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

Final Audit Report

Audit of the U.S. Office of Personnel Management's Administration of Federal Employee Insurance Programs

Report Number 4A-HI-00-19-007
October 30, 2020

EXECUTIVE SUMMARY

Audit of the U.S. Office of Personnel Management's Administration of Federal Employee Insurance Programs

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Why Did We Conduct The Audit?

The objective of the audit was to determine whether the U.S. Office of Personnel Management's (OPM) internal controls and program requirements were adequate to efficiently administer health care and insurance benefits to Federal employees, annuitants, and their dependents for operating year 2018.

What Did We Audit?

The Office of the Inspector General (OIG) completed a performance audit of OPM's administration of Federal employee insurance programs. Our audit consisted of a review of OPM's Healthcare and Insurance Division (H&I) and its groups that administer health care and insurance benefits, which include Audit Resolution and Compliance (ARC), Federal Employees Health Benefits (FEHB), the Federal Employees Dental and Vision Insurance Program (FEDVIP), Life and Ancillary Benefits, and the Performance Improvement Group for operating year 2018. We conducted site visits with H&I on October 25 and November 27 to 29, 2018, at OPM's headquarters in Washington, D.C.

What Did We Find?

We determined that OPM needs to strengthen internal controls and program requirements within its ARC, FEHB, and FEDVIP Groups to efficiently administer health care and insurance benefits to Federal employees, annuitants, and their dependents. No deficiencies were identified during our review of OPM's Life and Ancillary Benefits or Performance Improvement Groups. Our audit results are summarized as follows:

- OPM has unauthorized contracting officers (as a result of incomplete training records) and unofficial contracting officer representatives administering health care and insurance benefit contracts.
- ARC failed to resolve 46 percent of the OIG audit recommendations in a timely manner since 2011, including $103 million in outstanding questioned costs.
- OPM does not have sufficient controls in place to prevent ineligible family members from enrolling in the Federal Employees Health Benefits Program (FEHBP) or the FEDVIP.
- OPM does not have sufficient controls in place to track FEHBP carrier working capital.
- OPM lacks transparency standards for both pharmacy and medical claims in its community-rated health maintenance organization contracts.
- OPM is not conducting FEHBP health carrier site visits on a three-year rotational basis in accordance with its documented internal control to mitigate risks associated with the FEHBP payment process.
- OPM lacks internal policies to ensure timely and accurate submission of fraud, waste, and abuse reports for the FEHBP and FEDVIP.
- OPM lacks a formal fraud, waste, and abuse and debarment/suspension requirement for FEDVIP carriers.
- OPM does not have sufficient controls in place to collect and review FEDVIP annual accounting statements.
- OPM needs to improve the FEDVIP by establishing standardized performance measures with penalties.

Michael R. Esser
Assistant Inspector General for Audits

ABBREVIATIONS

AAS	**Annual Accounting Statements**
ARC	**Audit Resolution and Compliance**
ARRTS	**Audit Reports and Receivables Tracking System**
CLP	**Continuous Learning Points**
CO	**Contracting Officer**
COR	**Contracting Officer Representative**
ER	**Experience-Rated**
FAC-C	**Federal Acquisition Certification in Contracting**
FAC-COR	**Federal Acquisition Certification for Contracting Officer Representatives**
FAITAS	**Federal Acquisition Institute Training Application System**
FAR	**Federal Acquisition Regulation**
FEDVIP	**Federal Employees Dental and Vision Insurance Program**
FEHB	**Federal Employees Health Benefits**
FEHBAR	**Federal Employees Health Benefits Acquisition Regulation**
FEHBP	**Federal Employees Health Benefits Program**
FEIO	**Federal Employees Insurance Operations**
FFS	**Fee-For-Service**
FWA	**Fraud, Waste, and Abuse**
H&I	**Healthcare and Insurance Division**
HMO	**Health Maintenance Organization**
IOC	**Internal Oversight and Compliance**
MLR	**Medical Loss Ratio**
MOU	**Memorandum of Understanding**
OCFO	**Office of the Chief Financial Officer**
OIG	**Office of the Inspector General**
OMB	**U.S. Office of Management and Budget**
OPM	**U.S. Office of Personnel Management**
OPO	**Office of Procurement Operations**
PBM	**Pharmacy Benefit Manager**
TCR	**Traditional Community Rating**

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REPORT FRAUD, WASTE, AND MISMANAGEMENT

I. BACKGROUND

This report details the results of our audit of the U.S. Office of Personnel Management's (OPM) administration of Federal employee insurance programs. The audit included a review of OPM's Healthcare and Insurance (H&I) Division and its groups that administer health care and insurance benefits, which include Audit Resolution and Compliance (ARC), the Federal Employees Health Benefits (FEHB) Groups, the Federal Employees Dental and Vision Insurance Program (FEDVIP) Group, Life and Ancillary Benefits, and the Performance Improvement Group for operating year 2018. The audit was performed by OPM's Office of the Inspector General (OIG), as authorized by the Inspector General Act of 1978, as amended.

OPM's H&I Division is responsible for the administration of insurance and benefit programs for Federal employees, annuitants, and dependents. H&I is also responsible for coordinating and administering the annual Federal Benefits Open Season for the FEHB, FEDVIP, and the Federal Flexible Spending Account Program. The H&I Division was recently reorganized to include four major groups: the Office of the Actuaries, Federal Employee Insurance Operations (FEIO), Program Development and Support, and Operations and Resource Management.

FEIO is responsible for managing the negotiation and administration of health benefits and insurance programs for Federal employees, retirees, and their families, through the Federal Employees Health Benefits Program (FEHBP). FEIO is also responsible for administering the FEDVIP, the Federal Employees' Group Life Insurance Program, the Federal Flexible Spending Account Program, and the Federal Long Term Care Insurance Program.

ARC is responsible for resolving audit reports from the OIG and the U.S. Government Accountability Office; assessing implications of audit findings, evaluating corrective actions, and developing settlement strategies; and preparing contracting officer resolution letters for audit reports and findings.

The FEHB Groups consist of three groups that are responsible for negotiating benefits with health plans on an annual basis, administering and monitoring health insurance contracts, resolving customer disputes with health plans, developing brochures for each health plan describing benefits and program requirements, and reviewing and analyzing applications from health plans for participation in the FEHBP. Group 1 administers the Blue Cross and Blue Shield Service Benefit contract; Group 2 administers the fee-for-service and experienced-rated plan contracts; and Group 3 administers the community-rated health maintenance organization plan contracts.

The FEDVIP and Life and Ancillary Benefits groups, formerly known as the Individual Benefits and Life Group, was reorganized into two separate groups during the audit. The two groups are

responsible for administering and negotiating life insurance, long term care insurance, and Federal Flexible Spending Account Program contracts with private contractors as well as administering open seasons for its FEDVIP, Federal Long Term Care Insurance Program, and Federal Flexible Spending Account Program. The groups also develop requirements to ensure that claims are paid timely and accurately, and monitor carrier performance to ensure that quality cost-effective products and services are provided to Federal employees, annuitants and dependents.

The Performance Improvement Group is responsible for administering the FEHB plan performance assessment programs.

Compliance with laws and regulations applicable to OPM's administration of Federal employee insurance programs is the responsibility of its FEIO Group within the H&I Division. OPM is also responsible for establishing and maintaining a system of internal controls.

This was the OIG's first audit of OPM's administration of Federal employee insurance programs. The results of this audit were discussed with OPM during an exit conference on November 19, 2019. A draft report was provided to OPM on February 10, 2020, for its review and comment. OPM's response to the draft report was considered in preparation of this final report and is included as an Appendix.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The objective of the audit was to determine whether OPM's internal controls and program requirements were adequate to efficiently administer health care and insurance benefits to Federal employees, annuitants, and dependents.

Our specific audit objectives included:

General

- To determine whether contracting officers (CO), administering health care and insurance benefits, have the appropriate warrant authority.

- To determine whether the CO appropriately delegated authority to contracting officer representatives (COR) to assist in the technical monitoring and administration of insurance benefit contracts.

Audit Resolution and Compliance

- To determine whether ARC has adequate controls in place to effectively resolve audit findings and ensure that questioned costs have been returned to the FEHBP.

- To determine whether OIG audit recommendations were being resolved within the 180-day requirement.

Federal Employees Health Benefits

- To determine whether OPM has sufficient controls in place to ensure compliance with fraud, waste, and abuse (FWA) reporting requirements for FEHBP carriers.

- To determine whether OPM has sufficient controls in place to ensure contracts between Pharmacy Benefit Managers (PBM) and fee-for-service (FFS) and experienced-rated (ER) health maintenance organization (HMO) carriers are re-competed every three years or granted an exception by the CO.

- To determine whether OPM conducted health carrier site visits every three years in compliance with internal control requirements.

- To determine whether OPM has sufficient controls in place to ensure compliance with annual accounting statement (AAS) reporting requirements for FEHBP carriers.

- To determine whether OPM has sufficient controls in place to mitigate the risk of ineligible dependents being enrolled in the FEHBP.

- To determine whether the implementation of the Medical Loss Ratio (MLR) rating methodology had the desired effect of increasing the number of community-rated HMO plans participating in the FEHBP.

- To determine whether OPM has sufficient controls and program requirements for the MLR rating methodology used by community-rated HMO carriers.

- To determine whether OPM has sufficient oversight of costs charged by PBMs to community-rated HMO carriers.

- To determine whether OPM has sufficient controls in place to provide oversight of community-rated HMO carriers' premium contributions.

Federal Employees Dental and Vision Insurance Program

- To determine whether OPM has sufficient controls over the enrollment process for the FEDVIP.

- To determine whether OPM has sufficient FWA and provider debarment/suspension requirements for FEDVIP carriers.

- To determine whether OPM has sufficient controls in place to ensure compliance with AAS reporting requirements for FEDVIP carriers.

- To determine whether OPM has sufficient performance measures and penalties for FEDVIP carriers.

- To determine whether OPM has sufficient controls in place to ensure compliance with FWA reporting requirements for FEDVIP carriers.

Life and Ancillary Benefits

- To determine whether OPM has sufficient internal controls and program requirements in place for the administration of life insurance, long term care insurance, and flexible spending account benefits.

Performance Improvement Group

- To determine whether OPM has sufficient policies and procedures in place to provide oversight of plan performance assessments and to calculate the quality measures for FEHBP carriers.

SCOPE AND METHODOLOGY

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 and appropriate evidence to provide a reasonable basis for our findings and conclusions based on the audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on the audit objective.

This performance audit included a review of OPM's H&I Division and its groups that administer health care and insurance benefits, which include the ARC, FEHB, FEDVIP, Life and Ancillary Benefits, and Performance Improvement groups for operating year 2018[1]. We conducted site visits with H&I on October 25 and November 27 to 29, 2018, at OPM's headquarters located in Washington, D.C. Additional audit fieldwork was completed at our offices in Cranberry Township, Pennsylvania; Jacksonville, Florida; and Washington, D.C.

In planning and conducting the audit, we obtained an understanding of OPM's internal control structure, as it relates to the administration of Federal employee insurance programs, to help determine the nature, timing, and extent of our auditing procedures. This was determined to be the most effective approach for selecting areas of audit. For those areas selected, we primarily relied on substantive tests of transactions and not tests of controls. Based on our testing, we did not identify any significant matters involving OPM's internal control structure and its operations other than what was questioned in this report. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on OPM's system of internal controls taken as a whole.

We also conducted tests of accounting records and other auditing procedures as we considered necessary to determine whether OPM's internal controls and program requirements were adequate to efficiently administer insurance benefits to Federal employees, annuitants, and dependents. Exceptions noted in the areas reviewed are set forth in the "Audit Findings and Recommendations" section of this report. With respect to the items not tested, nothing came our attention that caused us to believe that OPM had not complied, in all material aspects, with those provisions.

[1] Policies, procedures, and reports that were current as of operating year 2018 may have been implemented or submitted in prior years.

In conducting our audit, we relied to varying degrees on computer-generated data provided by OPM. Due to the time constraints, we did not verify the reliability of the data generated by the various information systems involved. However, while utilizing the computer-generated data during our audit, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

To determine whether OPM's internal controls and program requirements were adequate to efficiently administer healthcare and insurance benefits to Federal employees, annuitants, and dependents, we performed the following audit steps:

General

- Verified certificates of appointment and subsequent training history reported in the Federal Acquisition Institute Training Application System (FAITAS) for COs within the FEIO to determine OPM's compliance with policies, procedures, and Federal regulations.

- Reviewed OPM's list of CORs, Federal acquisition regulations, and position descriptions for health insurance specialists and program analysis officers to determine OPM's compliance with policies, procedures, and Federal regulations.

Audit Resolution and Compliance

- Reviewed all audits from the last five years with questioned costs greater than $1,000,000 where ARC allowed amounts greater than $100,000 to determine whether OPM had sufficient controls in place to ensure that questioned costs were returned to the FEHBP.

- Reviewed OPM's current policies and procedures for resolving OIG audit recommendations, and analyzed the timeliness of all audit recommendations that were resolved since 2011, to determine whether OIG audit recommendations were being resolved timely.

Federal Employees Health Benefits

- Reviewed OPM's current policies and procedures related to carrier Fraud and Abuse Reports and analyzed the 2017 Fraud and Abuse Reports from FFS and ER HMO carriers to determine whether OPM had sufficient controls in place to ensure compliance with FWA reporting requirements.

- Reviewed PBM contracts for FFS and ER HMO carriers to determine whether OPM had sufficient controls in place to ensure that contracts were re-competed timely.

- Reviewed OPM's response to U.S. Office of Management and Budget (OMB) Circular A-123, and evaluated OPM's internal controls and program requirements for the FEHBP, to determine whether OPM conducted carrier site visits in compliance with its internal control requirements.

- Reviewed OPM's current policies and procedures for collecting and reviewing AAS from FEHBP carriers, and analyzed the 2017 AAS for FFS and ER HMO carriers, to determine whether OPM had sufficient controls in place to ensure compliance with AAS reporting requirements.

- Reviewed OPM's policies and procedures for verifying family member eligibility to participate in the FEHBP and determined if the controls were sufficient to reduce ineligible dependents.

- Reviewed subscription income reports from 2009 through 2018, to determine whether the implementation of the MLR rating methodology had its intended effect of increasing the number of community-rated HMO plans in the marketplace.

- Reviewed the current FEHBP contracts to determine the controls and transparency standards required of PBMs to help clarify and reduce prescription drug costs.

- Reviewed the MLR regulations, guidelines, and prior issues disclosed to OPM by the OIG to determine what new controls were implemented to help ensure accurate MLR calculations and reporting by community-rated carriers.

- Reviewed the 2018 bi-weekly premium rates and re-calculated the Government share percentages to determine whether OPM had sufficient controls in place to ensure equitable premium cost sharing.

Federal Employees Dental and Vision Insurance Program

- Reviewed BENEFEDS enrollment functions for FEDVIP operations to ensure that OPM had sufficient controls to verify the eligibility requirements for participation in the program.

- Reviewed OPM's policies, procedures, and contract requirements related to FWA and debarment to ensure that OPM had safeguards in place to help reduce FWA in the FEDVIP.

- Reviewed OPM's current policies and procedures for collecting and reviewing AAS from FEDVIP carriers, and analyzed the 2017 AAS from FEDVIP carriers, to determine

whether OPM had sufficient controls in place to ensure compliance with AAS reporting requirements.

- Reviewed the FEDVIP solicitation, and evaluated program controls and requirements, to determine whether OPM had sufficient performance measures with penalties for FEDVIP carriers.

- Reviewed OPM's FWA policy and analyzed the 2018 Fraud and Abuse Reports from FEDVIP carriers to determine whether OPM had sufficient controls in place to ensure compliance with FWA reporting requirements.

Life and Ancillary Benefits

- Reviewed OPM's internal controls and program requirements to ensure the proper administration of the Federal employees' life insurance, long term care insurance, and the flexible spending account programs for operating year 2018.

Performance Improvement Group

- Reviewed OPM's policies and procedures related to the assessment of plan performance and the calculation of quality measures for FEHBP carriers to determine if there was sufficient oversight of each carrier's performance for 2018.

Any samples that were selected and reviewed in performing the audit were not statistically based. Consequently, the results were not projected to the universe since it is unlikely that the results are representative of the universe taken as a whole.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. GENERAL

1. Unauthorized Contracting Officers — Procedural

We found that OPM had several unauthorized COs, due to incomplete training records, administering health care and insurance benefit contracts on behalf of the Federal Government without the appropriate warrant authority.

OPM had three contracting officers administering healthcare and insurance contracts without evidence of completing the required training.

Warrant obligations provide the CO delegated authority to enter into contracts on behalf of the Federal Government. Any contracting professional issued an unlimited CO warrant is required to have a Federal Acquisition Certification in Contracting (FAC-C) Level III. COs with a FAC-C Level III are required to earn 80 continuous learning points (CLP) every two years, beginning with the date of their certification. If an individual fails to obtain the required 80 CLPs, the FAC-C will lapse. Also, individuals and their supervisors are responsible for maintaining CLPs in the FAITAS.

To test OPM's current policies and procedures for warranted COs, we reviewed the certificates of appointment and training history reported in FAITAS for COs who signed health care and insurance benefit contracts or audit resolution letters for 2018. Our review showed that OPM had three COs who did not have the proper contracting certification or did not meet the continuous learning points requirements necessary to maintain a FAC-C Level III. Specifically, we found:

- One CO within the FEHB 1 Group received their FAC-C on September 5, 2008, but did not report any training in FAITAS for the two periods after receiving the certification (September 6, 2008 to September 5, 2010 and September 6, 2010 to September 5, 2012). As a result, we found that the CO signed the 2018 contract with the Blue Cross and Blue Shield Association under a 2008 FAC-C that lapsed in 2010/2012, due to the lack of reported training.

- The program manager of the FEDVIP and Life and Ancillary Benefits Groups did not have a FAC-C, as required by the Federal Acquisition Institute, to be appointed as a CO with warrant authority. Our review showed that the program manager administered five health care and insurance benefit contracts since the inception of the programs without the proper FAC-C. OPM's Office of Procurement Operations (OPO) became aware of this issue during a warrant refresh in 2015; however, the

program manager's certificate of appointment was not revoked until September 2018, when the OPO transferred authority for issuing warrants to the Director of Healthcare and Insurance.

- The Assistant Director of FEIO is currently the CO for all health care and insurance benefit contracts administered within the FEDVIP and Life and Ancillary Benefit Groups. We found that the CO retained warrant authority and signed contracts and/or audit resolution letters administered within the FEHB 3, FEDVIP, and Life and Ancillary Benefit Groups without maintaining evidence of completing the training required to maintain a FAC-C Level III. Our review of the training history in FAITAS showed that the CO only reported completing 17 CLPs since obtaining their FAC-C in 2012. In November 2014, the CO received notification that their FAC-C had lapsed due to not satisfying the training requirements. After the CO's FAC-C was revoked in FAITAS, a former OPM employee who transferred to the Small Agency Council reinstated the warrant authority for the CO. We obtained a certificate recognizing that the CO attained the required CLPs to maintain a FAC-C Level III warrant authority for the period of November 15, 2014, through November 14, 2016; however, we found that the courses and certificates of completion were not reported in FAITAS, as required. We were also unable to verify the completion of 80 CLPs for the period of November 15, 2016 through November 14, 2018.

OPM personnel stated that the COs satisfied the training requirements necessary to maintain a FAC-C Level III, but needed to record the certificates of completion in FAITAS. Despite multiple requests, we have not received any evidence that the three COs completed the required training. Based on our review, we found that the lack of training has occurred because OPM does not have sufficient internal policies and procedures or controls for managing warrants to ensure that the training requirements are satisfied in accordance with regulations. As a result, OPM potentially has three COs who are making unauthorized commitments on behalf of the Federal Government. Additionally, the lack of training, or incomplete training records, can adversely impact the ongoing management of these contracts.

Recommendation 1

We recommend that the three COs obtain the proper training to meet the 80 CLP requirement every two years and submit the training certificates in FAITAS.

<u>OPM's Response</u>:

"OPM does not concur with the draft report's findings under 'Unauthorized Contracting Officers' or its conclusion that three FEIO Contracting Officers (CO's) made or are making unauthorized commitments on behalf of the federal government due to lapsed Federal Acquisition Certifications in Contracting (FAC-C). Pertinent history and facts include:

- ***Prior to September 2018, the Office of Procurement Operations (OPO) issued warrants, tracked training and periodically revalidated credentials for HI.***
- ***All three CO's were fully certified and warranted by OPO and were in good standing when the delegation of authority that transferred the issuance of these warrants from OPO to HI was issued.***
- ***OPO periodically performed internal validations to reevaluate its warrants to ensure their certifications were proper and up to date. An OPO assessment of OPM warrants under its authority was done in 2015 with all three Contracting Officers questioned in the draft audit report adjudicated successfully.***
- ***HI assumed warrant management in 2018, after the Acting OPM Director signed a change in the delegated authority for HI's benefit programs.***
- ***Turnover within OPO resulted in loss of institutional knowledge as the warrant for the Chief of Life and Ancillary Benefits was being reissued. Turnover took place up and down key positions throughout OPO, including two Senior Procurement Executives, Director of Contracting, Division Director, Acquisition Policy & Innovation, and the Procurement Analyst who managed the CALYPTUS contractor's evaluation of OPM's warrants.***
- ***Prior to the transfer of delegation, OPO was prepared to reissue HI warrants, but negotiation of the wording on the warrants themselves, pertaining to OPO's delegated authority, delayed the process, which was never completed after some key management losses, noted above.***
- ***OPO may have inadvertently deleted some training history while completing a 'scrub' of its early training history.***
- ***There were chronic problems with FAITAS, the system of record for contracting certifications and warrant issuances, including a period of time when the system was not available to Federal civilian employees during a period of urgent need for Department of Defense training, resulting in the inability to update, edit and access properly completed training.***
- ***If a CO's warrant had been revoked or invalidated, our understanding is that OPO would have informed the CO of such action. This never occurred. Absent that, the CO remained in good standing.***

- ***It is incorrect and inappropriate for OIG to assert an audit scope of 2018 and seek to verify training records from 2012, 2010, and 2008. It is also inappropriate to develop findings against HI while the warrant management was under OPO.***
- ***Finally, where HI could not verify that one of the three individuals had the requisite FAITAS requirements upon transfer of the authority to HI, a warrant was not issued. The other two individuals referenced in the OIG audit have met all requirements and OIG's assertion that the CLPs are not reflected in FAITAS is wrong. The correct information is reflected in FAITAS.***

To summarize, the organization charged with designating and maintaining FAC-C III warrants, the Senior Procurement Executive and key managers, the Delegation of Authority, warrant management processes and the FAITAS system itself all experienced substantial change, transition or 'down time' over a period of approximately 18 months, resulting in the inability to simply pull an accurate, comprehensive set of FAC courses and CLPs in every case. In exceptional circumstances such as this, sufficient weight must be given to the fact that no warrants were rescinded by OPO due to any CO being unable to support his/her warrant and continuous education, despite agency refresh efforts performed by the SPE. Once the delegation of authority for warrants transitioned to HI, extreme diligence and caution were exercised before reissuing warrants. When full history could not be confirmed in FAITAS and/or via historical OPO records and accounts, due to their own attrition, HI made the decision not to reissue the one CO's warrant, despite the fact that completion of FAC-C III credentials and CLPs had never previously been questioned by OPO."

OIG Comments:

OPM asserts that it is inappropriate to state that our scope was 2018, and then request documentation from prior years. However, as explained in detail in the finding, warrants remain valid only if the required training is completed. In order to verify that the mandatory training was completed, we need to review each year from the time the warrants were awarded. Furthermore, it is disconcerting that H&I contends that other organizations (FAITAS and OPO) are responsible for maintaining training records for its own employees. While FAITAS and OPO play a role, at the end of the day it is the employee's responsibility to support completion of the necessary training.

OPM has not provided evidence showing that the three COs in question completed the required training needed to maintain their warrants. This recommendation can be resolved once OPM provides evidence that the COs completed 80 CLPs every two years after being awarded their current and active warrants.

Recommendation 2

We recommend that OPM develop policies and procedures to strengthen its monitoring and oversight of training related to CO warrants to ensure that the warrants are rescinded if certification of 80 CLPs every two years is not documented in FAITAS.

OPM's Response:

"Non-Concur[.]

As noted above, this recommendation is prescriptive. Upon assumption of warrant management responsibilities, HI developed and put in place procedures to monitor and ensure that the required training to maintain CO warrants is completed and documented in FAITAS. Further, OPM does not concur with the premise that any HI warrants were revoked, rescinded or should not have been granted in the first instance. OIG's inability to obtain documentation that required training was completed does not mean that Contracting Officer warrants are, were, or ever should have been revoked. While OPO was managing the warranting process prior to October 2018, it periodically performed a 'refresh' or revalidation of OPM Contracting Officers. This included a review of educational qualifications, FAC-C courses and continuous learning requirements. The last refresh was performed in 2015, which confirmed the validity of all HI CO warrants. The warrant for the CO over Life and Ancillary Benefits (LAB) contracts, then called Individual Benefits and Life (IBL), was in the process of being reissued, but a mistake was made in its issuance, after which there were key losses within OPO. Shortly thereafter, discussions surrounding changing the delegation of authority from OPO to HI resulted in further delays.

There have been periods where FAITAS was not functioning properly (e.g. Fall 2018) and did not accept training uploads and some training history may have been lost during a 'scrub' of historical records by OPO. These operational realities help to explain apparent gaps in FAITAS' records.

With HI having been delegated contracting authority over the insurance benefit programs, overall administration and maintenance of CO warrants have been and will continue to be enhanced. This includes ensuring CLP requirements are met and documented and taking appropriate actions when they are not."

OIG Comments:

Regardless of any "mistake," "delegation of authority," or systems "not functioning properly" as stated by OPM, it still has not provided evidence showing that the three COs in question completed the required training needed to maintain their warrants; therefore, their warrants could have lapsed. OPM also confirmed that the OIG was unable to "obtain documentation" to prove that the required training was met. As a result of these deficiencies, our recommendation is for OPM to "strengthen its monitoring and oversight of training." This recommendation matches what OPM stated in the second to last paragraph, so we are unsure why it disagrees with our recommendation and is unwilling to make improvements where deficiencies exist.

Additionally, our findings and recommendations are inappropriately labelled "prescriptive" by OPM. Our audits follow the Generally Accepted Government Auditing Standards, also known as the Yellow Book. Yellow Book section 9.23 requires that "When feasible, auditors should recommend actions to correct deficiencies and other findings identified during the audit and to improve programs and operations when the potential for improvement in programs, operations, and performance is substantiated by the reported findings and conclusions. Auditors should make recommendations that flow logically from the findings and conclusions, are directed at resolving the cause of identified deficiencies and findings, and clearly state the actions recommended." Also, section 9.28 states, "Effective recommendations encourage improvements in the conduct of government programs and operations. Recommendations are effective when they are addressed to parties with the authority to act and when the recommended actions are specific, feasible, cost-effective, and measurable."

2. Uncertified Personnel Acting as Contracting Officer Representatives — Procedural

We found that OPM had health insurance specialists and program analysis officers acting in the capacity of a COR without the proper letter of designation, certification, or training.

OPM's position descriptions state that health insurance specialists and program analysis officers serve as CORs responsible for administering contracts for health care and insurance programs and advising the CO. OPM also maintains a list of CORs and a COR policy on THEO, OPM's intranet. The 2018 Memorandum of Understanding (MOU) between OPO and H&I also states that OPO will rescind any COR designations and H&I COs should issue new letters of designation for CORs in accordance with Federal Acquisition Regulation (FAR) 1.604.

Additionally, FAR 1.604 states that a COR is one who assists in the technical monitoring or administration of a contract. The COR is required to have a letter of designation from the CO which describes their duties and responsibilities; a copy of the contract administration functions delegated to a contract administration office which may not be delegated to the COR; and documentation of COR actions taken in accordance with the delegation of authority.

OPM has unofficial contracting officer representatives monitoring and administering FEHBP and FEDVIP contracts.

Finally, the Federal Acquisition Certification for Contracting Officer's Representatives (FAC-COR) program is for acquisition professionals in the Federal Government performing contract management activities and functions. CORs play a critical role in ensuring that contractors meet the commitment of their contracts. They ensure proper development of requirements and assist COs in managing their contracts. The purpose of this program is to establish training and experience requirements for those acquisition professionals. The FAC-COR program is required for all CORs and applies to all executive agencies, except for the Department of Defense. CORs with a FAC-COR Level II and III are required to earn 40 and 60 CLPs every two years, respectively, beginning with the date of their certification. If an individual fails to obtain the required CLPs, the FAC-COR will lapse.

To test OPM's current policies and procedures for CORs, we requested a list of certified CORs who were delegated authority to assist in the technical monitoring and administration of healthcare and insurance benefit contracts active in 2018. Our review showed that OPM did not have any certified CORs within the FEHB or FEDVIP groups even though officials were acting in this capacity. In the place of certified CORs, we found that the health insurance specialists and program analysis officers were carrying out COR functions without the proper certification, training, or delegation of authority from COs. After we inquired about CORs, H&I had at least two program analysis officers within the FEDVIP Group obtain FAC-CORs Level II. These newly certified CORs are still operating without a letter of designation from the CO, a copy of the contract administration functions delegated to a contract administration office and not the COR, and documentation of COR actions taken in accordance with the delegation of authority.

The use of unofficial CORs occurred because OPM's FEIO officials were under the impression that health insurance specialists and program analysis officers were not required to be certified CORs since they operate under the Federal Employees Health Benefits Acquisition Regulation (FEHBAR), not the FAR. Although FEIO operates under the FEHBAR, the FEHBAR is intended to implement and supplement the FAR for the purposes of acquiring and administering health insurance contracts under the FEHBP. Therefore, health insurance specialists and program analysis officers who assist in the technical

monitoring or administration of large contracts are required to be certified CORs and meet all COR requirements.

Recommendation 3

We recommend that OPM require its health insurance specialists and program analysis officers within FEIO, who are acting in the capacity of a COR, to obtain the proper FAC-COR.

OPM's Response:

"Non-Concur[.]

All HI staff, including Program Analysis Officers and Health Insurance Specialists within FEIO are required to obtain FAC-COR designation before they are assigned to act as a COR on a FAR-based contract, including FEHB Program contracts. But, Health Insurance Specialists do not act as CORs on FEHB Program contracts, and Program Analysis Officers do not act as CORs on FEDVIP contracts.

HISCs [Health Insurance Specialists Contracts] assist in FEHB program administration. There is absolutely no benefit to requiring HI Health Insurance Specialists to obtain FAC-COR designation. In fact, it would be wasteful and inefficient. The recommendation arises from the following misconception, on page 4 of the Draft report (italics added):

> ***'The use of unofficial CORs occurred because OPM's FEIO officials were under the impression that health insurance specialists and program analysis officers were not required to be certified CORs since they operate under the Federal Employees Health Benefits Acquisition Regulation (FEHBAR), not the FAR. Although FEIO operates under the FEHBAR, it is intended to implement and supplement the FAR for the purposes of acquiring and administering health insurance contracts under the Federal Employees Health Benefits Program (FEHBP). Therefore, health insurance specialists and program analysis officers who assist in the technical monitoring or administration of large contracts are required to be certified CORs and meet all COR requirements.'***

As stated above, the HISCs assist with FEHB program administration only. While interacting with the FEHB carriers is a necessary part of carrying out their program administration functions, HISCs do not have any authority to bind the government or make contract decisions; The Contracting Officers within HI rely on the expertise of the

HISCs and Program Analysis Officers in order to protect the interests of the United States in accordance with FAR 1.602-2(c.) However the Contracting Officers retain and execute COR duties and HISCs and Program Analysis Officers do not perform any COR duties.

The draft report notes that OPM's Position Description (PD) states that Health Insurance Specialists Contracts (HISC) serve as CORs responsible for administering contracts for HI programs and advising the CO. HI rewrote the HISC Position Description several years ago, after the positions were upgraded from GS 12 to GS 13. The duties listed in the PD do not include COR responsibilities. However, when the remaining components of the PD (the factors justifying the general schedule grade) were assembled by OPM's Classification Specialist, the language was not in line with the actual duties in the PD. Thus, a passing reference to HISC's acting as CORs was added in error. There is no requirement for an HISC to be a COR to fulfill their responsibilities related to FEHB contracts.

For the same reasons, HI's Program Analysis Officers in FEDVIP are not required to be CORs. Nonetheless, the two Program Analysis Officers currently working in FEDVIP have either completed training as a FAC-COR Level II or are certified as a Level II- COR. In reviewing the PDs for this response, FEIO noted the 20-year-old Program Analysis Officer PD has an incorrect reference to the PAO as a Contracting Officer's Representative that "administers specific contracts," but nowhere indicates that the PAO must be FAR-COR certified CORs, with delegated contracting authority. Further, when the PD in question was written, it was written by individuals who were not warranted Contracting officers or 1102s who would be familiar with the FAR-based term of art. This term was included incorrectly and FEIO will update our PD's to reflect their accurate, current functional responsibilities.

HISC or Program Analysis Officers may serve as CORs on other contracts such as the consultant contract for medical reviews, or on the contracts HI has for CAHPS and HEDIS reporting services. When an HI employee serves in a COR capacity, we ensure they have met the FAC-COR requirements."

OIG Comments:

OPM states that health insurance specialists and program analysis officers are not performing the duties of a COR and that the reference to COR duties in the position descriptions is an error. However, evidence obtained during the audit does not support OPM's assertion that an error was made within the position descriptions. The definition of a COR matches the position description for health insurance specialists and program analysis officers. Once we identified CORs acting in this capacity, OPM immediately sent two program analysis officers

to receive their COR certification as stated in its response. Our recommendation is for anyone acting as a COR to become certified. There is no reason for OPM to refute this finding unless it believes those acting as CORs do not require certification, which we contest.

Recommendation 4

We recommend that OPM require each COR to obtain a letter of designation from the CO that describes their duties and responsibilities, a copy of the contract administration functions delegated to a contract administration office which may not be delegated to the COR, and documentation of COR actions taken in accordance with the delegation of authority.

OPM's Response:

"As noted above, the reference to COR's in the HISC's and PAOs PDs were made in error. We do not concur with the follow-on recommendation that HISCs and PAOs must obtain a letter of designation from the CO describing their duties, etc."

OIG Comments:

Again OPM's response is not in line with our recommendation. We did not recommend that all HISCs and PAOs must obtain a letter of designation from the CO describing their duties. Instead, in accordance with Federal regulations, our recommendation refers only to those HISC's and PAOs who act in the capacity of a COR.

B. AUDIT RESOLUTION AND COMPLIANCE

1. Untimely Resolution of OIG Audit Recommendations — Procedural

We reviewed OPM's current policies and procedures for resolving OIG audit recommendations and analyzed the timeliness of all audit recommendations that were resolved since fiscal year 2011. Our review showed that the audit resolution function has evolved since 2011, going from a few available people within a larger program group to an independent branch to ultimately the separate group it is today. Given the complexity and range of the various benefit programs and the audit issues that require resolution, OPM recognized the need for changes to the audit resolution function and placed an emphasis on resolving long-standing recommendations and improving resolution timeliness.

These changes have helped OPM move toward compliance with OMB Circular No. A-50, which requires agencies to resolve audit recommendations within six months after the issuance of a final audit report. However, additional improvement is still needed as our review found that ARC failed to resolve audit recommendations in 114 out of 246 audits, or approximately 46 percent, within the six-month period after the report was issued by the OIG. Of the 114 audits with recommendations that were not resolved within six months, 11 audits with 29 recommendations still remained open at the time of our review, including 12 monetary recommendations with over $103 million in questioned costs[2].

OPM failed to resolve 46 percent of audits within six months of the OIG issuing its final reports.

Based on our review, we found that ARC lacks the resources and support needed to resolve audit recommendations in a timely manner. Despite the many positive improvements, the reorganization of ARC into its present structure is not yet complete, and ARC still needs additional staff with the necessary skill sets and training to help resolve audit recommendations within six months after the issuance of a final report. Further, the skills of existing and future staff members should be assessed to determine what additional training may be required. Training to further the understanding of the various benefit programs OPM administers as well as potential audit issues is extremely important.

In addition, OPM needs an audit resolution tracking system that can replace the current manual processes. OPM and the OIG previously used the Audit Reports and Receivables Tracking System (ARRTS) to help track and resolve audit recommendations. However, OPM decommissioned ARRTS in 2017 due to its age and technical obsolescence. Previous attempts to develop and implement a new resolution tracking system did not come to fruition, resulting in a largely manual process to track and document the audit resolution process. This is inefficient and the development and implementation of a new resolution tracking system that all relevant parties can use is essential to help ARC meet the requirements of OMB Circular No. A-50. If ARC is not provided the needed resources, OPM will be at risk for the continued untimely resolution of audit recommendations and the recovery of funds.

Recommendation 5

We recommend that OPM provide ARC with a new audit resolution system that tracks, records, and reports resolution transactions.

[2] The majority of the $103 million has since been resolved. As of August 31, 2020, the balance for questioned costs from recommendations over six months old with ARC was $2,460,320.

OPM's Response:

"Non-Concur (as written). A re-wording of the Recommendation may lead to OPM Concurrence.

The draft audit report evaluated resolution timeliness since fiscal year 2011, which is well beyond the scope of the audit. During this nearly ten-year period, virtually every aspect of the audit resolution function has radically changed: its staffing levels, processes, systems, structure and even the type of audit findings and recommendations. The audit resolution function has grown from two people assigned to resolve audits within the former Program Planning and Evaluation Group to becoming its own Group, Audit Resolution and Compliance, composed of eight full time employees including two supervisors.

The report certainly acknowledges improvements made; we note, however, that of the three oldest audits currently open (with over $98M total contested questioned costs) we only very recently received OIG's counsel's response to HI's written positions provided more than six months prior. We agree that the 2017 loss of ARRTS, the OIG, OCFO and HI jointly owned system, represents a serious internal control deficiency that must be addressed. OPM concurs that Audit Resolution and Compliance requires additional resources and that an agency-wide system is needed to document, track, monitor, report, share and perform basic analyses on audits, resolution trends, and compliance activities. This system should be OPM-owned (not an ARC system) and requires access, data and/or approvals from HI, OCFO, OIG and IOC. All four organizations are stakeholders in a system since each owns or reports data from components in the system.

OPM may concur with a recommendation that reads: We recommend that OPM acquire an agency-wide audit resolution system that records and tracks recoveries and resolutions, and reports and performs analyses on resolutions to be shared by HI, the Office of the Chief Financial Officer (OCFO), the Office of the Inspector General (OIG) and Internal Oversight and Compliance (IOC)."

OIG Comments:

OPM again asserts that the OIG went beyond its audit scope when reviewing the audit resolution process. Similar to our comments under Recommendation 1, in order to assess ARC's progress in meeting the 180-day resolution timeframe, it was necessary to perform a historical review of audit recommendation closures over time. The 180-day requirement was implemented in 2011 and thus, we began with that year to track resolution activities over a 7-year period. We acknowledged that there were significant changes to the audit resolution

process during that time and the loss of ARRTS created problems. However, ARC's function is to effectively work with all stakeholders in resolving audits. In addition, compliance with the audit resolution timeliness requirement rests with ARC for benefit programs carrier audits. Other organizations are involved with the resolution process, but ARC owns the audit resolution process.

Recommendation 6

We recommend that OPM provide ARC with the proper staffing and training needed to resolve audit recommendations timely based on an assessment of the workload, critical skills, and core competencies required to be knowledgeable in each of OPM's employee benefit programs.

OPM's Response:

"Partially-Concur[.]

We consider this recommendation prescriptive. It is also closely aligned with Section C of the Draft FEHB Contract Amendment MAR NFR, titled – Audit Resolution Concerns, to which HI recently responded.

OPM concurs that additional resources for ARC are needed. OPM rejects the implication that ARC lacks the 'competencies required to be knowledgeable' in the benefit programs that HI administers. ARC staff average in excess of 5 years in Audit Resolution and Compliance, more than 10 years' experience in Healthcare and Insurance, and over 15 years with OPM, with the typical ARC employee holding an advanced degree. The Group is regularly availed of training and growth opportunities to strengthen foundational skills and develop new ones. ARC as a Group or individual team members have been recognized with OPM Director's Awards on multiple occasions and have been nominated other times. HI's Audit Resolution and Compliance function has been recognized by OPM's Internal Oversight and Compliance for its high closure rates, reduction in aged audits and collaborative resolution approach. ARC is a high-performing team, which has worked diligently and reliably to improve HI's benefits administration through the recovery of erroneous payments, improvement of information systems and strengthening of carrier and OPM's own internal controls.

Despite those efforts, the scope of OIG carrier audit reports continues to evolve from assessing established attributes such as Duplicate Claims, Coordination of Benefits with Medicare, Cash Management and Access Controls, and routine MLR findings, to

questioning costs and actions that may be based on OPM management actions or areas beyond the scope of the current contract being evaluated. This expansion of audit scope has often resulted in lengthy analyses, OGC and Plan counsel involvement, and entrenched, divergent positions on contested audit findings. These findings often have questioned costs that remain open for months or even years, with little likelihood of being recovered in the absence of OPM-OIG concurrence on the validity of findings prior to their issuance in a final report, based on the contract in place during the audit. This often means that there is also no consensus that the contract(s) between the carrier and OPM should be changed to prospectively cover these disputed findings.

For context, OIG's Office of Audits leverages an Experience Rated Audits Group (ERAG), a Community Rated Audits Group (CRAG), an Advanced Claims Audits Team (ACAT), a Special Audits Group (SAG) and an Information System Audits Group (ISAG) to assess and perform audits of HI's insurance benefit programs. Further, its Office of Investigations performs or assists in generating fraud, waste and abuse findings, while another OIG Audit Group performs the annual audit of the agency's financial statements. Together, OIG's Audit and Investigative Groups, who perform vital program oversight, leverage resources that rival or exceed all of HI's offices and resources combined. All audits, regardless from which IG group they originate, go through ARC for resolution. However, given the sheer size and scope of the audits there is not a simple and direct correlation between increased training and timely resolution; HI (not just ARC) would need to substantially increase its footprint to cover the breadth of audit findings generated by OIG's various audit groups. Further, the nature of many of the findings requires specific expertise in areas such as: statistical sampling, tax accounting, actuarial science, provider networks and sub-contracting, policy and legal analyses, information systems, capitation, letter of credit accounts, working capital, Federal Acquisition Regulations and more. These are in addition to the basic audit resolution procedures as well as the foundational knowledge required of the specific audit types themselves (e.g. Experience Rating, Community Rating, voluntary benefits, etc.).

It is not feasible for any small group to be fully knowledgeable across such a broad portfolio of plan types, procedures, issues and their associated systems. ARC's role is to serve as an agent of the CO's and facilitate resolution through a collaborative process with internal and external stakeholders, such as HI Program Analysis and Development (formerly known as Policy), the Office of the Actuary, OCFO, OGC, OCIO, Carriers and OIG's many groups and teams. We agree that training and subject matter expertise is a continuous pursuit, but as the resolution function has evolved, we believe that a combination of more resources and an agency-wide system will yield the greatest improvement on the resolution process versus targeted training for existing staff."

OIG Comments:

OPM points out that these recommendations overlap with those in another report that is not yet final. Our stance is that we will report on any issue identified from the scope of our audit that has not yet been resolved.

Furthermore, OPM states that the OIG implies that ARC staff lack the competencies to be knowledgeable; however, this is simply not true. As OPM states, "training and subject matter expertise is a continuous pursuit." We concur with this statement, which is why we recommend that OPM allocate sufficient resources to staff and train ARC. OPM partially agrees with this finding and recommendation, including the need for additional ARC resources. However, we continue to recommend additional training in the areas where OPM states, "It is not feasible for any small group to be fully knowledgeable across such a broad portfolio of plan types, procedures, issues and their associated systems … ."

C. FEDERAL EMPLOYEES HEALTH BENEFITS

1. Ineligible Dependents in the FEHBP — Procedural

During our audit, we found that OPM does not have an eligibility verification process in place to validate family member relationships at the time of enrollment in the FEHBP. As a result of this insufficient control for the FEHBP enrollment process, there is an estimated loss of anywhere from $256 million to $3 billion in fraud, waste, and abuse charged to the program on an annual basis from ineligible dependents participating in the FEHBP.

Title 5, Code of Federal Regulations, Section 890.302, allows eligible family members to enroll in the FEHBP. Eligible family members include spouses and children (natural or foster children) under the age of 26. Dependent children who are incapable of self-support due to a disability that existed prior to age 26 may be able to continue coverage beyond their 26th birthday.

To assess the ongoing issue of ineligible dependents in the FEHBP, we surveyed OPM's policies and procedures for verifying family member eligibility to ensure that controls were in place to safeguard the program from ineligible members. The survey results showed that OPM has no controls in place to verify dependent eligibility at the time of enrollment other than requiring foster child certifications and certification of disabled child dependents age 26 or older who are incapable of self-support. Per OPM's response to our survey, "enrollees self-certify the eligibility of other family members" for the FEHBP. The survey also showed that OPM estimates 1 to 3 percent of enrolled spouses and 4 to 12 percent of enrolled

children are ineligible for coverage. At a cost of $6,400 per member per year, the FEHBP is potentially losing between $256 million and $3 billion[3] each year due to fraud, waste, and abuse from ineligible dependents, since OPM does not have a family member verification process in place.

OPM lacks sufficient controls to ensure that only eligible family members are enrolled in the FEHBP

We asked OPM why there is no verification process in place to ensure that only eligible family members participate in the FEHBP, but we did not receive a sufficient response. Instead, OPM explained that it has controls in place to verify foster children and disabled dependents, although the actual relationship to the subscriber is not verified. OPM also reported that enrollees self-certify the eligibility of family members through acknowledging that any intentionally false statement or misrepresentation to gain enrollment into the federal program is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than five years, or both. Nonetheless, OPM acknowledges that 1 to 12 percent of dependents are estimated to be ineligible for coverage in the FEHBP.

The OIG is not aware of any other employer group that purchases health insurance benefits and enrolls members without verifying family member eligibility at the time of enrollment. We have identified several commercial employer groups that request supporting documentation, such as marriage and birth certificates, to validate the relationship at the time of enrollment or use a third party vendor to verify family member relationships for eligibility. Without implementing basic controls to verify dependent eligibility, the FEHBP will continue to be at risk of covering ineligible members, which could result in significant overcharges to the program.

Recommendation 7

We recommend that OPM implement an eligibility verification process for family members to participate in the FEHBP by requiring marriage or birth certificates for all new enrollments. OPM should make it mandatory for federal agencies and/or insurance carriers to request proof of eligibility for family members to participate in the FEHBP, and the eligibility documentation should be maintained in accordance with records retention requirements. If OPM finds it unfeasible to have federal agencies and insurance carriers

[3] The actual number and cost of ineligible dependents in the FEHBP is unknown. Estimates are based on OPM's published figures under final regulation 83 FR 3059 in the Federal Register on January 23, 2018, showing approximately 4 million family members participating in the FEHBP with 1-3 percent of the spouses and 4-12 percent of the children being ineligible for coverage. The 2018 Subscription Income Report showed an average annual member cost of $6,400 for the FEHBP (1-12 percent of 4 million x $6,400 = $256 million to $3 billion). This estimate is not based on a random statistical sample.

verify and maintain eligibility documentation for family members who participate in the FEHBP, it should consider contracting with a third party vendor to verify family member relationships.

OPM's Response:

"Partially-Concur (Duplicative)[.]

We consider this recommendation prescriptive. It is also duplicative, in that OIG Recommendations pertaining to family member eligibility are found in numerous final audit reports, including: Global Enrollment (17-048), Mail Handlers (16-044), Compass Rose (17-026), United (17-047), Humana (17-040), Triple S (17-017), Health Alliance Plan (17-031), GHC (18-015), Aetna (17-007), Blue Care Network of MI (18-031), Presbyterian (18-014), TakeCare (18-029). More eligibility recommendations are found in the BENEFEDS and FEDVIP audits.

Because the current FEHB enrollment process by regulation is decentralized at the agency level, OPM's role in eligibility verification is to provide policy and guidance to agencies and carriers. Each agency has determined its own manner for enrollment processing, including its choice for an electronic processing platform. Multiple different platforms are used throughout the government with differing capabilities. We acknowledge that errors may occur because of the regulatory decentralization, and we are taking steps to provide guidance to agencies and carriers.

On January 23, 2018, OPM published final regulations providing that proof of family member eligibility may be required to cover family members under an FEHB enrollment and establishing a process for agencies and FEHB carriers to request proof. OPM is in the process of drafting guidance on implementing the regulation to agencies and carriers that will require family member verification, including what constitutes acceptable documentation, during the following enrollment events:

- ***New employees during their Initial Enrollment Opportunity***
- ***Existing employees and annuitants submitting an enrollment change due to a qualifying life event (QLE)***
- ***New family member(s) being added to an existing Self and Family enrollment***

OPM is also drafting guidance on processes for removing ineligible family members from current enrollments when an agency or carrier has determined ineligibility.

Due to the high volume of Open Season transactions and limitations in agencies' self-service systems, we do not currently believe it feasible to have agencies and carriers verify a new enrollment's family members during that time period. However, agencies and carriers have the authority to request documentation from enrollees at any time.

Without centralized FEHB enrollment, there will always be a significant problem with agencies maintaining eligibility documentation due to FEHB enrollees' changing agency employing offices, retiring, changing personal family statuses, and changing insurance carriers.

OPM has an agency priority goal in FY 2020-2021 to develop a Master Enrollment Index (MEI) of all FEHB subscribers and family members. The MEI will reside in OPM's Health Insurance Data Warehouse (HIDW). We are examining the feasibility of a future enhancement to include storage of eligibility documentation."

OIG Comments:

Although OPM partially agrees with this finding and recommendation, the audit examples reported by OPM contained findings related to overaged dependents who did not have documentation supporting a disability that renders them incapable of self-support. In addition, the regulation published on January 23, 2018, only allows (i.e., "may be required"), and does not require, carriers and agencies to request eligibility documentation and terminate enrollment at any time based on the evidence received. It does not establish a formal eligibility verification system at the time of initial enrollment. The weakness we identified in this report was based primarily on Federal employees and annuitants self-certifying family members without anyone verifying the spouse or dependent relationship. This means one can list a friend, neighbor, cousin, grandchild, niece, nephew, etc. without providing support that the member is a spouse or dependent child. OPM published industry estimates that, when applied to the FEHBP, amount to between $256 million and $3 billion lost annually to ineligible dependents. OPM should prioritize the implementation of a verification system for family members to enroll in the FEHBP instead of allowing billions in taxpayer funds to be wasted.

2. Insufficient Oversight of FEHBP Carrier Working Capital **Procedural**

During our review of OPM's current policies and procedures for collecting and reviewing FEHBP carrier Annual Accounting Statements (AAS), we found that OPM had insufficient oversight of the FEHBP carriers' working capital. Specifically, OPM is not verifying that the

working capital schedule is being submitted with the carriers' AAS or tracking each carrier's working capital balance.

FEHB Program Carrier Letter No. 2018-03 provides reporting instructions for FFS and ER HMO carriers for submitting their AAS for calendar year 2017 by March 30, 2018. OPM's instructions require carriers to include a working capital schedule with their AAS that shows a beginning of year balance, monthly increase/decrease, and end of year balance.

OPM lacks sufficient controls for tracking and reporting FEHBP carrier working capital.

Based on our review of the 2017 AAS submitted by FFS and ER HMO carriers, we found four carriers with inaccurate or incomplete working capital schedules. We then reviewed prior OIG audit reports from the last three years to determine how often working capital issues were identified. Our review showed that there were four audits since 2016 that reported a finding related to excess working capital (two carriers from above and two additional carriers). OPM has addressed part of this issue with new working capital guidelines for 2018, but the issue will not be fully resolved until OPM properly tracks and reviews working capital balances.

The lack of oversight related to working capital occurred partly because the FEHB 2 Group delegates the responsibility of reviewing and verifying the accuracy and completeness of data reported in the carriers' AAS to the OCFO Trust Funds Management Team without having a formal structure documenting this shift in responsibility (i.e., MOU). Additionally, our review showed that the instructions and review sheet used by the OCFO lacks guidance on verifying the accuracy and completeness of the working capital schedule. Finally, our review showed that the OCFO does not maintain a master list of working capital deposits held by the FEHBP carriers, which makes it difficult to track and verify the accuracy of the working capital amounts reported in the AAS.

Without sufficient controls in place to ensure the accurate reporting and tracking of each carrier's working capital, the FEHBP is at risk of improper handling of funds, especially if a carrier decides to drop out of the program.

Recommendation 8

We recommend that OPM develop a formal MOU between the FEHB 2 Group and the OCFO to specifically outline the shift in responsibility for reviewing AAS from FFS and ER HMO carriers, including who is tasked with verifying the submission of working capital schedules.

OPM's Response:

"Non-Concur[.]

We consider this recommendation prescriptive. While we agree that FEIO and OCFO can strengthen controls and improve our communication in order to eliminate mistakes and improve oversight, an MOU between FEIO and the OCFO is unnecessary. OCFO issues financial guidance to carriers and maintains responsibility for reviewing carrier AAS. FEIO works closely with the OCFO to ensure carrier compliance with financial requirements. We work collaboratively with each other to fulfill our mission. HI partners and collaborates with several offices on many key functions across the agency in order to effectively administer the FEHB Program. An MOU is neither needed nor appropriate in every shared process or engagement with another office. To strengthen controls and communication within FEIO and OCFO, HI has already taken and is taking the following actions:

- ***FEIO developed a list of carriers that utilize working capital accounts and has shared it with OCFO. We will update the list of carriers annually or more often as appropriate and provide it to OCFO. It is important to note that using a working capital account is strongly recommended but not mandatory. FEIO maintains the list because the OPM Contracting Officer must approve use of a working capital account.***
- ***FEIO and OCFO will use the list to confirm that carriers with working capital accounts have completed the working capital schedule according to the AAS instructions issued by the OCFO.***
- ***OCFO has indicated they will add an entry to the AAS review index checklist they use to verify that a working capital schedule is present.***
- ***HI FEIO (each FEHB group that has one or more Experience-Rated carriers) will monitor carriers to ensure that they are reviewing working capital accounts monthly and adjusting them quarterly if necessary, as required by OPM's Letter of Credit (LOC) System Guidelines (Carrier Letter 2018-08, Attachment B)."***

OIG Comments:

OPM disagreed with the finding and recommendation, yet it agreed to strengthen controls after we identified the weakness. Having a detailed process and formal agreement, such as an MOU, is necessary to clearly establish the duties and expectations of each office, especially since one office has not taken the responsibility for ensuring the complete

submission of AAS. OPM can simply include the strengthened controls listed above in a formal document similar to the MOU it created with the OCFO for FEDVIP AAS.

Recommendation 9

We recommend that OPM work with the OCFO to establish internal procedures for properly reviewing and verifying the accuracy and completeness of the working capital schedules reported in the AAS by FFS and ER HMO carriers.

OPM's Response:

"OPM disagrees with this recommendation, as written. OPM's internal procedures are found in Attachment B of C.L. 2018-08, the Letter of Credit Account (LOCA) Manual. These guidelines prescribe the actions to be followed by both carriers and OPM internally.

The Draft report also recommends that OPM verify the accuracy of WC schedules. Ultimately, OPM verifies accuracy through contract administration and through the audit function. OPM is not in a position to confirm the accuracy of carriers' WC transactions on a real-time basis, although errors identified via OIG audit are addressed by the appropriate OPM office. OIG may wish to specify its expectations regarding what 'accuracy' means in this recommendation. If what is meant is to verify accuracy beyond that which is currently done via OIG audit, this may merit discussion with OPM to determine whether this can be achieved.

OPM seeks to confirm what the Draft report means by verifying 'completeness' of the WC schedule. If completeness refers to ensuring that all carriers with WC provide schedules, per the audits noted in the Draft Report from the 2017 AAS review, where four carriers failed to correctly provide their WC schedules, then OPM concurs that this verification is appropriate and has already taken corrective action to ensure carriers using WC schedules report them.

FEIO and OCFO have acknowledged that there are improvements that need to be made to the LOCA Manual. Thus, FEIO and OCFO are working together in order to expand guidance provided by the manual. This expansion will include instructions for plans that need a waiver from the standard formula. FEIO and OCFO will also review the manual to determine if additional instructions are needed for reviewing adjustments (increases and decreases) of the WC schedule.

We would concur with a recommendation that reads:

We recommend that OPM improve its internal procedures to ensure FFS and ER HMO carriers are appropriately completing and submitting the working capital schedule, as reported in the AAS."

OIG Comments:

OPM initially disagreed with our finding and recommendation, but as shown in its response, it actually agrees with our stance. OPM's interpretation in its third paragraph is accurate, and we look forward to our recommendation being resolved through IOC's verification that OPM established internal procedures for properly reviewing working capital schedules.

Recommendation 10

We recommend that OPM work with the OCFO to develop a master list to track the working capital deposits held by FFS and ER HMO carriers.

OPM's Response:

"Partially-Concur[.]

We consider this recommendation prescriptive. The OIG identified issues related to excess working capital in several audits. OPM took actions to strengthen controls surrounding FEHB carriers' working capital in 2018 in Carrier Letter18-08. However, we recognize that some carriers did not fully comply, which was highlighted in OIG's findings. OPM is taking further steps to tighten its controls by the following:

- ***HI will provide OCFO with a master list on an annual basis, with updates as necessary, that indicates which carriers hold a working capital account.***
- ***The OCFO currently uses two worksheets that include tracking of receipt of the AAS and verifies cashflows and other financial data. The CFO will add a section for the working capital to ensure that the spreadsheet is included in the submitted AAS.***

HI will continue to track working capital per our guidance, which requires carriers to report monthly and adjust quarterly. This tracking monitors FEHB working capital without being too prescriptive. We suggest that this recommendation be reworded to:

'We recommend that OPM improve its tracking of the working capital deposits held by FFS and ER HMO carriers.'"

OIG Comments:

Again, OPM's partial agreement and response corresponds with our recommendation. We will not change our recommendation language based on OPM's preference. Our language simply recommends that a master list be established to track working capital deposits. OPM states that "HI will provide OCFO with a master list on an annual basis" and "The CFO will add a section for the working capital to ensure that the spreadsheet is included in the submitted AAS." IOC should verify these actions in order to help resolve this recommendation.

3. Lack of PBM Transparency for Community-Rated HMOs — Procedural

OPM has not implemented PBM transparency standards for community-rated HMO carriers participating in the FEHBP. As a result, there is no oversight of costs charged by PBMs to these carriers and their members for pharmacy benefits.

OPM is responsible for the overall administration and oversight of the FEHBP, which includes developing regulations, providing guidance, and negotiating with the health insurance carriers on an annual basis to provide the best rates and benefits for Federal employees, annuitants, and their family members. As part of this responsibility, OPM required PBM transparency standards for FFS and ER HMO contracts to help ensure low costs and provide insight into PBM markups. Additionally, under FAR 52.215-2 and FEHBAR 1652.246-70, all contracts and other documentation that support amounts charged to the carrier contract must be fully disclosed to and auditable by OPM.

Based on our review of the current FEHBP contracts, we found that OPM lacks PBM transparency standards in its community-rated HMO contracts. OPM has PBM transparency standards built into its FFS and ER HMO contracts to help disclose and maintain pharmacy costs, but it has no control over the pharmacy operations for community-rated HMOs. We asked OPM why it excluded community-rated HMO contracts from having PBM transparency standards and found that the decision was due to community-rated HMOs being a fully insured product with most of their business coming from other commercial groups. The OIG finds this rationale to be unfounded since OPM already requires ER HMOs to have PBM transparency standards, even with the majority of their business coming from commercial groups, not the FEHBP.

OPM lacks standards in its community-rated HMO contracts to ensure transparency of costs charged by PBMs.

Additionally, most community-rated HMOs no longer use a Traditional Community Rating (TCR) or Community Rating-by-Class methodology to develop premium rates. Instead, the majority of the community-rated HMOs use an Adjusted Community Rate methodology that

accounts for a group's past claims experience. They are also required to spend at least 85 percent of premium dollars on medical care under the Affordable Care Act's MLR guidelines. With these changes, OPM has no way of verifying actual pharmacy costs or rebates received if the PBM agreements with community-rated HMOs are not transparent.

The OIG has found little to no justification as to why OPM has not implemented PBM transparency standards for community-rated HMO contracts. The transparency standards simply allow OPM to see how much of a markup there is for administrative expenses and profit by the PBMs, and it affords the OIG a means of auditing the FEHBP pharmacy claims. By allowing the community-rated HMOs to continue paying PBMs any amount they dictate without making the costs fully transparent, OPM is unable to ensure that FEHBP members are receiving the best price and benefits for pharmacy operations under community-rated HMOs.

Recommendation 11

We recommend that OPM establish PBM transparency standards for all new, renewed, or amended contracts that are specific to community-rated HMOs.

OPM's Response:

"Non-Concur (Duplicative)[.]

OIG previously identified the lack of PBM transparency standards in community-rated HMOs in its annual Management Challenges, issued to the Director of OPM and published in the Agency Financial Report. OPM has responded to these concerns in that venue, where we would expect to see management recommendations as opposed to having them identified within an audit of internal controls.

OPM disagrees with OIG's stated purpose for including specific transparency standards in the CR HMO contracts. Under OPM's CR HMO contract, OIG is able to adequately audit Carriers for compliance with the FEHB MLR and, while some changes may be helpful to fill gaps identified by OPM and OIG, transparency standards as defined by the OIG are not appropriate. As OPM has stated repeatedly in discussions with OIG, the CR HMO contracts differ from ER HMO and FFS contracts because community-rated FEHB plans receive a fixed premium to provide comprehensive coverage, including prescription drugs. The carrier holds the full risk for any costs above and beyond premiums received. Experience-rated FEHB plans are reimbursed their claims expenses on a dollar-for-dollar basis. OPM does not need to know the specific claim pricing or rebates received by a

community-rated carrier's PBM because OPM is not paying the carrier for each claim. Rather, the aggregate amount paid to the PBM is what is necessary to audit to ensure compliance with HHS MLR and FEHB MLR requirements. Because OPM is paying experience-rated carriers for specific claims, it is necessary and appropriate for transparency standards in the ER HMO and FFS contracts. However, as we have stated before, the same standards are not appropriate for CR HMO contracts.

OIG's claim that PBM transparency standards will allow FEHB members to see the administrative markup and profit of PBMs that contract with community-rated HMOs is incorrect. There is no public sharing of this information and FEHB members have little insight into the financial information of FEHB carriers and their subcontractors. The financial information that FEHB members are interested in is the final premium and their respective out-of-pocket costs when shopping for health insurance.

OPM also disagrees that it is OPM's responsibility 'to ensure that FEHB members are receiving the best price and benefits for pharmacy operations.' The FEHB Program is a market-based health insurance program which allows Carriers to compete to earn subscribers. It is impossible for any plan to obtain the 'best price' for all drugs. Even under the ER HMO and FFS contracts, drug pricing will differ by plan. Some drugs may have lower costs for some members under one plan and others will have lower costs under other plans. This is due to the negotiating power of the respective Carriers and how they align their drug pricing with their population and business needs."

OIG Comments:

We agree that only OPM, not FEHBP members, would be able to see the markup and profit of PBMs operating under transparency standards, and the finding was adjusted accordingly. We also understand that community-rated HMO carriers receive a fixed premium and bear the risk of their premiums not being sufficient to cover expenses since they are not reimbursed for each claim. However, community-rated carriers use actual claim payments for both the development of premium rates and for ensuring compliance with MLR requirements. Furthermore, we understand that OPM allows free competition among the carriers to help keep premium rates low, and that community-rated carriers are incentivized to keep its costs, and thereby its premiums, low in order to remain competitive; but that does not mean transparency pricing standards should be excluded from community-rated contracts. OPM should implement transparency standards to stop carriers and PBMs from inflating pharmacy claims with spread pricing. Negotiated discounts on prescription drugs should be passed through to the FEHBP members, through a reduction to the claims used to develop rates and the MLR, not retained by the PBM and carriers as additional profits.

4. Insufficient MLR Criteria for Provider-Sponsored Plans — Procedural

We found that OPM's MLR regulations and criteria are insufficient to address issues stemming from health insurers that are owned by provider groups and health care systems (provider-sponsored plans). Specifically, the lack of criteria addressing provider-sponsored plans affords them the opportunity to shift profit and/or expenses down to the provider level through increased claims costs, while still meeting the 85 percent MLR requirement.

MLR is the portion of the health insurance premium collected by a health insurer that is spent on medical services. The MLR for each insurer is calculated by dividing the amount of health insurance premium spent on claims (plus quality improvement expenses) by the total amount of health insurance premium collected (less taxes and fees). The MLR is important because it requires health insurers to provide consumers with value for their premium dollars. Beginning in 2011, the Affordable Care Act required each large group health insurer to spend at least 85 percent of collected health insurance premium on claims each year or provide a rebate to the consumer. OPM adopted a similar policy and issued new FEHBP regulations for community-rated HMO carriers that require the same 85 percent MLR. However, this does not apply to carriers that are required by their state to use TCR. TCR plans will continue to use a Similarly Sized Subscriber Group methodology.

A loophole in the MLR requirement allows for increased profits and expenses at the claim level for provider-sponsored plans.

As part of our evaluation of OPM's internal controls and program requirements for the FEHBP, we reviewed regulations applicable to community-rated HMO carriers and researched known issues that have been identified by prior audits. During this review, we identified a significant weakness in OPM's MLR regulation. Specifically, insufficient FEHBP MLR criteria allow health insurers to bypass the 85 percent MLR requirement when there is joint ownership with providers that does not allow for an arm's length transaction. As an example, if a health insurer is unable to meet the 85 percent MLR requirement, it can simply have its own providers increase profits and/or expenses through their claims costs so that 85 percent of the carrier's premium is then spent on claims. The OIG identified a similar risk in the past and found that it is virtually impossible to determine if the claims costs are appropriate under current guidelines when there is shared ownership between health insurers and providers.

We acknowledge that OPM's MLR requirement is still relatively new and there are many risks associated with this new regulation. Nonetheless, OPM should tighten controls related to MLR for provider-sponsored plans by adopting new transparency standards and issuing FEHBP-specific criteria for medical claims, encounters, capitated rates, and any other

applicable medical costs. Any failure to address this issue will allow the health insurers to bypass the MLR process when there is joint ownership with the providers, thereby increasing the rates paid by FEHBP members without the insurer having to pay an MLR penalty or by carrying over artificial credits to offset future MLR penalties.

Recommendation 12

We recommend that OPM implement the following rate instruction changes:

- Include transparency standards requiring the carriers to provide support for all claims, encounters, and capitated rates, including those from their provider-owned networks or related entities used in the MLR, rate proposal, and rate reconciliation calculations; and

- Improve MLR criteria to provide complete, clear, and concise instructions of the FEHBP MLR process, including specific instructions concerning provider-sponsored health plans and capitated arrangements in its cost reporting.

OPM's Response:

"Non-Concur (Duplicative)[.]

We consider this recommendation prescriptive. We disagree that there is weakness in OPM's rate instructions or MLR regulation. We also find this recommendation duplicative, as the OIG brought these concerns to our attention in both a carrier audit where there was a provider-sponsored plan, Dean Health Plan (15-039) and the Draft MLR MAR, where OIG raised similar concerns. In each audit, HI met with the OIG to discuss our concerns and we provided our position and final resolution decision, where applicable in a written response.

OPM does not need to change its FEHB MLR requirements to include transparency standards and to improve the MLR criteria. OPM currently has standards in the FEHB contract which require carriers to submit claims experience to the OIG in a data format specified by the OIG. During an audit, OIG is able to review what carriers paid their providers to determine the MLR. Carriers are already required to provide support for all claims, encounters, and capitated rates paid to providers. Furthermore, the recommendation is not clear as to the purpose of the recommended additional instructions.

In addition, we disagree that OPM's criteria are not complete, clear, or concise. OPM generally follows the HHS MLR requirements and provides FEHB-specific requirements where necessary. However, OPM is not seeking to impose separate MLR calculations

standards on FEHB Carriers. OPM allows carriers to calculate their FEHB MLR consistent with HHS MLR requirements. The purpose of OPM's FEHB MLR requirements is to ensure that the FEHB groups are receiving fair value for premiums and are not subsidizing other Carrier groups. Where it may be necessary to include FEHB-specific MLR instructions, OPM adds specific requirements. Furthermore, OIG has not stated how either OPM or OIG would be capable of determining a reasonable reimbursement rate or capitation rate for providers, regardless of the ownership relationship to the Carrier.

HI does not believe it should change its MLR guidance based on one carrier's arrangement. As noted in our response and acknowledged by the OIG, in response to a previous audit, the specific arrangement that the carrier has with its owners is not addressed in OPM's MLR instructions or HHS's MLR instructions. The carrier has had this arrangement well before the ACA's MLR requirements or OPM's MLR requirements and did not switch to this methodology to circumvent these rules.

The Office of the Actuaries believes the carrier calculated their MLR appropriately and indicated that the carrier's MLR has been above the MLR threshold (89% in 2012 and 85% in 2013-2016) every year.

We also note that OIG's statement on page 11 is incorrect and should be deleted: 'The MLR for each insurer is calculated by dividing the amount of health insurance premium spent on claims by the total amount of health insurance premium collected.' The correct MLR formula is (claims + quality improvement expenses) / (premiums - taxes and fees). Generally, HHS MLR requirements specify what may or may not be included in each of the terms in the MLR formula. When necessary, OPM's FEHB MLR requirements will clarify the terms.

Again, in cases where OPM's MLR requirements are silent we default to HHS's requirements. The OIG uses an example of a carrier who can have its own providers increase profits and/or expenses through their claims cost to meet the 85% MLR threshold. We disagree with this scenario. If a provider increases expenses to the plan solely to avoid an MLR penalty, the provider would have to know the MLR prior to the plan year. The provider could, however, set an unreasonably high reimbursement schedule but then the premium rates would rise to reflect that.

We disagree that carriers with this arrangement are bypassing the MLR process which increases premiums or allows carriers to carry over artificial credits to offset future MLR penalties. Carriers with unreasonably high rates will not survive in the FEHB Program.

Increasing reimbursements solely to increase MLR may give a carrier a profit in one year but would have long term negative consequences as enrollees would move to another plan. This is how a market-based system like the FEHB Program operates to keep premiums low and competitive.

Finally, OIG's Draft MLR Management Advisory Report (18-043, March 27, 2019) is wholly dedicated to Medical Loss Ratio audit findings. HI responded to this Draft MAR and it will be reviewed, discussed and resolved upon its issuance in Final."

OIG Comments:

There are multiple carriers in the FEHBP that are owned by providers and this finding is not related to just one carrier's arrangement, but is meant to highlight the risk related to such an arrangement. We adjusted the finding to include the specific MLR formula. OPM again refers to a market-based system and free competition as the sole driver in reducing premium rates. We agree that competition helps to keep premiums low, but it should not be the only mechanism to ensure a fair and accurate rate. If that were the case, audits of the FEHBP carriers and the ACA's MLR process would not be necessary to ensure fair premium rates. We would also like to add that in this response OPM states that the "OIG is able to review what carriers paid their providers to determine the MLR." In its response to recommendation 11, OPM stated that it "does not need to know the specific claim pricing or rebates received by a community-rated carrier's PBM because OPM is not paying the carrier for each claim." This demonstrates that OPM is focused on refuting each recommendation instead of staying consistent with the fact that claim amounts should be audited to determine the accuracy of MLR and fairness of premium rates.

5. Health Carrier Site Visits Not Being Performed **Procedural**

We found that FEIO is not conducting carrier site visits every three years as reported by the OCFO for an internal control to mitigate risk over the FEHBP payment process.

OPM does not have policies to ensure that carrier site visits are conducted every three years.

OCFO's Risk Management and Internal Control Group reported that the FEHB contract specialists (CO or health insurance specialist) will conduct site visits on a three-year rotational basis as an internal control activity in Appendix A of OMB Circular A-123 for oversight of the FEHBP payment process.

During our pre-audit review of OPM's internal controls and program requirements for the FEHBP, we found that contract specialists are required to conduct carrier site visits every three years on a rotational

basis. When we held our survey meetings, OPM reported that the contract specialists are conducting some site visits, especially for the larger FEHBP carriers, but they are not conducting site visits on all carriers every three years. This was due in part to not having a formal policy to address the internal control requirement that has been in place for the past 11 years. Additionally, some contract specialists were unaware of the requirement and pointed out that it would not be cost beneficial. Regardless, OPM should either be following the controls it reported in response to OMB Circular A-123 or modify them with an updated control.

By not following its own internal controls, OPM is failing to meet the requirements of OMB Circular A-123 while increasing the risks associated with the FEHBP payment process.

Recommendation 13

We recommend that OPM develop formal policies to ensure that site visits are conducted every three years for FEHBP carriers in accordance with its control to meet OMB Circular A-123 requirements. If the time and costs to perform the site visits outweigh the benefits, OPM should modify its controls and report new procedures to mitigate risks for the FEHBP payment process.

OPM's Response:

"Non-Concur[.]
We consider this recommendation prescriptive. The OIG found that OPM is not conducting site visits on all carriers every three years per the site visit guidelines reported in the Office of the Chief Financial Officer (OCFO) Risk Management Internal Control (RMIC) OMB Circular A-123 Internal Control over Financial Reporting Process Documentation (pages 5-8). HI confirmed that this was a draft document produced by RMIC which sought to describe its processes. This Internal Control over Financial Reporting Process document was never finalized nor intended to be released as an authoritative reference on HI's processes and it is unlikely that this process would be tested or documented going forward. It was never reviewed by HI and was not formally released to OIG. RMIC indicated that they were meeting with the financial statement auditors (who report to the OIG) to discuss changes in their internal control testing protocol, expecting that OIG auditors would become aware of their new approach to Internal Control testing.

FEIO does not agree with the information related to site visits in this document as it is inaccurate. HI performs in-person and virtual/administrative site visits to FEHB Carriers as a part of its program oversight. HI continues to expand and evolve its approach to site

visits and is open to a discussion of its site visits so that OIG can have an accurate, balanced view of this component of HI's administration of the program.

FEIO does not agree with OIG's statement on page 13 in the first paragraph that states, 'This was due in part to no formal policy to address the internal control requirement that has been in place for the past 11 years.' OIG doesn't identify what 'internal control requirement' has been in place for the past 11 years.

Given the inaccuracies in the finding and recommendation, based on a document that was never finalized nor formally released, this recommendation should be removed from the report."

OIG Comments:

OPM identified this process of conducting site-visits as an internal control during its pre-audit documentation submission. Additionally, OPM confirmed this control during our first survey meeting held November 28, 2018. Finally, after following up with a confirmation email, OPM stated that, "The three year period you are referring to is an internal policy for FEHB 1 in order to ensure that each Carrier is visited at least once every three years. It has been in place for at least the last eleven plus years, and the PBMs have been annually."

If OPM no longer wants to use this control, then it should provide an updated response to OMB Circular A-123 requirements. If OPM wants to continue using this control, then it should document a formal policy since the evidence originally provided to the audit team does not match OPM's current response, hence the need for a formal document.

6. Non-Compliance of Carrier Fraud, Waste, and Abuse Reporting — Procedural

During our review of OPM's current policies and procedures for ensuring carrier compliance with FWA reporting requirements, we found that OPM's health insurance specialists did not perform sufficient reviews of the 2017 FEHBP carriers' Fraud and Abuse Reports that were submitted in 2018. In addition, OPM did not have controls in place to hold carriers accountable for the timely submission of reports.

Section 1.9 of the FEHBP contract requires carriers to submit annual reports, including an analysis of its FWA program costs and benefits, to OPM by March 31.

Additionally, FEHB Program Carrier Letter No. 2017-13 provides supplemental reporting requirements related to the annual Fraud and Abuse Reports from carriers. Specifically,

carriers are required to submit a Fraud and Abuse Report, containing both medical and pharmacy data, to the health insurance specialists for each OPM contract by March 31, covering the prior calendar year. The carrier letter states that all fields of the report are required to be completed. All FEHBP carriers are also required to develop a manual that includes its plans, policies, and procedures for the prevention, detection, investigation, and reporting of FWA.

Finally, OPM provided internal guidelines for reviewing the annual Fraud and Abuse Reports stating that health insurance specialists should ensure that reports are complete, containing both medical and pharmacy data. Carriers should also provide explanations for cells that are blank, report an amount of zero, or contain discrepancies. If the carrier does not report pharmacy data in its annual Fraud and Abuse Report, the health insurance specialist should request a copy of the FWA Manual to verify that all requirements are included in the manual, and obtain evidence from the carrier that the FWA requirements are being communicated to its PBM.

OPM does not conduct sufficient oversight of the FEHBP carriers' fraud and abuse reporting requirements.

Based on our review of OPM's guidelines for health insurance specialists and the 2017 Fraud and Abuse Reports from FFS and ER HMO carriers submitted in 2018, we found that 9 of the 20 reports contained multiple non-compliance issues that were not identified by health insurance specialists. Specifically, our review showed that the health insurance specialists did not:

- Ensure that FFS and ER HMO carriers submitted required medical and/or pharmacy data in their annual Fraud and Abuse reports; or
- Require one FEHBP carrier to develop an FWA manual to comply with the requirements of Carrier Letter 2017-13.

Additionally, we were unable to determine when the Blue Cross and Blue Shield Association submitted its 2017 Fraud and Abuse Report for the service benefit plan. Furthermore, we were unable to obtain documentation to support any efforts made to follow-up with the carriers to obtain missing or incomplete data, which is a requirement for health insurance specialists.

This insufficient oversight occurred because OPM's health insurance specialists lacked a clear understanding of FWA reporting requirements and did not have a sufficient tracking mechanism to log the receipt of annual Fraud and Abuse Reports from FEHBP carriers. Without sufficient reviews or controls to ensure receipt of the carriers' annual Fraud and Abuse Reports, OPM is unable to ensure that FEHBP carriers have effective fraud and abuse programs to help mitigate FWA.

Recommendation 14

We recommend that OPM improve its oversight procedures for reviewing FEHBP carrier Fraud and Abuse Reports and develop a checklist for health insurance specialists to use during their review as a control to ensure compliance with FWA reporting requirements.

OPM's Response:

"We partially concur with this recommendation based on the FWA activities and annual review currently in place. We formalized our use of the existing FWA annual review guidelines into a checklist to be completed for each carrier report received. We also consider this recommendation prescriptive. OPM remains committed to effective oversight and administration of the FEHB Program, and strengthening controls surrounding carriers' Fraud Waste and Abuse (FWA) program continues to be a priority. HI has a dedicated FWA team and continues to expand its representation to strengthen FWA oversight. There is more work to do, however.

FEHB carrier FWA reports are due to their respective Health Insurance Specialists (Contracts) (HISC) each March 31. This deadline may be extended program wide or to individual carriers for various reasons. This was the case in both 2017 and 2019, due to an issue with the Fraud and Abuse Report spreadsheet and, separately, when March 31 fell on a Sunday. The HISC notes receipt of each report for the contract file and reviews their assigned carrier's Fraud Waste and Abuse report. All FWA reports identified as untimely in the Draft audit report were subject to deadline extensions, which can be verified. FEIO's FEHB Groups track the receipt of the reports in different ways, providing an opportunity to move towards reasonable standardization across FEHB 1, 2 and 3. This will be addressed initially by the FWA team, which provides annual training to the HISCs on reviewing the reports. The HISCs utilize various resources when reviewing the FWA reports such as the PowerPoint presentation used in the training, Guidelines for Reviewing FWA Reports, and Carrier Letter 2017-13 and its attachments. These resources were developed in collaboration with the OIG.

Each year the FWA team reviews and updates the current FWA resources, as needed, to assess areas that can be strengthened. The FWA team is considering adding a column to the Guidelines for Reviewing FWA reports to show that each line item was reviewed for each FWA report. Plans to enable carriers to upload FWA reports into Benefits Plus would provide digital tracking of the number and date of all reports received.

The 2018 training presentation and the Guidelines for Reviewing the Fraud and Abuse Reports are available on request. This guidance is updated annually and used by HISC in

their screening and evaluation of carrier's FWA reports. HI reviews and updates its FWA procedures annually and will continue to do so."

OIG Comments:

We agree that the new evidence provided by OPM extended the deadline for submitting FWA reports, and we adjusted the finding accordingly to show that timeliness was only an issue for one carrier. OPM agreed with the rest of the finding and stated that it adopted a new checklist to improve controls. IOC should verify that the newly established checklist is fully documented and implemented.

Recommendation 15

We recommend that OPM implement a tracking mechanism to log the receipt of annual Fraud and Abuse Reports and hold FEHBP carriers accountable for the timely submission of their reports.

OPM's Response:

"Non-Concur[.]

As noted in our response to recommendation 14, HI decided in 2018 to extend the Fraud and Abuse reporting deadline from March 31st to April 13th (for the 2017 reporting period) when an error in one of the Carrier Letter attachments delayed transmission of the final set of carrier responses. Attachment I is a copy of the listserv extending the deadline along with copies of emails from the plans showing they met the deadline. Attachment II is an email exchange to show the approved extension given to BCBSA for April 30th. Attachment III shows CareFirst met the deadline.

To facilitate tracking of receipt of the Fraud and Abuse Reports, we are adding functionality to our carrier database, Benefits Plus, to allow carriers to upload the report along with the certification. When the reports are uploaded, they are date stamped. The functionality also allows us to run reports to identify which Fraud and Abuse Reports are missing and will enable the HISC to communicate to the carriers regarding any missing data or data that does not align with our Guidelines for Reviewing Fraud and Abuse Reports.

Carriers are held accountable for timely submission of reports through the Contract Oversight score of the Plan Performance Assessment."

OIG Comments:

We agree that the new evidence provided by OPM extended the deadline for submitting FWA reports, and we adjusted the finding accordingly to show that timeliness was only an issue for one carrier. OPM also states that it adopted a new functionality for its carrier database to help ensure timely and complete FWA report submissions, essentially addressing our recommendation; however, we did not receive any evidence to support the addition of this new functionality. To help resolve this finding, IOC should verify that this new functionality was implemented and determine if the appropriate tracking mechanism is in place to hold carriers accountable.

D. FEDERAL EMPLOYEES DENTAL AND VISION INSURANCE PROGRAM

1. Ineligible Family Members in the FEDVIP — Procedural

OPM has no controls in place to verify family member relationships for FEDVIP. Instead, Federal employees and annuitants "self-certify" the eligibility of members they want added to their dental and vision plans.

In accordance with the Federal Employees Dental and Vision Benefits Enhancement Act of 2004 (H.R. 5295), the FEDVIP makes dental and vision benefits available to Federal employees, retirees, and their eligible family members. Eligible family members include an enrollee's spouse, unmarried dependent children under the age of 22, and dependent children of any age who were incapable of self-support due to a disability that occurred prior to their 22nd birthday.

To test OPM's controls over the enrollment process for FEDVIP, we reviewed BENEFEDS enrollment and eligibility functions for FEDVIP operations. Our review showed that OPM does not have sufficient controls in place to prevent ineligible family members from enrolling in the FEDVIP. BENEFEDS, which administers enrollment for the FEDVIP, allows Federal employees and annuitants to self-certify members that the enrollee wants added to their dental and vision family plan throughout the year. The only eligibility check that BENEFEDS performs is verifying that the enrollee is a Federal employee or annuitant, and ensuring that dependents who continue coverage beyond their 22nd birthday are incapable of self-support due to a disability. There is no verification of family member relationships, such as obtaining marriage and birth certificates, which is a standard practice for other employer groups in the insurance

OPM does not require BENEFEDS or the FEDVIP carriers to verify the relationship of family members at the time of enrollment.

industry. All carriers participating in the FEDVIP, and even BENEFEDS, admitted that this was a weakness in the program, but they pointed out that the cost for the carriers to verify eligibility for FEDVIP alone could exceed any savings. Although the OIG agrees that a carrier verification process for FEDVIP could be costly and redundant, OPM should still conduct a study to determine the number of ineligible dependents in the FEDVIP and consider adopting a family member verification system that is used for all Federal employee insurance benefits, since the FEHBP also does not verify family member relationships.

OPM reported that it allows "self-certification" for dependents in the FEDVIP since the cost to verify family member relationships could potentially outweigh any savings. BENEFEDS also reported that OPM does not give it authority to request eligibility documentation other than for continued coverage with disabled dependents. At this time, only the carriers have authority to request eligibility documentation, but none of them are exercising that authority.

Because stakeholders are not verifying the marriage and birth certificates for family members to participate in the FEDVIP, ineligible dependents may be using benefits and increasing premiums paid by Federal employees and annuitants.

Recommendation 16

We recommend that OPM eliminate the self-certification process for FEDVIP and implement an enrollment verification process that requires documentation to prove family member relationships at the time of enrollment. In the meantime, BENEFEDS, as the sole enrollment portal for FEDVIP, should have the authority to request eligibility documentation that includes marriage and birth certificates.

OPM's Response:

"Non-Concur[.]

We consider this recommendation prescriptive. This recommendation appears to originate from OIG's Final Audit Report No. 1G-LT-00-18-040, dated September 11, 2019, an audit of BENEFEDS as administered by Long Term Care Partners. BENEFEDS is a web-based portal that handles enrollment and/or premium administration services for the Federal Employees Dental and Vision Insurance Program (FEDVIP), the Federal Flexible Spending Account Program (FSAFEDS), and the Federal Long-Term Care Insurance Program (FLTCIP). LTCP administers the BENEFEDS portal with OPM having the contract authority and oversight of the program.

The BENEFEDS audit included the following Recommendation:

> ***We recommend that OPM eliminate the self-certification process and implement a verification system to stop ineligible members from participating in the FEDVIP. Proper administration of FEDVIP enrollment should include verification of dependent eligibility by either BENEFEDS or the FEDVIP carriers.***

OPM's response to this carrier audit recommendation is the same as our response to the nearly identical recommendation in this OPM Administration draft audit report. We do not concur with this recommendation. While OPM recognizes the need to strengthen dependent enrollment, requiring BENEFEDS to share and maintain dependent eligibility documentation to ensure eligibility for our enrollee-pay-all programs is beyond the scope of the current contract and, in the HI's judgment, is therefore inappropriate. Further, OPM currently does not have the financial, technological or human resources to create and maintain an eligibility file.

It should be noted that we have initiated procurement activities for the next BENEFEDS contract, effective 2022, and OPM is in the process of considering changes to the current contract, including activities surrounding the verification of dependent eligibility.

As a result of our current restraints, OPM cannot eliminate the self-certification process at this time. As noted in response to the BENEFEDS final audit report, HI will periodically update OIG on the progress of the Central Enrollment Portal (CEP), including controls designed to address dependent eligibility. Therefore, OPM will not take the recommended action per this draft audit report at this time."

OIG Comments:

OPM does not dispute the weakness identified by the audit and confirms that it allows self-certification for family member eligibility. Although we agree that the FEDVIP premiums are 100 percent funded by the enrollee, we disagree that OPM does not have an obligation to put controls in place that help stop ineligible dependents from enrolling in the Federal program. Implementing a verification system for family members to enroll in the FEDVIP should not be outside OPM's ability, and it should be a requirement to help reduce fraud, waste and abuse of Federal employee and annuitant funds.

We acknowledge that there are resource constraints impacting OPM's ability to develop and implement a centralized enrollment eligibility and verification file. Also, it is encouraging to note that OPM is willing to make changes to the BENEFEDS contract to include dependent

eligibility verification activities, in addition to its plans to develop a Central Enrollment Portal. However, until eligibility verification activities and the Central Enrollment Portal are developed and implemented, OPM should implement mitigating controls to help address the problem of ineligible dependents.

2. Informal Fraud, Waste, and Abuse and Debarment Requirements **Procedural**

We found that OPM does not have a vigorous FWA and debarment requirement properly communicated to the FEDVIP carriers or included in their contracts.

OPM issued an FWA memo to the FEDVIP carriers in 2016, via email, with some basic requirements that mirrored the FEHBP. Additionally, OPM's program analysis officer issued a debarment requirement in 2018, via email, that stated, "Please ensure that any providers listed on either the U.S. Department of Health and Human Services' debarment lists or on OPM's debarment lists are removed from your plan's provider network and flagged from receiving payments in your claims system."

OPM lacks a formal fraud, waste, and abuse and debarment requirement for FEDVIP carriers.

Under the FEDVIP solicitation section I.10, the CO may at any time, by written order, make changes within the general scope of the contract to include a description of services to be performed. If any such change causes an increase or decrease in cost then the CO will make an equitable adjustment in the contract price, the delivery schedule, or both, and will modify the contract. Additionally, I.15 of the FEDVIP solicitation states that no oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in the contract. The duly authorized CO must make all modifications to the contract in writing.

Based on our review of the FWA memo, debarment email, and FEDVIP contracts, we found that OPM did not formally communicate the new FWA and debarment requirements to the FEDVIP carriers. Additionally, the debarment requirement was issued by a program analysis officer and not the CO. Finally, none of the requirements became a contract modification or were issued as a formal carrier letter even though the carrier could be faced with increased costs to perform the new services.

OPM stated that the new requirements were not formally issued to the FEDVIP carriers because the FEDVIP Group is accustomed to communicating directly with the carriers, via email, due to the small number within the program. However, the program is still at risk of fraudulent claim payments, including those made by debarred providers, without formally developing and communicating the FWA and debarment guidance to FEDVIP carriers.

Recommendation 17

We recommend that OPM develop a formal and robust FWA and debarment policy for the FEDVIP and communicate the requirements in a carrier letter followed by a contract modification.

OPM's Response:

"Partially Concur[.]
We consider this recommendation prescriptive. The recommendation implies that no FWA and debarment policies exist and specifies how they should be communicated. Given that the FEDVIP contract is expiring and a new procurement is underway, issuance of a carrier letter is not appropriate with the new contract becoming effective in 2021. Therefore, we request that the recommendation be written as follows:

We recommend that OPM enhance its FWA guidance and debarment policy for the FEDVIP and formally communicate these requirements to FEDVIP carriers.

HI currently has a formal FWA and debarment policy. FEDVIP has reviewed its current policies and procedures to identify areas that can be strengthened regarding FWA and debarment requirements. Because we are in the final months of the existing FEDVIP contracts, the FWA and debarments policies will be included in the 2021 contract solicitation.

The former FEDVIP Contracting Officer's standard practice was to communicate requirements and guidance to FEDVIP carriers via email and this was delegated from the Contracting Officer to a Program Analysis Officer. This had been the case in our communication of FWA requirements and debarment requirements to FEDVIP carriers. However, HI has recently made a decision to communicate all requirements and guidance via carrier letter for its benefits programs.

HI is reviewing its current policies and procedures to identify areas that can be strengthened regarding FWA and debarment requirements. In addition, the FWA and debarments policies will be included in the upcoming 2021 contract."

OIG Comments:

We have not been provided evidence of a formal FWA and debarment policy for FEDVIP. Once IOC verifies that a formal FWA and debarment policy has been created and communicated to the FEDVIP carriers, this recommendation can be resolved.

Recommendation 18

We recommend that OPM include FWA and debarment requirements in the new solicitation for FEDVIP carriers.

OPM's Response:

"Concur[.]

HI has included the FWA and debarment requirements in the 2021 application for new FEDVIP Carriers. In addition, FEIO is adding the FWA and debarment requirements to the FEDVIP carrier handbook."

OIG Comments:

This recommendation should be considered resolved once IOC verifies the corrective action.

3. Insufficient Oversight of Annual Accounting Statements — Procedural

We found that OPM does not have sufficient controls in place for collecting, tracking, or reviewing AAS for FEDVIP carriers.

Section K.9, Accounting and Allowable Cost, of the FEDVIP contract requires the carriers to submit to OPM certified AAS by May 31, summarizing the financial results of its operations for the previous calendar year. Additionally, H&I partially delegated the responsibility of reviewing FEDVIP carrier certified financial statements to the OCFO and documented its oversight procedures in a MOU. The MOU states that the FEDVIP Group is responsible for collecting and tracking AAS in a spreadsheet, as well as reviewing the carrier financial statements for accuracy and completeness only. The OCFO is responsible for performing a full review of the financial statements using an established template. It also states that a FEDVIP carrier is subject to a negative evaluation on its performance report if it fails to submit its AAS by the May 31 due date.

OPM does not have sufficient controls in place to collect, track, or review AAS from FEDVIP carriers.

Based on our review of OPM's MOU and the FEDVIP carriers' AAS, we found that OPM failed to collect an AAS from one FEDVIP carrier in 2018 and the two previous years. Additionally, our review showed that 7 of the 14 FEDVIP carriers failed to submit their AAS by the May 31 due date. Although the FEDVIP Group uses a log to track the receipt of carrier AAS, it does not have effective controls for holding carriers accountable for the timely submission of those statements. We also reviewed prior audit reports issued by the OIG over the last five years and found that 6 of the 14 FEDVIP carriers had deficiencies related to their AAS, such as overstated income tax, overpaid premium tax, unallowable expenses, misstated expenses and premiums, and failure to submit their AAS.

This lack of oversight occurred because OPM does not have adequate procedures for collecting, tracking, and reviewing certified AAS from FEDVIP carriers, plus OPM does not hold carriers accountable for late financial statements. Another contributing factor to the increase in findings related to AAS is likely due to OPM no longer requiring FEDVIP carriers to have their financial statements audited by an independent public accountant. This requirement was removed by OPM in 2014, due to the cost of the audits.

Without sufficient controls in place to ensure the accurate reporting and tracking of each FEDVIP carrier AAS, OPM is unable to verify overall plan performance and compliance with any guarantees, which are needed to establish premium rates.

Recommendation 19

We recommend that OPM establish procedures related to collecting, tracking, and reviewing FEDVIP carrier AAS that include measures to ensure receipt of financial statements from all carriers, a verification process for ensuring carriers certify the statements, and instructions outlining how to review AAS for accuracy and completeness.

OPM's Response:

"Partially Concur[.]

Per our introduction, we consider this recommendation prescriptive. Since 2018, OPM has utilized a tracking spreadsheet to verify that carrier's certified AAS are received and retained. The spreadsheet is an effective tool to record the following: (1) Contract year to which the report applies; (2) Date the report is received; (3) Carrier Code, representing which contractor submitted the report; (4) Description of the report received; (5) Distribution of report; (6) Contractor's contact information; and (7) Which report was sent/received. OPM requires carriers to certify their AAS for accuracy.

However, OPM cannot guarantee the accuracy of the carriers' AAS beyond the required carrier certification. OPM's review process assesses the reasonableness of the AAS submission and as noted below, the 2021 solicitation will require audited AAS. HI is in the process of updating its Standard Operating Procedure (SOP) for carrier submissions of the AAS and OPM will work collaboratively to review and implement those procedures to ensure that FEDVIP carrier AAS are collected, tracked, and reviewed timely."

OIG Comments:

We recognize that OPM is improving its controls related to this finding, but we would like to reiterate that some FEDVIP AAS were not submitted, were not certified, and were not properly completed. IOC should ensure that H&I makes the needed improvements.

Recommendation 20

We recommend that OPM develop compliance measures and/or penalties to hold carriers accountable for the timely submission of AAS.

OPM's Response:

"Concur[.]

OPM has an established process in place to hold carriers accountable if they fail to submit their financial statement or submit it untimely. In those instances, the carrier's performance report will reflect this deficiency. This penalty is outlined in the February 27, 2019 Memorandum of Understanding (MOU) between OPM Healthcare and Insurance and OCFO. In addition, OPM is updating this MOU to ensure that it adequately addresses the annual review of the FEDVIP carrier's certified financial statements by the OCFO. OPM will work collaboratively to review and implement its updated MOU guidelines to strengthen controls that serve to hold carriers accountable for the timely submission of AAS."

OIG Comments:

This recommendation should be considered resolved once IOC verifies the corrective action.

Recommendation 21

We recommend that OPM develop language for the new FEDVIP solicitation that requires carriers to once again have their AAS audited by an independent public accountant.

OPM's Response:

"Concur[.]

We consider this recommendation prescriptive. Beginning in Contract Year 2015, FEIO's then-Assistant Director decided that carriers must have their AAS certified in lieu of requiring carriers to have their AAS audited by an independent public accountant. OPM recognizes the value of having carrier AAS audited annually by an independent public accountant. However, HI concluded that certified Annual Accounting Statements provided sufficient assurance to the program.

Nonetheless, as OPM developed the 2021 FEDVIP solicitation, we developed language that requires carriers to have their AAS audited on an annual basis. In the Application to Participate as a Qualified Company Under the Federal Employees Dental and Vision Benefits Enhancement Act of 2004, 5 U.S.C. Chapters 89A and 89B, Effective January 1, 2021, proposed language currently reads:

> ***'Contractors are required to have audited annual accounting statements that must be submitted to OPM in advance of annual rate negotiations as well as made available upon request. Contractors are required to identify a location for OPM to perform on-site evaluations of their records and facilities. A template for the annual accounting statement is distributed as an attachment to this application.'***
>
> ***Additionally:***
>
> ***'The Carrier will prepare an audited annual accounting statement summarizing the financial results of its FEDVIP contract for the previous calendar year. This statement will be prepared in accordance with the requirements issued annually by OPM and will be due to OPM in accordance with a date established by those requirements.'***

C. Further, the carrier CEO and CFO must attest to the following:

1. The statement was prepared in conformity with the guidelines issued by the Office of Personnel Management and fairly presents the financial results of this calendar year in conformity with those guidelines;
2. The costs included in the statement are allowable and allocable in accordance with the terms of the contract and with the cost principles of the Federal Acquisition Regulation (FAR);
3. Income, overpayments, refunds, and other credits made or owed in accordance with the terms of the contract and applicable cost principles have been included in the statement.

Beginning with the new FEDVIP contract, effective 2021, OPM will require carriers to submit AAS that have been audited by an independent public accountant."

OIG Comments:

This recommendation should be considered resolved once IOC verifies the corrective action.

4. Lack of Consistent Performance Standards with Penalties **Procedural**

During the audit, we found that OPM lacks standard performance metrics with penalties for its FEDVIP contracts.

OPM is responsible for the administration of the FEDVIP and the level of service that carriers are required to provide FEDVIP members. As part of this authority, OPM issues a solicitation for FEDVIP carriers every seven years and includes multiple requirements which carriers must follow. The 2014 FEDVIP solicitation allows carriers to select which performance standards it will guarantee and whether or not a penalty will be assessed if the carrier does not meet the standard.

OPM does not have standard performance metrics or penalties to hold FEDVIP carriers accountable for services provided to its members.

Based on our review of the FEDVIP solicitation in effect for the scope of our audit, we found that OPM does not require carriers to have standard performance guarantees or any associated penalties. OPM stated that it does not require standardized performance measures for FEDVIP carriers because it is not conducive to an efficient and effective customer service experience for enrollees. When we reviewed other multi-carrier insurance programs administered by OPM, we found that standard performance metrics with penalties for all carriers were imposed. However, we learned that the FEDVIP and Performance Improvement Groups are working together to develop standardized performance guarantees to be included in the upcoming FEDVIP

contracts. These proposed performance guarantees are not finalized and do not include associated penalties.

Without standard performance metrics and penalties, OPM is unable to hold FEDVIP carriers accountable for a standardized level of service offered to all members.

Recommendation 22

We recommend that OPM develop standard performance metrics with penalties to be included in all new or renewed contracts with FEDVIP carriers.

OPM's Response:

"We partially concur based on actions and procedures currently in place. In the performance of any contract, OPM has Solicitation Provisions in place to ensure that a Quality Assurance Surveillance Plan (QASP) will be used as codification of a portion of OPM's method of assessing carrier performance. To encourage high quality customer service in the FEDVIP program, OPM may amend the QASP elements and reporting requirements during the 7-year cycle of the contract to include new measures as well as a performance assessment process that supports dental health. OPM invites carriers to engage in this process by proposing additional measures that OPM can review and consider for future use.

The QASP includes:

1. Element: the requirement and definition of calculation, where applicable.
2. Performance Standard: where specified, OPM's standard of performance. Where not specified, carriers are to propose standards.
3. Acceptable Quality Level (AQL): the range of deviation within which the Government will consider performance to be acceptable. Where not specified, carriers are to propose AQLs.
4. Monitoring Method: the method OPM will use to determine the extent to which contractor performance has met the standard.

Carriers may propose an incentive for performance that exceeds the AQL or a penalty for performance that fails to meet the AQL. Any incentive or penalty proposed must also include the method used to determine each. OPM will monitor the performance of each Contractor to ensure acceptable performance as determined by the Contracting Officer.

Experience from this contracting period will be used to define performance standards for future contracting periods."

OIG Comments:

Our review of the 14 FEDVIP carriers' performance standards showed some similar measurements but also different requirements. Most carrier metrics did not include incentives or penalties, thereby having no effect when the performance standards were not met.

Instead of allowing the carriers to develop different standards and choose penalties, OPM should mandate specific standards with penalties for consistency across the FEDVIP and fairness among all members.

5. No Procedures for Reviewing or Tracking Fraud and Abuse Reports — Procedural

We found that OPM's program analysis officers did not perform sufficient reviews of the FEDVIP carrier Fraud and Abuse Reports for 2018 or have controls in place to hold carriers accountable for the timely submission of reports.

OPM does not have sufficient oversight controls to ensure that FEDVIP carriers comply with fraud and abuse reporting requirements.

OPM's Fraud, Waste, and Abuse Policy Memorandum, issued in May 2016, requires FEDVIP carriers to submit annual reports to OPM by March 31 and follow industry standards to prevent, detect, investigate, and report FWA. Industry standards include: establishing an FWA Hotline, conducting formal employee training to ensure FWA awareness, educating enrollees, using fraud protection software, implementing information security safeguards, addressing patient safety security, and publishing an FWA Manual.

Based on our review of OPM's FWA policy for FEDVIP carriers and the 2018 Fraud and Abuse Reports, we found that 6 of the 14 reports contained multiple non-compliance issues that were not identified by the program analysis officers. Specifically, our review showed that the program analysis officers did not:

- Ensure FEDVIP carriers completed all required fields in their annual Fraud and Abuse Reports;
- Require one FEDVIP carrier to inform enrollees of its FWA practices; or
- Require three FEDVIP carriers to use fraud protection/detection software to comply with FWA industry standards.

Additionally, we found that 6 of the 14 FEDVIP carriers submitted their Fraud and Abuse Reports after the March 31, 2019 deadline. We were unable to obtain documentation to support that any efforts were made to follow-up with the FEDVIP carriers to obtain missing or incomplete data.

This lack of oversight occurred because OPM does not have procedures for reviewing carriers' Fraud and Abuse Reports or a tracking mechanism to log the receipt of reports from FEDVIP carriers.

Without sufficient reviews or controls to ensure receipt of Fraud and Abuse Reports, OPM is unable to ensure that FEDVIP carriers have effective fraud and abuse programs, and the FEDVIP is at risk of increased program costs.

Recommendation 23

We recommend that OPM establish oversight procedures for reviewing FEDVIP carriers' Fraud and Abuse Reports and develop a checklist for program analysis officers to use during their review as a control to ensure compliance with FWA reporting requirements.

OPM's Response:

"Concur[.]

We consider this recommendation prescriptive. However, FEIO will develop formal oversight procedures for reviewing FEDVIP FWA Reports. FEIO will develop a checklist to use when reviewing the Carrier's FWA Reports."

OIG Comments:

This recommendation should be considered resolved once the corrective action is implemented and verified by IOC.

Recommendation 24

We recommend that OPM implement the use of a tracking mechanism to log the receipt of annual Fraud and Abuse Reports and hold FEDVIP carriers accountable for the timely submission of reports.

OPM's Response:

"Partially Concur[.]

FWA report tracking has been used since we received the first annual report for contract year 2016 in 2017. HI (FEDVIP) maintains a tracking spreadsheet documenting when FEDVIP Carriers submit their reports and is in the process of updating the FEDVIP Carrier Handbook, which includes the timeline of events, and notes when the report is due. This tracking is being evaluated and will be updated to strengthen controls surrounding FEDVIP carrier reporting. The deadline for the FWA report is also clearly stated in the carrier application for the coming contract period. Additionally, the Program Office sends reminders to carriers one month before the due date, requesting their FWA reports. Regarding FEDVIP carrier accountability, the Program Office considers the timeliness of FWA reporting during each plans' annual performance reporting and subsequent annual review. Untimely FWA reporting may adversely affect a carrier's performance review."

OIG Comments:

We recognize that OPM is improving its controls related to this finding, but we would reiterate that some FWA reports were either not submitted or were untimely. IOC should ensure that H&I makes the needed improvements.

E. LIFE AND ANCILLARY BENEFITS

With the exception of the unauthorized CO and CORs previously identified, the results of our review showed that the Life and Ancillary Benefits Group had sufficient internal controls and program requirements in place for the administration of life insurance, long term care insurance, and flexible spending account benefits for Federal employees, annuitants, and their dependents during operating year 2018.

F. PERFORMANCE IMPROVEMENT GROUP

The results of our review showed that the Performance Improvement Group had sufficient policies and procedures in place to provide oversight of plan performance assessments and to calculate the quality measures for FEHBP carriers for operating year 2018.

APPENDIX

June 1. 2020

MEMORANDUM FOR: Michael R. Esser
Assistant Inspector General for Audits

FROM: Laurie E. Bodenheimer /s/
Acting Director, Healthcare and Insurance

SUBJECT: Response to the Draft Report of the Audit of the U.S. Office of Personnel Management's Administration of Federal Employee Insurance Programs, Report Number 4A-HI-00-19-007, dated February 10, 2020

Thank you for providing the U.S. Office of Personnel Management (OPM) the opportunity to respond to the Office of the Inspector General (OIG) Draft Audit of OPM's Administration of Federal Employee Insurance Programs, 4A-HI-00-19-007. A key Healthcare and Insurance (HI) goal under the current OPM Strategic Plan is to increase the quality and affordability of health plans offered by Federal Employees Health Benefits (FEHB) Program Carriers, and we value your input and our partnership which supports our ability to meet this goal.

This audit is unique, being OIG's first global assessment of HI's oversight and administration of the benefit programs for which we are responsible. From its initiation in September 2018, this audit represented an opportunity to share how HI's Federal Employee Insurance Operations (FEIO) and its subcomponents perform their contractual, program administration and management oversight for the insurance and benefit programs in our span of control. Those subgroups and program responsibilities are outlined below:

- FEHB 1, FEHB 2, and FEHB 3 each manage one or more contracts with health insurance carriers offering coverage under the Federal Employees Health Benefits (FEHB) Program;
- FEDVIP manages the Federal Employees Dental and Vision Insurance Program (FEDVIP);
- Life and Ancillary Benefits (LAB) oversee the Federal Employees' Group Life Insurance (FEGLI) Program, the Federal Flexible Spending Account Program (FSAFEDS), the Federal Long-Term Care Insurance Program (FLTCIP) and the BENEFEDS contract/contractor, which performs enrollment and/or premium administration for several of the voluntary benefits programs;
- Performance Improvement Group, which manages the FEHB Plan Performance Assessment Program; and
- Audit Resolution and Compliance (ARC) Group

The OIG indicated these FEIO Groups were the primary scope of this audit for operating year 2018.

In the period between audit work being completed and the issuance of this draft report, HI responded to 38 Information Requests, held multiple meetings with OIG's audit team and replied to many follow-up inquiries. Based on that communication and collaboration, we expected to receive Notices of Findings and Recommendations (NFRs) from OIG for all its findings. We find NFRs to be enormously helpful, potentially reducing the number of recommendations in the draft audit report and ensuring that the draft report is as accurate and balanced as possible. Bypassing the NFR process often results in substantial additional review, discussion and vetting by HI, the Office of the General Counsel (OGC), Internal Oversight and Compliance (IOC), and the Office of the Director, that might otherwise have been avoided. We would like to engage with OIG on how we might implement a consistent NFR process going forward for the benefit of all parties involved in working through audit findings.

The draft audit includes 24 recommendations. Our response for some recommendations (5, 7, 11, and 12) are lengthy, because history and context are needed to better understand HI's position and the actions HI has taken in each situation. At least five recommendations are duplicative of those previously issued in carrier audits, other OPM specific audit engagements or were conveyed via an OIG Management Challenge to the agency, where HI's responses and/or resolutions were negotiated and implemented, or a final decision was communicated with OIG's awareness and input. Additionally, we find many recommendations in the draft report prescriptive; that is, those recommendations offer a preferred solution rather than focusing on improving FEIO processes, without stipulating how improvements should be made. A recommendation that is prescriptive may substantially limit our ability to address a recommendation or finding that we might otherwise generally agree with. The Program office is in the best position to identify and decide the best approach(es) to mitigate issues and to strengthen controls.

HI will continue to engage OIG in resolving contested audit findings to achieve the most effective outcomes. However, where mutual agreement cannot be achieved, OPM is committed to a collaborative process that will bring final, definitive closure to repeated audit findings and recommendations in compliance with OMB Circular A-50's guidance on Audit Resolution and Agency Follow-Up activities.

Our responses to the draft audit report include the agency's position on each recommendation as well as supporting comments to the report's narrative findings. In some instances, a recommendation should be re-written to be more accurate, applicable or less prescriptive. We may provide suggested wording for a rewrite, and request you consider this or similar updated wording if the recommendation is included in the final audit report. Where we believe it appropriate, we have requested that a recommendation be considered for removal from the final audit report.

Recommendation 1 We recommend that the three COs obtain the proper training to meet the 80 CLP requirement every two years and submit the training certificates in FAITAS.

OPM Response: **Non-Concur**

OPM does not concur with the draft report's findings under "Unauthorized Contracting Officers" or its conclusion that three FEIO Contracting Officers (CO's) made or are making unauthorized commitments on behalf of the federal government due to lapsed Federal Acquisition Certifications in Contracting (FAC-C). Pertinent history and facts include:

- Prior to September 2018, the Office of Procurement Operations (OPO) issued warrants, tracked training and periodically revalidated credentials for HI.
- All three CO's were fully certified and warranted by OPO and were in good standing when the delegation of authority that transferred the issuance of these warrants from OPO to HI was issued.
- OPO periodically performed internal validations to reevaluate its warrants to ensure their certifications were proper and up to date. An OPO assessment of OPM warrants under its authority was done in 2015 with all three Contracting Officers questioned in the draft audit report adjudicated successfully.
- HI assumed warrant management in 2018, after the Acting OPM Director signed a change in the delegated authority for HI's benefit programs.
- Turnover within OPO resulted in loss of institutional knowledge as the warrant for the Chief of Life and Ancillary Benefits was being reissued. Turnover took place up and down key positions throughout OPO, including two Senior Procurement Executives, Director of Contracting, Division Director, Acquisition Policy & Innovation, and the Procurement Analyst who managed the CALYPTUS contractor's evaluation of OPM's warrants.
- Prior to the transfer of delegation, OPO was prepared to reissue HI warrants, but negotiation of the wording on the warrants themselves, pertaining to OPO's delegated authority, delayed the process, which was never completed after some key management losses, noted above.
- OPO may have inadvertently deleted some training history while completing a 'scrub' of its early training history.
- There were chronic problems with FAITAS, the system of record for contracting certifications and warrant issuances, including a period of time when the system was not available to Federal civilian employees during a period of urgent need for Department of Defense training, resulting in the inability to update, edit and access properly completed training.
- If a CO's warrant had been revoked or invalidated, our understanding is that OPO would have informed the CO of such action. This never occurred. Absent that, the CO remained in good standing.
- It is incorrect and inappropriate for OIG to assert an audit scope of 2018 and seek to verify training records from 2012, 2010, and 2008. It is also inappropriate to develop findings against HI while the warrant management was under OPO.
- Finally, where HI could not verify that one of the three individuals had the requisite FAITAS requirements upon transfer of the authority to HI, a warrant was not issued. The other two individuals referenced in the OIG audit have met all requirements and OIG's

assertion that the CLPs are not reflected in FAITAS is wrong. The correct information is reflected in FAITAS.

To summarize, the organization charged with designating and maintaining FAC-C III warrants, the Senior Procurement Executive and key managers, the Delegation of Authority, warrant management processes and the FAITAS system itself all experienced substantial change, transition or 'down time' over a period of approximately 18 months, resulting in the inability to simply pull an accurate, comprehensive set of FAC courses and CLPs in every case. In exceptional circumstances such as this, sufficient weight must be given to the fact that no warrants were rescinded by OPO due to any CO being unable to support his/her warrant and continuous education, despite agency refresh efforts performed by the SPE. Once the delegation of authority for warrants transitioned to HI, extreme diligence and caution were exercised before reissuing warrants. When full history could not be confirmed in FAITAS and/or via historical OPO records and accounts, due to their own attrition, HI made the decision not to reissue the one CO's warrant, despite the fact that completion of FAC-C III credentials and CLPs had never previously been questioned by OPO.

This recommendation should not be included in the final audit report.

Recommendation 2 We recommend that OPM develop policies and procedures to strengthen its monitoring and oversight of training related to CO warrants to ensure that the warrants are rescinded if certification of 80 CLPs every two years is not documented in FAITAS.

OPM Response: **Non-Concur**

As noted above, this recommendation is prescriptive. Upon assumption of warrant management responsibilities, HI developed and put in place procedures to monitor and ensure that the required training to maintain CO warrants is completed and documented in FAITAS. Further, OPM does not concur with the premise that any HI warrants were revoked, rescinded or should not have been granted in the first instance. OIG's inability to obtain documentation that required training was completed does not mean that Contracting Officer warrants are, were, or ever should have been revoked. While OPO was managing the warranting process prior to October 2018, it periodically performed a 'refresh' or revalidation of OPM Contracting Officers. This included a review of educational qualifications, FAC-C courses and continuous learning requirements. The last refresh was performed in 2015, which confirmed the validity of all HI CO warrants. The warrant for the CO over Life and Ancillary Benefits (LAB) contracts, then called Individual Benefits and Life (IBL), was in the process of being reissued, but a mistake was made in its issuance, after which there were key losses within OPO. Shortly thereafter, discussions surrounding changing the delegation of authority from OPO to HI resulted in further delays.

There have been periods where FAITAS was not functioning properly (e.g. Fall 2018) and did not accept training uploads and some training history may have been lost during a "scrub" of historical records by OPO. These operational realities help to explain apparent gaps in FAITAS' records.

With HI having been delegated contracting authority over the insurance benefit programs, overall administration and maintenance of CO warrants have been and will continue to be enhanced. This includes ensuring CLP requirements are met and documented and taking appropriate actions when they are not.

This recommendation should not be included in the final audit report.

Recommendation 3 We recommend that OPM require its health insurance specialists and program analysis officers within FEIO, who are acting in the capacity of a COR, to obtain the proper FAC-COR.

OPM Response: **Non-Concur**

All HI staff, including Program Analysis Officers and Health Insurance Specialists within FEIO are required to obtain FAC-COR designation before they are assigned to act as a COR on a FAR-based contract, including FEHB Program contracts. But, Health Insurance Specialists do not act as CORs on FEHB Program contracts, and Program Analysis Officers do not act as CORs on FEDVIP contracts.

HISCs assist in FEHB *program* administration. There is absolutely no benefit to requiring HI Health Insurance Specialists to obtain FAC-COR designation. In fact, it would be wasteful and inefficient. The recommendation arises from the following misconception, on page 4 of the Draft report (italics added):

> "The use of unofficial CORs occurred because OPM's FEIO officials were under the impression that health insurance specialists and program analysis officers were not required to be certified CORs since they operate under the Federal Employees Health Benefits Acquisition Regulation (FEHBAR), not the FAR. Although FEIO operates under the FEHBAR, it is intended to implement and supplement the FAR for the purposes of acquiring and administering health insurance contracts under the Federal Employees Health Benefits Program (FEHBP). *Therefore, health insurance specialists and program analysis officers who assist in the technical monitoring or administration of large contracts are required to be certified CORs and meet all COR requirements*."

As stated above, the HISCs assist with FEHB *program* administration only. While interacting with the FEHB carriers is a necessary part of carrying out their program administration functions, HISCs do not have any authority to bind the government or make contract decisions; The Contracting Officers within HI rely on the expertise of the HISCs and Program Analysis Officers in order to protect the interests of the United States in accordance with FAR 1.602-2(c.) However the Contracting Officers retain and execute COR duties and HISCs and Program Analysis Officers do not perform any COR duties.

The draft report notes that OPM's Position Description (PD) states that Health Insurance Specialists Contracts (HISC) serve as CORs responsible for administering contracts for HI

programs and advising the CO. HI rewrote the HISC Position Description several years ago, after the positions were upgraded from GS 12 to GS 13. The duties listed in the PD do not include COR responsibilities. However, when the remaining components of the PD (the factors justifying the general schedule grade) were assembled by OPM's Classification Specialist, the language was not in line with the actual duties in the PD. Thus, a passing reference to HISC's acting as CORs was added in error. There is no requirement for an HISC to be a COR to fulfill their responsibilities related to FEHB contracts.

For the same reasons, HI's Program Analysis Officers in FEDVIP are not required to be CORs. Nonetheless, the two Program Analysis Officers currently working in FEDVIP have either completed training as a FAC-COR Level II or are certified as a Level II- COR.
In reviewing the PDs for this response, FEIO noted the 20-year-old Program Analysis Officer PD has an incorrect reference to the PAO as a Contracting Officer's Representative that "administers specific contracts," but nowhere indicates that the PAO must be FAR-COR certified CORs, with delegated contracting authority. Further, when the PD in question was written, it was written by individuals who were not warranted Contracting officers or 1102s who would be familiar with the FAR-based term of art. This term was included incorrectly and FEIO will update our PD's to reflect their accurate, current functional responsibilities.

HISC or Program Analysis Officers may serve as CORs on other contracts such as the consultant contract for medical reviews, or on the contracts HI has for CAHPS and HEDIS reporting services. When an HI employee serves in a COR capacity, we ensure they have met the FAC-COR requirements.

This recommendation should not be included in the final audit report.

Recommendation 4 We recommend that OPM require each COR to obtain a letter of designation from the CO that describes their duties and responsibilities, a copy of the contract administration functions delegated to a contract administration office which may not be delegated to the COR, and documentation of COR actions taken in accordance with the delegation of authority.

OPM Response: Non-Concur

As noted above, the reference to COR's in the HISC's and PAOs PDs were made in error. We do not concur with the follow-on recommendation that HISCs and PAOs must obtain a letter of designation from the CO describing their duties, etc.

This recommendation should not be included in the final audit report.

Recommendation 5 We recommend that OPM provide ARC with a better audit resolution system that tracks, records, and reports resolution transactions that can be shared by H&I, the Office of the Chief Financial Officer (OCFO), and Internal Oversight and Compliance.

OPM Response: **Non-Concur** (as written). A re-wording of the Recommendation may lead to OPM Concurrence.

The draft audit report evaluated resolution timeliness since fiscal year 2011, which is well beyond the scope of the audit. During this nearly ten-year period, virtually every aspect of the audit resolution function has radically changed: its staffing levels, processes, systems, structure and even the type of audit findings and recommendations. The audit resolution function has grown from two people assigned to resolve audits within the former Program Planning and Evaluation Group to becoming its own Group, Audit Resolution and Compliance, composed of eight full time employees including two supervisors.

The report certainly acknowledges improvements made; we note, however, that of the three oldest audits currently open (with over $98M total contested questioned costs) we only very recently received OIG's counsel's response to HI's written positions provided more than six months prior. We agree that the 2017 loss of ARRTS, the OIG, OCFO and HI jointly owned system, represents a serious internal control deficiency that must be addressed. OPM concurs that Audit Resolution and Compliance requires additional resources and that an *agency-wide* system is needed to document, track, monitor, report, share and perform basic analyses on audits, resolution trends, and compliance activities. This system should be OPM-owned (not an ARC system) and requires access, data and/or approvals from HI, OCFO, OIG and IOC. All four organizations are stakeholders in a system since each owns or reports data from components in the system.

OPM may concur with a recommendation that reads: We recommend that OPM acquire an agency-wide audit resolution system that records and tracks recoveries and resolutions, and reports and performs analyses on resolutions to be shared by HI, the Office of the Chief Financial Officer (OCFO), the Office of the Inspector General (OIG) and Internal Oversight and Compliance (IOC).

Recommendation 6 We recommend that OPM provide ARC with the proper staffing and training needed to resolve audit recommendations timely based on an assessment of the workload, critical skills, and core competencies required to be knowledgeable in each of OPM's employee benefit programs.

OPM Response: **Partially Concur**

We consider this recommendation prescriptive. It is also closely aligned with Section C of the Draft FEHB Contract Amendment MAR NFR, titled – Audit Resolution Concerns, to which HI recently responded.

OPM concurs that additional resources for ARC are needed. OPM rejects the implication that ARC lacks the 'competencies required to be knowledgeable' in the benefit programs that HI administers. ARC staff average in excess of 5 years in Audit Resolution and Compliance, more than 10 years' experience in Healthcare and Insurance, and over 15 years with OPM, with the typical ARC employee holding an advanced degree. The Group is regularly availed of training

and growth opportunities to strengthen foundational skills and develop new ones. ARC as a Group or individual team members have been recognized with OPM Director's Awards on multiple occasions and have been nominated other times. HI's Audit Resolution and Compliance function has been recognized by OPM's Internal Oversight and Compliance for its high closure rates, reduction in aged audits and collaborative resolution approach. ARC is a high-performing team, which has worked diligently and reliably to improve HI's benefits administration through the recovery of erroneous payments, improvement of information systems and strengthening of carrier and OPM's own internal controls.

Despite those efforts, the scope of OIG carrier audit reports continues to evolve from assessing established attributes such as Duplicate Claims, Coordination of Benefits with Medicare, Cash Management and Access Controls, and routine MLR findings, to questioning costs and actions that may be based on OPM management actions or areas beyond the scope of the current contract being evaluated. This expansion of audit scope has often resulted in lengthy analyses, OGC and Plan counsel involvement, and entrenched, divergent positions on contested audit findings. These findings often have questioned costs that remain open for months or even years, with little likelihood of being recovered in the absence of OPM-OIG concurrence on the validity of findings prior to their issuance in a final report, based on the contract in place during the audit. This often means that there is also no consensus that the contract(s) between the carrier and OPM should be changed to prospectively cover these disputed findings.

For context, OIG's Office of Audits leverages an Experience Rated Audits Group (ERAG), a Community Rated Audits Group (CRAG), an Advanced Claims Audits Team (ACAT), a Special Audits Group (SAG) and an Information System Audits Group (ISAG) to assess and perform audits of HI's insurance benefit programs. Further, its Office of Investigations performs or assists in generating fraud, waste and abuse findings, while another OIG Audit Group performs the annual audit of the agency's financial statements. Together, OIG's Audit and Investigative Groups, who perform vital program oversight, leverage resources that rival or exceed all of HI's offices and resources combined. All audits, regardless from which IG group they originate, go through ARC for resolution. However, given the sheer size and scope of the audits there is not a simple and direct correlation between increased training and timely resolution; HI (not just ARC) would need to substantially increase its footprint to cover the breadth of audit findings generated by OIG's various audit groups. Further, the nature of many of the findings requires specific expertise in areas such as: statistical sampling, tax accounting, actuarial science, provider networks and sub-contracting, policy and legal analyses, information systems, capitation, letter of credit accounts, working capital, Federal Acquisition Regulations and more. These are in addition to the basic audit resolution procedures as well as the foundational knowledge required of the specific audit types themselves (e.g. Experience Rating, Community Rating, voluntary benefits, etc.).

It is not feasible for any small group to be fully knowledgeable across such a broad portfolio of plan types, procedures, issues and their associated systems. ARC's role is to serve as an agent of the CO's and facilitate resolution through a collaborative process with internal and external stakeholders, such as HI Program Analysis and Development (formerly known as Policy), the Office of the Actuary, OCFO, OGC, OCIO, Carriers and OIG's many groups and teams. We

agree that training and subject matter expertise is a continuous pursuit, but as the resolution function has evolved, we believe that a combination of more resources and an agency-wide system will yield the greatest improvement on the resolution process versus targeted training for existing staff.

Recommendation 7 We recommend that OPM implement an eligibility verification process for family members to participate in the FEHBP by requiring marriage or birth certificates for all new enrollments. OPM should make it mandatory for federal agencies and/or insurance carriers to request proof of eligibility for family members to participate in the FEHBP, and the eligibility documentation should be maintained in accordance with records retention requirements. If OPM finds it unfeasible to have federal agencies and insurance carriers verify and maintain eligibility documentation for family members who participate in the FEHBP, it should consider contracting with a third-party vendor to verify family member relationships.

OPM Response: **Partially Concur (Duplicative)**

We consider this recommendation prescriptive. It is also duplicative, in that OIG Recommendations pertaining to family member eligibility are found in numerous final audit reports, including: Global Enrollment (17-048), Mail Handlers (16-044), Compass Rose (17-026), United (17-047), Humana (17-040), Triple S (17-017), Health Alliance Plan (17-031), GHC (18-015), Aetna (17-007), Blue Care Network of MI (18-031), Presbyterian (18-014), TakeCare (18-029). More eligibility recommendations are found in the BENEFEDS and FEDVIP audits.

Because the current FEHB enrollment process by regulation is decentralized at the agency level, OPM's role in eligibility verification is to provide policy and guidance to agencies and carriers. Each agency has determined its own manner for enrollment processing, including its choice for an electronic processing platform. Multiple different platforms are used throughout the government with differing capabilities. We acknowledge that errors may occur because of the regulatory decentralization, and we are taking steps to provide guidance to agencies and carriers.

On January 23, 2018, OPM published final regulations providing that proof of family member eligibility may be required to cover family members under an FEHB enrollment and establishing a process for agencies and FEHB carriers to request proof. OPM is in the process of drafting guidance on implementing the regulation to agencies and carriers that will require family member verification, including what constitutes acceptable documentation, during the following enrollment events:

- New employees during their Initial Enrollment Opportunity
- Existing employees and annuitants submitting an enrollment change due to a qualifying life event (QLE)
- New family member(s) being added to an existing Self and Family enrollment

OPM is also drafting guidance on processes for removing ineligible family members from current enrollments when an agency or carrier has determined ineligibility.

Due to the high volume of Open Season transactions and limitations in agencies' self-service systems, we do not currently believe it feasible to have agencies and carriers verify a new enrollment's family members during that time period. However, agencies and carriers have the authority to request documentation from enrollees at any time.

Without centralized FEHB enrollment, there will always be a significant problem with agencies maintaining eligibility documentation due to FEHB enrollees' changing agency employing offices, retiring, changing personal family statuses, and changing insurance carriers.

OPM has an agency priority goal in FY 2020-2021 to develop a Master Enrollment Index (MEI) of all FEHB subscribers and family members. The MEI will reside in OPM's Health Insurance Data Warehouse (HIDW). We are examining the feasibility of a future enhancement to include storage of eligibility documentation.

Recommendation 8 We recommend that OPM develop a formal MOU between the FEHB 2 Group and the OCFO to specifically outline the shift in responsibility for reviewing AAS from FFS and ER HMO carriers, including who is tasked with verifying the submission of working capital schedules.

OPM Response: Non-Concur

We consider this recommendation prescriptive. While we agree that FEIO and OCFO can strengthen controls and improve our communication in order to eliminate mistakes and improve oversight, an MOU between FEIO and the OCFO is unnecessary. OCFO issues financial guidance to carriers and maintains responsibility for reviewing carrier AAS. FEIO works closely with the OCFO to ensure carrier compliance with financial requirements. We work collaboratively with each other to fulfill our mission. HI partners and collaborates with several offices on many key functions across the agency in order to effectively administer the FEHB Program. An MOU is neither needed nor appropriate in every shared process or engagement with another office. To strengthen controls and communication within FEIO and OCFO, HI has already taken and is taking the following actions:

- FEIO developed a list of carriers that utilize working capital accounts and has shared it with OCFO. We will update the list of carriers annually or more often as appropriate and provide it to OCFO. It is important to note that using a working capital account is strongly recommended but not mandatory. FEIO maintains the list because the OPM Contracting Officer must approve use of a working capital account.
- FEIO and OCFO will use the list to confirm that carriers with working capital accounts have completed the working capital schedule according to the AAS instructions issued by the OCFO.

- OCFO has indicated they will add an entry to the AAS review index checklist they use to verify that a working capital schedule is present.
- HI FEIO (each FEHB group that has one or more Experience-Rated carriers) will monitor carriers to ensure that they are reviewing working capital accounts monthly and adjusting them quarterly if necessary, as required by OPM's Letter of Credit (LOC) System Guidelines (Carrier Letter 2018-08, Attachment B).

Recommendation 9 We recommend that OPM work with the OCFO to establish internal procedures for properly reviewing and verifying the accuracy and completeness of the working capital schedule reported in the AAS by FFS and ER HMO carriers.

OPM Response: Non-Concur

OPM disagrees with this recommendation, as written. OPM's internal procedures are found in Attachment B of C.L. 2018-08, the Letter of Credit Account (LOCA) Manual. These guidelines prescribe the actions to be followed by both carriers and OPM internally.

The Draft report also recommends that OPM verify the *accuracy* of WC schedules. Ultimately, OPM verifies accuracy through contract administration and through the audit function. OPM is not in a position to confirm the accuracy of carriers' WC transactions on a real-time basis, although errors identified via OIG audit are addressed by the appropriate OPM office. OIG may wish to specify its expectations regarding what "accuracy" means in this recommendation. If what is meant is to verify accuracy beyond that which is currently done via OIG audit, this may merit discussion with OPM to determine whether this can be achieved.

OPM seeks to confirm what the Draft report means by verifying "completeness" of the WC schedule. If completeness refers to ensuring that all carriers with WC provide schedules, per the audits noted in the Draft Report from the 2017 AAS review, where four carriers failed to correctly provide their WC schedules, then OPM concurs that this verification is appropriate and has already taken corrective action to ensure carriers using WC schedules report them.

FEIO and OCFO have acknowledged that there are improvements that need to be made to the LOCA Manual. Thus, FEIO and OCFO are working together in order to expand guidance provided by the manual. This expansion will include instructions for plans that need a waiver from the standard formula. FEIO and OCFO will also review the manual to determine if additional instructions are needed for reviewing adjustments (increases and decreases) of the WC schedule.

We would concur with a recommendation that reads:

> We recommend that OPM improve its internal procedures to ensure FFS and ER HMO carriers are appropriately completing and submitting the working capital schedule, as reported in the AAS.

Recommendation 10 We recommend that OPM work with the OCFO to develop a master list to track the working capital deposits held by FFS and ER HMO carriers.

OPM Response: **Partially Concur**

We consider this recommendation prescriptive. The OIG identified issues related to excess working capital in several audits. OPM took actions to strengthen controls surrounding FEHB carriers' working capital in 2018 in Carrier Letter18-08. However, we recognize that some carriers did not fully comply, which was highlighted in OIG's findings. OPM is taking further steps to tighten its controls by the following:

- HI will provide OCFO with a master list on an annual basis, with updates as necessary, that indicates which carriers hold a working capital account.
- The OCFO currently uses two worksheets that include tracking of receipt of the AAS and verifies cashflows and other financial data. The CFO will add a section for the working capital to ensure that the spreadsheet is included in the submitted AAS.

HI will continue to track working capital per our guidance, which requires carriers to report monthly and adjust quarterly. This tracking monitors FEHB working capital without being too prescriptive. We suggest that this recommendation be reworded to:

"We recommend that OPM improve its tracking of the working capital deposits held by FFS and ER HMO carriers."

Recommendation 11 We recommend that OPM establish PBM transparency standards for all new, renewed, or amended contracts that are specific to community-rated HMOs.

OPM Response: **Non-Concur (Duplicative)**

OIG previously identified the lack of PBM transparency standards in community-rated HMOs in its annual Management Challenges, issued to the Director of OPM and published in the Agency Financial Report. OPM has responded to these concerns in that venue, where we would expect to see management recommendations as opposed to having them identified within an audit of internal controls.

OPM disagrees with OIG's stated purpose for including specific transparency standards in the CR HMO contracts. Under OPM's CR HMO contract, OIG is able to adequately audit Carriers for compliance with the FEHB MLR and, while some changes may be helpful to fill gaps identified by OPM and OIG, transparency standards as defined by the OIG are not appropriate. As OPM has stated repeatedly in discussions with OIG, the CR HMO contracts differ from ER HMO and FFS contracts because community-rated FEHB plans receive a fixed premium to provide comprehensive coverage, including prescription drugs. The carrier holds the full risk for any costs above and beyond premiums received. Experience-rated FEHB plans are reimbursed

their claims expenses on a dollar-for-dollar basis. OPM does not need to know the specific claim pricing or rebates received by a community-rated carrier's PBM because OPM is not paying the carrier for each claim. Rather, the aggregate amount paid to the PBM is what is necessary to audit to ensure compliance with HHS MLR and FEHB MLR requirements. Because OPM is paying experience-rated carriers for specific claims, it is necessary and appropriate for transparency standards in the ER HMO and FFS contracts. However, as we have stated before, the same standards are not appropriate for CR HMO contracts.

OIG's claim that PBM transparency standards will allow FEHB members to see the administrative markup and profit of PBMs that contract with community-rated HMOs is incorrect. There is no public sharing of this information and FEHB members have little insight into the financial information of FEHB carriers and their subcontractors. The financial information that FEHB members are interested in is the final premium and their respective out-of-pocket costs when shopping for health insurance.

OPM also disagrees that it is OPM's responsibility "to ensure that FEHB members are receiving the best price and benefits for pharmacy operations." The FEHB Program is a market-based health insurance program which allows Carriers to compete to earn subscribers. It is impossible for any plan to obtain the "best price" for all drugs. Even under the ER HMO and FFS contracts, drug pricing will differ by plan. Some drugs may have lower costs for some members under one plan and others will have lower costs under other plans. This is due to the negotiating power of the respective Carriers and how they align their drug pricing with their population and business needs.

This recommendation should not be included in the final audit report.

Recommendation 12 We recommend that OPM implement the following rate instruction changes:

- Include transparency standards requiring the carriers to provide support for all claims, encounters, and capitated rates, including those from their provider-owned networks or related entities used in the MLR, rate proposal, and rate reconciliation calculations; and

- Improve MLR criteria to provide complete, clear, and concise instructions of the FEHBP MLR process, including specific instructions concerning provider-sponsored health plans and capitated arrangements in its cost reporting.

OPM Response: **Non-Concur (Duplicative)**

We consider this recommendation prescriptive. We disagree that there is weakness in OPM's rate instructions or MLR regulation. We also find this recommendation duplicative, as the OIG brought these concerns to our attention in both a carrier audit where there was a provider-sponsored plan, Dean Health Plan (15-039) and the Draft MLR MAR, where OIG raised similar

concerns. In each audit, HI met with the OIG to discuss our concerns and we provided our position and final resolution decision, where applicable in a written response.

OPM does not need to change its FEHB MLR requirements to include transparency standards and to improve the MLR criteria. OPM currently has standards in the FEHB contract which require carriers to submit claims experience to the OIG in a data format specified by the OIG. During an audit, OIG is able to review what carriers paid their providers to determine the MLR. Carriers are already required to provide support for all claims, encounters, and capitated rates paid to providers. Furthermore, the recommendation is not clear as to the purpose of the recommended additional instructions.

In addition, we disagree that OPM's criteria are not complete, clear, or concise. OPM generally follows the HHS MLR requirements and provides FEHB-specific requirements where necessary. However, OPM is not seeking to impose separate MLR calculations standards on FEHB Carriers. OPM allows carriers to calculate their FEHB MLR consistent with HHS MLR requirements. The purpose of OPM's FEHB MLR requirements is to ensure that the FEHB groups are receiving fair value for premiums and are not subsidizing other Carrier groups. Where it may be necessary to include FEHB-specific MLR instructions, OPM adds specific requirements. Furthermore, OIG has not stated how either OPM or OIG would be capable of determining a reasonable reimbursement rate or capitation rate for providers, regardless of the ownership relationship to the Carrier.

HI does not believe it should change its MLR guidance based on one carrier's arrangement. As noted in our response and acknowledged by the OIG, in response to a previous audit, the specific arrangement that the carrier has with its owners is not addressed in OPM's MLR instructions or HHS's MLR instructions. The carrier has had this arrangement well before the ACA's MLR requirements or OPM's MLR requirements and did not switch to this methodology to circumvent these rules.

The Office of the Actuaries believes the carrier calculated their MLR appropriately and indicated that the carrier's MLR has been above the MLR threshold (89% in 2012 and 85% in 2013-2016) every year.

We also note that OIG's statement on page 11 is incorrect and should be deleted: "The MLR for each insurer is calculated by dividing the amount of health insurance premium spent on claims by the total amount of health insurance premium collected." The correct MLR formula is (claims + quality improvement expenses) / (premiums - taxes and fees). Generally, HHS MLR requirements specify what may or may not be included in each of the terms in the MLR formula. When necessary, OPM's FEHB MLR requirements will clarify the terms.

Again, in cases where OPM's MLR requirements are silent we default to HHS's requirements. The OIG uses an example of a carrier who can have its own providers increase profits and/or expenses through their claims cost to meet the 85% MLR threshold. We disagree with this scenario. If a provider increases expenses to the plan solely to avoid an MLR penalty, the provider would have to know the MLR prior to the plan year. The provider could, however, set

an unreasonably high reimbursement schedule but then the premium rates would rise to reflect that.

We disagree that carriers with this arrangement are bypassing the MLR process which increases premiums or allows carriers to carry over artificial credits to offset future MLR penalties. Carriers with unreasonably high rates will not survive in the FEHB Program. Increasing reimbursements solely to increase MLR may give a carrier a profit in one year but would have long term negative consequences as enrollees would move to another plan. This is how a market-based system like the FEHB Program operates to keep premiums low and competitive.

Finally, OIG's Draft MLR Management Advisory Report (18-043, March 27, 2019) is wholly dedicated to Medical Loss Ratio audit findings. HI responded to this Draft MAR and it will be reviewed, discussed and resolved upon its issuance in Final.

This recommendation should not be included in the final audit report.

Recommendation 13 We recommend that OPM develop formal policies to ensure that site visits are conducted every three years for FEHBP carriers in accordance with its control to meet OMB Circular A-123 requirements. If the time and costs to perform the site visits outweigh the benefits, OPM should modify its controls and report new procedures to mitigate risks for the FEHBP payment process.

OPM Response: **Non-Concur**

We consider this recommendation prescriptive. The OIG found that OPM is not conducting site visits on all carriers every three years per the site visit guidelines reported in the Office of the Chief Financial Officer (OCFO) Risk Management Internal Control (RMIC) OMB Circular A-123 Internal Control over Financial Reporting Process Documentation (pages 5-8). HI confirmed that this was a draft document produced by RMIC which sought to describe its processes. This Internal Control over Financial Reporting Process document was never finalized nor intended to be released as an authoritative reference on HI's processes and it is unlikely that this process would be tested or documented going forward. It was never reviewed by HI and was not formally released to OIG. RMIC indicated that they were meeting with the financial statement auditors (who report to the OIG) to discuss changes in their internal control testing protocol, expecting that OIG auditors would become aware of their new approach to Internal Control testing.

FEIO does not agree with the information related to site visits in this document as it is inaccurate. HI performs in-person and virtual/administrative site visits to FEHB Carriers as a part of its program oversight. HI continues to expand and evolve its approach to site visits and is open to a discussion of its site visits so that OIG can have an accurate, balanced view of this component of HI's administration of the program.

FEIO does not agree with OIG's statement on page 13 in the first paragraph that states, "This was due in part to no formal policy to address the internal control requirement that has been in

place for the past 11 years." OIG doesn't identify what "internal control requirement" has been in place for the past 11 years.

Given the inaccuracies in the finding and recommendation, based on a document that was never finalized nor formally released, this recommendation should be removed from the report.

Recommendation 14 We recommend that OPM improve its oversight procedures for reviewing FEHBP Carrier Fraud and Abuse Reports and develop a checklist for health insurance specialists to use during their review as a control to ensure compliance with FWA reporting requirements.

OPM Response: **Partially Concur**

We partially concur with this recommendation based on the FWA activities and annual review currently in place. We formalized our use of the existing FWA annual review guidelines into a checklist to be completed for each carrier report received. We also consider this recommendation prescriptive. OPM remains committed to effective oversight and administration of the FEHB Program, and strengthening controls surrounding carriers' Fraud Waste and Abuse (FWA) program continues to be a priority. HI has a dedicated FWA team and continues to expand its representation to strengthen FWA oversight. There is more work to do, however.

FEHB carrier FWA reports are due to their respective Health Insurance Specialists (Contracts) (HISC) each March 31. This deadline may be extended program wide or to individual carriers for various reasons. This was the case in both 2017 and 2019, due to an issue with the Fraud and Abuse Report spreadsheet and, separately, when March 31 fell on a Sunday. The HISC notes receipt of each report for the contract file and reviews their assigned carrier's Fraud Waste and Abuse report. All FWA reports identified as untimely in the Draft audit report were subject to deadline extensions, which can be verified. FEIO's FEHB Groups track the receipt of the reports in different ways, providing an opportunity to move towards reasonable standardization across FEHB 1, 2 and 3. This will be addressed initially by the FWA team, which provides annual training to the HISCs on reviewing the reports. The HISCs utilize various resources when reviewing the FWA reports such as the PowerPoint presentation used in the training, Guidelines for Reviewing FWA Reports, and Carrier Letter 2017-13 and its attachments. These resources were developed in collaboration with the OIG.

Each year the FWA team reviews and updates the current FWA resources, as needed, to assess areas that can be strengthened. The FWA team is considering adding a column to the Guidelines for Reviewing FWA reports to show that each line item was reviewed for each FWA report. Plans to enable carriers to upload FWA reports into Benefits Plus would provide digital tracking of the number and date of all reports received.

The 2018 training presentation and the Guidelines for Reviewing the Fraud and Abuse Reports are available on request. This guidance is updated annually and used by HISC in their screening and evaluation of carrier's FWA reports. HI reviews and updates its FWA procedures annually and will continue to do so.

Recommendation 15 We recommend that OPM implement the use of a tracking mechanism to log the receipt of annual Fraud and Abuse Reports and hold FEHBP carriers accountable for the timely submission of their reports.

OPM Response: Non-Concur

As noted in our response to recommendation 14, HI decided in 2018 to extend the Fraud and Abuse reporting deadline from March 31st to April 13th (for the 2017 reporting period) when an error in one of the Carrier Letter attachments delayed transmission of the final set of carrier responses. Attachment I is a copy of the listserv extending the deadline along with copies of emails from the plans showing they met the deadline. Attachment II is an email exchange to show the approved extension given to BCBSA for April 30th. Attachment III shows CareFirst met the deadline.

To facilitate tracking of receipt of the Fraud and Abuse Reports, we are adding functionality to our carrier database, Benefits Plus, to allow carriers to upload the report along with the certification. When the reports are uploaded, they are date stamped. The functionality also allows us to run reports to identify which Fraud and Abuse Reports are missing and will enable the HISC to communicate to the carriers regarding any missing data or data that does not align with our Guidelines for Reviewing Fraud and Abuse Reports.

Carriers are held accountable for timely submission of reports through the Contract Oversight score of the Plan Performance Assessment.

This recommendation should not be included in the final audit report.

Recommendation 16 We recommend that OPM eliminate the self-certification process for FEDVIP and implement an enrollment verification process that requires documentation to prove family member relationships at the time of enrollment through BENEFEDS. BENEFEDS, as the sole enrollment portal for FEDVIP, should have the authority to request eligibility documentation that includes marriage and birth certificates.

OPM Response: Non-Concur

We consider this recommendation prescriptive. This recommendation appears to originate from OIG's Final Audit Report No. 1G-LT-00-18-040, dated September 11, 2019, an audit of BENEFEDS as administered by Long Term Care Partners. BENEFEDS is a web-based portal that handles enrollment and/or premium administration services for the Federal Employees Dental and Vision Insurance Program (FEDVIP), the Federal Flexible Spending Account Program (FSAFEDS), and the Federal Long-Term Care Insurance Program (FLTCIP). LTCP administers the BENEFEDS portal with OPM having the contract authority and oversight of the program.

The BENEFEDS audit included the following Recommendation:

We recommend that OPM eliminate the self-certification process and implement a verification system to stop ineligible members from participating in the FEDVIP. Proper administration of FEDVIP enrollment should include verification of dependent eligibility by either BENEFEDS or the FEDVIP carriers.

OPM's response to this carrier audit recommendation is the same as our response to the nearly identical recommendation in this OPM Administration draft audit report. We do not concur with this recommendation. While OPM recognizes the need to strengthen dependent enrollment, requiring BENEFEDS to share and maintain dependent eligibility documentation to ensure eligibility for our enrollee-pay-all programs is beyond the scope of the current contract and, in the HI's judgment, is therefore inappropriate. Further, OPM currently does not have the financial, technological or human resources to create and maintain an eligibility file.

It should be noted that we have initiated procurement activities for the next BENEFEDS contract, effective 2022, and OPM is in the process of considering changes to the current contract, including activities surrounding the verification of dependent eligibility.

As a result of our current restraints, OPM cannot eliminate the self-certification process at this time. As noted in response to the BENEFEDS final audit report, HI will periodically update OIG on the progress of the Central Enrollment Portal (CEP), including controls designed to address dependent eligibility. Therefore, OPM will not take the recommended action per this draft audit report at this time. Accordingly, this recommendation should not be included in the final audit report.

Recommendation 17 We recommend that OPM develop a formal and robust FWA and debarment policy for the FEDVIP and communicate the requirements in a carrier letter followed by a contract modification.

OPM Response: **Partially Concur**

We consider this recommendation prescriptive. The recommendation implies that no FWA and debarment policies exist and specifies how they should be communicated. Given that the FEDVIP contract is expiring and a new procurement is underway, issuance of a carrier letter is not appropriate with the new contract becoming effective in 2021. Therefore, we request that the recommendation be written as follows:

We recommend that OPM enhance its FWA guidance and debarment policy for the FEDVIP and formally communicate these requirements to FEDVIP carriers.

HI currently has a formal FWA and debarment policy. FEDVIP has reviewed its current policies and procedures to identify areas that can be strengthened regarding FWA and debarment requirements. Because we are in the final months of the existing FEDVIP contracts, the FWA and debarments policies will be included in the 2021 contract solicitation.

The former FEDVIP Contracting Officer's standard practice was to communicate requirements and guidance to FEDVIP carriers via email and this was delegated from the Contracting Officer

to a Program Analysis Officer. This had been the case in our communication of FWA requirements and debarment requirements to FEDVIP carriers. However, HI has recently made a decision to communicate all requirements and guidance via carrier letter for its benefits programs.

HI is reviewing its current policies and procedures to identify areas that can be strengthened regarding FWA and debarment requirements. In addition, the FWA and debarments policies will be included in the upcoming 2021 contract.

Recommendation 18 We recommend that OPM include FWA and debarment requirements in the new solicitation for FEDVIP carriers.

OPM Response: Concur

HI has included the FWA and debarment requirements in the 2021 application for new FEDVIP Carriers. In addition, FEIO is adding the FWA and debarment requirements to the FEDVIP carrier handbook.

Recommendation 19 We recommend that OPM establish procedures related to collecting, tracking, and reviewing FEDVIP carrier AAS that include measures to ensure receipt of financial statements from all carriers, a verification process for ensuring carriers certify the statements, and instructions outlining how to review AAS for accuracy and completeness.

OPM Response: **Partially Concur**

Per our introduction, we consider this recommendation prescriptive. Since 2018, OPM has utilized a tracking spreadsheet to verify that carrier's certified AAS are received and retained. The spreadsheet is an effective tool to record the following: (1) Contract year to which the report applies; (2) Date the report is received; (3) Carrier Code, representing which contractor submitted the report; (4) Description of the report received; (5) Distribution of report; (6) Contractor's contact information; and (7) Which report was sent/received. OPM requires carriers to certify their AAS for accuracy.

However, OPM cannot guarantee the accuracy of the carriers' AAS beyond the required carrier certification. OPM's review process assesses the reasonableness of the AAS submission and as noted below, the 2021 solicitation will require audited AAS. HI is in the process of updating its Standard Operating Procedure (SOP) for carrier submissions of the AAS and OPM will work collaboratively to review and implement those procedures to ensure that FEDVIP carrier AAS are collected, tracked, and reviewed timely.

Recommendation 20 We recommend that OPM develop compliance measures and/or penalties to hold carriers accountable for the timely submission of AAS.

OPM Response: **Concur**

OPM has an established process in place to hold carriers accountable if they fail to submit their financial statement or submit it untimely. In those instances, the carrier's performance report will reflect this deficiency. This penalty is outlined in the February 27, 2019 Memorandum of Understanding (MOU) between OPM Healthcare and Insurance and OCFO. In addition, OPM is updating this MOU to ensure that it adequately addresses the annual review of the FEDVIP carrier's certified financial statements by the OCFO. OPM will work collaboratively to review and implement its updated MOU guidelines to strengthen controls that serve to hold carriers accountable for the timely submission of AAS.

Recommendation 21 We recommend that OPM develop language for the new FEDVIP solicitation that requires carriers to once again have their AAS audited by an independent public accountant.

OPM Response: **Concur**

We consider this recommendation prescriptive. Beginning in Contract Year 2015, FEIO's then-Assistant Director decided that carriers must have their AAS certified in lieu of requiring carriers to have their AAS audited by an independent public accountant. OPM recognizes the value of having carrier AAS audited annually by an independent public accountant. However, HI concluded that certified Annual Accounting Statements provided sufficient assurance to the program.

Nonetheless, as OPM developed the 2021 FEDVIP solicitation, we developed language that requires carriers to have their AAS audited on an annual basis. In the Application to Participate as a Qualified Company Under the Federal Employees Dental and Vision Benefits Enhancement Act of 2004, 5 U.S.C. Chapters 89A and 89B, Effective January 1, 2021, proposed language currently reads:

"Contractors are required to have audited annual accounting statements that must be submitted to OPM in advance of annual rate negotiations as well as made available upon request. Contractors are required to identify a location for OPM to perform on-site evaluations of their records and facilities. A template for the annual accounting statement is distributed as an attachment to this application."

Additionally:

"The Carrier will prepare an audited annual accounting statement summarizing the financial results of its FEDVIP contract for the previous calendar year. This statement will be prepared in accordance with the requirements issued annually by OPM and will be due to OPM in accordance with a date established by those requirements."

C. Further, the carrier CEO and CFO must attest to the following:

1. The statement was prepared in conformity with the guidelines issued by the Office of Personnel Management and fairly presents the financial results of this calendar year in conformity with those guidelines;
2. The costs included in the statement are allowable and allocable in accordance with the terms of the contract and with the cost principles of the Federal Acquisition Regulation (FAR);
3. Income, overpayments, refunds, and other credits made or owed in accordance with the terms of the contract and applicable cost principles have been included in the statement.

Beginning with the new FEDVIP contract, effective 2021, OPM will require carriers to submit AAS that have been audited by an independent public accountant.

Recommendation 22 We recommend that OPM develop standard performance metrics with penalties to be included in all new or renewed contracts with FEDVIP carriers.

OPM Response: **Partially Concur**

We partially concur based on actions and procedures currently in place. In the performance of any contract, OPM has Solicitation Provisions in place to ensure that a Quality Assurance Surveillance Plan (QASP) will be used as codification of a portion of OPM's method of assessing carrier performance. To encourage high quality customer service in the FEDVIP program, OPM may amend the QASP elements and reporting requirements during the 7-year cycle of the contract to include new measures as well as a performance assessment process that supports dental health. OPM invites carriers to engage in this process by proposing additional measures that OPM can review and consider for future use.

The QASP includes:

1. Element: the requirement and definition of calculation, where applicable.
2. Performance Standard: where specified, OPM's standard of performance. Where not specified, carriers are to propose standards.
3. Acceptable Quality Level (AQL): the range of deviation within which the Government will consider performance to be acceptable. Where not specified, carriers are to propose AQLs.
4. Monitoring Method: the method OPM will use to determine the extent to which contractor performance has met the standard.

Carriers may propose an incentive for performance that exceeds the AQL or a penalty for performance that fails to meet the AQL. Any incentive or penalty proposed must also include the method used to determine each. OPM will monitor the performance of each Contractor to ensure acceptable performance as determined by the Contracting Officer. Experience from this contracting period will be used to define performance standards for future contracting periods.

Recommendation 23 We recommend that OPM establish oversight procedures for reviewing FEDVIP carriers' Fraud and Abuse Reports and develop a checklist for program analysis officers to use during their review as a control to ensure compliance with FWA reporting requirements.

OPM Response: Concur

We consider this recommendation prescriptive. However, FEIO will develop formal oversight procedures for reviewing FEDVIP FWA Reports. FEIO will develop a checklist to use when reviewing the Carrier's FWA Reports.

Recommendation 24 We recommend that OPM implement the use of a tracking mechanism to log the receipt of annual Fraud and Abuse Reports and hold FEDVIP carriers accountable for the timely submission of reports.

OPM Response: Partially Concur

FWA report tracking has been used since we received the first annual report for contract year 2016 in 2017**.** HI (FEDVIP) maintains a tracking spreadsheet documenting when FEDVIP Carriers submit their reports and is in the process of updating the FEDVIP Carrier Handbook, which includes the timeline of events, and notes when the report is due. This tracking is being evaluated and will be updated to strengthen controls surrounding FEDVIP carrier reporting. The deadline for the FWA report is also clearly stated in the carrier application for the coming contract period. Additionally, the Program Office sends reminders to carriers one month before the due date, requesting their FWA reports. Regarding FEDVIP carrier accountability, the Program Office considers the timeliness of FWA reporting during each plans' annual performance reporting and subsequent annual review. Untimely FWA reporting may adversely affect a carrier's performance review.

Conclusion

In conclusion, as noted above, HI has previously shared responses to these recommendations as several of these issues have appeared in prior OIG audit reports or other engagements which were collaboratively resolved. We welcome this collaboration and other opportunities to provide input proactively into potential audit findings, such as the use of Notices of Findings and Recommendations (NFRs) prior to the issuance of Draft Audit Reports. HI will continue to routinely engage OIG in the resolution of contested audit findings to achieve the most effective outcomes.

We appreciate the opportunity to respond to this draft report and are available to discuss our responses and comments. If you have any questions regarding our response, please contact Angela Calarco at 202 606-5139 or angela.calarco@opm.gov.

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