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

Final Audit Report

Audit of the Federal Employees Health Benefits Program Operations at Kaiser Foundation Health Plan, Inc.

Report Number 1C-59-00-20-043
August 16, 2022

Executive Summary

Audit of the Federal Employees Health Benefits Program Operations at Kaiser Foundation Health Plan, Inc.

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Why Did We Conduct the Audit?

The primary objective of the audit was to determine if Kaiser Foundation Health Plan, Inc. (Plan), plan codes 59, 62, KC, and NZ, complied with the provisions of its contract and the laws and regulations governing the Federal Employees Health Benefits Program (FEHBP). To accomplish this objective, we verified whether the FEHBP premium rates and Medical Loss Ratio (MLR) were developed in accordance with contract regulations and rating instructions established by the U.S. Office of Personnel Management (OPM).

What Did We Audit?

Under Contracts CS 1044-A, CS 1044-B, and CS 1044-D, the Office of the Inspector General completed a performance audit of the FEHBP premium rate developments and FEHBP MLR submissions for contract years 2016 through 2018. We conducted our audit fieldwork remotely from February 8, 2021, through September 9, 2021.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

We were unable to determine whether the Plan complied with OPM's MLR requirements for years 2016 through 2018. The Plan utilized an integrated health care system that was fundamentally unable to meet the FEHBP MLR reporting requirements.

The Plan's MLR submissions for years 2016 through 2018 did not meet OPM's Community-Rated Guidelines, the terms of its contracts with OPM, nor other related filing requirements. Specifically, the Plan's financial and pricing systems tracked claims and membership data differently for its MLR reporting and premium rate calculations. Additionally, the Plan's system logic issues and claims payment errors resulted in inaccurate data being used in the FEHBP MLR, and the Plan was not in compliance with the Data Requirement Carrier Letters 2017-06, 2018-12, and 2019-07. These issues were due to the nature of the Plan's integrated health care system and weak internal controls and oversight over the Plan's systems used to report data applied in the FEHBP MLR.

We determined that the Certificates of Accurate Pricing for contract years 2016 through 2018 were defective due to the Plan's pricing systems' inability to identify Medicare [redacted] members less than age 65 and payment of claims related to non-covered pharmacy drugs. These issues are designated as procedural in this report, as we found that there was no material cost impact to the FEHBP rates.

Abbreviations

ACA	**Patient Protection and Affordable Care Act**
ACR	**Adjusted Community Rating**
CFR	**Code of Federal Regulations**
CL	**Carrier Letter**
CMS	**Centers for Medicare and Medicaid Services**
Contract	**Contracts CS 1044-A, CS 1044-B, and CS 1044-D**
DRG	**Diagnosis Related Group**
FEHBP	**Federal Employees Health Benefits Program**
FRESNO	**Northern California Fresno Plan Code NZ**
HEDIS	**Healthcare and Effectiveness Information Set**
IBNR	**Incurred but Not Reported**
IDR	**Integrated Data Repository**
KFH	**Kaiser Foundation Hospital(s)**
KFHP	**Kaiser Foundation Health Plan**
MLR	**Medical Loss Ratio**
NAIC	**National Association of Insurance Commissioners**
NOCAL	**Northern California Plan Codes 59 and KC**
NPS	**National Pricing System**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
PBM	**Pharmacy Benefit Manager**
Plan	**Kaiser Foundation Health Plan, Inc. (plan codes 59, 62, KC, NZ)**
PMG	**Permanente Medical Group**
SOCAL	**Southern California Plan Code 62**
SSSG	**Similarly-Sized Subscriber Group**

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Exhibit D (Medical Claims Sample Selection Criteria and Methodology)

Appendix (Plan's November 18, 2021, Response to the Draft Report)

Report Fraud, Waste, and Mismangement

I. Background

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at Kaiser Foundation Health Plan, Inc. (Plan), plan codes 59, 62, KC, and NZ. The audit was conducted pursuant to the provisions of Contracts CS 1044-A, CS 1044-B, and CS 1044-D (Contract); 5 United States Code Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract years 2016 through 2018 and was conducted remotely by U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG) staff.

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

In April 2012, OPM issued a final rule establishing an FEHBP-specific Medical Loss Ratio (MLR) requirement to replace the similarly-sized subscriber group (SSSG) comparison requirement for most community-rated FEHBP carriers (77 Federal Register 19522). The MLR is the portion of FEHBP premiums collected by a carrier that is spent on clinical services and quality health improvements.

The MLR was established to ensure that health plans are meeting specified thresholds for spending on medical care and health care quality improvement measures, and thus limiting spending on administrative costs, such as executive salaries, overhead, and marketing of the health plan. However, the FEHBP MLR is not as transparent as intended and does not provide an assessment of the fairness of the premium paid for benefits received.

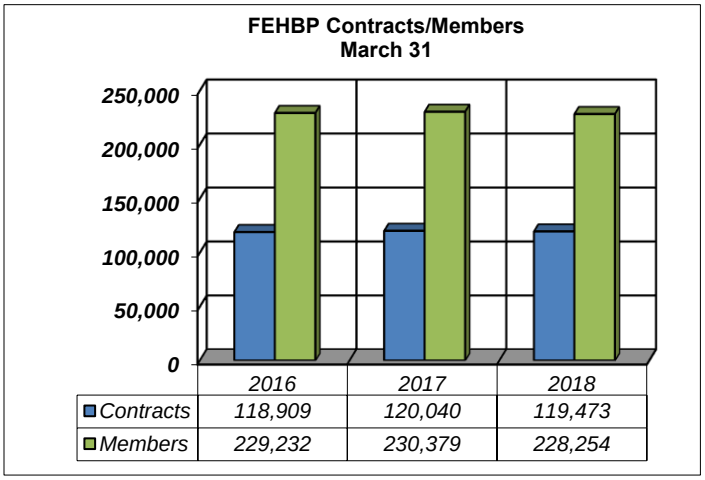
The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act (P.L. 111-148) and defined by the U.S. Department of Health and Human Services in 45 CFR Part 158. In 2012, community-rated FEHBP carriers could elect to follow the FEHBP-specific MLR requirements, instead of the SSSG requirements. Beginning in 2013, the MLR methodology was required for all community-rated carriers, except those that are state-mandated to use traditional community rating. State-mandated traditional community-rated carriers continue to be subject to the SSSG comparison rating methodology.

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

expenditures in various categories, including reimbursement for clinical services provided to enrollees, activities that improve health care quality, and all other non-claims costs. If a carrier fails to meet the FEHBP-specific MLR threshold, it must make a subsidization penalty payment to OPM within 60 days of notification of amounts due.

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

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



	2016	2017	2018
Contracts	118,909	120,040	119,473
Members	229,232	230,379	228,254

The number of FEHBP contracts and members reported by the Plan as of March 31 for each contract year audited is shown in the chart above. The table represents the sum of all plan codes included in this audit.

The Plan has participated in the FEHBP since 1960 and provides health benefits to FEHBP members in Northern and Southern California. The last audit of the Plan conducted by our office was in 2013 and included a review of the FEHBP premium rate developments for contract years 2010 through 2012. The prior audit did not identify any deficiencies.

The preliminary results of this audit were discussed with Plan officials at an exit conference and in subsequent correspondence. A draft report was also provided to the Plan for review and comment. The Plan's comments were considered in preparation of this report and are included, as appropriate, as an Appendix to the report.

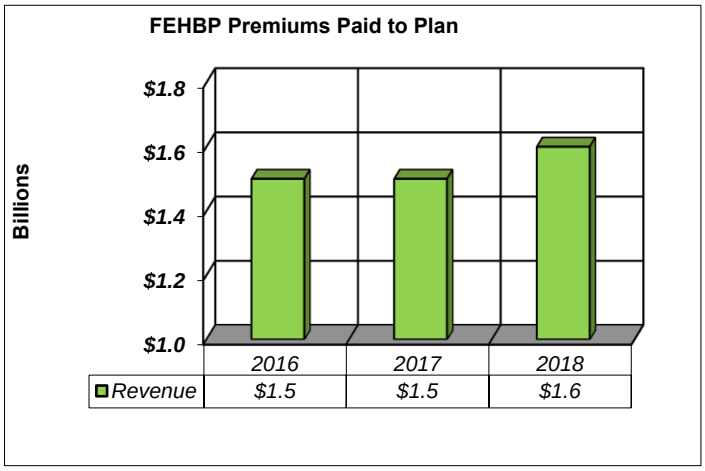
II. Objectives, Scope, and Methodology

Objectives

The primary objective of this performance audit was to determine whether the Plan complied with the provisions of its Contract and the laws and regulations governing the FEHBP. Specifically, we verified whether the Plan met the MLR requirements and developed its FEHBP premium rates in accordance with the applicable regulations and rating instructions established by OPM.

Scope

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.



This performance audit covered contract years 2016 through 2018. For these years, the FEHBP paid approximately $4.6 billion in premiums to the Plan.

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

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

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

In conducting the audit, we relied to varying degrees on computer-generated billing, enrollment, and claims data provided by the Plan. We did not verify the reliability of the data generated by the various information systems involved. However, nothing came to our attention during our audit utilizing the computer-generated data to cause us to doubt its reliability. We believe that the available data was sufficient to achieve our audit objectives. Except as noted above, the audit was conducted in accordance with generally accepted government auditing standards, issued by the Comptroller General of the United States.

We remotely conducted our audit fieldwork from February 8, 2021, through September 9, 2021.

Methodology

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

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

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

III. Audit Findings and Recommendations

A. The FEHBP Medical Loss Ratio Requirements: Procedural

Throughout our review of Kaiser Foundation Health Plan's (Plan) Federal Employee Health Benefits Program (FEHBP) Medical Loss Ratio (MLR), it was apparent that due to the Plan's integrated health care system, which provides both medical care and coverage, compliance with the reporting requirements was and is in many cases unattainable. FEHBP carriers with integrated health systems like the Plan, including other carriers with complicated corporate structures, are fundamentally unable to meet the reporting requirements that the FEHBP MLR requires of them. This represents a huge time and monetary burden that is placed on carriers, which, based on the OIG's audits of the application of the MLR process by a number of FEHBP carriers over the last several years, results in an unreliable FEHBP MLR that should not be used by OPM to ascertain that the Government and Federal employees are receiving a fair market rate and a good value for their premium dollars. Although this report addressed the Plan's compliance with the provision of its OPM Contracts CS 1044-A, CS 1044-B, and CS 1044-D (Contracts) and the laws and regulations governing the FEHBP, we would be remiss if we did not note the underlying cause of many of the issues addressed in this report is the FEHBP MLR requirements themselves.

Recommendation 1:

We recommend that OPM revise or replace the FEHBP MLR requirements to provide a reliable measure of the premium dollars spent on the FEHBP program, including the impact of carrier corporate structure and the current community-rated product market.

Plan Response:

The Plan agrees that the current FEHBP MLR requirements should be updated, however, the Plan disagrees with the replacement of the MLR overall. Specifically, the Plan "concurs that applying the FEHB Program's current medical loss ratio requirements to integrated delivery systems like the Carrier or to other complex arrangements imposes a considerable burden and requires flexibility. However, the Carrier disagrees that its MLR is 'unreliable' and 'should not be used by OPM to ascertain that the Government and Federal employees are receiving a fair market rate and a good value for their premium dollars.' … A plan's medical loss ratio provides OPM with considerable transparency into how carriers expend FEHB premiums and a more objective understanding of the value that OPM and Federal employees and retirees derive for their dollars.

The Carrier is part of an integrated delivery system in which most care is furnished internally by itself, [redacted] In addition, the Carrier's contracts [redacted] contain relatively complex reimbursement arrangements not based solely on fee-for-service claims payments. For these reasons, a claims-based data extract can never accurately and completely capture what the Carrier spends on clinical services.

[redacted] **ensure substantial compliance with both the requirement to create and submit a data file and to ensure that its reported expenses were complete, accurate and aligned with annual financial reporting. Without this flexibility, the existing MLR guidelines do not accommodate the financial reporting approaches used by integrated delivery systems like the Carrier's. … The Carrier supports efforts to revise, but not replace, the current FEHBP MLR requirements."**

OIG Comment:

The OIG maintains that the FEHBP MLR is an unreliable measure of premium dollars spent on the cost of care due to the reporting discrepancies in the numerator and denominator of the ratio itself as discussed throughout this report. Based on the OIG's audits of the application of the MLR process by a number of FEHBP carriers over the last several years, it is our assessment that the FEHBP MLR does not accomplish the objectives for which it was established. A lack of FEHBP MLR specific criteria creates an environment for varying carrier interpretation, inconsistent MLR results, and audit restrictions, significantly impacted by Carrier corporate structure. Therefore, the FEHBP MLR calculation is not transparent and can result in skewed results as well as inaccurate penalty payments or credit adjustments. The FEHBP MLR is not available for public viewing and FEHBP members are unable to use the results when comparing carriers.

B. Medical Loss Ratio Review

The Plan's FEHBP MLR submissions for contract years 2016 through 2018 did not meet OPM's Community-Rated Guidelines, the terms of Contracts CS 1044-A, CS 1044-B, and CS 1044-D held with OPM, nor other related filing requirements, rendering the ratios inconsistent and unreliable. Specifically, the Plan's financial and pricing systems used in the numerator and denominator of the FEHBP MLR submissions tracked materially different [redacted], and the data reported as the numerator of the FEHBP MLR submissions contained errors due to system logic issues and claims payment errors. Also, the Plan was not

compliant with the terms of Data Requirement Carrier Letters (CLs) 2017-06, 2018-12, and 2019-07. These issues were due to the nature of the Plan's integrated care system and in other cases weak internal controls and oversight of the systems used to report data for the FEHBP MLR submissions.

1. Inconsistent FEHBP Claims Tracking and Reporting: Procedural

During our review of the Plan's response to our information requests, we determined that the Plan reported FEHBP claims expenses [redacted] inconsistently, resulting in material differences. Specifically, the Plan tracked and reported FEHBP claims and claim type costs using its [redacted] reporting systems for the FEHBP MLR numerator differently than it tracked and reported FEHBP claims and claim type costs in its [redacted] reporting systems for the development of FEHBP premium rates used as the FEHBP MLR denominator. The numerator claims data included inconsistencies that were inexplicable and could not be verified using the MLR FEHBP claims data submitted to OPM OIG (claims extracts), which we discovered were not representative of the claims costs in the FEHBP MLR submission. Additionally, the accounting for membership, [redacted], contained different [redacted] coverage and termination system logic for the FEHBP MLR and the pricing. Finally, there were FEHBP claims adjustments built into the FEHBP MLR claims costs that do not meet applicable guidelines.

The Plan's claims expenses were inconsistently tracked and reported.

a. Claim Accounting Inconsistencies

The Plan utilizes two fundamentally different business models sourced from different systems for the MLR (financial) reporting and the premium rate development (pricing) reporting. The financial reporting, [redacted], is primarily sourced from the Plan's Integrated Data Repository (IDR), [redacted]. The pricing reporting utilizes the Plan's National Pricing System (NPS), which queries multiple claim source systems and consolidates medical and pharmacy expenses (claims costs) for use in the premium rate development. In addition to having separate systems, the claims reporting basis is also different. The MLR [redacted] accounting is based on cost information that ties to the audited financial statements; however, the [redacted] used in the pricing process is based on members' utilization where [redacted] expenses are based on [redacted]. Since the FEHBP MLR numerator utilizes the costed claims data and the FEHBP MLR denominator utilizes claims costs [redacted], we determined

there was a high risk that the claims reporting inconsistencies would have a material impact on the FEHBP MLRs.

Due to the high risk placed on claims reporting, we requested that the Plan reconcile the 2016 MLR claims data to the calendar year 2016 claims data used as the experience period of the 2018 FEHBP premium rates. [redacted]

We recognize that the claims portion of the MLR claims/premium ratio may not match the paid claims seen in the premium rate renewals and the claims extracts may not be identical to the MLR calculation; however, the variances in Table I (also Exhibit B for detail by plan code) illustrate material claims variances that cannot be attributed solely to timing.

Table I
2016 Calendar Year FEHBP Claims Comparison

Claim Timing	Claim Category	Total All California Plan Codes
Calendar Year 2016	2016 FEHBP MLR Form Line 2.1b - Adjusted Incurred Claims	[redacted]
	Less: Medicare Capitation Payment*	[redacted]
	FEHBP MLR Adjusted Incurred Claims excluding Medicare	[redacted]
	2018 FEHBP Rate Development Experience Paid Claims**	[redacted]
	Difference	[redacted]
	Variance	[redacted]
[redacted]		

Since there were material differences in the tracking and reporting of FEHBP claims for the MLR and premium rate developments, we intended to use the Plan's claims data submissions, required by Carrier Letters (CLs) 2017-06, 2018-12, and 2019-07 (claims extracts), as verification for the FEHBP MLR claims (numerator). The claims extracts are meant to support the claims in the FEHBP MLR form, and to fulfill the guidelines which state, the plan must be able to fully support all claims values. However, we

discovered that the claims extracts are not fully representative of the claims costs used in the MLR submissions. The Plan explained that to meet the MLR requirements in 45 Code of Federal Regulations (CFR) 158 they utilize final year-end (December 31st) financial data, which ties to their financial statements as support. [redacted] Only the FEHBP member external claims include the required run-out through June 30th of the following year.

Additionally, there was an inexplicable monetary variance pertaining to the December 31st claims costs reported on the FEHBP MLR compared to the claims extracts. Specifically, the claims extracts that contain at least six months of run-out are materially less than the claims data reported as of December 31st of the MLR submission year. Theoretically, this should be the opposite, as OPM established the 6-month run-out period to capture full payment of claims in the MLR submission year and therefore eliminate the need for an incurred but not reported (IBNR) adjustment. As such, the claims extracts should contain a greater amount of claims costs than the costs reported as of December 31st of the submission year. However, we found that the Plan's [redacted] claims data, queried using the same process as the claims extracts, was materially greater than the claims extracts. The Plan categorized this material difference as a timing adjustment. The final year-end claims data, [redacted], was materially greater than the raw year-to-date claims data. See Exhibit C for more detail.

Table II
Timing and Scaling Differences in Claims Reporting

Plan Codes - Combined	Claims Period	Total
Northern California (NOCAL [redacted]), Southern California (SOCAL [redacted]), Northern California (FRESNO [redacted])	**2016 Total Timing and Scaling Difference**	[redacted]
	2017 Total Timing and Scaling Difference	[redacted]
	2018 Total Timing and Scaling Difference	[redacted]
	Total Timing and Scaling Difference	[redacted]

As illustrated in Table II, the unadjusted FEHBP claims costs used in the FEHBP MLR submissions for the scope of our audit were [redacted] higher than the claims data extracts submitted to the OPM OIG for the scope of the audit. It is unclear why the final year-end claims data totals are materially higher than the extracts and the [redacted] claims when both of the latter two data sources include more time for claims to be completed, not less. Furthermore, it is unclear why the basis of the timing and scaling adjustment calculation utilizes data that includes the [redacted], even though the reported claims extracts are net of those amounts since they were not paid by the Plan.

In performance audits where the reported claims on line 2.1b of the FEHBP MLR form do not match the claims extracts, we utilize the claims extracts as support and recalculate the FEHBP MLR. However, in addition to the issues mentioned above, we found other issues with the claims extracts that render them unreliable as well (see Section A.3). As such, we cannot verify the FEHBP claims used in the FEHBP MLR numerator for the scope of our audit. The varying claim reporting methodologies limited our ability to verify claims data or quantify the monetary impact of the issues identified within the FEHBP MLR calculation. Due to the material variances in reported FEHBP claims data used in the numerator and denominator of the FEHBP MLR calculation, we believe the Plan's FEHBP MLR is unreliable.

Recommendation 2:

We recommend that the Plan work towards reporting FEHBP claims and membership data more consistently when developing and submitting premium rates and MLR submissions to OPM.

Plan Response:

"Even before OPM finalized its initial MLR regulations and guidance, the Carrier reached out to OPM to explain that, because its structure and arrangements differ dramatically from most other carriers, in the interest of accuracy, transparency and compliance, the Carrier calculated its MLRs [redacted]

[redacted] **In doing so, it undertook good faith efforts to ensure substantial compliance with both the**

requirement to create and submit a data file and to ensure that expenses were complete, accurate and aligned with annual financial reporting.

The Carrier is committed to refining its existing MLR processes to better align with its rate development methodology, however as noted in Recommendation 1 above existing MLR guidelines do not accommodate the financial reporting approaches used by integrated delivery systems like the Carrier's. The Carrier would welcome the opportunity to discuss potential changes in the MLR guidelines with OPM."

OIG Comment:

The OIG recognizes that the Plan undertook good faith efforts to comply with the FEHBP MLR requirements; however, due to the Plan's integrated healthcare system, compliance in many cases could not be met. We acknowledge that the Plan is committed to refining its existing FEHBP MLR process to better align with the rate development methodology. Since these modifications fall outside of our scope, we will review and assess the effectiveness in a future audit.

b. [redacted] Coverage and [redacted] Membership Termination Logic Discrepancies

In contract years 2016 through 2018, the Plan utilized different primary coverage logic and retroactive membership termination logic during their financial reporting process (MLR) and pricing reporting process (premium rate development). Specifically, the financial reporting rules for determining [redacted] coverage were aligned with the [redacted] For pricing reporting, the rules for determining [redacted] coverage were aligned with the National Association of Insurance Commissioners (NAIC) model rules and the [redacted] membership logic was processed to include up to two months of changes from the transaction date. Since Kaiser utilizes [redacted] to allocate and determine the cost of care and other claims type expenses for both financial reporting and pricing reporting, independent of each other, the use of different [redacted] logic and [redacted] logic could materially impact how the cost of care, per member, is reported.

When asked to provide an illustration of the impact of these issues, the Plan provided examples for both system logic issues. [redacted]

[redacted] The monetary variance attributed to these members was immaterial to the FEHBP MLR numerator. The Plan was otherwise unable to calculate the impact of the difference between 2 months and 24 months of retroactive termination logic.

Ultimately, these issues result in an inconsistent FEHBP MLR since the claims costs used as the numerator of the MLR were not accounted for in the same manner as the FEHBP claims used to build the premium rates used as the MLR denominator. The Plan's use of dual [redacted] coverage logic to report FEHBP membership and ultimately the FEHBP claims expense is not in compliance with Contract Section 2.6(c), which stipulates, "The Carrier shall follow the order of precedence established by the NAIC Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits, as specified by OPM … (f) Changes in the order of precedence established by the NAIC Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits, implemented after January 1 of any given year shall be required no earlier than the beginning of the following contract term."

Although the Plan is unaware of the reason the systems used to produce the financial reporting and pricing reporting have different rules regarding [redacted] coverage and [redacted] membership terminations logic, it is evident that the Plan's controls did not identify these issues prior to this audit. Additionally, the Plan does not have any controls in place to assess the impact of tracking and reporting group membership for financial reporting systems differently than pricing reporting systems, and ultimately the effect on FEHBP reporting requirements.

Recommendation 3:

We recommend that the Plan implement consistent dual [redacted] coverage logic and [redacted] membership termination logic in their financial and pricing systems to ensure reliable reporting of FEHBP claims and membership data in the MLR and premium rate developments.

Recommendation 4:

We recommend that the Plan consistently utilize the NAIC primary coverage rules, as specified in the OPM Contract, when determining FEHBP membership and allocating claim type costs in the development of the FEHBP premium rates and the FEHBP MLR.

Recommendation 5:

We recommend that the Plan implement an internal control process to assess the extent to which membership and claims are tracked and reported differently due to the use of two wholly independent business models for financial reporting (MLR reporting) and pricing (premium rate development and reporting).

Plan Response:

With regard to Recommendation 3, "The Carrier agrees in part and disagrees in part. As explained … , the Carrier is unable to assess the dual coverage issue any further. The Carrier is committed to making necessary changes prospectively."

[redacted]

Additionally,

With regard to Recommendation 5 as discussed in response to Recommendation 2 above, "The Carrier is committed to refining its MLR reporting processes to better align with its pricing methodology. However as noted in Recommendation 1 above, existing MLR guidelines do not accommodate the financial reporting approaches used by integrated delivery systems like the Carrier's."

OIG Comment:

The OIG acknowledges that the Plan is making adjustments prospectively to address the [redacted] coverage logic and [redacted] termination logic; however, they fall outside the scope of our audit. As such, we will evaluate their effectiveness to address the recommendations in a future audit. However, if the Plan continues to track and report FEHBP claims and membership data inconsistently for [redacted] reporting and [redacted] reporting, the FEHBP MLR will continue to be unreliable.

As stated in the FEHBP MLR Requirements in Section A above, OPM should revise or replace the FEHBP MLR requirements to provide a reliable measure of the premium

dollars spent on the FEHBP program, including the impact of carrier corporate structure and the current community-rated product environment.

c. Claims Adjustment Issues

From the final year-end data totals (Table II), the Plan makes additional adjustments to the FEHBP MLR claims totals. These adjustments include: [redacted] These adjustments appear to meet the FEHBP MLR submission requirements; however, there are three additional adjustments for change in IBNR, non-member costs, and unidentified amounts, which conflict with FEHBP MLR guidelines.

Regarding the IBNR adjustment, the Plan stated, "the adjustment removed any IBNR activity from our [redacted]." However, in the 2018 FEHBP MLR submission for Northern California, [redacted], the Plan added [redacted] to account for IBNR. So, although we identified that this adjustment reduced overall claims expenses in other audit scope years and plan codes, it is clear from the 2018 Northern California FEHBP MLR that the change in IBNR is not always a reduction. As such, this adjustment is not compliant with OPM's guidelines, [redacted]

In 2017 and 2018, the Plan allocated claim expenses for [redacted] members to the FEHBP claims costs used in the MLR submission. Although it is the Plan's standard policy to [redacted], it does not adhere to OPM's Community Rating Guidelines that specify "Only FEHB claims associated with benefits covered in the plan's FEHB contract may be included in the MLR calculation."

Finally, the Plan lists adjustments within the FEHBP claims costs as "unidentified." [redacted] Although these amounts are in the FEHBP's favor, their existence in the FEHBP MLR claims total does not provide assurance that the other claims values within the FEHBP claims costs are accounted for correctly, especially when paired with the other FEHBP claims cost variances reported above. [redacted] they do not meet the guidelines mentioned in the previous paragraph that state only FEHB claims associated with benefits covered can be included in the MLR calculation.

Recommendation 6:

We recommend that the Plan exclude claims costs from the FEHBP MLR numerator related to [redacted]

Plan Response:

"[T]he Carrier's response to each issue follows the order in which they were presented. …

The Carrier disagrees with the finding and recommendation related to the IBNR adjustment because the adjustment is necessary to remove IBNR from the Carrier's MLR calculations as required by OPM's guidelines. The Carrier's [redacted] statement includes an accrual for IBNR which, for any given year, may be positive or negative. When a prior year's IBNR is larger than the current year's IBNR, the [redacted] statement reflects a reduction to medical expenses driven by the accrual activity. To comply with OPM's guidelines, the Carrier makes an adjustment to remove the change in IBNR accrual. In this case, the [redacted] adjustment referenced in the finding offsets a negative IBNR accrual, effectively removing IBNR accrual activity and leaving only paid activity in the calendar year. Reversing the Carrier's adjustment would result in the inclusion of IBNR accrual activity in the Carrier's MLR calculations in violation of OPM's instructions. …

As explained in the Carrier's response to Recommendation 2 above, the Carrier is part of an integrated delivery system that provides medical care. Its financial reporting reflects its organizational structure. As with other care providers, the Kaiser Permanente delivery system may not turn away individuals seeking care who do not have coverage. Other providers in the community rely on the fee schedules they negotiate with commercial payors to cover the net cost of these services. However, because the Carrier does not process claims to reimburse itself for the services it provides internally, it must account for these provider operations cost by [redacted]. Current FEHB MLR guidelines do not take into consideration that a carrier may be both a provider of health care services and an insurer/HMO. [redacted]

As the Carrier has explained previously, in preparing our MLR calculations, we have taken a number of steps to ensure substantial compliance with OPM's MLR guidelines related to alignment with the Carrier's MLR submissions to CMS as well

as OPM's claims data file requirement. The adjustment for 'unidentified costs' essentially reflects an adjustment necessary to align the two requirements and ensure the accuracy and consistency of the Carrier's MLR calculations. Removing this adjustment would not only increase the Carrier's reported medical loss ratio, but also violate OPM's requirement that the FEHB MLR calculations align with the Carrier's MLR calculations for CMS. This issue is directly related to the concerns raised in Recommendation 1. As noted in Recommendation 1 above existing MLR guidelines do not accommodate the financial reporting approaches used by integrated delivery systems like the Carrier's. The Carrier would welcome the opportunity to discuss potential changes in the MLR guidelines with OPM to address this issue."

OIG Comment:

We were unable to ascertain how the IBNR accrual and adjustments function in the accounting of the FEHBP MLR; however, we maintain that the inclusion of IBNR in any capacity in the FEHBP MLR is unallowable per OPM's guidelines. Additionally, the FEHBP MLR must only allocate costs associated to the FEHBP members and not any other groups or members from the Plan's book of business, regardless of the system used by the Plan. The fact that the current FEHBP MLR methodology does not address carriers with complex and fully integrated health care systems, especially those that own their providers, such as the Plan, is another reason why we believe revisions to the FEHBP MLR methodology are necessary.

Inconsistent FEHBP Claims Tracking and Reporting Conclusion

Our review of the FEHBP MLR claims for the scope of the audit indicated that the Plan's reporting of FEHBP claims and membership data was inconsistent and could not be verified using source data. The use of two separate systems for [redacted] reporting and [redacted] reporting lead to material variances in claims reporting and membership usage to derive claims and [redacted]. Furthermore, the Plan made claims adjustments that did not meet the terms of the FEHBP MLR guidelines. As such, the [redacted] variances and discrepancies render the FEHBP MLR calculation unreliable.

2. FEHBP MLR Reporting Errors: Procedural

During our review of the Plan's claims and claim-type costs reported as part of the numerator of the FEHBP MLR, errors were identified related to newborn member claims, claims incorrectly reprocessed due to system migration, inclusion of pharmacy benefit manager

(PBM) administrative fees, and claims paid for non-covered weight management drugs, as discussed below.

a. [redacted] Member Claim Coding [redacted] Error

As part of our claims sample review, generated from the Plan's medical claims extract required by Carrier Letter 2017-06, we selected two [redacted] claims for review. In reviewing these claims and the Plan's responses to our information requests, it was identified that a [redacted] error, [redacted] during contract years 2016 through 2018. Per our request, the Plan summarized the FEHBP monetary impact of the coding logic error (see Table III below), which affects both the financial reporting (FEHBP MLR numerators) and the medical claims extracts for all contract years and plan codes in our audit scope.

Table III
Overstated Professional Fees on [redacted] Inpatient Services

Year	SOCAL	NOCAL	FRESNO	Total
2016	[redacted]	[redacted]	[redacted]	[redacted]
2017	[redacted]	[redacted]	[redacted]	[redacted]
2018	[redacted]	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]	[redacted]

During our fieldwork inquiry process, the Plan stated that they identified this error in January 2019 and implemented corrective action prospectively the same month. The Plan also stated, "The Carrier is recovering these overpayments and evaluating whether adjustments to policies or procedures are necessary."

The Plan's initial recovery process, in response to notice of this finding, [redacted]

Although this [redacted] adjustment specifically addressed the FEHBP claims overpayment, it does not accurately account for the overpaid claims in the year they were

overpaid, and due to the Plan's integrated system, [redacted] It is unclear why the Plan waited to make these adjustments after they identified this issue in January 2019. Per Contract Section 2.3(g), "If the Carrier determines that a Member's claim has been paid in error for any reason (except fraud and abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the Member from the Member or, if to the provider, from the provider."

Since this coding [redacted] occurred over multiple years without detection, it is evident that the Plan's controls over the [redacted] claims [redacted] were weak and should be examined to ensure other coding errors are not currently the cause of claim overpayments and inaccurate financial reporting. Also, the Plan should implement tracking of recouped funds and specify how the collected funds will be credited to the FEHBP.

Recommendation 7:

We recommend that the Plan develop policies and procedures to address how FEHBP claim overpayments, from Kaiser owned providers, will be promptly and diligently recovered and credited specifically to the FEHBP.

Recommendation 8:

We recommend that the Plan implement additional internal controls and system testing to ensure that the claims processing complies with the OPM contract and that pricing changes are correctly coded and processed in the system.

Plan Response:

The Plan agrees that the amounts listed in Table III are correct and were recovered. However, the Plan disagrees that their controls over the [redacted] coding logic were weak. Specifically, the Plan states, "The Carrier aligns with the requirements of Section 404 of the Sarbanes-Oxley Act of 2002, and are based on the updated framework stablished in the Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). Our controls are designed and operate to mitigate our risk of a material misstatement in our financial statements. The [redacted] claims issue of [redacted] represents a very small portion of the [redacted] of the total amount paid to [redacted] for [redacted] services for FEHBP members during the same period.

We concluded errors of [redacted] as immaterial and our Internal Controls Over Financial Reporting are effective. The Carrier has ongoing processes to monitor and enhance controls as necessary."

Additionally, "While [the Plan] believes the appropriate controls are in place to identify material issues, we take OIG's concerns seriously and will be performing additional analysis on the following two items: (1) potential identification of new internal business controls [redacted] and (2) potential additions to existing policies and procedures [redacted] In regard to system testing, as noted previously, the [redacted] issue was a '[redacted] error,' and did not represent a system error. We already have existing controls over the system, and as this issue is not system related, no further assessment is planned over the system."

OIG Comment:

Although the Plan's conclusion that .71 percent is immaterial and as such indicates that the internal controls over financial reporting were effective, we do not agree. The Plan's statistic was based solely on the [redacted] data and did not address this error for its [redacted] book of business, although it was applicable for all groups, including the FEHBP. Although the Plan stated that they prospectively implemented corrective action when they identified the issue in January 2019, there was no mention of determining the total cost of this error and adjusting the [redacted] expenses and KFH's [redacted] in the general ledger accordingly. Since costs, including claims costs, are allocated to groups via membership, accounting for claim overpayments for the [redacted], when applicable, must occur to ensure costs are accurately reported. However, we are currently only aware of the adjustment made in April 2021 for the FEHBP's portion of the finding, which will be spread across the Plan's [redacted] expenses.

Although the Plan agreed to make the one-time adjustment specific to the FEHBP on the MLR submission, this does not correct the underlying issue of the Plan's process of [redacted]. We recognize that the Plan is willing to analyze their internal business controls to identify internal claim overpayments and how the overpayments can be credited and incorporated in current processes. In future audits, we will assess the Plan's improvements in this area and their effectiveness.

b. [redacted] Implementation Configuration Logic Error

In 2016, the Plan adopted [redacted], a [redacted] adjudication system, to replace three prior source systems. When [redacted] was first implemented, the Plan identified a system configuration logic error [redacted] As such, if [redacted] codes were updated after the [redacted], but prior to the [redacted] they were retroactively denied, even though they were previously processed and paid correctly. Although this error was identified and corrected in October 2017, the [redacted] logic was also updated to use a different Diagnosis Related Group (DRG) format. As such, the claims that were [redacted] denied in error, were then reprocessed incorrectly at a service line level rather than the DRG level.

There were eight 2016 FEHBP claims impacted by [redacted] Additionally, in October 2017 the Plan identified $326,832 and $44,096 in FEHBP claims underpayments related to [redacted] The claim underpayments were not identified prior to submitting the 2017 FEHBP MLR reporting; as such, these claims were understated on the FEHBP MLR forms.

Although the absence of claim underpayments in 2018 indicates that this issue was resolved, we recommend that the Plan examine the policies and procedures surrounding the implementation of [redacted] in [redacted] and the Plan's processes related to the denial and reprocessing of claims where configuration logic was updated and resulted in a change of prior reported claims costs.

Recommendation 9:

We recommend that the Plan strengthen their controls over the configuration logic within [redacted] and evaluate the impact of [redacted] adjustments on claims that were previously processed and paid correctly.

Plan Response:

"Since the [redacted] implementation, the [redacted] teams have developed processes with controls to track and monitor [redacted] adjustments.

Improvements include communications between the teams involved in [redacted] adjustments, an improved process to identify claims that qualify for [redacted] processing, as well as single-team accountability for the retrospective processing. The Carrier has also added a [redacted] process to assess and evaluate the impact of [redacted] processing before actual reprocessing is run … The Carrier's internal quality control processes are aligned with industry best practices and utilize standard sampling methodologies providing a [redacted] control mechanism."

OIG Comment:

We reviewed the Plan's [redacted] Policy, which was updated on December 7, 2020. The content of the policy appears to address the issues identified above; however, its implementation occurred outside the scope of our audit. Therefore, we cannot comment on its effectiveness.

c. Inclusion of Pharmacy Benefit Manager Fees

For Plan network and external pharmacies, the Plan utilizes Pharmacy Benefit Managers (PBMs) to manage their prescription drug benefits utilized by members. In contract years 2016 through 2018, the overall pharmacy cost (pharmacy claims and fees) was invoiced to the Plan and paid accordingly. The total pharmacy cost was allocated to [redacted]s as pharmacy claim costs; however, per 45 CFR 158.140(b)(3)(ii) administrative fees associated with using a PBM should not be included in the numerator of the MLR.

In 2017 and 2018, the Plan estimates the external PBM fees included in the FEHBP MLR as shown in Table IV.

Table IV
External PBM Fees Included in FEHBP MLR Numerator

Year	SOCAL	NOCAL	FRESNO	Total
2017	[redacted]	[redacted]	[redacted]	[redacted]
2018	[redacted]	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]	[redacted]

Due to the immateriality of the PBM fees included in the 2017 and 2018 FEHBP MLR numerators, we did not request that the Plan determine the PBM fees for contract year 2016, and we will not adjust the FEHBP MLR calculations since we cannot access the accuracy of the FEHBP claims data as stated in section B.1 of the report. However, [redacted]

[redacted]

The Plan indicated to us that they began removing the [redacted] PBM administrative fees from the MLR [redacted] in contract year 2019. Since that contract year is not in the scope of this audit, we did not verify if the Plan excluded these fees from the FEHBP MLR numerator prospectively; however, the Plan did not provide revised policies and procedures that were implemented in 2019 to address this issue and has not addressed the issue of PBM fees incurred by Kaiser [redacted] PBMs and if those fees impact the FEHBP MLR [redacted]. As such, we believe this is a reportable issue and request that the Plan address the recommendation below.

Recommendation 10:

We recommend that the Plan provide their documented policies and procedures that address the exclusion of Kaiser [redacted] PBMs and [redacted] PBM fees in the FEHBP MLR [redacted] to OPM's Audit Resolution and Compliance Office and the Contracting Officer.

Plan Response:

"The Carrier identified and disclosed this issue during the audit and has updated its MLR procedures [redacted] PBM fees starting with the 2019 contract year. We submitted revised procedures prior to this response. [redacted]

OIG Comment:

The OIG did not receive the revised procedures from the Plan. As such, we remain uncertain of the impact of the administrative fees in the FEHBP MLR numerator. Additionally, the Plan did not further address the exclusion of Kaiser owned and external PBM fees and without the revised procedure, we cannot validate the Plan's assertions.

d. Claims Paid for Non-Covered Weight Management Prescription Drugs

During fieldwork, the Plan notified us that weight management prescription drugs were paid for FEHBP members, even though drugs used in the treatment of weight management are specifically designated in the FEHBP benefit brochure as "not covered."

According to the Plan, this was a benefit administration error. The dollar amount attributed to these incorrectly paid pharmacy claims was immaterial in all three audit scope years, and since we cannot access the accuracy of the FEHBP claims data as stated in section B.1 of the report, we will not adjust the 2016 through 2018 FEHBP MLR submissions.

Recommendation 11:

We recommend that the Plan strengthen claims processing procedures to ensure that only claims related to covered FEHBP benefits are paid and included in the FEHBP MLR calculation.

Plan Response:

"The Plan did not assign a benefit administration system code for weight management drugs because weight management drugs are not on its formulary; however, in a few circumstances the Plan covered weight management drugs when a provider prescribed weight management drugs as a formulary exception. OPM approved adding coverage for weight management drugs effective 1/1/2022. However, to mitigate this error from reoccurring with other prescription drugs, the Plan will review all prescription drug benefits to ensure all excluded drugs are addressed with benefit administration codes. [redacted]

FEHBP MLR Reporting Errors Conclusion

Although the errors discussed above warrant monetary adjustments to the FEHBP MLR calculations during our audit scope, we did not adjust the claims costs and recalculate the MLRs since we found the variation in claims accounting methods for the numerator and denominator rendered the FEHBP MLR calculation unreliable (see Report section B.1).

3. Data Requirement Carrier Letter Non-Compliance

The Plan was not in compliance with the FEHBP Carrier Letters 2017-06, 2018-12, 2019-07 for contract years 2016 through 2018, respectively. Specifically, the Plan's medical claims extracts included duplicate claims, the FEHBP medical and pharmacy claims extracts were not populated with claims data used in the FEHBP MLR forms, [redacted]

payment amounts, and the data did not meet the FEHBP MLR timing specifications. These issues affected all plan codes over the scope of our audit.

Per FEHBP Claims Data Requirements Carrier Letters 2017-06, 2018-12, 2019-07 (Claims Data CLs) for contract years 2016 through 2018, respectively, community-rated carriers required to submit an MLR form must submit to the OPM OIG detailed FEHBP claims data used in its MLR calculation. The data should include FEHB claims incurred during the calendar year and paid through June 30th of the following year. No other claims will be considered, and completion factors should not be applied to the data. The claims data submitted to the OIG should also only include FEHBP MLR claims associated with covered benefits. To meet the Claims Data CLs, the Plan submitted claims extracts to the OPM OIG.

a. Duplicate Claims and Claims Extract Exclusion from MLR

Upon review of the medical claims extracts and in conjunction with our Standard Information Request C and subsequent information requests, the Plan notified us that the medical claims extracts submitted to OPM OIG during our audit scope reported the full cost of inpatient services twice where an outpatient service was also performed during an inpatient hospital stay. The Plan indicated that the duplicate reporting was due to a programming error of the Plan's business rule, which affected the creation of the FEHBP medical claims extracts for contract years 2016 through 2018. As such, the FEHBP medical claims extracts were overstated by the following amounts:

Table V
Duplicate Reporting of Inpatient Services Costs in the Medical Claims Extracts

Contract Year	NOCAL	SOCAL	FRESNO	Total
2016	[redacted]	[redacted]	[redacted]	[redacted]
2017	[redacted]	[redacted]	[redacted]	[redacted]
2018	[redacted]	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]	[redacted]

Although Section 2.3 of the Contract specifies actions the Plan must take when claim overpayments occur, we identified that these duplicates were not paid or accounted for twice in the FEHBP MLR since the medical and pharmacy claims [redacted]

[redacted] which the Plan believes meets the requirements outlined in 45 CFR 158. However, the Claims Data CLs are specific in that the data submitted to the OPM OIG must represent the data used in the FEHBP MLR calculation.

b. Member Cost Share Deducted Twice

In response to our Standard Information Request C and additional information requests, the Plan identified an error in another business rule (query language) used to generate the claims extract files which deducted the patient liability amount from commercial members; however, the patient liability costs were already deducted. As such, the claims extracts were understated by the amounts in Table VI.

Table VI
Understated Claims Costs Due to Duplicative Removal of Patient Liability Charges

Year	SOCAL	NOCAL	FRESNO	Total
2016	[redacted]	[redacted]	[redacted]	[redacted]
2017	[redacted]	[redacted]	[redacted]	[redacted]
2018	[redacted]	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]	[redacted]

As indicated in the prior section, since the Plan utilizes a [redacted] claims extracts, effectively utilizing December 31st data of the MLR reporting year, these understated claims did not impact the FEHBP MLR calculations. This issue is another example of the Plan's non-compliance with the Claims Data CLs and indicates an overall lack of controls related to reporting actual and accurate FEHBP MLR claims data to the OIG.

Recommendation 12:

We recommend that the Plan implement corrective actions to resolve the business rule issues that led to duplicate claim reporting and duplicative removal of patient liability costs in the claims extracts submitted to the OIG.

Plan Response:

"The Plan agrees that it notified the OIG that the medical claims extracts accounted for duplicate inpatient services and duplicate member cost share" as shown in tables

V and VI. "The Plan is in the process of updating the business rules for the claims extracts to correct errors that resulted in the duplicate claims and member cost share issues. The Plan also agrees that the issues were specifically related to the claims extracts since the amount reported on the FEHBP MLR form is representative of final year end data.

The Plan disagrees with all OIG statements that express that the medical and pharmacy claims extracts [redacted]. Specifically, the Carrier created its MLR data extracts in a good faith effort to comply with OPM's requirements that it prepare and submit an FEHBP-specific data file and that it use the MLR data extracts as the [redacted]. However, as the Carrier has explained, the Carrier is part of an integrated delivery system in which most care is furnished internally and for which it does not [redacted]. For these reasons, a claims-based data extract can never accurately and completely capture the Carrier's expenses for clinical services.

Additionally, the Carrier must make adjustments to the [redacted] in order to ensure that its MLR calculations are not only accurate and complete, but that they also comply with OPM's other requirement - that the Carrier's FEHBP-specific MLR reporting reflects the CMS [Centers for Medicare & Medicaid Services] requirements for MLR reporting under the ACA [Patient Protection and Affordable Care Act], [redacted]

OPM's requirements for an MLR data extract would only be appropriate for FEHBP carriers who reimburse external contracted providers on the basis of fee-for-service claims which then flow directly into the carriers' financial statements in the form of expenses. Because not every carrier in the FEHBP operates that way, flexibility is required in interpreting and applying OPM's twin MLR reporting requirements (i.e. an FEHBP-specific data file and alignment with CMS requirements).

By explicitly adopting the CMS approach to MLR reporting, OPM incorporated into its MLR requirements the considerable flexibility that CMS built in to its MLR regulations under the ACA. For its part, CMS clearly recognized the impossibility of requiring a single approach to reporting expenses for clinical services. Although

CMS refers to all 'reimbursement for clinical services' as 'incurred claims' (45 CFR 158.140(a)), it does not require preparation or submission of a claims data file. Instead, CMS recognizes that expenses, including reimbursement for clinical services are subject to adjustment and allocation. In this regard, CMS does not dictate the allocation methodology to be used, but instead requires only that an issuer's methodology 'should be based on a generally accepted accounting method that is expected to yield the most accurate results.' 45 CFR 158.170(b)(1). Issuers are required to describe their methodology as part of their submissions. 45 CFR 158.170(b). This approach ensures complete and accurate reporting not only for integrated delivery systems like the Carrier's, but also for other types of value-based arrangements like accountable care organizations. By emphasizing the importance of accuracy over a uniform reporting approach and explicitly authorizing broad flexibility in reporting, CMS ensures that every issuer can comply, regardless of its delivery system or contractual relationships.

[redacted]

[redacted] **In doing so, it undertook good faith efforts to ensure substantial compliance with both the requirement to create and submit a data file and to ensure that expenses were complete, accurate and aligned with annual financial reporting."**

OIG Comment:

While we recognize that the Plan put forth a good faith effort to comply with the data carrier letter requirements, the data was not representative of the [redacted] claims reported on the FEHBP MLR form. Even if the claims extract file supported the amount reported on FEHBP MLR form, the duplicate accounting of the inpatient services and member cost share would have prohibited us from using the file as an FEHBP claims verification source. As such, we were unable to ensure that the claims costs reported by the Plan in

the FEHBP MLR calculation are truly FEHBP-specific claims costs or related to FEHBP member cost of care.

c. Integrated Data Repository Algorithm Issue

As part of our audit, we selected 6 claims from the 2016 medical claims extract to review in detail. In response to our information requests related to a transplant services claim sample, the Plan identified an algorithm issue in their IDR which incorrectly grouped claims using authorization (referral) number and service dates instead of member number and service dates to determine [redacted]

The Plan researched this issue and found two additional claims in the FEHBP 2016 claims data that were impacted by this algorithm issue, but no additional claims in the 2017 and 2018 claims data extracts. The Plan explained that this issue is a [redacted] reporting issue only and does not affect [redacted] reporting since IDR is not used to determine pricing. The FEHBP MLR was not impacted by this issue since the Plan makes a [redacted] adjustment back to December 31st data and then adds six months of external claims data to account for the run-out. Since the claims impacted by this [redacted] issue are [redacted] claims that would have an [redacted] number attached to them, they would be picked up in the [redacted] claims run-out adjustment.

The Plan stated that this reporting issue was corrected in October of 2020 and provided the following statement, "the entire [redacted] algorithm in IDR was revised and redesigned. As a result, the correct [redacted] algorithm is now used for all of California. The algorithm now correctly groups all [redacted] claims received for the same MRN [member number] from a particular [redacted] provider over a [redacted] range of dates. This fix will be applied to MLR extracts effective January 1, 2020." Although the Plan states that they have taken steps to correct this issue, to date, the Plan has not provided any evidence of updated policies and procedures to address these reporting errors and the details surrounding the algorithm redesign.

Recommendation 13:

We recommend that the Plan implement additional internal controls and oversight reviews of their IDR system to ensure that system algorithms are accurately compiling the cost of an episode of care.

Plan Response:

The Plan disagrees with the characterization of this finding. Specifically, they stated, "During the MLR claims extract process, if payment has not been made, the expected amount would be used. In the 2016 claims extract, the total [redacted] 0.72 % higher than the [redacted] amount. For sample #3, because of an issue with the episode algorithm, the actual claim was not updated … [redacted]

The Plan also states that it updated its policies and procedures to address this error. The Plan agrees additional oversight should be considered and it is assessing additional review and monitoring procedures." [redacted]

OIG Comment:

The OIG acknowledges that the Plan implemented additional oversight measures to ensure the accuracy of the [redacted] of care algorithm; however, the implementation falls outside the scope of our audit. As such, we will evaluate the effectiveness of these policies and procedures in a future audit.

d. Use of Expected Claims Data

The claims data in the medical and pharmacy extracts were populated with [redacted] claims payments instead of actual claim payments in situations where the claim was not fully paid. [redacted] The Claims Data CLs are clear that the data submitted to the OPM OIG should include only FEHB claims incurred in the calendar year and paid through June 30th of the following year. Specifically, "no other claims will be considered and completion factors should not be applied to this data." As such, the Plan's inclusion of expected claims does not comply with the Claims Data CLs.

Recommendation 14:

We recommend that the Plan implement additional internal controls, including written procedure reviews, to ensure that only actual paid claims, not expected claims, are submitted to the OPM OIG as specified in the Claims Data CLs.

Plan Response:

"The Plan disagrees with this finding and included these costs in the claims data as they are reported on the Plan's financial statements. The Plan states that its approach, 'is consistent with the CMS requirements for MLR reporting under ACA ((45 CFR 158.140(a)(2) [redacted]

OIG Comment:

As discussed in section A of this report, the Plan's integrated health care system and business model limits its ability to meet the requirements of the FEHBP MLR, specifically in the reporting of claims expenses. Although this reporting method may meet the terms of 45 CFR 158.140(a)(2), it does not meet the terms of OPM's Community Rated Guidelines and related CLs.

e. Timing Discrepancies

In contract year 2016, the medical and pharmacy claims extracts for all plan codes in our scope included calendar year claims paid through November 2017, which is four months past the June 30th run-out period established in the Carrier Letter. Contract years 2017 and 2018 medical and pharmacy claims data [redacted] also contain run-out claims data through the date the extracts were created, [redacted]

Due to the Plan's dynamic system, the IDR data gets refreshed constantly, keeping only the most up to date information. As such, the Plan must pull the FEHBP medical and pharmacy claims extracts on the [redacted] date to meet the rules and regulations surrounding the completion of the FEHBP MLR. Since the Plan's stated procedure does not specifically [redacted], the FEHBP claims extract data may contain more run-out days than prescribed by OPM's Community-Rated Guidelines and the yearly Claims Data CLs. Furthermore, if there are

errors found in the FEHBP claims data extracts [redacted], as was the case in 2016, the Plan has no ability to create a medical and pharmacy claims extract with a June 30th run-out date or comply with the yearly claims data requirements carrier letter.

Recommendation 15:

We recommend that the Plan implement written policies and procedures that address the June 30th claims run-out date, as specified in the Claims Data CLs and MLR rating instructions, to ensure only claims that meet the timing requirements are included in the claims data extracts.

Plan Response:

"The Carrier agrees that its MLR claims data extract inadvertently contained a limited amount of data processed after the run-out period. [redacted]

Data Requirement Carrier Letter Non-Compliance Conclusion

Based on the issues identified above, we determined that the Plan is not in compliance with Carrier Letters 2017-06, 2018-12, 2019-07 for contract years 2016 through 2018, respectively. As such, we could not use the claims extracts to verify the FEHBP claims data used in the FEHBP MLRs for the scope of our audit.

Plan Response:

"The Carrier believes that it has undertaken good faith efforts to ensure substantial compliance with OPM's requirements for calculating the Carrier's Medical Loss Ratios. As indicated previously, given the Carrier's unique structure and delivery system, these efforts require flexibility in the application of OPM's guidance. The Carrier's calculations provide OPM with a substantially transparent and accurate measure of its care delivery [redacted] as a percentage of FEHBP premium."

OIG Comment:

As stated in the FEHBP MLR Requirements in Section A above, we cannot ascertain the accuracy of the Plan's FEHBP MLR. We reiterate that OPM should revise or replace the

FEHBP MLR requirements to provide a reliable measure of the premium dollars spent on the FEHBP program, including the impact of carrier corporate structure and the current community-rated product market. Although we recognize that the Plan acted in good faith, its inability to reconcile FEHBP claims data for rating and financial reporting, and differing sets of information, cause us to question the reliability of the FEHBP MLR.

C. Premium Rate Review

Carriers proposing rates to OPM are required to submit a Certificate of Accurate Pricing certifying that the cost or pricing data submitted in support of the FEHBP rates were developed in accordance with the requirements of 48 CFR, Chapter 16 and the contract. We determined that the Certificates of Accurate Pricing for contract years 2016 through 2018 were defective due the pricing systems' inability to identify Medicare [redacted] members less than age 65, and payment of claims related to non-covered pharmacy drugs.

1. Lack of System Logic to Identify Medicare [redacted] Members Less Than Age 65

During our review of the Plan's pricing system, we discovered that the Plan does not have system logic to identify Medicare [redacted] members less than age 65. These members would most likely be disabled or have end stage renal disease, and who the Plan categorized with the "Commercial < 65" group. Since the Plan cannot identify the Medicare [redacted] members less than age 65, by default the Plan determines their premiums using the commercial member adjusted community rating (ACR).

This directly contradicts the Plan's [redacted] group rating methodology. Specifically, the Plan stated, "In California, our [redacted] group rating methodology uses only [redacted] rating categories: [redacted]. In California, we historically separate [redacted] because of the substantial differences in utilization and third-party (CMS) reimbursement." Based on the Plan's rating methodology and the demographics of the Medicare population, it is logical to assume that Medicare [redacted] members less than age 65 are also high utilizers and receiving CMS reimbursements, indicating that the Medicare manual rate methodology may provide a more accurate rate.

Although the Plan includes Medicare [redacted] members less than age 65 in all commercial [redacted] rate developments, their reason for doing so was that it was a historical approach brought over to NPS when it was implemented in 2006. Even though the Plan's rating methodology reduces FEHBP claims [redacted] from all other sources, including CMS, it is spread across the Plan's book of business and is not allocated back to the specific members

and groups, except for recoveries for external services. If the FEHBP has proportionally more Medicare [redacted] members in the Commercial population than other [redacted], the FEHBP will receive less of a CMS reimbursement than warranted.

Since the Plan's system lacks the logic to determine the number of FEHBP Medicare [redacted] members less than age 65 in the FEHBP Commercial population, we cannot evaluate the impact to premium if the Medicare manual rate development included those members instead of the Commercial ACR development. Also, we cannot evaluate what percentage of the FEHBP population is considered Medicare [redacted] members less than age 65.

Recommendation 16:

We recommend that the Plan evaluate their membership system logic and implement a configuration that would account for Medicare [redacted] members less than age 65.

Plan Response:

"The Plan disagrees with this finding and recommendation, but [states,] the Carrier agrees that it has limited capability to identify members under age 65 with dual coverage for whom Medicare [redacted]. This issue does not substantially impact our standard rating methodology. The Carrier believes that its [redacted] rating methodology is consistent for all groups and that, in the vast majority of cases, members are placed in the [redacted]. The issue concerning members under 65 with dual coverage for whom Medicare is [redacted] does not undermine the overall consistently and accuracy of the Carrier's [redacted] rating methodology."

Also,

"The Carrier believes that its claims and [redacted] systems have the appropriate logic to determine the number of [redacted] Medicare members under the age 65. The issue is that the Carrier's systems lack the configuration to properly transmit and process the necessary data to NPS. As a result, the NPS logic defaults to [redacted] for these members. Because this issue involves the Carrier's [redacted] system, the Carrier will take this under advisement to be addressed after the deployment of its new [redacted] system. The first phase of deployment is scheduled for completion in 2023. The second phase, which will include [redacted] and [redacted] for [redacted] commercial groups, will follow the first phase, but has not yet been scheduled."

OIG Comment:

We recognize that the Plan will take our recommendation under advisement during its implementation of its future membership system. Since we cannot evaluate the monetary impact of including FEHBP Medicare [redacted] members in the ACR portion of the rate development, we cannot assess if this is a material issue or not. As such, we intend to review this matter in future premium rate audits and evaluate the Plan's future membership system once implemented.

2. Claims Paid for Non-Covered Weight Management Prescription Drugs

As discussed in section B.2.d of this report, the Plan notified us that weight management prescription drugs were paid for FEHBP members, even though drugs used in the treatment of weight management are specifically designated in the FEHBP benefit brochure as "not covered." Although the dollar amount attributed to these incorrectly paid pharmacy claims varies slightly from the amount reported in section B.2.d for the FEHBP MLR due to the difference in accounting methods (see report section B.1.a), the amount is also immaterial to the premium rate calculation. As such, we did not deduct the amount from the experience claims used to develop the 2016 through 2018 FEHBP premium rates, and we are not making another recommendation since Recommendation 11 addresses this same issue.

Plan Response:

See the Plan's response to Recommendation 11.

OIG Comment:

See the OIG's Comment for Recommendation 11.

Exhibit A

Kaiser Foundation Health Plan of California 2018 Plan Submitted Medical Loss Ratio				
2018 FEHBP MLR Lower Threshold (a)	85%			
2018 FEHBP MLR Upper Threshold (b)	89%			
Item	**See Report Section**	**Per Plan NOCAL**	**Per Plan SOCAL**	**Per Plan FRESNO**
Claims Extracts (Medical and Pharmacy)*	B.3	[redacted]	[redacted]	[redacted]
Timing Adjustment	B.1.a. and Exhibit C	[redacted]	[redacted]	[redacted]
Scaling Adjustment	B.1.a. and Exhibit C	[redacted]	[redacted]	[redacted]
Change in IBNR	B.1.c.	[redacted]	[redacted]	[redacted]
Unidentified	B.1.c.	[redacted]	[redacted]	[redacted]
PY Allocation & Non-Member Costs	B.1.c.	[redacted]	[redacted]	[redacted]
Additional Adjustments	B.1.c.	[redacted]	[redacted]	[redacted]
Nonmembers	B.1.c.	[redacted]	[redacted]	[redacted]
Payment to Permanente Medical Group	B.1.a.	[redacted]	[redacted]	[redacted]
KFHP to KFH Capitation	Exhibit B	[redacted]	[redacted]	[redacted]
Other Claims Adjustments and Allocations		[redacted]	[redacted]	[redacted]
Total FEHBP MLR Claims (Line 2.1b)		[redacted]	[redacted]	[redacted]
Fraud & Abuse		[redacted]	[redacted]	[redacted]
Numerator [Total Adjusted Incurred Claims]		[redacted]	[redacted]	[redacted]
Premium Income		[redacted]	[redacted]	[redacted]
Taxes and Regulatory Fees		[redacted]	[redacted]	[redacted]
Denominator [Total Adjusted Premium (c)]		[redacted]	[redacted]	[redacted]
FEHBP Unadjusted Medical Loss Ratio Calculation (d)		[redacted]	[redacted]	[redacted]
Credit Calculation (If (d) is greater than (b), ((d-b)*c)		[redacted]	[redacted]	[redacted]
Penalty Calculation (If (d) is less than (a), ((a-d)*c)		[redacted]	[redacted]	[redacted]
[redacted]				

Exhibit A - continued

Kaiser Foundation Health Plan of California 2017 Plan Submitted Medical Loss Ratio				
2017 FEHBP MLR Lower Threshold (a)	85%			
2017 FEHBP MLR Upper Threshold (b)	89%			
Item	**See Report Section**	**Per Plan**	**Per Plan**	**Per Plan**
Claims Extracts (Medical and Pharmacy)	B.3	[redacted]	[redacted]	[redacted]
Timing Adjustment	B.1.a. and Exhibit C	[redacted]	[redacted]	[redacted]
Scaling Adjustment	B.1.a. and Exhibit C	[redacted]	[redacted]	[redacted]
Change in IBNR	B.1.c.	[redacted]	[redacted]	[redacted]
Unidentified	B.1.c.	[redacted]	[redacted]	[redacted]
PY Allocation & Non-Member Costs	B.1.c.	[redacted]	[redacted]	[redacted]
Additional Adjustments	B.1.c.	[redacted]	[redacted]	[redacted]
Nonmembers	B.1.c.	[redacted]	[redacted]	[redacted]
Payment to Permanente Medical Group	B.1.a.	[redacted]	[redacted]	[redacted]
KFHP to KFH Capitation	Exhibit B	[redacted]	[redacted]	[redacted]
Other Claims Adjustments and Allocations		[redacted]	[redacted]	[redacted]
Total FEHBP MLR Claims (Line 2.1b)		[redacted]	[redacted]	[redacted]
Quality Health Improvements		[redacted]	[redacted]	[redacted]
Fraud & Abuse		[redacted]	[redacted]	[redacted]
Numerator [Total Adjusted Incurred Claims]		[redacted]	[redacted]	[redacted]
Premium Income		[redacted]	[redacted]	[redacted]
Taxes and Regulatory Fees		[redacted]	[redacted]	[redacted]
Denominator [Total Adjusted Premium (c)]		[redacted]		[redacted]
FEHBP Unadjusted Medical Loss Ratio Calculation (d)		[redacted]	[redacted]	[redacted]
Credit Calculation (If (d) is greater than (b), ((d-b)*c)		[redacted]	[redacted]	[redacted]
Penalty Calculation (If (d) is less than (a), ((a-d)*c)		[redacted]	[redacted]	[redacted]
[redacted]				

Exhibit A - continued

Kaiser Foundation Health Plan of California 2016 Plan Submitted Medical Loss Ratio				
2016 FEHBP MLR Lower Threshold (a)	85%			
2016 FEHBP MLR Upper Threshold (b)	89%			
Item	**See Report Section**	**Per Plan NOCAL**	**Per Plan SOCAL**	**Per Plan FRESNO**
Claims Extracts (Medical and Pharmacy)*	B.3	[redacted]	[redacted]	[redacted]
Timing Adjustment	B.1.a. and Exhibit C	[redacted]	[redacted]	[redacted]
Scaling Adjustment	B.1.a. and Exhibit C	[redacted]	[redacted]	[redacted]
Change in IBNR	B.1.c.	[redacted]	[redacted]	[redacted]
Unidentified	B.1.c.	[redacted]	[redacted]	[redacted]
Additional Adjustments	B.1.c.	[redacted]	[redacted]	[redacted]
Nonmembers	B.1.c.	[redacted]	[redacted]	[redacted]
Payment to Permanente Medical Group	B.1.c.	[redacted]	[redacted]	[redacted]
KFHP to KFH Capitation	B.1.a.	[redacted]	[redacted]	[redacted]
Other Claims Adjustments and Allocations		[redacted]	[redacted]	[redacted]
Total FEHBP MLR Claims (Line 2.1b)		[redacted]		[redacted]
Quality Health Improvements		[redacted]	[redacted]	[redacted]
Fraud & Abuse		[redacted]	[redacted]	[redacted]
Numerator [Total Adjusted Incurred Claims]		[redacted]	[redacted]	[redacted]
Premium Income		[redacted]	[redacted]	[redacted]
Taxes and Regulatory Fees		[redacted]	[redacted]	[redacted]
Denominator [Total Adjusted Premium (c)]		[redacted]	[redacted]	[redacted]
FEHBP Unadjusted Medical Loss Ratio Calculation (d)		[redacted]	[redacted]	[redacted]
Credit Calculation (If (d) is greater than (b), ((d-b)*c)		[redacted]	[redacted]	
Penalty Calculation (If (d) is less than (a), ((a-d)*c)		$0	$0	$0
[redacted]				

Exhibit B

Table I 2016 Calendar Year FEHBP Claims Comparison					
Claim Timing	**Claim Category**	**NOCAL**	**SOCAL**	**FRESNO**	**Total**
Calendar Year 2016	2016 FEHBP MLR Form Line 2.1b - Adjusted Incurred Claims	[redacted]	[redacted]	[redacted]	[redacted]
	Less: Medicare Capitation Payment*	[redacted]	[redacted]	[redacted]	[redacted]
	FEHBP MLR Adjusted Incurred Claims excluding Medicare	[redacted]	[redacted]	[redacted]	[redacted]
	2018 FEHBP Rate Development Experience Paid Claims	[redacted]	[redacted]	[redacted]	[redacted]
	Difference	[redacted]	[redacted]	[redacted]	[redacted]
	Variance	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]					

Exhibit C

Table II
Incurred and Paid FEHBP MLR Claims - Medical and Pharmacy

Claims Source	Claims Period	NOCAL	SOCAL	FRESNO	Total
2016 Raw Year-end Data [A]	Claims Paid from 1/1/2016 through 12/31/2016	[redacted]	[redacted]	[redacted]	[redacted]
2016 Claims Extract [B]	Claims Paid 1/1/2016 through 11/8/2017	[redacted]	[redacted]	[redacted]	[redacted]
[C] = [A]-[B]	Difference (Plan's Timing Adjustment)	[redacted]	[redacted]	[redacted]	[redacted]
2016 Final Year-end Data [D]	Claims Paid 1/1/2016 through 12/31/2016	[redacted]	[redacted]	[redacted]	[redacted]
[E] = [D]-[A]	Difference (Plan's Scaling Adjustment)	[redacted]	[redacted]	[redacted]	[redacted]
[F] = [C]+[E]	**2016 Total Timing and Scaling Difference**	[redacted]	[redacted]	[redacted]	[redacted]
2017 Raw Year-end Data [G]	Claims Paid 1/1/2017 through 12/31/2017	[redacted]	[redacted]	[redacted]	[redacted]
2017 Claims Extract [H]	Claims Paid 1/1/2017 through 6/30/2018*	[redacted]	[redacted]	[redacted]	[redacted]
[I] = [G]-[H]	Difference (Plan's Timing Adjustment)	[redacted]	[redacted]	[redacted]	[redacted]
2017 Final Year-end Data [J]	Claims Paid 1/1/2017 through 12/31/2017	[redacted]	[redacted]	[redacted]	[redacted]
[K] = [J]-[G]	Difference (Plan's Scaling Adjustment)	[redacted]	[redacted]	[redacted]	[redacted]
[L] = [I]+[K]	**2017 Total Timing and Scaling Difference**	[redacted]	[redacted]	[redacted]	[redacted]
2018 Raw Year-end Data [M]	Claims Paid 1/1/2018 through 12/31/2018	[redacted]	[redacted]	[redacted]	[redacted]
2018 Claims Extract [N]	Claims Paid 1/1/2018 through 6/30/2019*	[redacted]	[redacted]	[redacted]	[redacted]
[O] = [M]-[N]	Difference (Plan's Timing Adjustment)	[redacted]	[redacted]	[redacted]	[redacted]
2018 Final Year-end Data [P]	Claims Paid 1/1/2018 through 12/31/2018	[redacted]	[redacted]	[redacted]	[redacted]
[Q] = [P]-[M]	Difference (Plan's Scaling Adjustment)	[redacted]	[redacted]	[redacted]	[redacted]
[R] = [O]+[Q]	**2018 Total Timing and Scaling Difference**	[redacted]	[redacted]	[redacted]	[redacted]
		[redacted]			[redacted]

[redacted]

Exhibit D

Kaiser Foundation Health Plan, Inc.
Medical Claims Sample Selection Criteria and Methodology

Universe Criteria	Universe (Number)	Universe (Dollars)	Sample (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
NOCAL ([redacted]) and SOCAL ([redacted]) medical claims paid from 1/1/2016 through 12/31/2016	[redacted]	[redacted]	[redacted]	Selected six high dollar In-Network Inpatient[1], Outpatient[2], and Professional[3] claims (one claim per plan code).	Judgmental	No

[1] Claims that were greater than $250,000 in amount paid.
[2] Claims that were greater than $50,000 in amount paid.
[3] Claims that were greater than $20,000 and $10,000 in amount paid for plan codes 59 and 62, respectively.

Appendix

Kaiser Foundation Health Plan, Inc. [Full] Response to Audit Report Number 1C-59-00-20-043
Received November 18, 2021

A. The FEHBP Medical Loss Ratio Requirements

Deleted by the OIG – Not Relevant to the Final

Carrier Response:
The Carrier concurs that applying the FEHB Program's current medical loss ratio requirements to integrated delivery systems like the Carrier or to other complex arrangements imposes a considerable burden and requires flexibility. However, the Carrier disagrees that its MLR is "unreliable" and "should not be used by OPM to ascertain that the Government and Federal employees are receiving a fair market rate and a good value for their premium dollars." To the contrary, the MLR process is worth the effort. A plan's medical loss ratio provides OPM with considerable transparency into how carriers expend FEHB premiums and a more objective understanding of the value that OPM and Federal employees and retirees derive for their dollars.

The Carrier is part of an integrated delivery system in which most care is furnished internally by itself, [redacted] contain relatively complex reimbursement arrangements not based solely on fee-for-service claims payments. For these reasons, a claims-based data extract can never accurately and completely capture what the Carrier spends on clinical services.

[redacted] Without this flexibility, the existing MLR guidelines do not accommodate the financial reporting approaches used by integrated delivery systems like the Carrier's.

To satisfy OPM's requirements, the Carrier must make adjustments to the information from its MLR [redacted] to ensure that its MLR calculations are accurate and complete, and that they also comply with OPM's other requirement - that the Carrier's FEHBP-specific MLR reporting reflects the CMS requirements for MLR reporting under the ACA, including alignment with the

[redacted] (OPM Carrier Letter 2015-09, 2016 Community Rating Guidelines, p. 9 "HHS MLR Guidelines will apply for issues not covered in these instructions." See also 48 CFR 1602.170-14(a) ("Medical Loss Ratio (MLR) means the ratio of plan incurred claims, including the issuer's expenditures for activities that improve health care quality, to total premium revenue determined by OPM, as defined by the Department of Health and Human Services in 45 CFR part 158") and 77 Fed. Reg. 19522, 19523 (Apr. 2, 2012) (" Because formula for calculating the MLR required in this context is the same as that outlined in 45 CFR part 158, OPM intends to model its form closely on the HHS form.")

Because the current FEHBP MLR requirements impose unique, substantial challenges on integrated delivery systems and other complex carriers, the Carrier would welcome the opportunity to discuss with OPM changes in the MLR guidelines to clarify and simplify the process for the Carrier and similar plans.

However, these efforts should not obscure the fact that the MLR process provides OPM with much greater insight into how premium dollars are spent than in the years before the MLR standard was launched. The prior approach, which compared the rates charged FEHBP with those charged to similarly-sized subscriber groups (SSSGs), ensured only that OPM was treated fairly relative to its peer customers. It did not show OPM how much of its premiums were used to purchase care or provide a remedy when that percentage fell below OPM's reasonable expectations. In short, the SSSG approach focused only on price and unlike MLR, not on value.

For these reasons, the Carrier supports efforts to revise, but not replace, the current FEHBP MLR requirements.

B. Medical Loss Ratio Review

1. Inconsistent FEHBP Claims Tracking and Reporting

a. Claim Accounting Inconsistencies

Deleted by the OIG – Not Relevant to the Final

Carrier Response:

Even before OPM finalized its initial MLR regulations and guidance, the Carrier reached out to OPM to explain that, because its structure and arrangements differ dramatically from most other carriers, in the interest of accuracy, transparency and compliance, the Carrier calculated its MLRs based on its [redacted] encounters.

[redacted] In doing so, it undertook good faith efforts to ensure substantial compliance with both the requirement to create and submit a data file and to ensure that expenses were complete, accurate and aligned with annual financial reporting.

The Carrier is committed to refining its existing MLR processes to better align with its rate development methodology, however as noted in Recommendation 1 above existing MLR guidelines do not accommodate the financial reporting approaches used by integrated delivery systems like the Carrier's. The Carrier would welcome the opportunity to discuss potential changes in the MLR guidelines with OPM.

1. Inconsistent FEHBP Claims Tracking and Reporting
b. [redacted] Coverage and [redacted] Membership Termination Logic Discrepancies

Deleted by the OIG – Not Relevant to the Final

Carrier Response:
The Carrier agrees in part and disagrees in part. As explained…, the Carrier is unable to assess the dual coverage issue any further. The Carrier is committed to making necessary changes prospectively.

[redacted]

The Carrier is committed to refining its MLR reporting processes to better align with its pricing methodology. However as noted in Recommendation 1 above, existing MLR guidelines do not accommodate the financial reporting approaches used by integrated delivery systems like the Carrier's.

1. Inconsistent FEHBP Claims Tracking and Reporting
c. Claims Adjustment Issues

Deleted by the OIG – Not Relevant to the Final

Carrier Response:
Because Recommendation 6 addressed three separate issues, the Carrier's response to each issue follows the order in which they were presented.

Appendix

6a. IBNR

The Carrier disagrees with the finding and recommendation related to the IBNR adjustment because the adjustment is necessary to remove IBNR from the Carrier's MLR calculations as required by OPM's guidelines. The Carrier's [redacted] statement includes an accrual for IBNR which, for any given year, may be positive or negative. When a prior year's IBNR is larger than the current year's IBNR, the [redacted] statement reflects a reduction to medical expenses driven by the accrual activity. To comply with OPM's guidelines, the Carrier makes an adjustment to remove the change in IBNR accrual. In this case, the [redacted] adjustment referenced in the finding offsets a negative IBNR accrual, effectively removing IBNR accrual activity and leaving only paid activity in the calendar year. Reversing the Carrier's adjustment would result in the inclusion of IBNR accrual activity in the Carrier's MLR calculations in violation of OPM's instructions.

6b. Non-FEHBP Member costs

As explained in the Carrier's response to Recommendation 2 above, the Carrier is part of an integrated delivery system that provides medical care. Its financial reporting reflects its organizational structure. As with other care providers, the Kaiser Permanente delivery system may not turn away individuals seeking care who do not have coverage. Other providers in the community rely on the fee schedules they negotiate with commercial payors to cover the net cost of these services. However, because the Carrier does not process claims to reimburse itself for the services it provides internally, it must account for these provider operations cost by [redacted]. Current FEHB MLR guidelines do not take into consideration that a carrier may be both a provider of health care services and an insurer/HMO. Because the Carrier is using a cost-based provider/financial statement methodology for MLR these amounts should remain part of the numerator.

6c. Unidentified Cost

As the Carrier has explained previously, in preparing our MLR calculations, we have taken a number of steps to ensure substantial compliance with OPM's MLR guidelines related to alignment with the Carrier's MLR submissions to CMS as well as OPM's claims data file requirement. The adjustment for "unidentified costs" essentially reflects an adjustment necessary to align the two requirements and ensure the accuracy and consistency of the Carrier's MLR calculations. Removing this adjustment would not only increase the Carrier's reported medical loss ratio, but also violate OPM's requirement that the FEHB MLR calculations align with the Carrier's MLR calculations for CMS. This issue is directly related to the concerns raised in Recommendation 1. As noted in Recommendation 1 above existing MLR guidelines do not accommodate the financial reporting approaches used by integrated delivery systems like the Carrier's. The Carrier would welcome the opportunity to discuss potential changes in the MLR guidelines with OPM to address this issue.

2. FEHBP MLR Reporting Errors

a. [redacted] Member Claim Coding [redacted] Error

Deleted by the OIG – Not Relevant to the Final

Carrier Response to Recommendations 7 and 8:
While Kaiser believes the appropriate controls are in place to identify material issues, we take OIG's concerns seriously and will be performing additional analysis on the following two items:

[redacted]

[redacted]

In regard to system testing, as noted previously, the [redacted] issue was a "coding [redacted] error," and did not represent a system error. We already have existing controls over the system, and as this issue is not system related, no further assessment is planned over the system.

2. FEHBP MLR Reporting Errors
b. Tapestry Implementation Configuration Logic Error

Deleted by the OIG – Not Relevant to the Final

Carrier Response
Since the [redacted] implementation, the [redacted] teams have developed processes with controls to track and monitor [redacted] adjustments. Improvements include communications between the teams involved in [redacted] adjustments, an improved process to identify claims that qualify for retrospective processing, as well as single-team accountability for the [redacted] processing. The Carrier has also added a [redacted] process to assess and evaluate the impact of retrospective processing before actual reprocessing is run…The Carrier's internal quality control processes are aligned with industry best practices and utilize standard sampling methodologies providing a [redacted] control mechanism.

2. FEHBP MLR Reporting Errors
c. Inclusion of Pharmacy Benefit Manager Fees

Deleted by the OIG – Not Relevant to the Final

Carrier Response:
The Carrier identified and disclosed this issue during the audit and has updated its MLR procedures related to Kaiser [redacted] PBM fees starting with the 2019 contract year. We submitted revised procedures prior to this response. [redacted]

[redacted]

[redacted]

2. FEHBP MLR Reporting Errors

d. Claims Paid for Non-Covered Weight Management Prescription Drugs

Deleted by the OIG – Not Relevant to the Final

Carrier Response:

The Plan did not assign a benefit administration system code for weight management drugs because weight management drugs are not on its formulary; however, in a few circumstances the Plan covered weight management drugs when a provider prescribed weight management drugs as a formulary exception. OPM approved adding coverage for weight management drugs effective 1/1/2022. However, to mitigate this error from reoccurring with other prescription drugs, the Plan will review all prescription drug benefits to ensure all excluded drugs are addressed with benefit administration codes.

3. Data Requirement Carrier Letter Non-Compliance

a. Duplicate Claims and Claims Extract Exclusion from MLR

b. Member Cost Share Deducted Twice

Deleted by the OIG – Not Relevant to the Final

Carrier Response:

The Plan agrees that it notified the OIG that the medical claims extracts accounted for duplicate inpatient services and duplicate member cost share. **Deleted by the OIG – Not Relevant to the Final** The Plan is in the process of updating the business rules for the claims extracts to correct errors that resulted in the duplicate claims and member cost share issues. The Plan also agrees that the issues were specifically related to the claims extracts since the amount reported on the FEHBP MLR form is representative of final year end data.

The Plan disagrees with all OIG statements that express that the medical and pharmacy claims extracts were not used to populate the FEHBP MLR. Specifically, the Carrier created its MLR data extracts in a good faith effort to comply with OPM's requirements that it prepare and submit an FEHBP-specific data file and that it use the MLR data extracts MLR calculations. However, as the Carrier has explained, the Carrier is part of an integrated delivery system in which most care is . For these reasons, a claims-based data extract can never accurately and completely capture the Carrier's expenses for clinical services.

Additionally, the Carrier must make adjustments to the information from its MLR [redacted] in order to ensure that its MLR calculations are not only accurate and complete, but that they also comply with OPM's other requirement - that the Carrier's FEHBP-specific MLR reporting reflects the CMS [Centers for Medicare & Medicaid Services] requirements for MLR reporting under the ACA [Patient Protection and Affordable Care Act], [redacted]

OPM's requirements for an MLR data extract would only be appropriate for FEHBP carriers who reimburse external contracted providers on the basis of fee- for-service claims which then flow directly into the carriers' financial statements in the form of expenses. Because not every carrier in the FEHBP operates that way, flexibility is required in interpreting and applying OPM's twin MLR reporting requirements (i.e. an FEHBP-specific data file and alignment with CMS requirements).

By explicitly adopting the CMS approach to MLR reporting, OPM incorporated into its MLR requirements the considerable flexibility that CMS built in to its MLR regulations under the ACA. For its part, CMS clearly recognized the impossibility of requiring a single approach to reporting expenses for clinical services. Although CMS refers to all "reimbursement for clinical services" as "'incurred claims'" (45 CFR 158.140(a)), it does not require preparation or submission of a claims data file. Instead, CMS recognizes that expenses, including reimbursement for clinical services are subject to adjustment and allocation. In this regard, CMS does not dictate the allocation methodology to be used, but instead requires only that an issuer's methodology "should be based on a generally accepted accounting method that is expected to yield the most accurate results." 45 CFR 158.170(b)(1). Issuers are required to describe their methodology as part of their submissions. 45 CFR 158.170(b). This approach ensures complete and accurate reporting not only for integrated delivery systems like the Carrier's, but also for other types of value- based arrangements like accountable care organizations. By emphasizing the importance of accuracy over a uniform reporting approach and explicitly authorizing broad flexibility in reporting, CMS ensures that every issuer can comply, regardless of its delivery system or contractual relationships.

In the case of the FEHBP, flexibility is also required because OPM insists that the Carrier include in its MLR calculations populations of FEHBP members rated using traditional community rating (the Carrier's Medicare fee-for-service members) and community rating by class (Medicare Advantage risk-adjusted members). [redacted]

[redacted]

[redacted] In doing so, it undertook good faith efforts to ensure substantial compliance with both the requirement to create and submit a data file and to ensure that expenses were complete, accurate and aligned with annual financial reporting.

3. Data Requirement Carrier Letter Non-Compliance
c. Integrated Data Repository Algorithm Issue

Deleted by the OIG – Not Relevant to the Final

Carrier Response:
During the MLR claims extract process, if payment has not been made, the expected amount would be used. In the 2016 claims extract, the total expected amount is [redacted] higher than the actual amount. For sample #3, because of an issue with the [redacted], the actual claim was not updated…[redacted].

The Plan also states that it updated its policies and procedures to address this error. The Plan agrees additional oversight should be considered and it is assessing additional review and monitoring procedures.

[redacted]

3. Data Requirement Carrier Letter Non-Compliance
d. Use of Expected Claims Data

Deleted by the OIG – Not Relevant to the Final

Carrier Response:
The Plan disagrees with this finding and included these costs in the claims data as they are reported on the Plan's financial statements. The Plan states that its approach, "is consistent with the CMS requirements for MLR reporting under ACA ((45 CFR 158.140(a)(2) ("Incurred claims must include the current year's unpaid claims reserves, including claims reported in the process of adjustment, percentage withholds from payments made to contracted providers, claims that are recoverable for anticipated coordination of benefits (COB), and claim recoveries received as a result of subrogation.")

3. Data Requirement Carrier Letter Non-Compliance
e. Timing Discrepancies

Deleted by the OIG – Not Relevant to the Final

Carrier Response:
The Carrier agrees that its MLR claims data extract inadvertently contained a limited amount of data processed after the run-out period. However, [redacted]

C. Premium Rate Review

Deleted by the OIG – Not Relevant to the Final

2. Lack of System Logic to Identify Medicare [redacted] Members Less Than Age 65

Deleted by the OIG – Not Relevant to the Final

Carrier Response:
The Plan disagrees with this finding and recommendation, but the Carrier agrees that it has limited capability to identify members under age 65 with dual coverage for whom Medicare is [redacted]. This issue does not substantially impact our standard rating methodology. The Carrier believes that its [redacted] rating methodology is consistent for all groups and that, in the vast majority of cases, members are placed in the [redacted]. The issue concerning members under 65 with dual coverage for whom Medicare is primary does not undermine the overall consistency and accuracy of the Carrier's [redacted] rating methodology.

The Carrier believes that its claims and [redacted] systems have the appropriate logic to determine the number of primary Medicare members under the age 65. The issue is that the Carrier's systems lack the configuration to properly transmit and process the necessary data to NPS. As a result, the NPS logic defaults to [redacted] for these members. Because this issue involves the Carrier's [redacted] system, the Carrier will take this under advisement to be addressed after the deployment of its [redacted]. The first phase of deployment is scheduled for completion in 2023. The second phase, which will include group set-up and [redacted] commercial groups, will follow the first phase, but has not yet been scheduled.

3. Claims Paid for Non-Covered Weight Management Prescription Drugs

Deleted by the OIG – Not Relevant to the Final

Carrier Response:
Please see the Carrier's response to Recommendation 11.

Exhibit A (Kaiser Foundation Health Plan of California 2018 Plan Submitted Medical Loss Ratio

Carrier Response:
The Carrier has reviewed calculation in Appendix A and is requesting the following corrections:
• 2017 Fresno Premium should be [redacted]
• 2017 Fresno Tax and Regulatory Fees should be [redacted]
• 2017 Fresno Denominator should be [redacted]
• 2017 Fresno FEHBP Unadjusted Medical Loss Ratio Calculation should be [redacted]
• 2017 Fresno Credit Calculation [redacted]

Report Fraud, Waste, and Mismanagement

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

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U.S. Office of Personnel Management
1900 E Street, NW
Room 6400
Washington, DC 20415-1100