied, and determined to yield the most accurate results. Based on our review, the supposed internal control activities cited by the Plan were inadequate to prevent errors from occurring; such as:

**The Plan’s lack of documented FEHBP MLR policies and procedures led to numerous reporting errors, recreated documentation, and inaccurate support.**

#### a. Inaccurate and/or Recreated Documentation

In response to our requests for support, Aetna responded by providing documentation, which in many cases was not originally used to populate and file their 2013 FEHBP MLR filings. The Plan's inability to adequately support the values reported in the FEHBP MLR filing stems from a lack of defined processes for gathering and tracking this data and reporting it in the FEHBP MLR filing. This was most evident in the following review sections:

**i. Non-Income Tax Expenses**

The Plan was unable to provide original support for the non-income Federal and State Taxes and Licensing or Regulatory Fees reported in the FEHBP MLR filings for plan codes HF, HY, P3, UB, WQ, and YE. For each of these plan codes, the initial documentation provided and all resubmissions were recreated subsequent to the FEHBP MLR filings, and did not support the values originally submitted to OPM.

During our initial review of the non-income related tax expenses, the Plan was unable to show how the amounts allocated to the FEHBP tie to the annual statements and the general ledger. Additionally, over the course of our review, the Plan provided numerous data resubmissions, including a recalculation of the Patient Centered Outcome Research Institute fee based on membership and Aetna Health Insurance Company (AHIC) data that was unintentionally excluded from the original MLR forms. Despite these multiple resubmissions, at no time was the Plan able to fully support that a consistent allocation methodology was utilized to determine the non-income tax expenses for each legal entity's HHS MLR large group, or that the expenses were consistently supported by the annual statement or the general ledger.

**Plan Response:**

*The Plan does not agree that the non-income tax expenses were insufficiently supported, and made every attempt to support the values, including a tax crosswalk and walk-through on August 16, 2018.*

*Furthermore, since the 2013 FEHBP MLR process, the Plan has made several improvements to their internal controls and review processes. This includes an intensive tax allocation review process by the FEHBP underwriting team in conjunction with the Plan's tax department.*

**OIG Comment:**

Although Aetna attempted on numerous occasions to address and provide sufficient support for the non-income tax expenses allocated from the large group pool to the FEHBP, ultimately a consistent methodology and sufficient support could not be verified.

We acknowledge that the Plan has taken steps to improve their internal controls and review process related to the FEHBP MLR tax allocation process. However, the implementation of these controls occurred outside the scope of our audit. Therefore, we will evaluate the effectiveness during future audits. This comment applies to all other

Plan responses in this report that refer to improvements in internal controls after the scope of this audit.

**ii. Vendor Payments**

As regulated by 45 CFR 158.140 (b)(3), when health plans pay a third party vendor for activities such as network development, administrative fees, claims processing, and utilization management as part of incurred claims, then administrative fees and profits from these transactions must be removed from the numerator of the MLR calculation. However, the Plan's adjustment included inaccurate vendor payment amounts in their 2013 MLR filings.

During the course of our review, the Plan submitted revised vendor payment support on three separate occasions for the non-California plan codes, and five separate occasions for the California plan code (plan code 2X). The vendor payment data was recreated for a variety of errors, including the following: broken formula links in their vendor payment Excel workbook, incorrect total CVS prescription amounts, and incorrect member month usage for plan code 2X.

**Plan Response:**

***The Plan agrees that the vendor payment amounts were incorrectly reported on the FEHBP MLR forms.***

***As it pertains to the internal controls aspect of the finding, the Plan agrees that they did not have documented FEHBP-specific MLR policies and procedures for contract year 2013. However, since that contract year, new internal controls, policies and procedures have been implemented that provide a "strong guideline for intense review and documentation of support for the FEHBP MLR filing, which will help prevent reporting errors in future MLR filings and their support."***

**iii. Membership Used in Allocations**

During the course of the audit, the Plan utilized membership to allocate dental claims to each plan code. The Plan also used membership to allocate OPM premium dollars to each of the lines of business by state (situs) within plan code P3. In each of these instances, the Plan could not provide the original enrollment report used to determine the amount reported in the FEHBP MLR filings. Therefore, the Plan's internal controls related to the retention of documentation used to complete the 2013 FEHBP MLR was insufficient. Additionally, the Plan does not have documented policies and procedures

surrounding the data sources and allocation processes employed in the FEHBP MLR process.

**Plan Response:**

*The Plan agrees that the original membership reports used to determine the plan code P3 premium allocation and all plan code dental claims were not maintained. Specific to the plan code P3 premium ratio issue, the Plan stated that they will implement necessary record retention controls to maintain required documentation.*

*As previously stated in the Plan's response above, additional internal controls, policies and procedures have been implemented since contract 2013 to deter issues such as these from occurring during future FEHBP MLR processes.*

**b. Reporting Errors**

Numerous errors were identified during the course of the audit, resulting from a lack of internal controls adherence and accentuated by the lack of documented policies and procedures related to the FEHBP MLR processes. The lack of sufficient review of the FEHBP MLR forms and verification of source documentation prior to submitting the FEHBP MLR forms to OPM resulted in the following errors:

**i. MLR Database Error and AHIC**

The Plan established an MLR database to compile data in response to the Affordable Care Act regulations and the institution of 45 CFR 158 for health plans implementing the MLR requirements. The Plan's MLR database stores data that is collected from each of the Plan's sites, at all Plan locations in the United States. This data is then used to populate the Supplemental Health Care Exhibits (SHCE) and HHS MLR filings by legal entity. Since the FEHBP receives allocations from the HHS MLR filings, ultimately, the data from the MLR database impacts the FEHBP filings as well.

In responding to our requests for supporting documentation, the Plan discovered that the Selling, General, and Administrative (SG&A) expenses; Quality Health Improvement (QHI) expenses; and tax expenses for the AHIC were not included in the HHS MLR filings prior to allocating these expenses to the FEHBP. The AHIC information would normally be reported in the "Dual Contract" column of the HHS MLR filings and included as part of the March 31 reporting columns, where appropriate. The premium and claims related to AHIC business were correctly included in the HHS MLR filings.

AHIC Pennsylvania and AHIC New York are Plan legal entities that account for member services received out of the network. All FEHBP plan codes in the audit scope, excluding California (2X), had a portion of coverage provided under an AHIC entity. However, since this information was not correctly included in the HHS MLR filings, the FEHBP did not receive the appropriate allocation.

For purposes of the FEHBP MLR, the Plan provided the auditors with the additional AHIC information, which they supported with the AHIC SHCEs, reported as of December 31.

**Plan Response:**

***“The Plan agrees that the SG&A expenses, QHI, and tax expenses for AHIC were not included in the original 2013 HHS MLR submission prior to allocating these expenses over to the FEHBP”. However, the acceptance of the AHIC 12/31 data in no way indicates that the Plan agrees to the use of Aetna Health Inc. 12/31 data in the remainder of the MLR calculation.***

***The Plan’s response to the internal controls portion of the finding is posted at the end of section A.1.b.***

ii. **Quality Health Improvement Expenses**

Per 45 CFR 158.221, the numerator of the MLR filing can include Plan “expenditures for activities that improve health care quality,” as defined in 45 CFR 158.150 and 158.151. Such activities must have the ability to be objectively measured and produce verifiable results.

To determine the QHI expenses, the Plan collects applicable data by cost center for QHI activities. This data is collected at a company-wide level then allocated to Aetna Health Management (AHM) and the Aetna Life Insurance Company (ALIC). The legal entities under AHM are allocated a portion of the AHM QHI expenses based on the legal entity’s percentage of cost containment expenses to the total cost containment expenses related to AHM. Additional QHI expenses, generated by business support and information technology, are also allocated to the legal entities based on cost containment expense ratios. The Government related QHI is backed out of this total prior to allocating to each legal entity’s large groups, based on a premium ratio. Finally, the FEHBP is allocated QHI expenses based on the premium ratio of large group premium to FEHBP premium.

During our review of the Plan's QHI process and expense allocations used to determine the FEHBP QHI expense, the following issues were identified:

**a. Incorrect Reporting of QHI Expenses**

In collecting data for the QHI expense adjustments, as required for all MLR reporting (both HHS and the FEHBP), the Plan used full year dollars (estimates) instead of actual QHI dollars incurred for some of the QHI cost centers. The result was overstated QHI expenses for AHM and ALIC, which ultimately were allocated to the FEHBP.

Since this error occurred at the highest level legal entities, it impacted the QHI amounts reported on the Aetna Health Inc. (all legal entities) SHCE and the 2013 HHS MLR filings, from which the FEHBP receives allocations.

**b. AHIC QHI Exclusion**

The Plan inadvertently excluded AHIC QHI on their HHS MLR filings, and therefore also excluded a portion of applicable QHI expenses on the FEHBP MLR filings. During fieldwork, the Plan supplied revised information for the HHS MLR filings' large group pool, which is the starting point for many of the allocations to the FEHBP. The revised QHI amounts were supported by the AHIC SHCE, which, as mentioned previously, is reported as of December 31.

**c. ICD-10 Expenses**

For the 2013 reporting year, the implementation of International Classification of Diseases, Tenth Revision (ICD-10) code sets that are designed to improve quality are considered quality health improvements per 45 CFR 158.150. However, in responding to our requests for supporting documentation, the Plan found that the allowable ICD-10 expenses were accounted for twice on the 2013 HHS MLR filings, once in lines 4.1 through 4.5 and once in aggregate on line 4.6. Since this error was identified prior to the 2013 FEHBP MLR filing, the Plan allocated quality health improvement expenses to the FEHBP from lines 4.1 through 4.5 of the applicable HHS MLR filings, correctly accounting for the ICD-10 costs on the FEHBP MLR filings only once.

While we agree that the ICD-10 costs should only be accounted for once in the FEHBP MLR filing, we found that the Plan did not have sufficient controls nor documented policies and procedures to prevent similar oversights and reporting errors from occurring in the future.

**Plan Response:**

*“The Plan agrees that a portion of the 2013 QHI expenses were inadvertently calculated using budgeted dollars instead of actual dollars. This mistake was an isolated event caused by human error.”*

*The Plan also agrees that AHIC QHI expenses were inadvertently excluded in the HHS and FEHBP MLR filings, and that the ICD-10 expenses were accounted for twice in the HHS MLR submissions.*

*The Plan’s response to the internal controls portion of the finding is posted at the end of section A.1.b*

**iii. Capitation Reporting Error (exclusive to plan code HF)**

The Plan reported plan code HF’s capitation expense as a negative value. Since a negative capitation amount is an abnormal adjustment to the numerator of the MLR, an inquiry was issued. Upon further review, the Plan explained that there were a number of voided capitation checks that were not marked by product or segment and, therefore, could not be tied back to a specific customer. To spread the cost among the coverage area groups, the voided check totals were allocated by member months. However, this was not an appropriate methodology, since it disproportionately credited group capitation accounts more than what was paid.

**Plan Response:**

*The Plan agrees with this finding.*

*The Plan’s response to the internal controls portion of the finding is posted at the end of section A.1.b*

**iv. Pharmacy Manual Adjustments**

Per 45 CFR 158, HHS requires the reporting of various factors in the MLR calculation on a calendar-year basis. These factors include premium earned, claims, QHI expenses, and other non-claims costs incurred under health insurance that is in force during the calendar year. To meet this requirement, some claims adjustments are required to correctly account for claims generated for the calendar year. Specifically, the Plan makes a manual adjustment to the pharmacy claims to exclude transactions that are processed outside the

normal monthly interface, such as one-time settlements with pharmacies and manufacturers, which are not allowable in the MLR reporting year.

In responding to our requests for supporting documentation regarding the pharmacy manual adjustments, the Plan determined that a portion of the adjustment reported in seven of the nine plan code's 2013 MLR filings included amounts that were not related to 2013. Based on the support provided, we agree with the Plan that some of the pharmacy manual adjustments were incorrectly reported on the MLR forms.

**Plan Response:**

***The Plan agrees that pharmacy manual adjustments were incorrectly reported on the FEHBP MLR forms.***

***The Plan's response to the internal controls portion of the finding is posted at the end of section A.1.b***

v. **Vendor Payments**

The vendor payment amounts reported on the FEHBP MLR forms were incorrect. See section A.1.a.ii. of this report for additional information.

**Plan Response:**

***The Plan agrees that the vendor payment amounts for all plan codes in the audit scope were incorrectly reported on the FEHBP MLR form.***

***The Plan's response to the internal controls portion of the finding is posted at the end of section A.1.b***

In summary, the reporting errors identified on the 2013 FEHBP MLR submissions are attributable to insufficient internal controls and documented policies and procedures surrounding the FEHBP MLR reporting process at that time.

**Plan Response:**

***The Plan agrees that they did not have documented FEHBP-specific MLR policies and procedures for contract 2013. However, as the MLR guidelines have been refined and clarified since their institution, the Plan has also implemented and updated documented policies and procedures related to the FEHBP. Specifically, the Plan states, "These newly***

*implemented internal controls policies and procedures provide a strong guideline for intense review and documentation of support for the FEHBP MLR filing, which will help prevent reporting errors in future MLR filing and their support.”*

*Furthermore, the Plan outlined several enhancements made to the FEHBP-specific MLR process from an internal control perspective. It stated, “the Plan has also worked with its internal HHS MLR teams to streamline the process of HHS MLR to FEHBP-specific MLR, which will help eliminate the types of errors uncovered during the ... audit.” The Plan believes these enhancements to its controls will be effective in reducing errors in future years’ MLR filings, and that there are currently sufficient internal controls in place to catch errors, such as the ICD-10 issue noted above, moving forward.*

## 2. Lack of MLR Oversight at a Sufficiently High Level

During the course of our audit, an MLR database error and a QHI reporting error were identified at the highest level of data collection and reporting for the MLR. The MLR database error impacted all HHS MLR filings for contract years 2013 through 2015 for the Plan legal entities that license out-of-network benefits under AHIC entities. The QHI reporting error impacts all of the Plan legal entities for 2013 that are required to file an SHCE and an HHS MLR filing. This includes all Aetna Health Inc. legal entities and the Aetna Life Insurance Company. The errors are detailed as follows:

Errors identified in the Plan’s 2013 MLR reporting process indicate that the Plan lacked MLR oversight at a sufficiently high level.

### a. MLR Database Error

The Plan discovered that the AHIC QHI, the Federal and State taxes and regulatory fees, and the SG&A were not carried forward from the SHCE to the applicable HHS MLR filings. This error essentially excluded those previously mentioned expenses from all legal entity HHS MLR filings where out-of-network benefits are licensed under AHIC. This error impacted all FEHBP plan codes in our audit scope, excluding California plan code 2X. Furthermore, this error impacts applicable HHS and FEHBP MLR filings in contract years 2013, 2014, and 2015.

### b. QHI Reporting Error

The Plan incorrectly used estimated QHI dollars instead of actual QHI dollars incurred when reporting QHI on the SHCE and the HHS MLR filings. Since the FEHBP receives an allocation of the QHI expenses, reported at the legal entity level, this issue impacted all of the FEHBP MLR filings in 2013.

This error was identified by the Plan in December of 2015, and subsequently adjusted in the prior year column of the 2015 HHS MLR filing. However, the Plan's FEHBP MLR team was not notified of the error until the fall of 2016. Furthermore, the OIG audit team was not notified of this error until February 2017. These errors clearly indicate that the Plan's inability to communicate errors, which impact other internal groups and regulatory agencies, stems from a lack internal controls and sufficient oversight at a high level.

**Plan Response:**

*“The Plan agrees that an MLR database error and a QHI reporting error were discovered during the course of the audit. However, the Plan strongly disagrees that this is an indication that there are insufficient internal controls in place to prevent these errors from occurring.”*

*The Plan goes on to explain that since the early years of MLR, the Plan has spent significant time and resources refining their policies and procedures, specific to the MLR workstreams that contribute the data that is ultimately used to complete the MLR. Additionally, there is a highly defined attestation process through which the completed HHS MLR must progress before being submitted. Furthermore, the Plan created a reconciliation tool, for use in contract years 2017 and beyond, as a method to verify that the out of network business (AHIC) expenses related to QHI, SG&A, and taxes are correctly reported in the 3/31 column of the HHS MLR form.*

*The Plan also states that they “completed a Risk Assessment with State of Connecticut Department of Insurance (CT DOI) as of December 31, 2015. The CT DOI reviewed and tested the Company's processes and controls designed to mitigate specific risks associated with the determination of its HHS MLR rebate liability. The CT DOI noted in its final reports ‘No material exceptions were identified.’”*

*Related specifically to the QHI reporting error, the Plan made prior period adjustments in the 2015 HHS MLR filing to account for the QHI reporting errors in 2013 and 2014, for which the HHS MLR form specifically allows. This update enabled the Plan to capture the actual QHI expenses, instead of the budgeted amounts that were previously reported on the HHS MLR form and allocated to the FEHBP. Furthermore, in 2016, the Plan refined and automated the QHI expenses for more accurate reporting.*

*Finally, the Plan states that they continue to review and improve their processes and procedures related to the reporting of the HHS MLR. The Data Management and Reporting team, who directly contribute to the completion of the HHS MLR, was restructured. Furthermore, the Plan implemented new processes, review requirements,*

*and internal controls to minimize risk surrounding the reporting of the HHS MLR. The Plan goes on to state that in 2017, employees participated in a training that contained an MLR internal controls segment to “heighten awareness and knowledge of the internal controls and to raise the bar around the MLR control environment.”*

**OIG Comment:**

We recognize that the Plan made improvements to their policies and procedures surrounding the completion of the MLR, including the internal controls, in more recent years. However, the policies, procedures, and attestation process in place during contract year 2013 were not sufficient to identify the issues pertaining to the MLR Database Error (March 31 reporting column errors) and the QHI reporting error. Additionally, the internal control document and the reconciliation tool, previously mentioned, were unavailable for review during the course of this audit.

Although HHS regulations and the MLR form allow for error correction in future MLR filings, there is currently no recourse for error corrections in the FEHBP MLR filings. Therefore, allocations of the AHIC expenses, particularly the non-income tax expenses, to the FEHBP MLR may not have an independent source to support its validity for contract years 2013, 2014, and 2015. Furthermore, the implementation of the Plan's updated internal control policies and procedures occurred outside the scope of our audit, and therefore their effectiveness cannot be evaluated at this time.

Finally, we reviewed the Connecticut Department of Insurance (CT DOI) Risk Assessment report that covered contract years 2011 through 2015 that was supplied by the Plan. Although the Plan's MLR policies and processes may be the same for all legal entities, the CT DOI report covered Aetna Health Insurance Company and other Aetna legal entities licensed in the state of Connecticut, none of which are legal entities in the scope of this FEHBP audit. Finally, the scope of the CT DOI tests performed to mitigate “specific risks associated with the determination of its [HHS] MLR rebate liability” were not defined in the report. However, it is clear that the tests did not identify the AHIC reporting error in the HHS MLR March 31 column nor the inclusion of budgeted QHI expenses reported on the HHS MLR filing. For these reasons, we cannot determine if the tests would also sufficiently mitigate risk as it pertains to the Plan's internal controls around the HHS MLR filing and other reported amounts that are allocated to the FEHBP MLR filing.

**Conclusion – Internal Control Review**

Based on the expansiveness of these errors across multiple legal entities and Federally regulated filing requirements, it is evident that the Plan did not have the contractually required internal controls for contract year 2013. Furthermore, in contract year 2013 the Plan did not have

adequate resources to ensure the effectiveness of the internal control system as it relates to the oversight of the FEHBP MLR filings.

### **Recommendation 1**

We recommend that the contracting officer verify that the Plan implemented internal controls, as specified in its response to the Draft Report, over the FEHBP MLR filing.

### **Recommendation 2**

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

## **B. Medical Loss Ratio Review**

### **1. Insufficient Criteria Surrounding FEHBP MLR Tax Expense Reporting**

Pursuant to the provision of HHS 45 CFR § 158.161, health plans are allowed to reduce the premium used in the MLR calculation by taxes and regulatory fees paid, excluding Federal income taxes paid on investment income and capital gains. For contract year 2013, OPM's Community-Rated Guidelines did not address calculating allowable tax expenses for purposes of the FEHBP MLR. Specifically OPM states, "HHS MLR Guidelines will apply

**OPM's Community-Rated Guidelines do not sufficiently address the calculation of FEHBP income tax expense, which materially impacts the outcome of the MLR.**

for issues not covered in these instructions." However, the criteria applicable to the HHS MLR tax expenses encompass the entire legal entity and are supported by the financial statement(s). They are representative of the tax expense incurred by that legal entity, including required adjustments, to be compliant with 45 CFR 158.161. However, this methodology cannot be extrapolated to the FEHBP.

The FEHBP plan codes are representative of one group (per plan code) within the large group pool of an HHS MLR filing.

Although the large group pool receives a portion of the overall legal entity tax, based on net income of the pool, the same application of tax to the FEHBP net income is not always equitable. For instance, Aetna Health Inc. (a New Jersey corporation) (AHI NJ), in which plan code P3 has enrollment, reported net income for contract year 2013 but inversely reported a large Federal income tax (FIT) benefit<sup>1</sup> normally associated with a net loss. When the AHI NJ effective tax rate or MLR compliant FIT expense is used to determine the FIT expense on FEHBP plan code P3, there is a disproportionate FIT benefit generated. The

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<sup>1</sup> The term benefit is used in the financial statements to identify a negative Federal income tax amount.

result of this calculation is a penalty almost equal to plan code P3 premiums paid to the Plan for *all* of contract year 2013. This was not the intent of the FEHBP MLR, although this methodology meets the tax expense criteria issued by OPM.

Additionally, the Plan's use of the Federal corporate tax rate in 2013 meets applicable regulations, but the results cannot be tied back to the MLR compliant FIT expense reported for the legal entity large group, in which each plan code resides. This issue was previously and separately reported for audits conducted on other 2013 FEHBP plan codes operated by the Plan. During the resolution process of those audits, OPM agreed that in the future the Plan could use their effective corporate tax rate. The Plan confirmed that based on OPM's guidance they applied Aetna Inc.'s (AI) 10-k corporate effective tax rate times the FEHBP plan code net income (loss) to determine the FEHBP FIT expense. However, AI's 2013 corporate effective tax rate is the result of the consolidation of 126 legal entities, as illustrated in their 2013 notes to the statutory financial statement shown in Exhibit E. The use of the Federal corporate tax rate of 35 percent, or AI's effective tax rate, yields FEHBP FIT expenses unrelated to the legal entity and large group. Therefore, the FEHBP tax expense is inequitable and inconsistent with the other components of the FEHBP MLR calculation.

Furthermore, prior to the issuance of this final report, OPM updated and issued the 2018 Community-Rating Guidelines for MLR Federal tax expenses which state, "If the carrier calculates the Federal income tax attributable to the FEHB plan ... based on its calculation of net income attributable to the FEHB plan, the carrier's calculation must tie to its financial statements and Federal income tax filing. If a tax rate is used in this calculation, and it is not the same rate that was used for the HHS large group MLR filing, the carrier must use its corporate effective tax rate for the year."

Although the intent of this language was to clarify the accounting of FEHBP MLR income tax expenses, it does not differentiate issues arising from health plans' varying corporate structures. Many health plans, like Aetna, have multiple legal entities and parent/subsidiary relationships that impact its tax position and reporting requirements. OPM's guidance does not specify if the corporate effective tax rate should be from the legal entity in which the FEHBP plan code resides or the corporate effective tax rate of the parent company. Furthermore, to be compliant with 45 CFR § 158.161, the corporate effective tax rate should be calculated after applicable adjustments for capital gains tax and tax on investments. However, none of these issues are addressed in the current criteria.

The insufficient criteria surrounding the calculation of the FEHBP MLR Federal and State Income Tax expenses can lead to material variations in the amount reported. Of the four tax methodologies we evaluated during the course of the audit, all produced differing amounts that materially impacted the calculation of the FEHBP MLR and the resulting credits and/or penalties. Yet all of the methodologies meet OPM's past and present criteria. Furthermore, 45 CFR § 158.161 does not have criteria to address the uniqueness of the FEHBP MLR, specifically the reporting of the FEHBP tax expenses.

For these reasons, we were unable to determine the tax expense attributable to the FEHBP plan codes in our audit scope. Since the tax expense represents a material adjustment to the FEHBP MLR calculation, we cannot assess the overall monetary impact of the other issues identified in this report. As such, we are not expressing an opinion on the numerical representation of the 2013 MLRs reported by the Plan and covered in the scope of our audit. Other issues identified in the MLR calculation are discussed throughout the report.

**The OPM OIG  
cannot express an  
opinion on the  
Plan's 2013 MLRs  
for the scope of  
this audit.**

**Plan Response:**

***The Plan did not have an opportunity to respond to this finding.***

**2. MLR Reporting Issues**

**a. Claims Paid for Ineligible Dependents**

We reviewed a judgmental sample of 224 members who were aged 26 or older in contract year 2013 for the nine plan codes covered in the audit scope. Based on our review, we identified issues with 86 of these members, or 38 percent, across eight of the nine plan codes. These issues included unsupported dependent eligibility; maintenance of members in the Plan's system beyond their eligibility dates; improper claims payments; and inflated claims costs used in the Plan's FEHBP MLR filings.

The Plan cited manual processing errors and retroactive termination processing as the cause for these errors. However, the Plan did not have system controls or documented policies and procedures in place in 2013 to mitigate the risk of these errors; to identify when a dependent member is aged 26 or older; and, to prevent or allow, as appropriate, the processing of claims associated with these members. The Plan subsequently developed corrective action plans to address these control weaknesses, such as designating a point person to receive, scan, maintain, and track all eligibility waivers; follow-up communication with the payroll offices for copies of waivers; and system enhancements that allow for advance termination effective dates. However, these

corrective action plans do not specifically address recoupment of inappropriately paid claims in cases where retroactive terminations still occur. In addition, no formal procedures appear to have been developed to document the corrective action plans. Since these action plans were implemented outside our audit scope, we are unable to evaluate their effectiveness to mitigate the identified risks.

Specifically, our review identified the following issues:

**i. Unsupported Dependent Eligibility**

The Plan could not support the eligibility of 30 dependent members aged 26 and older in 2013.

According to the FEHBP benefit brochures, dependents are only eligible to be covered after age 26 if the dependent is disabled or incapable of self-support. In these cases, the FEHBP Handbook indicates that the subscriber's employment office will provide the insurance carrier with its decision about the dependent's eligibility.

**Neither the Plan nor OPM could provide documentation to support coverage for 30 FEHBP members.**

OPM Contracts CS-2867 and CS-2914 Section 1.11(b) require insurance carriers to maintain all records relating to the contract and to make these records available for a period of time specified by Federal Employees Health Benefits Acquisition Regulation 1652.204-70. The referenced clause is incorporated into the contracts at Section 3.4, which requires the carrier to maintain individual enrollee and/or patient claim records “for six years after the end of the contract term to which the claim records relate.” Because the member’s employing office certifies a disabled child’s status as a dependent, documentation should be maintained in accordance with the contract to ensure that claims for dependents aged 26 and older are allowable.

However, the Plan could not provide support to verify that the 30 members associated with seven plan codes were eligible to receive coverage after age 26. Although the Plan demonstrated that it was making an effort to obtain the supporting documentation from the relevant offices, the Plan is not in compliance with contractual and regulatory requirements for the maintenance of records. Without the proper support, we cannot verify whether the medical and pharmacy claims paid for these members in 2013 was allowable.

**Plan Response:**

*The Plan agrees that neither the Plan nor OPM could provide documentation to prove that the questioned members were indeed incapable of self-support.*

*When determining FEHBP dependent status after age 26, the Plan relies on the payroll office to provide certification and appropriate documentation to prove disability. However, many times the Plan does not receive support until after the member is terminated for reaching age 26. Furthermore, many of these disabled members have been enrolled with the Plan for greater than 10 years. The Plan states, "It is inappropriate to assume that these members' eligibility and claims should be disallowed because neither the payroll offices nor the Plan continued to maintain supporting documentation. Unless OPM instructs the payroll offices and the Plan to terminate these dependents' eligibility, the Plan will continue to provide coverage to these members and include their claims in the MLR calculations."*

*An action plan addressing record retention related to dependents incapable of self-support was submitted by the Plan. It includes actions to be taken by both the Plan and the Payroll Offices to ensure record retention certifying active status for dependents beyond the age of 26. The Plan also states, "[they are] open to further discussions with OPM and OIG to finalize the best plan of action to correct this issue going forward."*

**OIG Comment:**

We acknowledge that the Plan established an action plan to address the issues related to dependents incapable of self-support. However, the implementation of this action plan occurred outside the scope of our audit. Therefore, its effectiveness will be evaluated on a future audit.

**ii. Claims Paid After Termination of Dependent Coverage**

The Plan incorrectly paid claims for 31 dependents in 2013 after their coverage had been terminated for ineligibility or as a result of plan changes. According to the FEHBP benefit brochure, dependents who are not disabled or incapable of self-support are only eligible to be covered until age 26, at which point coverage will be terminated 31 days after the member becomes ineligible. For members who change plan options during open season, the FEHBP benefit brochure stipulates that "coverage begins on the first day of [the] first pay period that starts on or after January 1."

Although the Plan terminated coverage as of the date that the dependent members became ineligible or as of the date of plan changes that occurred during open enrollment, in compliance with criteria, it still paid 77 medical and pharmacy claims that the dependents incurred after the effective date of termination. The Plan explained that coverage for these members was retroactively terminated. Therefore, the claims were paid because the members were still active in the system until the retroactive termination date was processed. Nevertheless, the claims are ultimately unallowable because they were incurred after the date that coverage should have been terminated.

**Plan Response:**

*The Plan agrees with this finding.*

**iii . Untimely Termination of Dependent Coverage**

The Plan did not timely terminate coverage for 19 dependent members who had become ineligible for coverage in 2013. Specifically, the Plan terminated coverage for these members from 32 to 398 days after the date of their 26<sup>th</sup> birthday, which is not in accordance with requirements in the FEHBP benefit brochures to terminate coverage 31 days from the dependent's 26th birthday.

**Plan Response:**

*The Plan agrees with this finding and submitted an action plan to address this issue.*

**OIG Comment:**

We acknowledge that the Plan established an action plan to address the issues related to enrollment and eligibility processes for dependents over age 26. However, the implementation of this action plan occurred outside the scope of our audit. Therefore, its effectiveness will be evaluated on a future audit.

**iv. Claims Paid After Termination Date**

During the course of the audit, many supporting documents were supplied in response to our requests. In one response pertaining to claims paid for ineligible dependents, the Plan erroneously identified six member spouses as dependents. According to Aetna, this was the result of human error when manually responding to an audit request. However, we reviewed the eligibility for these members identified as

spouses, and found that some of these members incurred claims after the effective date of termination. Specifically, the Plan paid nine unallowable claims for three of the members in 2013. As with the dependent members who incurred claims after their effective date of termination, the Plan again explained that claims were paid for the member spouses because their coverage was retroactively terminated. However, the claims are ultimately unallowable because they were incurred after the effective date of termination.

**Plan Response:**

**The Plan agrees with this finding.**

**b. Claims paid for Non-Covered Benefits (exclusive to plan code JC)**

Specific to plan code JC, we identified abortion procedure codes in the 2013 medical claims data for FEHBP members. These codes are defined as non-covered benefits per the benefit brochure, and should not be covered and paid by the Plan.

**Plan Response:**

*The Plan agrees with this finding and submitted an action plan to address this issue.*

**OIG Comment:**

We acknowledge that the Plan established an action plan to address the issues related to claims paid for non-covered benefits. However, the implementation of this action plan occurred outside the scope of our audit. Therefore, its effectiveness cannot be evaluated at this time.

**c. Reporting Period**

For expense allocations to the FEHBP, the Plan utilized the March 31 large group data from their 2013 HHS MLR filings. However, during our review, we found that the premium, QHI, and tax expenses reported in the March 31 column of the HHS MLR filings could not be verified using any other independent support. Furthermore, when the Plan attempted to correct the AHIC reporting error (see A.1.b.i. on page 11 of the report), the Plan utilized data as of December 31. Due to the insufficient support

**The Plan could not support the March 31 large group data allocated to the FEHBP MLR. Therefore, December 31 data was used in our audited review.**

for the March 31 data and the AHIC reporting error, for consistency and accuracy, we utilized the December 31 data to test the components of the MLR where validated by supporting documentation.

**Plan Response:**

*The Plan disagrees with the OIG's decision to use the 12/31 data, as it is inconsistent with the intent of the FEHBP MLR regulation to follow HHS methodologies when making FEHBP MLR calculations. Furthermore, use of the 12/31 data does not lead to the most accurate result.*

*The Plan believes that the 3/31 data is more accurate and should be utilized in the FEHBP MLR calculation based on the following arguments:*

- *The 3/31 data is taken from the SHCE "as is" and is not independently verified or certified. In fact, it is the 3/31 HHS Data that is more accurate and precise as it is subject to the Plan's enhanced controls and verification process and is the data used for calculating rebates to policyholders. If the 3/31 HHS Data is inaccurate, the Plan is subject to significant consequences in an HHS or state MLR audit, in which rebates would be reprocessed and additional rebates with 10% interest and potentially other regulatory penalties would be due. As a result, it is the verified 3/31 HHS Data that is expected to yield the most accurate results when allocating expenses.*
- *The SHCE is for informational purposes only and is not mandated by the ACA.*
- *Membership is verified by the Plan after the SHCE is filed, to determine the groups allocated to the small and large group pools. So overall size of the pools can fluctuate between 12/31 and 3/31.*
- *The Plan must remove certain administrative expenses from the statutory definition of incurred claims at a claim level for certain vendors in the 12/31 HHS data. These expenses are either reported as general administrative expense or QHI. As a result, if the Plan used 12/31 claims data from the SHCE it would overstate the reported claim amounts for MLR expense allocation purposes.*
- *After the close of the 12/31 calendar year data, the Plan continues to verify the cost containment and general administrative expenses. Those adjustments are captured in the 3/31 data.*
- *The National Association of Insurance Commissioners (NAIC) issued guidance that supports the reporting of claims data and premium on a date of service basis*

*(as of 3/31). Per this guidance, HHS adopted a date of service approach to reporting claims data in their MLR final rule. They did not require a date of service approach for premium (although Aetna was able to and did report premium on a date of service basis starting in contract year 2014). However, the SHCE is not reported on a date of service basis.*

**OIG Comment:**

Our position as it pertains to the use of December 31 data versus March 31 data relates specifically to this audit of contract year 2013. As stated above, we could not verify the reported data using any other independent source. Furthermore, to account for the AHIC and QHI errors in the 2013 MLR filings, December 31 data was utilized. Therefore, for consistency in the calculation, we utilized the December 31 data to test the components of the calculation of the 2013 FEHBP MLR. However, the difference in timing did not materially impact the MLR calculations. Also, we recognize that the use of data from the March 31 column of the HHS MLR form may be used in future calculations of the FEHBP MLR if the data is accurately reported and verifiable by source documentation. Our verification of that data will be evaluated in future audits.

**d. Premium Ratio**

The Plan allocated non-income related taxes, regulatory fees, QHI expenses, and fraud reduction expenses that were applicable to the FEHBP by using a premium ratio allocation method. The premium ratio was calculated by dividing the FEHBP premium by total large group sector premium on the HHS grand total MLR filing (by legal entity), designated in the March 31 large group column as “Direct Premiums Written.” However, we believe the Plan’s use of “Direct Premiums Written” in determining the large group premium ratio does not produce the most accurate results. Instead, “Direct Premiums Earned” reported as of December 31 should be the basis for the allocation, since it more accurately represents the premiums earned by the Plan for the calendar year.

“Direct Premiums Earned” is calculated by taking the “Direct Premiums Written” amount, adding the difference of unearned premium in the prior and current year, and then subtracting premium balances written off for the calendar year. The result, “Direct Premiums Earned,” is the actual premium the Plan received. Since the actual FEHBP paid premium is used for the FEHBP portion of the ratio, we believe that the actual or “Direct Premiums Earned” amount should be used for the large group portion of the ratio.

**Plan Response:**

***The Plan does not agree with this finding and contends that the use of Direct Premiums Written in the premium allocation ratio is in keeping with the HHS filing guidelines, which OPM directs the Plan to use when OPM does not provide specific instructions for components of the MLR filing.***

***Additionally, the Plan clarifies that they began reporting premium on a date of service basis in 2013. Since 2013 was the transition year, the Direct Premiums Written reported on the HHS MLR form included unearned premium from contract year 2012. In 2014 and forward, Direct Premiums Written will be reported on a date of service basis and be fully adjusted to include only premium related to the applicable calendar year.***

**OIG Comment:**

We agree with the Plan that the FEHBP MLR regulations instruct plans to refer back to the HHS rules when they do not provide specific instructions for components of the MLR filing. However, the HHS rules do not explicitly state “Direct Premiums Written” should be used when allocating expenses. The regulations state that, “HHS has therefore not prescribed a standardized method for allocating costs ... All costs ... must be allocated according to generally accepted accounting methods that yield the most accurate results and are well documented.” Our audit tests of “Direct Premiums Earned” yields the most accurate result for 2013 FEHBP MLR purposes.

The Plan also states it allocates expenses in the HHS filing using a “Direct Premium Written” ratio and the same methodology should apply when allocating expenses to the FEHBP MLR calculation. However, the intent of OPM’s instructions was to include calendar year revenue, incurred claims, and expenses. In contract year 2013, “Direct Premiums Earned” is calculated in the same manner as OPM subscription income, by incorporating the written annual premium for the year and adjusting by unearned premium in the prior and current years. “Direct Premiums Written” does not take into account adjustments for unearned premium in the prior and current years and does not present an accurate premium amount for the calendar year period. Therefore, we disagree with the Plan’s position and assert that “Direct Premiums Earned” should be used when calculating the premium allocation ratio in 2013.

As to the Plan’s move to a date of service premium methodology to derive its premium allocation ratios beginning in 2014, we tentatively agree that this move should address this issue going forward. However, we will need to analyze this methodology on a future

audit before we can offer a full opinion. Since the difference in timing did not materially impact the MLR calculations and the Plan intends to move to another methodology, we are not making a recommendation to address this issue in this final report; however, we maintain that “Direct Premiums Earned” continues to represent the most accurate premium amount for allocation purposes.

**e. FEHBP MLR Claims Compliance**

On July 29, 2014, OPM issued Carrier Letter 2014-18 regarding claims data requirements for non-traditional community-rate carriers [health plans]. Beginning in 2013, all Carriers submitting MLR forms to OPM must also submit the claims data reported as the numerator in the MLR. The mandatory format for the claims data fields was included as part of the Carrier Letter.

When the Plan sent their 2013 FEHBP MLR filings to OPM in November 2014, the Plan also sent the related claims data. Upon review of this data in March 2015, we determined that two of the mandatory claims data fields in the pharmacy claims data were incorrectly reported. The OPM OIG requested that the Plan resubmit the data to correct the reporting errors, and the Plan complied. However, due to the delay in timing from the original extraction of the claims data in November 2014, to the resubmitted data in March 2015, the pharmacy claims data no longer matched the pharmacy claims used in the 2013 FEHBP MLR filings.

During the course of our review, we evaluated the variance between the original pharmacy claims data and the resubmitted claims data and found the overall variance to be immaterial. Therefore, we accepted the pharmacy claims total originally submitted to OPM in November 2014, as part of the numerator in our audited MLR calculations.

**Plan Response**

*The Plan agrees with this finding.*

**f. Other MLR Review Areas**

We identified other MLR reporting errors that stem from a lack of internal controls. These issues and the Plan’s responses can be found in section A.1.b.i. through A.1.b.v. of this report.

## **Conclusion – Medical Loss Ratio Review**

Due to insufficient criteria surrounding the FEHBP MLR tax expense calculation, we cannot assess the appropriateness of the Plan’s reported FEHBP MLR Federal and State Income Tax expenses. Since the Federal and State Income Tax expenses are material adjustments to the denominator of the MLR, we cannot evaluate the monetary impact of the other MLR reporting issues or express an opinion on the reported 2013 MLR as a whole.

### **Recommendation 3**

We recommend that OPM issue FEHBP MLR criteria that addresses the impact of corporate structure on the determination of Federal and State income tax expenses that are deductible from the FEHBP MLR denominator.

### **Recommendation 4**

We recommend that the contracting officer verify that the submitted action plans and documented policies and procedures are active and provide direction to claims processors regarding claims payments when coverage is retroactively terminated.

### **Recommendation 5**

We recommend that the contracting officer verify that the Plan implemented the additional processes and controls outlined in “Aetna's Action Plan to Correct Processing of Ineligible Abortion Claims.”

### **Recommendation 6**

We recommend that the Plan only allocate MLR data that is supportable by an independent source.

### **Recommendation 7**

We recommend that the Plan retain all data and documentation used to determine the FEHBP MLR submission in accordance with their contracts.

### **Recommendation 8**

We recommend that the Plan review and submit accurate claims data, per the requirements outlined in the yearly claims data requirement carrier letter.

# EXHIBIT A

## Claims and Sample Selection Criteria/Methodology Medical Dependent Eligibility Claims Sample

Medical Claims Review Area	Universe Criteria	Universe (Number)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Dependent Eligibility-Plan Code 2X	Utilized SAS to select all dependent members age 26 or older that incurred medical claims.	6 members	All universe members.	N/A	N/A
Dependent Eligibility-Plan Code HF	Utilized SAS to select all dependent members age 26 or older that incurred medical claims.	1 member	All universe members.	N/A	N/A
Dependent Eligibility-Plan Code HY	Utilized SAS to select all dependent members age 26 or older that incurred medical claims.	3 members	All universe members.	N/A	N/A
Dependent Eligibility-Plan Code JC	Utilized SAS to select all dependent members age 26 or older that incurred medical claims.	32 members	All universe members.	N/A	N/A
Dependent Eligibility-Plan Code P1	Utilized SAS to select all dependent members age 26 or older that incurred medical claims.	2 members	All universe members.	N/A	N/A
Dependent Eligibility-Plan Code P3	Utilized SAS to select all dependent members age 26 or older that incurred medical claims.	37 members	All universe members.	N/A	N/A
Dependent Eligibility-Plan Code UB	Utilized SAS to select all dependent members age 26 or older that incurred medical claims.	9 members	All universe members.	N/A	N/A
Dependent Eligibility-Plan Code WQ	Utilized SAS to select all dependent members age 26 or older that incurred medical claims.	17 members	All universe members.	N/A	N/A
Dependent Eligibility-Plan Code YE	Utilized SAS to select all dependent members age 26 or older that incurred medical claims.	14 members	All universe members.	N/A	N/A

# EXHIBIT B

## Pharmacy Dependent Eligibility Claims Sample

Pharmacy Claims Review Area	Universe Criteria	Universe (Number)	Sample Criteria and Size	Sample (Number)	Sample Type	Results Projected to the Universe?
Dependent Eligibility-Plan Code 2X	Utilized SAS to select all dependent members age 26 or older that incurred pharmacy claims.	19 members	Selected all members from the universe that were not included in the Medical claims review.	14 members	Judgmental	No
Dependent Eligibility-Plan Code HF	Utilized SAS to select all dependent members age 26 or older that incurred pharmacy claims.	1 member	Selected all members from the universe that were not included in the Medical claims review.	0 members	Judgmental	No
Dependent Eligibility-Plan Code HY	Utilized SAS to select all dependent members age 26 or older that incurred pharmacy claims.	4 members	Selected all members from the universe that were not included in the Medical claims review.	3 members	Judgmental	No
Dependent Eligibility-Plan Code JC	Utilized SAS to select all dependent members age 26 or older that incurred pharmacy claims.	35 members	Selected all members from the universe that were not included in the Medical claims review.	23 members	Judgmental	No
Dependent Eligibility-Plan Code P1	Utilized SAS to select all dependent members age 26 or older that incurred pharmacy claims.	4 members	Selected all members from the universe that were not included in the Medical claims review.	3 members	Judgmental	No
Dependent Eligibility-Plan Code P3	Utilized SAS to select all dependent members age 26 or older that incurred pharmacy claims.	36 members	Selected all members from the universe that were not included in the Medical claims review.	10 members	Judgmental	No
Dependent Eligibility-Plan Code UB	Utilized SAS to select all dependent members age 26 or older that incurred pharmacy claims.	11 members	Selected all members from the universe that were not included in the Medical claims review.	5 members	Judgmental	No
Dependent Eligibility-Plan Code WQ	Utilized SAS to select all dependent members age 26 or older that incurred pharmacy claims.	25 members	Selected all members from the universe that were not included in the Medical claims review.	15 members	Judgmental	No
Dependent Eligibility-Plan Code YE	Utilized SAS to select all dependent members age 26 or older that incurred pharmacy claims.	14 members	Selected all members from the universe that were not included in the Medical claims review.	4 members	Judgmental	No

# EXHIBIT C

## Additional Medical Dependent Eligibility Claims Sample

Medical Claims Review Area	Universe Criteria	Universe (Number)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Dependent Eligibility-Plan Code 2X	Utilized SAS to select all additional members determined to have dependent status after the initial claims sample selection and were age 26 or older.	1 member	All universe members.	N/A	N/A
Dependent Eligibility-Plan Code HF	Utilized SAS to select all additional members determined to have dependent status after the initial claims sample selection and were age 26 or older.	0 members	All universe members.	N/A	N/A
Dependent Eligibility-Plan Code HY	Utilized SAS to select all additional members determined to have dependent status after the initial claims sample selection and were age 26 or older.	0 members	All universe members.	N/A	N/A
Dependent Eligibility-Plan Code JC	Utilized SAS to select all additional members determined to have dependent status after the initial claims sample selection and were age 26 or older.	10 members	All universe members.	N/A	N/A
Dependent Eligibility-Plan Code P1	Utilized SAS to select all additional members determined to have dependent status after the initial claims sample selection and were age 26 or older.	1 member	All universe members.	N/A	N/A
Dependent Eligibility-Plan Code P3	Utilized SAS to select all additional members determined to have dependent status after the initial claims sample selection and were age 26 or older.	7 members	All universe members.	N/A	N/A
Dependent Eligibility-Plan Code UB	Utilized SAS to select all additional members determined to have dependent status after the initial claims sample selection and were age 26 or older.	7 members	All universe members.	N/A	N/A
Dependent Eligibility-Plan Code WQ	Utilized SAS to select all additional members determined to have dependent status after the initial claims sample selection and were age 26 or older.	1 member	All universe members.	N/A	N/A
Dependent Eligibility-Plan Code YE	Utilized SAS to select all additional members determined to have dependent status after the initial claims sample selection and were age 26 or older.	1 member	All universe members.	N/A	N/A

# EXHIBIT D

## Medical Non-Covered Benefit Claims Sample

Medical Claims Review Area	Universe Criteria	Universe (Number)	Sample Criteria	Sample (Number)	Sample Type	Results Projected to the Universe?
Non-Covered Benefits - Plan Code 2X	Utilized SAS to select all medical claims with procedure codes 59812, 59820, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 59866, and 59821.	7 claims	Selected all claims from the universe with elective abortion procedure codes.	1 claim	Judgmental	No
Non-Covered Benefits - Plan Code HF		0 claims	Selected all claims from the universe with elective abortion procedure codes.	0 claims	Judgmental	No
Non-Covered Benefits - Plan Code HY		2 claims	Selected all claims from the universe with elective abortion procedure codes.	0 claims	Judgmental	No
Non-Covered Benefits - Plan Code JC		19 claims	Selected all claims from the universe with elective abortion procedure codes.	5 claims	Judgmental	No
Non-Covered Benefits - Plan Code P1		0 claims	Selected all claims from the universe with elective abortion procedure codes.	0 claims	Judgmental	No
Non-Covered Benefits - Plan Code P3		1 claim	Selected all claims from the universe with elective abortion procedure codes.	0 claims	Judgmental	No
Non-Covered Benefits - Plan Code UB		3 claims	Selected all claims from the universe with elective abortion procedure codes.	0 claims	Judgmental	No
Non-Covered Benefits - Plan Code WQ		4 claims	Selected all claims from the universe with elective abortion procedure codes.	0 claims	Judgmental	No
Non-Covered Benefits - Plan Code YE		6 claims	Selected all claims from the universe with elective abortion procedure codes.	0 claims	Judgmental	No

# EXHIBIT E

## Aetna Inc. Consolidated Entities: Excerpt from 2013 Financial Statements

At December 31, 2013, the Company's Federal Income Tax Return was consolidated with the following entities:

Aetna Inc. - Parent Company	Coventry Health Care of Illinois, Inc.
@ Credentials Inc.	Coventry Health Care of Iowa, Inc.
Active Health Management, Inc.	Coventry Health Care of Kansas, Inc.
Adminco, Inc.	Coventry Health Care of Louisiana, Inc.
Administrative Enterprises, Inc.	Coventry Health Care of Missouri, Inc.
AE Fourteen, Incorporated	Coventry Health Care of Nebraska, Inc.
AET Health Care Plan, Inc.	Coventry Health Care of Pennsylvania, Inc.
Aetna ACO Holdings, Inc.	Coventry Health Care of Texas, Inc.
Aetna Better Health Inc. (Connecticut)	Coventry Health Care of the Carolinas, Inc.
Aetna Better Health Inc. (Florida)	Coventry Health Care of Virginia, Inc.
Aetna Better Health Inc. (Georgia)	Coventry Health Care of West Virginia, Inc.
Aetna Better Health Inc. (Illinois)	Coventry Health Care Workers' Compensation, Inc.
Aetna Better Health Inc. (New Jersey)	Coventry Health Care, Inc.
Aetna Better Health Inc. (New York)	Coventry Health Plan of Florida, Inc.
Aetna Better Health Inc. (Ohio)	Coventry HealthCare Management Corporation
Aetna Better Health Inc. (Pennsylvania)	Coventry Management Services, Inc.
Aetna Better Health Inc. (Tennessee) (f/k/a HealthCare USA of Tennessee, Inc.)	Coventry Prescription Management Services, Inc.
Aetna Better Health, Inc. (Louisiana)	Coventry Rehabilitation Services, Inc. (f/k/a First Health Strategies, Inc.)
Aetna Dental Inc. (New Jersey)	Coventry Summit Health Plan, Inc.
Aetna Dental Inc. (Texas)	Coventry Transplant Network, Inc.
Aetna Dental of California Inc.	CoventryCares of Michigan, Inc.
Aetna Health and Life Insurance Company	Delaware Physicians Care, Incorporated
Aetna Health Finance, Inc.	First Health Group Corp.
Aetna Health Inc. (Connecticut)	First Health Life and Health Insurance Company
Aetna Health Inc. (Florida)	First Script Network Services, Inc.
Aetna Health Inc. (Georgia)	Florida Health Plan Administrators, LLC
Aetna Health Inc. (Maine)	FOCUS Healthcare Management, Inc.
Aetna Health Inc. (Michigan)	Group Dental Service of Maryland, Inc.
Aetna Health Inc. (New Jersey)	Group Dental Service, Inc.
Aetna Health Inc. (New York)	Health and Human Resource Center, Inc.
Aetna Health Inc. (Pennsylvania)	Health Data & Management Solutions, Inc.
Aetna Health Inc. (Texas)	Health Re, Incorporated
Aetna Health Insurance Company	HealthAmerica Pennsylvania, Inc.
Aetna Health Insurance Company of New York	HealthAssurance Financial Services, Inc.
Aetna Health of California Inc.	HealthAssurance Pennsylvania, Inc.
Aetna Insurance Company of Connecticut	HealthCare USA of Missouri, LLC
Aetna Integrated Informatics, Inc.	Jaguar Merger Subsidiary, Inc.
Aetna International Inc.	Luettgens Limited
Aetna Ireland Inc.	Managed Care Coordinators, Inc.
Aetna Life and Casualty (Bermuda) Ltd.	Medicity Inc.
Aetna Life Assignment Company	Mental Health Associates, Inc.
Aetna Life Insurance Company	Mental Health Network of New York IPA, Inc.
Aetna Risk Indemnity Company Limited	Meritain Health, Inc.
Aetna Student Health Agency Inc.	MetraComp, Inc.
AHP Holdings, Inc.	MHNet Life and Health Insurance Company

## EXHIBIT E...continued

Allviant Corporation	MHNet of Florida, Inc.
Altius Health Plans, Inc.	Missouri Care, Incorporated
American Health Holding, Inc.	Niagara Re, Inc.
AUSHC Holdings, Inc.	PayFlex Holdings, Inc.
Broadspire National Services, Inc.	PayFlex Systems USA, Inc.
Cambridge Life Insurance Company	Performax, Inc.
Carefree Insurance Services, Inc.	Precision Benefit Services, Inc.
CHC Casualty Risk Retention Group, Inc.	Prime Net, Inc.
Chickering Claims Administrators, Inc.	Prodigy Health Group, Inc.
Claims Administration Corporation	Professional Risk Management, Inc.
Cofinity, Inc.	Resources for Living, LLC
Coventry Consumer Advantage, Inc.	Schaller Anderson Medical Administrators, Incorporated
Coventry Financial Management Services, Inc.	Strategic Resource Company
Coventry Health and Life Insurance Company	The Vasquez Group Inc.
Coventry Health Care National Accounts, Inc.	U.S. Healthcare Properties, Inc.
Coventry Health Care National Network, Inc.	WellPath of South Carolina, Inc.
Coventry Health Care of Delaware, Inc.	Work and Family Benefits, Inc.
Coventry Health Care of Florida, Inc.	
Coventry Health Care of Georgia, Inc.	

# APPENDIX

October 1, 2018

Ms. [REDACTED]  
Chief, Community-Rated Audits Group  
U.S. Office of Personnel Management  
Office of the Inspector General  
1900 E Street NW, Room 6400  
Washington, DC 20415

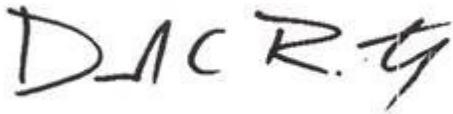
Re: Audit of Aetna Open Access – Global Audit  
Contract Numbers CS 2867 & CS 2914  
Plan Codes 2X, HF, HY, P1, UB, WQ, YE, JC, P3  
Draft Audit Report No. IC-99-00-17-007

Dear Ms. [REDACTED]:

Thank you for the opportunity to respond to the above referenced draft audit report dated June 29, 2018. After careful review of the draft report, we agree with several of the draft report's findings and recommendations. However, we respectfully disagree with a number of the findings and recommendations, which we detail in our attached response.

We look forward to continuing to work with the OIG in the coming weeks to address and resolve all of the concerns in the draft report prior to the final audit report's completion. Please feel free to contact me when you have reviewed our response and are ready to discuss our next steps.

Sincerely,

A handwritten signature in black ink that reads "D.C. Rotay". The signature is written in a cursive, slightly slanted style.

David C. Rotay  
Executive Director

cc: Honorable Michael J. Rigas  
Deputy Director

Michael D. Dovilla  
Acting Chief of Staff

Theodore M. Cooperstein  
General Counsel

Alan P. Spielman  
Director, Healthcare and Insurance

Laurie E. Bodenheimer  
Acting Deputy Director, Healthcare and Insurance

Edward M. DeHarde  
Assistant Director, Federal Employee Insurance Operations

Mark W. Lambert  
Associate Director, Merit System Audit and Compliance

Janet L. Barnes  
Director, Internal Oversight and Compliance

  
Chief, Audit Resolution and Compliance

Thomas Bernatavitz  
President, Federal Plans, Aetna

**Response to Draft Report dated June 29, 2018**

**Audit of Aetna Open Access – Global Audit  
Blue Bell, Pennsylvania**

**Report No. IC-99-00-17-007**

Aetna submits the following comments to the above-referenced draft report (“Draft Report”) issued by the Office of Personnel Management (“OPM”) Office of the Inspector General (“OIG”) in connection with the OIG’s audit of the Federal Employees Health Benefits Program (“FEHBP”) medical loss ratio (“MLR”) submissions to OPM for contract year 2013. The Global Audit covered the FEHBP contracts for Aetna Open Access – Contracts CS 2867 and CS 2914, Plan Codes 2X, HF, HY, P1, UB, WQ, YE, JC, and P3, (hereinafter, the “Plan”).

### **Background**

According to the Draft Report, the primary objective of the audit was to determine if the Plan was in compliance with the provisions of its contract and the laws and regulations governing the FEHBP and, to accomplish this objective, the OIG verified whether the Plan met the MLR requirements established by OPM.

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

The Plan’s compliance must be assessed in the context of the FEHBP and MLR requirements that were in effect for contract year 2013. Those requirements included OPM’s regulations in Chapter 16 of Title 48 of the Code of Federal Regulations as well as OPM’s 2013 Community Rating Guidelines. Importantly, OPM’s 2013 Community Rating Guidelines instructed carriers that “[Department of Health and Human Services] MLR guidelines will apply for issues not covered in these instructions.” As detailed below, several of the Draft Report’s findings reflect the OIG’s disagreement with the Plan’s reliance on HHS MLR guidelines where OPM’s MLR instructions were silent. These areas of disagreement cannot be the basis for any findings of noncompliance. In addition, OPM’s subsequent revisions to the MLR guidelines for the FEHBP to clarify its guidelines are useful guidance on how the Plan’s MLR calculations should be evaluated.

### **Plan’s Specific Responses to Draft Report’s Findings and Recommendations**

The following is the Plan’s finding-by-finding response to the Draft Report’s preliminary findings and recommendations. Included with this response is a revised MLR penalty calculation that incorporates those adjustments on which the Plan agrees with the Draft Report.

### **Draft Report Executive Summary**

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

#### **I. Reporting Period (Report Section A.1.(d))**

In the Draft Report, OIG used the December 31, 2013, premium, quality health improvement (QHI), and tax expense data from the National Association of Insurance Commissioners (“NAIC”) Supplemental Health Care Exhibit (“12/31 SHCE Data”) instead of data from the March 31, 2014, Department of Health and Human Services (“HHS”) MLR form (“3/31 HHS Data”) to

restate the Plan's expense allocations to the FEHBP. The Plan disagrees with the OIG's decision to use the December 31, 2013 data as it is inconsistent with the intent of the FEHBP MLR regulation to follow HHS methodologies when making FEHBP MLR calculations and as it does not lead to the most accurate result.<sup>2</sup> Given the importance of this issue in general, we restate the Draft Report's preliminary finding in full before the Plan's response.

**The Draft Report states:**

For expense allocations to the FEHBP, the Plan utilized the March 31, 2014, large group data from their 2013 U.S. Department of Health and Human Services (HHS) MLR submissions. However, during our review, we found that the premium, quality health improvements (QHI), and tax expenses reported in the March 31, 2014, column of the HHS MLR submissions could not be verified using any other independent support. Furthermore, when the Plan attempted to correct the Aetna Health Insurance Company (AHIC) reporting error (see (1)(A)(k) on page 13 of the report), the Plan utilized data as of December 31, 2013. Due to the insufficient support for the March 31, 2014, data and the AHIC reporting error, for consistency and accuracy, we utilized the December 31, 2013, data where validated by supporting documentation. Most notably, this affected all allocated expenses utilizing a premium ratio (see (1)(A)(e) on page 3 of the report), including QHI expenses (see (1)(A)(l) on page 14 of the report) and tax expenses (see (1)(A)(m) on page 17 of the report).

**The Plan's Response is as follows:**

For the following reasons, the Draft Report's assumption that 12/31 SHCE Data is more accurate than the 3/31 HHS Data is incorrect and is inconsistent with the recommendations of the NAIC and the HHS MLR instructions.

- 1. The 3/31 HHS Data is more reliable than the 12/31 SHCE Data**
  - a. The 3/31 HHS Data is used to calculate rebates under the HHS MLR rule.**

The Draft Report claims that the Plan's 3/31 HHS Data (premium, QHI and tax expenses) "could not be verified using any other independent source." This claim may refer to the fact that the 12/31 column on the HHS MLR Form can be "verified" by the 12/31 SHCE Data while the 3/31 HHS Data cannot as easily be traced back to the SHCE or general ledger. However, as discussed below, the 12/31 SHCE Data is not intended to be relied upon as the HHS MLR form instructions require carriers to use the preliminary 12/31 SHCE Data in the 12/31 column of the HHS MLR

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<sup>2</sup> In making its recommendations to HHS, the NAIC did not mandate the use of a specific methodology for allocating non-claims costs and HHS adopted their "flexible approach." In general, expenses are to be allocated according to generally accepted accounting methods that yield the most accurate results. See 75 Fed. Reg. 74864, 74879 (Dec. 1, 2010).

Form “as is” without any enrichment, further verification or modification.<sup>3</sup> Moreover, the Plan’s independent auditors do not audit the SHCE. Therefore, there is no real independent or additional verification of the 12/31 SHCE Data when it is transferred to the 12/31 column of the HHS MLR Form. In fact, it is the 3/31 HHS Data that is more accurate and precise as it is subject to the Plan’s enhanced controls and verification process and is actually the data used for calculating rebates to our policyholders.

Moreover, if the 3/31 HHS Data is inaccurate, the Plan is subject to significant consequences in an HHS or state MLR audit of having to reprocess and pay additional rebates with 10% interest and potentially other regulatory penalties. As a result, it is the verified 3/31 HHS Data that is expected to yield the most accurate results when allocating expenses.

**b. The 12/31 SHCE Data lacked critical MLR attributes that are contained in the 3/31 HHS Data.**

Unlike the HHS MLR Form, the SHCE is intended to be an information-only exhibit and is not required by the ACA itself. In fact, some states do not even require an issuer to file a SHCE. As a result, the NAIC website includes the following cautionary statement advising issuers not to use the December 31<sup>st</sup> (SHCE) to calculate rebates:

Carriers that provide comprehensive individual and group health insurance have filed their 20XX SHCE (due April 1) with the NAIC and state insurance regulators. The form is filed on a state-by-state basis and in grand total. Line 7 on Part 1 reports a “Preliminary MLR” for the individual, small group, large group market segments and other market segments covered by the federal Patient Protection and Affordable Care Act (ACA). The line is meant to report exactly that—a **preliminary MLR. It is not meant to represent or replicate the MLR calculated by HHS/CMS in its MLR reporting form for actual rebate purposes.** (bold added) (See Exhibit A - shce\_cautionary\_statement)<sup>4</sup>

There are also differences between the 12/31 SHCE Data and 3/31 HHS Data that make the 3/31 HHS Data more appropriate to use as a basis for expense allocation. These differences include, but are not limited to, the following:

- **Membership:** The 2013 12/31 SHCE Data is on a legal entity basis without certain adjustments needed for group size. As a result, to accurately report membership in the large group pool used to allocate expenses to the FEHBP, the Plan had to determine whether each policyholder was in the large group or small group market by verifying each Policyholder’s number of total average employees (“TAE”). This verification and data enrichment process was completed after the

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<sup>3</sup> For example, the 2013 HHS MLR Instructions direct issuers to report direct premium written in the HHS 12/31 column “as filed on the NAIC SHCE filing for the MLR reporting year.”

<sup>4</sup>See [https://www.naic.org/documents/committees\\_e\\_app\\_blanks\\_related\\_shce\\_cautionary\\_statement.pdf](https://www.naic.org/documents/committees_e_app_blanks_related_shce_cautionary_statement.pdf)

SHCE was filed and impacted all allocations that used a membership basis. There were also other updates made to accurately report 3/31 HHS Data that were not captured in the SHCE due to the timing of the SHCE filing versus the HHS submission dates (4/1 versus 7/31 of each year).

- **Incurred Claims/Admin Expense:** The 12/31 SHCE Data is generally based on the way the Plan conducts its statutory accounting. There are, however, differences in the rules for statutory accounting of claims and definition of claims calculated under the HHS MLR rules. For example, for the 3/31 HHS Data, the Plan must remove certain administrative expenses from the statutory definition of incurred claims at a claim level for certain vendors. These expenses are either reported as general administrative expense or QIA/QHI. As a result, if the Plan used 12/31 claims data from the SHCE it would overstate the Plan's reported claim amounts for MLR expense allocation purposes.
- **Cost Containment and General Administrative Expenses:** After the close of the experience year, the Plan continues to verify the accuracy of cost containment and general administrative expenses that are then reported as part of the 3/31 HHS Data. The preliminary 12/31 SHCE Data filed in April 1 does not have the benefit of the additional months of verification. For example, the Plan conducts additional due diligence with respect to the accuracy of its QIA/QHI amounts after the filing of the SHCE on April 1<sup>st</sup>. In contrast, the 12/31 SHCE Data is not updated but simply transferred over to the HHS form "as is".<sup>5</sup>

## 2. The 12/31 SHCE Data is not on a date of service (DOS) basis.

Both HHS and the NAIC provide for and support the use of date of service claims and premium as of 3/31 for MLR purposes and for allocating expenses. The NAIC found that using such a date of service methodology for calculating HHS MLR rebates was both more accurate than using a December 31<sup>st</sup> estimate and more practical than using a longer run out period. Prior to the NAIC drafting its proposed MLR regulations to submit to HHS for adoption, it stated:

Evaluating the remaining liability for claim payments at March 31, allows estimates of claims expected to be paid in the first quarter to mature into actual payments. They become a factual record. Replacing this estimate with known values increases the accuracy of the MLR rebate.<sup>6</sup>

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<sup>5</sup> Under statutory accounting principles an issuer's annual statement must be free from material misstatements. The SHCE is an addendum to the annual statement. There is, however, no express materiality standard for any error stated in the MLR rules with respect to the MLR HHS form filing.

<sup>6</sup> See Master Issue Resolution Document No. IRD010 issued August 25, 2010.  
[https://www.naic.org/documents/committees\\_lhatf\\_ahwg\\_ppaca\\_ird\\_master.pdf](https://www.naic.org/documents/committees_lhatf_ahwg_ppaca_ird_master.pdf)

HHS agreed with the NAIC and adopted a date of service approach to calculating claims in its final MLR rule<sup>7</sup> as did OPM with respect to its own FEHBP MLR calculation.<sup>8</sup>

The same rationale applies to the use of a date of service premium in the HHS MLR Form and for consistency in the Plan's allocation of expenses in its FEHBP MLR form. In fact, in the 2013 draft HHS MLR Instructions, issuers were required to report premium for rebate purposes on a 3/31 date of service basis to increase the accuracy of reported premium and to match the time period reported for date of service claims.

Eventually, because of administrative issues with certain carriers in being unable to report premium on a date of service basis, HHS' final instructions in 2013 did allow (but not require) premium to be reported using 12/31 SHCE data as an alternative to using the more accurate 3/31 date of service data.<sup>9</sup> The Plan, however, was able to report premium on a date of service basis and used the more accurate premium in calculating its 2013 HHS MLRs consistent with the HHS instructions.

### **3. FEHBP regulations and OPM MLR instructions defer to the HHS MLR regulations and guidelines.**

Throughout the MLR rulemaking process as well as in its annual MLR instructions, OPM has confirmed the applicability of the HHS MLR regulations and guidelines. For example, prior to issuing the final FEHB MLR rule in 2012, OPM expressed its intention to follow the HHS MLR methodology: "OPM intends to be consistent with the HHS methodology unless doing so conflicts with the FEHB contract."<sup>10</sup>

Elsewhere in that preamble in response to a commenter's concern about OPM's plan to use a different form than HHS for submitting MLR information, OPM provided the following reassurance: "Because formula for calculating the MLR required in this context *is the same* as that outlined in 45 CFR part 158, OPM intends to model its form closely on the HHS form."<sup>11</sup>

In a similar context, OPM stated that it would adopt HHS clarifications on allocation issues. Specifically, in response to a comment on the need for clarity and consistency regarding the identification and allocation of costs and revenues for the MLR calculations, OPM advised:

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<sup>7</sup> The 2013 MLR Instruction state: "Include [in the 3/31 columns]: Experience of policies in each market, incurred, paid or received relevant only to the MLR reporting year, reported as of March 31 of the subsequent MLR reporting year."

<sup>8</sup> 76 Fed. Reg. 38282, 38283 (June 29, 2011).

<sup>9</sup> Ultimately, the 2013 HHS MLR Instructions stated that in the 3/31 (premium for coverage in MLR reporting year only) "issuers may choose to report amounts on the same basis as in the 12/31 columns." See <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2013-mlr-reporting-form-instructions-20140326.pdf>

<sup>10</sup> 77 Fed. Reg. 19522, 19523 (April 2, 2012).

<sup>11</sup> *Id.* (emphasis added).

As stated in the interim final regulation, OPM will adopt the HHS definition of MLR for purposes of MLR-based rate negotiation in FEHB. We anticipate that any clarifications around this calculation that are offered by HHS will be adopted by OPM.<sup>12</sup>

Finally, OPM's MLR instructions advise carriers that the HHS MLR guidelines will apply for issues not addressed by OPM: "HHS MLR guidelines will apply for issues not covered in these instructions." Thus, since there were no FEHBP laws and regulations or OPM requirements on expense allocations for the 2013 MLR calculation, the Plan's reliance on HHS MLR rules was appropriate.<sup>13</sup> And, as demonstrated under subsection 2 above, HHS clearly allows issuers to allocate plan expenses on a date of service basis.<sup>14</sup>

**4. The Plan's use of 12/31 SHCE Data for the very limited purpose of allocating AHIC non-claim expenses should not result in discarding 3/31 HHS Data entirely.**

The Plan asserts that premium and claims were correctly represented in the Large Group "Total as of 3/31/14," column 12. The Plan acknowledges that it inadvertently omitted non-claim expenses in the Large Group "Total as of 3/31/14," column 12 when it reported its 2013 HHS MLR filing for its HMO affiliates. When it corrected this error for the FEHBP filing, the Plan used AHIC non-claim expenses on a 12/31 Financial Statement basis and mapped these expenses to each affiliated HMO. This was done because AHIC does not bill premium and there is no 3/31 basis for the allocation. The 12/31 Financial Statement premium reported on the SHCE for AHIC is inferred based on out-of-network claim utilization, but it is actually billed by the affiliated HMO.

Finally, the Plan respectfully submits that if OPM should decide to require an alternate methodology, it should do so on a prospective basis in official guidance or changes to the FEHB contract, as suggested in the commentary to the OPM Final Rule, and not through a retrospective audit.<sup>15</sup>

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<sup>12</sup> *Id.* at 19522.

<sup>13</sup> Nothing in the Draft Report, the Plan's contract with OPM, or the 2013 Community Rating Guidelines, prohibits using date of service premium for the FEHB-specific MLR expense allocations.

<sup>14</sup> OPM released eight FEHBP-specific MLR rules in 2011. The eighth rule directs plans to refer to the HHS regulations for any item not addressed in the previous seven rules to complete the FEHBP-specific MLR filings (*Exhibit B - FEHBP MLR Instructions*), and the Plan has adhered to this rule since the FEHBP-specific MLR's inception. The details of this ACA-required MLR formula comparing non-claim costs to overall expenditures were promulgated in an HHS interim final regulation published in the Federal Register on December 1, 2010 (75 FR 74864).

<sup>15</sup> While the FEHB regulation deviated from the HHS rate setting mechanisms (See Section 1615.402 Pricing Policy), The FEHBP MLR regulation stated that "OPM will base its MLR definitions on the HHS interim final rule of December 1, 2010." While a few differences between the calculation exist, the HHS MLR calculation is on a three year basis, the FEHB-specific MLR is calculated on a one year basis and the size of any credibility adjustment lower due to the relative small size of FEHB enrollee populations. ... "FEHB carriers will report the same categories of information for the FEHB-specific MLR threshold calculation as reported for the ACA-required MLR calculation;" *Id.*

## II. Premium Ratio (Report Section A.1.(c))

The Plan allocated non-income related taxes, regulatory fees, quality health improvement expenses, and fraud reduction expenses applicable to the FEHBP filing using a premium ratio allocation method. The premium ratio is calculated by taking OPM premium for the Plan divided by the HHS large group Direct Premiums Written (HHS Part 2 line 1.1 on a date of service basis). The Draft Report alleges that “[t]he Plan’s use of “Direct Premiums Written” in determining the large group premium ratio “does not produce the most accurate results.” Instead, the Draft Report argues that “Direct Premiums Earned” reported as of December 31, 2013, should be the basis for the allocation claiming that it more accurately represents the premiums earned by the Plan. As previously explained under Section I and for the additional reasons described below, the Plan disagrees with the Draft Report. The 3/31 premium column of the HHS MLR form provides the more accurate basis for expense allocation.

As noted above, the FEHBP MLR Rules instruct carriers to apply the HHS rules when OPM does not provide specific instructions for components of the MLR filing, as is the case with expense allocation. The Plan allocated expenses on the HHS filing using a direct written premium ratio and applied a consistent approach to the FEHBP MLR filing. As explained in Section 1 above, the use of the direct written premium allocation is explicit in the HHS filing expense narrative. Allocating the FEHBP expenses on a direct premium earned basis as the Draft Report recommends would result in allocating the expenses on a different basis than the expenses that are derived in the large group pool on the HHS filing. Calculating the premium ratio allocation using direct premiums earned for the FEHBP would be in direct conflict with the HHS expense allocation method and in conflict with the FEHBP instructions that direct carriers to apply the HHS filing guidelines.

In 2013, Aetna began to report date of service (DOS) premium on the HHS filing as direct written premium (HHS Part 2 line 1.1).<sup>16</sup> As 2013 was a transition year, the HHS MLR form included the prior year’s (2012) unearned premium reported. However, beginning in 2014, the use of DOS premium eliminated the need to report unearned premium adjustments. In addition, the Plan used OPM’s subscription premium in its FEHBP-specific MLR calculations. The subscription premium represents what is truly due for the applicable calendar year (e.g. 2014). When calculating the subscription premium, any amounts paid in 2014 for calendar year 2013 were removed and any amounts that were to be paid in 2015 for 2014 were included. This calculation provided by OPM is consistent with the Plan’s DOS direct written premium reflected on the HHS filings beginning in 2013. Therefore, the use of the HHS DOS direct written premium will already be on an earned basis consistent with the OPM premium and will not need any further adjustments. By contrast, direct earned premium requires adjustment in order to

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<sup>16</sup> The 2013 HHS MLR Instructions stated: “3/31 Column (premium for coverage in MLR reporting year only) – report premium collected from 1/01 of the MLR reporting year through 3/31 of the year following the MLR reporting year for coverage in the MLR reporting year only, plus uncollected (due and unpaid) premium for coverage in the MLR reporting year only as of 3/31 of the year following the MLR reporting year. Premium should reflect retroactive eligibility adjustments related to coverage in the MLR reporting year. PLEASE NOTE that this methodology differs from NAIC SHCE methodology. However, issuers may choose to report amounts on the same basis as in the 12/31 columns.”

capture total unearned premium adjustments. As a result, direct earned premium is more difficult to audit and more subject to error than direct written premium, which tied directly to the HHS filing (part 2, line 1.1).

In order to remain consistent with the HHS filing and the OPM subscription premium in the FEHBP MLR calculation, the appropriate method for calculating the expense allocation is to apply direct premiums written to the premium ratio.

As previously explained, it is not appropriate to use the data as of December 31, 2013, but rather the data as of March 31, 2014.

### **III. Plan Code P3 Premium Ratio Issue (Report Section A.1.(i))**

The Plan agrees with OIG's approach in using recreated membership support to determine the OPM premium by state and legal entity. The Plan will implement necessary record retention control to maintain required documentation in support of the premium split for plan code P3.

### **IV. Claims Paid for Ineligible Dependents (Report Section A.1.(f))**

The Draft Report contains several findings related to claims paid by the Plan for ineligible dependents. While the Plan agrees with some of the findings and recommendations, the Plan disagrees with the findings pertaining to dependents incapable of self-support. In addition, in response to past audits, the Plan has implemented several action plans to address various claims findings, which the Plan has reassessed in the context of the Global Audit in order to address OIG's concerns about tracking their effectiveness. The Plan currently has a recoupment policy in place, which requires that claims over a certain dollar threshold be pursued, and has specific guidelines for how to enforce the policy.

#### **a. Unsupported Dependent Eligibility**

The Plan disagrees with the Draft Report's finding that **Deleted by the OIG – Not Relevant to the Final Report** claims were incorrectly paid for ineligible members. The members at issue are dependents who are incapable of self-support and are therefore entitled to dependent coverage under the FEHBP.

OPM requires the payroll offices to notify and provide carriers with a medical certificate supporting a disabled dependent's continued eligibility. Aetna will not flag a dependent as disabled without receiving the certificate and/or appropriate documentation from the payroll office. In fact, in researching this finding, the Plan determined that in most cases, the payroll office does not notify the Plan that a dependent is considered incapable of self-support until after the Plan has terminated the dependent for turning age 26.

The Plan agrees with the Draft Report that neither the Plan nor OPM could provide the appropriate documentation at the time of the audit review. However, many of these members have been enrolled in the Plan for over ten years. It is inappropriate to assume that these members' eligibility and claims should be disallowed because neither the payroll offices nor the Plan continued to maintain supporting documentation. Unless OPM instructs the payroll offices and the Plan to terminate these dependents' eligibility, the Plan will continue to provide coverage to these members and include their claims in the MLR calculations.

The Plan has provided to OIG action plans with improvements to the record retention policies specific to dependents incapable of self-support. The Plan has also requested that the payroll offices update their record retention policies and practices to further improve this process. The Plan will update the action plan to require that, in the event of both the Plan's and the payroll office's inability to locate the appropriate documentation for disabled dependents, the payroll office will be asked to contact the subscriber to request a copy of the supporting documentation.

The Plan is open to further discussions with OPM and OIG to finalize the best plan of action to correct this issue going forward. Please see the attached action plan (*Exhibit C - Action Plan - Claims Paid on Ineligible Members 9.13.16.docx*).

#### **b. Claims Paid After Termination of Dependent Coverage**

The Plan agrees that it incorrectly paid **Deleted by the OIG – Not Relevant to the Final Report** for 31 dependents after their coverage had been terminated for ineligibility or as a result of plan changes.

#### **c. Untimely Termination of Dependent Coverage**

The Plan agrees that it did not timely terminate coverage for 19 dependents who had become ineligible for coverage in 2013 after turning 26. The Plan implemented an action plan to address untimely termination of dependents, which sets the system to terminate the dependent with a future termination date. The Plan has also added a tracking element to this action plan to ensure that the action plan is effective and working according to its intent. Please see *Exhibit D - Action Plan - Dependents Over 26 - Update 8.15.18*.

#### **d. Spouses Erroneously Identified as Dependents**

The Plan agrees that when it responded to a request during this audit, the Plan inadvertently labelled six member spouses as dependents. However, this was merely an error in the audit response, and was quickly resolved when questioned during the audit. This labeling error should not be considered an audit finding. Separately, the Plan agrees that it erroneously paid \$ [REDACTED] in unallowable claims for three member spouses after their termination date.

**e. Claims Paid for Non-Covered Benefits (exclusive to plan code JC) (Report Section A.1.(g))**

The Plan agrees with the Draft Report's finding of **Deleted by the OIG – Not Relevant to the Final Report** claims paid for non-covered benefits. The Plan implemented an action plan in February 2016 to address this issue prospectively. The action plan is attached as *Exhibit E – Action Plan Ineligible Abortion Claims 2.22.16.docx*

**V. Capitation Reporting Error (exclusive to plan code HF) (Report Section A.1.(h))**

The Plan agrees with OIG's recommendation to account for voided checks as \$0 and to update the plan code HF 2013 capitations **Deleted by the OIG – Not Relevant to the Final Report**

**VI. Vendor Payments (Report Section A.1.(i))**

The Plan agrees with OIG's Audited Vendor Payments in OIG Exhibit VIII.

**VII. Pharmacy Manual Adjustments (Report Section A.1.(j))**

The Plan agrees with OIG's Audited Pharmacy Manual Adjustments in OIG Exhibit IX.

**VIII. Aetna Health Insurance Company (AHIC) Exclusion (Report Section A.1.(k))**

The Plan agrees that the SG&A expenses, QHI, and tax expenses for AHIC were not included in the original 2013 HHS MLR submission prior to allocating these expenses over to the FEHBP.

The Plan uncovered this omission in the 2013 HHS MLR submission while it was putting together materials to respond to a request for this audit. As a result of this oversight, the Plan updated the FEHBP tax allocations to appropriately allocate the AHIC expenses along with the AHI expenses by recreating the Large Group column of the HHS MLR filing to include the AHIC data. As previously explained in section I (4) above, when the Plan corrected this error for the FEHBP filing, the Plan used AHIC non-claim expenses on a 12/31 Financial Statement basis and mapped these expenses to each affiliated HMO. This was done due to the fact that AHIC does not bill premium and there is no 3/31 basis for the allocation. The 12/31 Financial Statement premium reported on the SHCE for AHIC is inferred based on out-of-network claim utilization and is actually billed by the affiliated HMO. The Plan aggregated the 3/31 HHS Data for the HMO (AHI companies) with the 12/31 SHCE Data for AHIC to create an updated 3/31 Large Group column, and used this new column to allocate over to the FEHBP.

The Plan's limited use of December 31<sup>st</sup> data to allocate AHIC non-claim expenses is not and should not be viewed as the Plan's concession that such data can be used for all allocations. The AHIC expenses are not reallocated between the December 31<sup>st</sup> and March 31<sup>st</sup> submissions

and the use of the December 31<sup>st</sup> data in this situation allowed the Plan to update the audit documents in a timely fashion. The AHI expenses, however, are reallocated between December 31<sup>st</sup> and March 31<sup>st</sup>, and therefore, it is more appropriate to base the AHI expenses off of the March 31<sup>st</sup> data in order to use the most accurate and consistent data available. Please refer to Section I “Reporting Period” for additional explanations of the Plan’s position.

**IX. Quality Health Improvements (QHI) (Report Section A.1.(l))**

**a. Incorrect Reporting of QHI Expenses:**

The Plan agrees that a portion of the 2013 QHI expenses were inadvertently calculated using budgeted dollars instead of actual dollars. This mistake was an isolated event caused by human error. The Plan updated the allocation of QHI dollars using 3/31 HHS Data during the audit and now has a detailed process document in place to help prevent the error from happening again. The Plan, however, disagrees with the Draft Report’s conclusion that QHI allocations should now be based on less accurate 12/31 SHCE Data as a result. As explained above, for 2013, the QHI expenses in total among the Large, Small, and Individual pools remained the same between December 31<sup>st</sup> and March 31<sup>st</sup>. However, for the 3/31 HHS Data, we realigned the pools based on TAE and premium. Additionally, in 2016, the Plan updated its QHI process to verify QHI expenses after the SHCE’s submission but prior to the HHS MLR Form’s submission. This process was effective in 2016 and will apply to all future years. Therefore, it is now even more accurate to use 3/31 HHS Data to allocate QHI to the FEHBP, as this allows the Plan to allocate the Large Group pool’s appropriate total consistent with HHS MLR regulations. Please see *Exhibit F - QIA Update* for the appropriate QHI allocations, which were provided to OIG during the audit.

**b. AHIC QHI Exclusion:**

Please refer to Section VIII Aetna Health Insurance Company (AHIC Exclusion).

**c. ICD-10 Expenses:**

The Plan agrees that the ICD-10 expenses were accounted for twice on the 2013 HHS MLR submissions, and that this error was identified prior to completion of the FEHBP MLR submissions. However, the Plan disagrees that there are not sufficient controls in place to prevent similar oversights and reporting errors from occurring in the future. The internal controls are discussed further down in this response.

**X. Federal and State Taxes and Licensing or Regulatory Fees (Report Section A.1.(m))**

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

OPM issued its 2018 Community Rating Guidelines, which allowed carriers to calculate federal taxes attributable to the FEHBP using the approach Aetna used with some adjustments. Those guidelines provide:

#### Federal Tax

If the carrier calculates the Federal income tax attributable to the FEHB plan (to be subtracted from premium in the denominator of the FEHB plan's MLR calculation) based on its calculation of net income attributable to the FEHB plan, the carrier's calculation must tie to its financial statements and Federal income tax filing. If a tax rate is used in this calculation, and it is not the same rate that was used for the HHS Large Group MLR filing, the carrier must use its corporate effective tax rate for the year.

For purposes of this FEHB plan net income calculation, a carrier must determine its FEHB plan's expenses using the Carrier's reasonable, usual, and customary allocation practices (for example, direct allocation or indirect allocation that is premium, enrollment, or activity-based); except that a carrier may first directly attribute specific expenses and remove expenses that do not specifically apply to the FEHB plan, and then indirectly allocate remaining expenses (if any) using the Carrier's reasonable, usual, and customary allocation practices.

Subsequently, in resolving the 2012 MLR audit, OPM accepted "Aetna's use of net income as the basis for calculating Federal income tax allocated to the Plan and reported on the 2012 OPM MLR filing for the Plan."<sup>17</sup>

In light of OPM's acceptance of the net income approach (and not a premium ratio approach) to calculating the federal taxes attributable to the FEHBP, the Plan does not believe there is any basis for the OIG to continue to assert that a premium ratio is a more appropriate method for allocating tax to the FEHBP. Nevertheless, the Plan provides the following support for its net income or loss approach.

#### **a. Aetna Open Access Income Tax Allocations**

The Plan adopted a method to allocate federal income tax that is based upon the net income or loss generated by the "reporting unit." With respect to the HHS MLR filing, the "reporting unit" is the MLR segment and contract situs or location ("MLR Pool") as outlined in the HHS filing form. Per OPM's MLR requirements, the "reporting unit" is the Plan Code that is included in the FEHBP MLR filing form. With respect to federal income tax returns, the "reporting unit" is the legal entity.

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<sup>17</sup> See OPM Letter dated July 31, 2017 from [REDACTED] and [REDACTED] to Thomas Bernatavitz at Aetna.

Allocated income tax can be either an expense or a refund depending on whether a reporting unit experiences net income or loss. For the HHS and FEHBP MLR tax allocations, Aetna allocates income tax expense to reporting units with net income and an income tax refund to reporting units with a net loss. This allocation is consistent with Generally Accepted Accounting Principles (“GAAP”) as promulgated by the Financial Accounting Standards Board and with Statutory Accounting Principles (“SAP”) as promulgated by the NAIC. In fact, the MLR calculation for income taxes instructs the use of SAP as the accounting standard for such taxes.

The income tax allocation method that the Plan uses for the FEHBP MLR reporting and HHS MLR reporting is consistent with the above US accounting principles. The only difference between the Plan’s HHS MLR reporting and FEHBP MLR reporting is that the HHS form includes all the MLR Pools in a legal entity. The FEHBP MLR form includes only the reported Plan Code activity and that Plan Code may include more than one legal entity. Therefore, the Plan allocates general and administrative expenses in order to determine the net income or loss for the Plan Code. The final step is the allocation of income tax expense or refund to the Plan Code using the tax rate applicable to the net income or loss in the Plan’s income tax returns. In addition, after coordination with Audit Resolution and OPM’s updated MLR rules, the Plan and OPM have agreed to the net income tax methodology as long as the Plan applies the corporate effective tax rate disclosed in Aetna’s annual 10K.

Unlike income taxes, non-income taxes, such as employment taxes, and QIA expenses, are not based on income. Therefore, these specific items are allocated based on the premium ratio allocation method used by the Plan, with which the Draft Report agrees.

#### **b. OIG Tax Allocation Audit Findings**

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

It is net income or loss that generates income tax expense and refunds under US tax laws and regulations, as well as US accounting principles.

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

#### **c. Aetna Open Access FEHBP Tax Allocation is proportionate, appropriate and a GAAM.**

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

The Plan maintains that, with respect to allocating income taxes, a GAAM must account for income net of expenses (i.e., net income or loss) in order to be appropriate and yield an accurate result. The Plan’s tax allocation method is appropriate as Plan Codes reporting net loss are allocated a proportionate income tax refund and Plan Codes reporting net income are allocated a proportionate income tax expense. This allocation method is consistent with the HHS MLR tax allocations that allocate a proportionate income tax refund to MLR Pools

reporting net losses and income tax expense to MLR Pools reporting net income. The Plan's income tax allocation method is a GAAM and conforms to both GAAP and SAP accounting principles that produce income tax expense for reporting units with net income and income tax refund for reporting units with net losses.

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

**d. Allocation of expenses to determine Plan's net income or loss**

The Plan applied the following premium ratio to allocate non-income tax expenses and other non-tax expenses to determine the Plan's net income or loss:

$$\frac{\text{Aetna Open Access Plan Code Premium}}{\text{Legal Entity Direct Written Premium for all HHS Large Group Pools}}$$

Since the Plan Code was included in the HHS Large Group pools, this ratio is a GAAM that yields the most accurate allocation of non-income tax expenses and other non-tax expenses such as QIA. With respect to the FEHBP, this allocation was used only for those expenses that are applicable to the FEHBP business. For instance, the Plan's expense allocation specifically excluded state premium tax expense and broker commissions since FEHBP premiums are exempt from state premium tax and the FEHBP does not use brokers.

**e. Income tax expense or refund allocated based on net income**

As discussed above, income tax expense or refunds are fundamentally different from non-income tax or other non-tax expenses because they are based upon the net income or loss of the reporting unit. Therefore, it is necessary to determine net income or loss in order to appropriately allocate income taxes to the Plan Code.

The Plan's method to allocate income tax expense or refund applies the non-income tax and non-tax expense allocation method discussed in the section above to determine the net income or loss from the Plan Code and then uses this result to allocate income tax expense or refund to the Plan Code. This is not an attempt to treat the Plan Code as if it was its own legal entity, but the allocation is necessary to determine the Plan Code's appropriate share of the legal entity income tax expense or refund to allocate to the Plan Code.

The Plan does not allocate income tax expense or refund on the HHS MLR filings using a premium ratio used for non-income taxes because a premium ratio would not be a GAAM that yields the most accurate result. The same method is necessary for the FEHBP MLR filing; the income tax allocation method must be different from the allocation method for non-income tax and other non-tax expenses in order to be a GAAM. If a premium ratio is used to allocate income tax, the same amount of income tax would be allocated to two Plan Codes with the

same premium income even though one incurred significantly higher claims. Please refer to the examples beginning on page 9 of Exhibit G (*Exhibit G - Aetna HealthFund 2012 Draft Report Response - FINAL.docx*). Example 1 illustrates how two hypothetical plan codes (Ohio and Texas) are allocated the same income tax expense under this method even though they incurred higher claims. That result is inconsistent with US accounting principles and is not the most accurate allocation method as required by the HHS MLR regulations. In addition, Aetna has had two published Center for Consumer Information and Insurance Oversight MLR Exam reports of Aetna Affiliated entities for the 2011-2013 reporting years for HealthAmerica PA (HAPA) and HealthAssurance-PA (HASPA) in which the regulators agreed to the Plan's tax methodology to allocate taxes based on net income. Included with this response is *Exhibit H - HealthAssurance-PA-HASPA-Final-MLR-Examination-Report* and *Exhibit I - HealthAmerica-PA-HAPA-Final-MLR-Examination-Report*, which are the published reports. Please refer to the below section on page 6 of the Exhibit H and page 7 of Exhibit I:

### ***Taxes***

*Based upon substantive testing, the taxes and regulatory fees excluded from 2011, 2012 and 2013 earned premium on the Company's 2013 MLR Annual Reporting Form complied with §158.161 and §158.162. Also based on substantive testing, taxes and regulatory fees were accurately reported and were reasonably allocated among the Company's states and markets, as required by §158.170 and in accordance with its Federal Income Tax Allocation Agreement with Coventry Health Care, Inc. In its 2013 MLR Annual Reporting Form, the Company reported that it allocated its federal and state income taxes to each state and market based on pre-tax underwriting gain or loss, which the examination confirmed.*

Furthermore, in 2016, the HHS MLR instructions were updated to clarify how pretax income should be computed and used as the most appropriate basis for allocating income tax. The instructions state:

### ***Section 3 – Federal and State Taxes and Licensing or Regulatory Fees***

*PLEASE NOTE: Any amounts for ACA fees collected in advance of the MLR reporting year in which the fee is payable may not be reported in Section 3. In most cases, the pre-tax underwriting gain/(loss) – which should reflect all relevant revenue and expenses, including cost-sharing reduction amounts, premium stabilization program amounts, and administrative expense amounts – is the most appropriate basis for allocating income taxes; consequently, a loss is expected to yield a negative income tax allocation.*

*Line 3.1 – Federal taxes and assessments incurred by the reporting issuer during the MLR reporting year*

The above update to the 2016 MLR instructions further supports that the Plan's method to determine the portion of Federal income taxes attributed to the FEHBP is based on a fair and equitable allocation method.

#### **f. Aetna Open Access Income Tax Allocation Method**

The Plan's method to allocate income tax expense or refund is based upon the net income or loss associated with the Plan Code for the year. The Plan Code's income tax allocation is the final allocation performed after calculating the Plan Code's net income. All applicable expenses other than income taxes are allocated to the Plan Code using a premium ratio that is calculated by dividing the Plan Code's premium by the direct written premium for all large group pools. The Plan Code's claims and these allocated expenses are deducted from the Plan Code's premium to generate the net income or loss per Plan Code. Then the income tax is allocated by multiplying the Plan Code net income or loss by the applicable tax rate. This produces an income tax expense for Plan Codes that generate net income or an income tax refund for Plan Codes that generate net losses.

The Draft Report method differs from the Plan's method in that it utilizes the premium ratio, used to allocate expenses other than income tax, to allocate the total income tax expense or refund for all large group pools. This method does not account for the fact that some Plan Codes generate net income and others generate a net loss.

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

#### **g. Insufficient Support for FEHBP MLR Submission**

The Plan agrees that the initial support provided with the pre-audit submission in October 2016 did not tie to the original MLR submissions in November 2014. When preparing for the audit, the Plan updated the tax support to incorporate suggestions from OIG from past audits; for example, OIG requested to see the impact of allocating PCORI using a member month allocation as opposed to a premium ratio allocation, which was the Plan's method for allocating PCORI in the original submission. All subsequent submissions for tax requests support the most current view of the tax methodology, based on these updates made during the pre-audit submission. This is consistent with the Plan's approach to past audits, and ensures that the Plan is incorporating the most accurate tax allocation into the final, audited MLR calculation.

On August 16, 2018, the Plan provided a tax crosswalk to OIG, which walks the tax allocations from the General Ledger to the FEHBP tax build up. The intent of the crosswalk is to provide sufficient support for the Plan's tax methodology, based on conversations and requests with OIG, and the Plan believes this recommendation should be closed. Please refer to *Exhibit J - Tax Crosswalk Files* for the crosswalk workbook.

#### **h. AHIC Tax Exclusion**

Please refer to Section VIII above. Aetna Health Insurance Company (AHIC Exclusion).

### **i. Non-Income Tax Expenses**

The Plan disagrees that the non-income tax expenses were insufficiently supported. During the audit, the Plan made every attempt to support the non-income tax allocations to OIG's expectations. In addition, on August 16, 2018, the Plan provided a tax crosswalk to OIG, which walks the tax allocations from the General Ledger to the FEHBP tax build up. The intent of the crosswalk is to provide sufficient support for the Plan's tax methodology, based on conversations with and requests from OIG. The allocation process from the Annual Statement to the FEHBP is consistently applied to all plan codes. Please refer to *Exhibit J - Tax Crosswalk Files* for the crosswalk workbook.

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

### **XI. Dental Claims (Report Section A.2.(a))**

The Plan agrees with the Draft Report's assessment of the membership used to allocate the dental claims.

### **XII. FEHBP MLR Claims Compliance (Report Section A.2.(b))**

The Plan agrees with the Draft Report's assessment of the pharmacy MLR claims submission.

### **XIII. Internal Controls Review (Report Section B)**

#### **a. Lack of Written Policies and Procedures (Report Section B.1)**

The Plan agrees that the Plan did not have documented FEHBP-specific MLR policies and procedures for the scope of time covered by the Global Audit. Contract year 2013 was only the second year for MLR submissions for the FEHBP. Since then, both HHS and OPM MLR guidelines have been refined and clarified and the Plan has, in turn, created and documented policies and procedures specific to the FEHBP MLR process. The Plan provided these to Audit Resolution in response to the plan code JN final audit report (See *Exhibit L - FEHBP MLR Procedures and Internal Controls*). These newly implemented internal controls and policies and procedures provide a strong guideline for intense review and documentation of support for the FEHBP MLR filing, which will help prevent reporting errors in future MLR filings and their support.

In addition, since the 2013 FEHBP MLR process, the Plan has made several enhancements to improve the FEHBP-specific MLR process both from a data collection perspective and from an internal control/review perspective. The data collection process consists of the following:

- The FEHBP underwriting team requests the supporting documentation for the various MLR components from each workstream's owner (e.g., claims, premium, taxes),

- The FEHBP underwriting team summarizes all data and applies reasonability checks,
- In collaboration with the tax department, the FEHBP underwriting team completes the tax allocations for the FEHBP MLR and completes an intense review process,
- Any questions or discrepancies are immediately communicated to the workstream owners, which are then researched and resolved, and
- All work is reviewed at multiple levels for accuracy and consistency.

The entire process is described in the policies and procedures and internal control documents previously referenced. The Plan has also worked with its internal HHS MLR teams to streamline the process of HHS MLR to FEHBP-specific MLR, which will help eliminate the types of errors uncovered during the Global Audit. Some of the enhancements include, but are not limited to:

- A monthly call with the HHS MLR team and the FEHBP Underwriting team to provide updates on project progress and to discuss any questions resulting from this work,
- A bi-weekly call with the HHS MLR team, FEHBP Underwriting team, and compliance teams,
- The FEHBP underwriting team participates in a weekly end-to-end call with the entire MLR project plan to stay apprised to all happenings of the HHS MLR filings, and
- Open and constant communication between HHS MLR and FEHBP MLR teams to ensure proper messaging of updates to filings.

The Plan has discussed these process changes at each audit and during the Aetna Risk Assessment that took place with OIG in November of 2015. The updated method is effective beginning with the 2014 FEHBP MLR submissions. It will assist in eliminating the types of errors listed on page 36 of the Draft Report, as well as similar issues going forward.

**b. Lack of Oversight at a Sufficiently High Level (Report Sections B.2(a) and (b))**

The Plan agrees that an MLR database error and a QHI reporting error were discovered during the course of the audit. However, the Plan strongly disagrees that this is an indication that there are insufficient internal controls in place to prevent these errors from occurring. As discussed throughout this response, the Plan's MLR-related policies and procedures and other internal controls have been enhanced and are significantly more robust than during the early years of the MLR program. The Plan performs various controls, and adheres to specific policies and procedures for all MLR workstreams. The Plan's internal controls are designed to mitigate financial reporting risk. Every year, the MLR workstreams review their processes to determine how each workstream can improve their policies and procedures and strengthen other internal controls. Each workstream owner is required to upload their updated process documents by a set date. The FEHBP underwriting team participates in the weekly end-to-end calls to ensure constant communication with the HHS MLR team. In addition, *Exhibit M - 2017 MLR\_attestation\_diagram* is a diagram of the MLR attestation process, during which each legal entity's Chief Executive Officer (CEO) and Chief Financial Officer (CFO) must attest to the accuracy of financial information provided in the HHS MLR form both internally and externally.

In addition, Aetna completed a Risk Assessment with State of Connecticut Department of Insurance (CT DOI) as of December 31, 2015. The CT DOI reviewed and tested the Company's processes and controls designed to mitigate specific risks associated with the determination of its HHS MLR rebate liability. The CT DOI noted in its final reports "No material exceptions were identified." Please see *Exhibit N - CT DOI Risk Assessment Report* for the published report.

As a result of the HHS MLR database error, i.e. the AHIC exclusion, the Plan created a reconciliation tool, whose purpose is to ensure that the out of network business recorded on AHIC PA and AHIC NY is properly reported on the legal entities with QPOS arrangements for the FEHBP MLR filing. The tool was created as a method to review the amounts reported on the SHCE and to ensure that these amounts are properly carried forward to the 3/31 column of the HHS MLR filing, which is used as the basis for the FEHBP MLR filing. The reconciliation includes the following expense sections: QHI, SG&A, and Taxes. The SHCE section of the reconciliation includes the amounts filed for AHIC PA and AHIC NY, which are assigned the members that utilize the QPOS products. The HHS MLR filing section of the reconciliation includes the AHIC PA and AHIC NY QPOS amounts from the SHCE within the 3/31 filing column of the affiliated entities per their intercompany contracting arrangements. The Plan reviewed with and provided a walk-through of the reconciliation tool to OIG on September 19, 2018.

The Plan also made enhancements to the QHI process. In the 2013 and 2014 HHS MLR filings, a subset of the QHI cost centers used full year budgeted dollars versus actual dollars incurred. This was identified during the 2015 HHS MLR preparation. The impact to the 2013 QHI was minimal, and the 2014 impact actually resulted in the Plan having overpaid rebates. However, the Plan modified its QHI process during the preparation of the 2015 filing to include the actual, year-end expense dollars in each cost center. The differences for 2013 and 2014 were corrected in the 2015 filing as prior year adjustments.

The modification made in 2015 was outlined in the Plan's process document and has continued for all future years. In addition, the QHI allocation process was refined in 2016 to allocate QHI to product at a cost center level (commercial risk, commercial self-insured, Medicare). The Plan has since automated portions of the process to provide the QIA data. The Plan tested the changes to verify that the data was flowing accurately and completely through the database, and validated the output by comparing QIA on a year-over-year basis to confirm it was in line with expectations.

As previously mentioned, the Plan reviews their processes regularly to improve and enhance the internal controls for the HHS MLR. Some of the enhancements include:

- The Data Management and Reporting (DM&R) team has restructured and become a part of a centralized team with appropriate level of oversight that report up to the Executive Director of Statutory Reporting, creating an end-to-end process for the HHS MLR filing.
- The DM&R team has implemented:

- a new standard format for submitting adjustments, which requires specific documentation complete with a reason for the requested change,
- a formalized review process for the data input into the MLR Form, which checks for reasonability and accuracy,
- a share point site for data providers, and
- a standard operating procedure for the MLR process.
- New documents were developed to identify and mitigate risks, including a risk control matrix that identifies any previous issues, remediation plans, description of the new or enhanced control, and the owner of that control.
- In 2017, employees participated in a training program that included an MLR Internal Controls segment to heighten awareness and knowledge of the internal controls and to raise the bar around the MLR control environment.
- Additionally, there are new policies within the finance department, which will also benefit the MLR process. These include the End User Computing (EUC) policy and Memo for Record Policy.

The Plan continues to review their policies and procedures regularly in order to improve their internal controls and the overall HHS MLR process.

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

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