



**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 Aetna
Healthfund CDHP and Value Plan**

Report Number 1C-99-00-21-029

August 10, 2022

Executive Summary

Audit of the Federal Employees Health Benefits Program Operations at Aetna HealthFund CDHP and Value Plan.

Report No. 1C-99-00-21-029

August 10, 2022

Why Did We Conduct the Audit?

The primary objective of the audit was to determine whether Aetna HealthFund Consumer Driven Health Plan (CDHP) and Value Plan (Plan) complied with the provisions of its contract and the laws and regulations governing the Federal Employees Health Benefits Program (FEHBP). To accomplish this objective, we verified whether the FEHBP premium rates 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 Contract CS 2938, the Office of the Inspector General (OIG) completed a performance audit of the FEHBP premium rate developments for contract year 2020. We conducted our audit fieldwork remotely from July 26, 2021, through April 26, 2022.

What Did We Find?

We determined that the Certificates of Accurate Pricing signed for the 2020 FEHBP premium rate developments of plan codes EP, F5, G5, H4, and JS were defective due to the incorrect calculation and application of benefit adjustments within the FEHBP premium rate developments. These benefit adjustment issues are designated as procedural in this report as we found there was no material cost impact to the FEHBP rates.

Although we determined that the amount of the Patient Protection and Affordable Care Act Section § 9010 Health Insurance Providers fee (HIPF) loading in the FEHBP premium rates was reasonable, we found that the Plan's development of the HIPF loading was not in compliance with Carrier Letter 2013-14, as the loading was based on premium and fees not attributable to the FEHBP.

Finally, we reviewed a judgmental sample of 50 medical claims to determine if the Plan priced and paid the claims for eligible members according to applicable criteria. Our review of the medical claims did not disclose any reportable issues.



Michael R. Esser
*Assistant Inspector General
for Audits*

Abbreviations

ACA	Patient Protection and Affordable Care Act
ACR	Adjusted Community Rating
CDHP	Consumer Driven Health Plan
CFR	Code of Federal Regulations
CL	Carrier Letter
Contract	Contract CS 2938
FEHBP	Federal Employees Health Benefits Program
HIPF	ACA Section § 9010 Health Insurance Providers Fee
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
Plan	Aetna HealthFund CDHP and Value Plan

Table of Contents

	Page
Executive Summary	i
Abbreviations	ii
I. Background	1
II. Objectives, Scope, and Methodology	3
III. Audit Findings and Recommendations	5
Premium Rate Review.....	5
1. Benefit Adjustment Issues.....	5
2. Carrier Letter 2013-14, Health Insurance Providers Fee, Compliance Issues	8
3. Medical Claims Review	9
Exhibit A (Medical Claims Sample Selection Criteria and Methodology)	
Appendix (Plan’s June 24, 2022, 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 Aetna HealthFund Consumer Driven Health Plan (CDHP) and Value Plan (Plan), plan codes EP, F5, G5, H4, and JS. The audit was conducted pursuant to the provisions of Contracts CS 2938 (Contract); 5 United States Code Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract year 2020 and was conducted remotely by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG) staff.

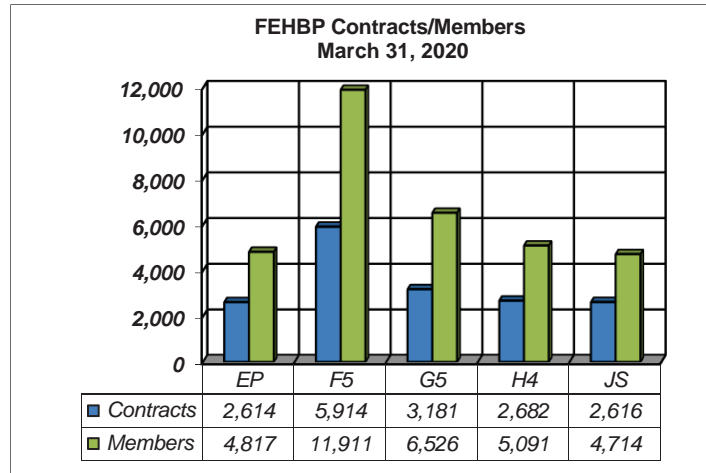
The FEHBP was established by the Federal Employees Health Benefits Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for Federal employees, annuitants, and dependents, and is administered by the OPM Healthcare and Insurance Office. The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

In April 2012, OPM issued a final rule establishing an FEHBP-specific Medical Loss Ratio (MLR) requirement to replace the similarly-sized subscriber group (SSSG) comparison requirement for most community-rated FEHBP carriers (77 Federal Register 19522). The MLR 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. 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.

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. Further, an independent professional must be able to follow the carriers' procedures and reach the same conclusion. OPM negotiates benefits and rates with each plan annually and all rate agreements between OPM and the carrier are subject to audit by the OPM OIG. The results of such audits may require modifications to previous agreements and subsequent rate adjustments.

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

The number of FEHBP contracts and members reported by the Plan as of March 31, 2020, for each plan code audited is shown in the chart (right). The membership by plan code represents the combined total of the CDHP and Value Plan benefit options.



The Plan has been in existence since 1850 and provides health benefits to FEHBP members in all 50 states and the District of Columbia.

The last audit of Aetna HealthFund was conducted by our office in 2014 and included a review of the 2012 FEHBP MLR and 2012 premium rates. The prior audit identified that the FEHBP rates were developed in accordance with applicable rules and regulations; however, there were issues related to the reporting of dental claims, vendor payments, non-covered benefits, and pharmacy claims in the FEHBP MLR. After making adjustments, OPM calculated the updated MLR penalty to be \$11,445,456, which was paid by the Plan and the audit was closed.

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

II. Objectives, Scope, and Methodology

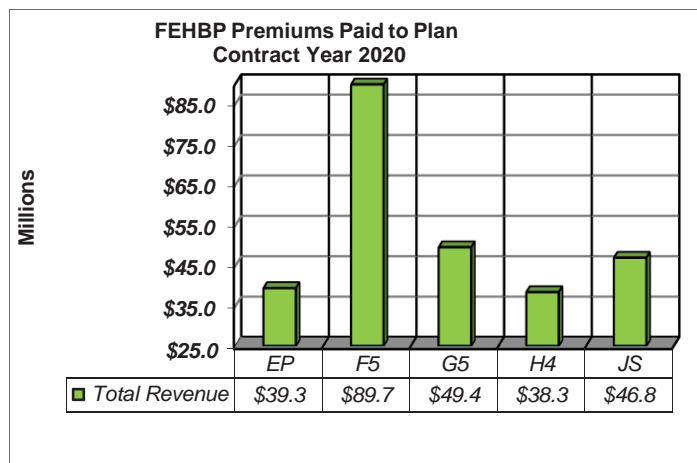
Objectives

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 developed its FEHBP premium rates in accordance with the applicable regulations and rating instructions established by OPM. We performed additional tests to determine whether the Plan followed the provisions of the laws and regulations governing the FEHBP as well as 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 year 2020. For this year, the FEHBP paid approximately \$263.5 million in premiums to the Plan. Each plan code summarized in the chart (right) includes the combined revenue paid for the CDHP and Value Plan benefit options. The plan codes in the scope of the audit each cover multiple states and in total cover all 50 states and the District of Columbia.



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 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 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 July 26, 2021, through April 26, 2022.

Methodology

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

To gain an understanding of the internal controls over the Plan's premium rate processes as well as its claims processing system, we reviewed the Plan's premium rate development and claims policies and procedures. We also interviewed appropriate Plan officials regarding the controls in place to ensure that the 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 A at the end of this report.

III. Audit Findings and Recommendations

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 FEHBP Contract CS 2938 (Contract). We determined that the Certificates of Accurate Pricing that Aetna HealthFund Consumer Driven Health Plan (CDHP) and Value Plan (Plan) signed for contract year 2020, plan codes EP, F5, G5, H4, and JS, were defective due to benefit loading errors and non-compliance with Carrier Letter 2013-14. The monetary findings associated with these issues were immaterial to the overall premium rate calculations; therefore, they are classified as procedural in nature in this report.

1. Benefit Adjustment Issues: Procedural

During our review of the 2020 FEHBP premium rate developments for plan codes EP, F5, G5, H4, and JS, we determined that the Plan did not accurately adjust the FEHBP experience claims for the benefits listed in the benefits brochure and, in some cases, did not retain the support used at the time of rating. Per OPM’s Community Rating Guidelines, benefit loadings for ACR methodologies are to include benefits (and adjust for benefits) not included in the claims data; however, the benefits listed in Table I and Table II were incorrectly accounted for or missing support in all premium rate developments in our audit scope.

Table I: Benefit Adjustment Factors Not Accounted for in Premium Rates

Benefit Option	Medical or Pharmacy Benefit	Change Period	Benefit	Plan's Adjustment	Audited Adjustment
CDHP	Pharmacy	2018 to 2019	INN OOP Max ^[1]		
Value	Pharmacy	2018 to 2019	INN OOP Max ^[1]		
CDHP	Medical	2019 to 2020	Deductible TIF to Embedded ^[2]		
Value	Medical	2019 to 2020	Deductible TIF to Embedded ^[2]		

^[1] In-network out-of-pocket maximum

^[2] True Family (Non-Embedded) type deductible to Embedded type deductible

Table II: Benefit Adjustment Factors Missing Original Support

Benefit Option	Medical/Pharmacy Benefit	Change Period	Benefit	Plan's Original Adjustment	Audited (Recreated Plan Support)
CDHP	Medical	2018 to 2019	INN OOP Max ^[3]	████████	████████
CDHP	Medical	2018 to 2019	INN and OON OOP Max not cross accumulating ^[4]	████████	████████
CDHP	Medical	2018 to 2019	OON Deductible ^[5]	████████	████████
Value	Medical	2018 to 2019	INN and OON OOP Max not cross accumulating ^[4]	████████	████████
Value	Medical	2018 to 2019	INN OOP Max ^[3]	████████	████████
Value	Medical	2018 to 2019	Remove maternity cost share waiver	████████	████████
CDHP	Pharmacy	2018 to 2019	Specialty on First Fill	████████	████████
Value	Pharmacy	2018 to 2019	Specialty on First Fill	████████	████████
CDHP	Pharmacy	2019 to 2020	INN OOP Max ^[3]	████████	████████
Value	Pharmacy	2019 to 2020	INN OOP Max ^[3]	████████	████████

^[3] In-network out-of-pocket maximum
^[4] In-network and out-of-network out-of-pocket maximum not cross accumulating
^[5] Out-of-network deductible

The Plan explained during the audit process that due to the unique benefits contracted by the FEHBP, the Plan underwriters request that the Custom Actuarial Team price some of the benefits that the underwriting pricing tool cannot accommodate. The benefit adjustments from the Custom Actuarial Team were included in the 2020 FEHBP premium rate developments, but the Plan did not ensure that the correct benefits were included in final benefit adjustment factors and the source of the benefit adjustment factors was not stored for audit as prescribed in Contract Section 1.11, which states, “the [Plan] shall maintain and the [OPM OIG] shall have the right to examine and audit all books and records relating to the contract for purposes of the [OIG’s] determination of the [Plan’s] compliance with the terms of the contract, including its payment ... and performance provisions. The [Plan] shall make available at its office at all reasonable times those books and records for examination and audit for the record retention period specified in the Federal Employees Health Benefits Acquisition Regulation (FEHBAR), 48 CFR 1652.204-70.” By not having the source of the benefit adjustment data available for review, we are unable to validate the Plan’s numbers used in their calculation and had to recalculate the factor with the available data as a remedy.

As a result of our review, we adjusted for applicable benefit changes in the claims experience in accordance with the benefits listed in the FEHBP benefit brochure. In instances where documentation used at the time of rating was unavailable, we utilized the Plan’s recreated

support. Overall, we determined the benefit adjustment issues did not materially impact the premium rates charged to the FEHBP; therefore, this finding is procedural in nature. Nonetheless, due to the benefit errors identified throughout our review and the multiple iterations of benefit adjustment support, we determined the Plan's controls governing the calculation and application of FEHBP benefit adjustment factors were insufficient to meet the terms of the Contract 5.64(c)(2), which requires the Plan to establish an internal control system to facilitate timely discovery of contract compliance issues and promptly institute and carry out corrective action. If updated and enhanced FEHBP-specific policies and procedures are not implemented to strengthen internal controls, the Plan will continue to be in non-compliance with the Contract and FEHBP rules and regulations.

Recommendation 1:

We recommend that the Plan strengthen internal controls over the FEHBP premium rate development process by developing written FEHBP-specific policies and procedures related to the calculation and application of benefit adjustment factors.

Recommendation 2:

We recommend that the Plan implement a benefit adjustment verification process to ensure all contract benefits listed in the FEHBP benefit brochure are correctly accounted for and supported in the premium rate development, especially in instances where Plan personnel outside the underwriting department are solicited to calculate the benefit adjustment factors.

Recommendation 3:

We recommend that the Plan maintain all documentation supporting the FEHBP premium rate development, including benefit adjustment factor support used at the time of rating, as prescribed in Contract Section 1.11.

Plan's Response:

The Plan agreed with the factual accuracy of the audit issue and the recommendations discussed above. Specifically, the Plan stated, "Aetna has enhanced its policies and procedures for calculating the benefit adjustment factors to ensure all changes are accounted for and for maintaining adequate support from the underwriting pricing tools and actuarial team at the time of the rate proposal."

OIG Comment:

The Plan did not submit its enhanced policies and procedures and as such, we cannot confirm if the enhancements address the findings and recommendations. We will assess the effectiveness of the updated policies and procedures during future audits of the Plan's FEHBP premium rate developments.

2. Carrier Letter 2013-14, Health Insurance Provider Fee, Compliance Issues

During our review of the 2020 FEHBP premium rate developments for plan codes EP, F5, G5, H4, and JS, we determined that the Plan's loading of the Patient Protection and Affordable Care Act (ACA) Section § 9010 Health Insurance Providers Fee (HIPF) to the premium rates was not compliant with Carrier Letter (CL) 2013-14. Specifically, CL 2013-14 states, "OPM has determined that the portion of the section 9010 Providers Fee paid that is attributable to its FEHB business will be an allowable cost to the FEHB Program ..."; however, the Plan's 2020 HIPF premium rate loading calculation and fee was based on premiums from 39 different Aetna legal entities, the majority of which are not attributable to FEHB business.

Although the Plan applied the HIPF loading consistently to other large group rating models, the expense could not be specifically attributable to FEHB business per the terms of CL 2013-14. As such, we completed a test to assess the reasonableness of the HIPF loading for all plan codes in our scope. Utilizing the premium information reported by the Plan on the 2018 Internal Revenue Service Form 8963 and the HIPF fee reported in the 2018 Aetna Life Insurance Company (ALIC) financial statements, which is the legal entity that holds Contract 2938 with OPM, we estimated the amount of HIPF attributable to the plan codes in our scope. We then applied a gross-up factor based on future Federal and state tax assumptions, in the same manner that the Plan calculated the HIPF loading. The results of the test showed that the amount of HIPF tax loaded to the 2020 FEHBP rates, for the plan codes in our scope combined, was reasonable. As such, there are no questioned costs related to this issue and we are not making a recommendation since the HIPF was discontinued for contract year 2021 and beyond.

Plan's Response:

The Plan does not agree with the OIG's position on this finding. Specifically, the Plan states, "In developing its annual premiums, Aetna's FEHB underwriting team follows the National Accounts pricing methodologies. To suggest an alternate method for one component of the rate development would be inconsistent and risk bringing into

question all rating methodologies. Furthermore, the FEHB follows HHS guidelines for its MLR calculations. Aetna’s method for calculating one overall HIF for all wholly owned legal entities is compliant with HHS and IRS guidelines.

OIG’s ... [recommended methodology], however, would require two entirely separate calculations for the HIF; a calculation of one overall HIF for all wholly owned legal entities, including those with FEHBP business for all commercial group’s rate developments and HHS MLR calculations; and a second calculation of a separate HIF for only the wholly owned legal entities with FEHBP business for the FEHBP rate developments. Additionally, to meet OIG’s ...[recommended methodology], Aetna would be required to identify the specific legal entity and situs of every single customer to ensure only those with the same parameters were included in the FEHBP-specific calculation. This creates a cumbersome process that would be nearly impossible to complete with reasonable accuracy.”

OIG Comment:

We agree that it is cumbersome to determine the FEHBP’s portion of the HIF fee in cases where a Carrier is part of a complicated corporate structure, like the Plan; however, CL 2013-14 states that only the portion of the HIF fee attributable to FEHB business can be considered an allowable expense. Since the HIF fee assessed by the IRS is calculated based on premiums from 39 Aetna legal entities (in 2018), the majority of which are unrelated to FEHBP plan codes, the overall fee cannot be considered “attributable to its FEHB business.” Although we found that the combined total of the fee loaded to the FEHBP premium rate developments in our audit scope was reasonable, the methodology used to determine the HIF loading was not in compliance with CL 2013-14.

3. Medical Claims Review

We reviewed a judgmental sample of 50 medical claims (Exhibit A) to determine if the Plan priced and paid the claims for eligible members according to applicable criteria. Our review did not disclose any reportable issues.

Exhibit A

Aetna HealthFund CDHP and Value Plan Medical Claims Sample Selection Criteria and Methodology

Medical Claims Review Area	Universe of Unique Claims (Number)	Universe (Dollars)	Sample Criteria	Sample (Number)	Sample (Dollars)	Results Projected to the Universe?
FEHBP Plan Code F5 CDHP Medical claims incurred 03/1/2018 through 2/28/2019	275,638	\$39,649,781	Isolated CDHP Inpatient Claims and sorted by high dollar. Selected the first 10 unique patient IDs.	10	\$872,116	No
			Isolated CDHP Outpatient Claims and sorted by high dollar. Selected the first 10 unique patient IDs.	10	\$426,981	
			Isolated CDHP Physician Claims and sorted by high dollar. Selected the first 5 unique patient IDs.	5	\$397,123	
			Total FEHBP (Plan Code F5) CDHP Samples	25	\$1,696,220	
FEHBP Plan Code F5 Value Option Medical claims incurred 03/1/2018 through 2/28/2019	222,523	\$36,965,581	Isolated Value Inpatient Claims and sorted by high dollar. Selected the first 5 unique patient IDs.	5	\$810,746	No
			Isolated Value Outpatient Claims and sorted by high dollar. Selected the first 10 unique patient IDs.	10	\$276,284	
			Isolated Value Physician Claims and sorted by high dollar. Selected the first 10 unique patient IDs.	10	\$346,934	
			Total FEHBP (Plan Code F5) Value Option Samples	25	\$1,433,964	
Total FEHBP Claim Samples	498,161	\$76,615,362	Total FEHBP (Plan Code F5) CDHP and Value Option Samples	50	\$3,130,184	No

Appendix



1425 Union Meeting Road
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Received by the OIG on June 24, 2022

David C. Rotay
Executive Director FEHBP
Underwriting
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Email: RotayD@aetna.com

Mr. Matthew Knupp
Chief, Community-Rated Audits Group
U.S. Office of Personnel Management
Office of the Inspector General
800 Cranberry Woods Drive, Ste 270
Cranberry Township, PA 16066

Re: Audit of Aetna HealthFund – CDHP & Value
Contract Number CS 1766 – Plan Codes EP, F5, G5, H4, JS
Report No. 1C-99-00-21-029

Dear Mr. Knupp:

Thank you for the opportunity to respond to the draft audit report dated May 10, 2022. After careful review of the draft report, we agree with recommendations 1 -3 of the draft report. However, we respectfully disagree with OIG's findings that the Plan's development of the HIPF loading was not in compliance with Carrier Letter 2013-14.

Please see the attached response in support of Aetna HealthFund's position. We would also like to request another meeting with OIG to review the HIPF loading's development. If you are agreeable to this request, we will schedule a meeting accordingly.

If you have any questions as you review our response, please contact me.

Sincerely,

A handwritten signature in black ink that reads "D.C. Rotay".

David C. Rotay
Executive Director

Deleted by the OIG – Not Relevant to the Final Report

Response to Draft Report dated May 10, 2022

**Audit of Aetna HealthFund – CDHP/Value
Blue Bell, Pennsylvania**

Report No. 1C-99-00-21-029

Draft Report Recommendations:

Recommendation 1

We recommend that the Plan strengthen internal controls over the FEHBP premium rate development process by developing written FEHBP-specific policies and procedures related to the calculation and application of benefit adjustment factors.

Recommendation 2

We recommend the Plan implement a benefit adjustment verification process to ensure all contract benefits listed in the FEHBP benefit brochure are correctly accounted for and supported in the premium rate development, especially in instances where Plan personnel, outside the underwriting department, are solicited to calculate the benefit adjustment factors.

Recommendation 3

We recommend the Plan maintain all documentation supporting the FEHBP premium rate development, including benefit adjustment factor support used at the time of rating as prescribed in Contract Section 1.11.

Carrier Letter 2013-14, Health Insurance Provider Fee, Compliance Issues

During our review of the 2020 FEHBP premium rate developments for plan codes EP, F5, G5, H4, and JS, we determined that the Plan's loading of the Patient Protection and Affordable Care (ACA) Section § 9010 Health Insurance Providers Fee (HIPF) to the premium rates was not compliant with Carrier Letter (CL) 2013-14. Specifically, CL 2-13-14 states, "OPM has determined that the portion of the section 9010 Providers Fee paid that is attributable to its FEHBP business will be an allowable cost to the FEHB Program...", however, the Plan's 2020 HIPF premium rate loading calculation and fee was based on premiums from 39 different Aetna legal entities, the majority of which are not attributable to FEHB business.

Although the Plan applied the HIPF loading consistently to other large group rating models, the expense could not be specifically attributable to FEHBP business per the terms of CL 2013-14. As such, we completed a test to assess the reasonableness of the HIPF loading for all plan codes in our scope. Utilizing the premium information reported by the Plan on the 2018 Internal Revenue Service Form 8963 and the HIPF fee reporting in the 2018 Aetna Life Insurance Company (ALIC) financial statements, which is the legal entity that holds Contract 2938 with OPM, we estimated the amount of HIPF attributable to the plan codes in our scope. We then applied a gross-up factor based on future federal and state tax assumptions, in the same manner that the Plan calculated the HIPF loading. The results of the test showed that the amount of HIPF tax loaded to the 2020 FEHBP rates, for the plan codes in our scope combined, was reasonable. As such, there are no questioned costs related to this issue and we are not making a recommendation since the HIPF was discontinued for contract year 2021 and beyond.

Response:

Recommendation 1

Aetna agrees with the finding pertaining to the benefit adjustment calculations and support. Aetna has enhanced its policies and procedures for calculating the benefit adjustment factors to ensure all changes are accounted for and for maintaining adequate support from the underwriting pricing tools and actuarial team at the time of the rate proposal.

Recommendation 2

Aetna agrees with the finding pertaining to the benefit adjustment calculations and support. Aetna has enhanced its policies and procedures for calculating the benefit adjustment factors to ensure all changes are accounted for and for maintaining adequate support from the underwriting pricing tools and actuarial team at the time of the rate proposal.

Recommendation 3

Aetna agrees with the finding pertaining to the benefit adjustment calculations and support. Aetna has enhanced its policies and procedures for calculating the benefit adjustment factors to ensure all changes are accounted for and for maintaining adequate support from the underwriting pricing tools and actuarial team at the time of the rate proposal.


Carrier Letter 2013-14, Health Insurance Provider Fee, Compliance Issues



Aetna does not agree with the OIG's position on the development and application of the Health Insurance Fee (HIF) to its FEHBP 2020 rate development.

In developing its annual premiums, Aetna's FEHB underwriting team follows the National Accounts pricing methodologies. To suggest an alternate method for one component of the rate development would be inconsistent and risk bringing into question all rating methodologies. Furthermore, the FEHB follows HHS guidelines for its MLR calculations. Aetna's method for calculating one overall HIF for all wholly owned legal entities is compliant with HHS and IRS guidelines.

OIG's recommendation, however, would require two entirely separate calculations for the HIF; a calculation of one overall HIF for all wholly owned legal entities, including those with FEHBP business for all commercial group's rate developments and HHS MLR calculations; and a second calculation of a separate HIF for only the wholly owned legal entities with FEHBP business for the FEHBP rate developments. Additionally, to meet OIG's recommendations, Aetna would be required to identify the specific legal entity and situs of every single customer to ensure only those with the same parameters were included in the FEHBP-specific calculation. This creates a cumbersome process that would be nearly impossible to complete with reasonable accuracy.

As explained during the audit, Aetna's process for calculating the HIF is as follows:

- 
- At the time of setting the [REDACTED] HIF factor, the latest available market premium figure was \$713.0B that the IRS published in August 2018. This represented the market as of 2017 and it was used to determine the 2018 HIF allocation.
 - The 2018 HIF Market premium data was not available, since there is no HIF filing in 2019 (Form 8963) due to 2019 HIF suspension
 - HIF was suspended again for one year, in calendar year 2019. Prior one year suspension was in calendar year 2017.
 - HIF liability was scheduled to return in 2020
 - The 2018 Industry-wide HIF liability was \$14.3 billion
 - Unlike in prior years, the 2020 industry-wide HIF liability to be collected was not determined in advance. It was going to be allocated to insurers based on their 2019 market share.
 - The 2018 HIF Aetna's HIF expense rate was [REDACTED] before gross up for taxes.
 - The HIF assessment is paid with after-tax dollars. Each company has its own tax rate, Aetna's tax rate was approx. [REDACTED] when factoring in federal and state level taxes. This generated a gross up factor of [REDACTED].
 - Applying this gross up factor to the HIF expense rate we get [REDACTED] calculated as a premium load.



Per Carrier Letter 2013-14, "OPM has determined that the portion of the section 9010 Providers Fee paid that is attributable to its FEHB business will be an allowable cost to the FEHB Program as an expense to the "overall operation of the business" of providing health insurance according to the FEHB Contract Section 3.2(b)(2)(iii)." Aetna calculated expenses in a similar fashion, by setting the expense total at the enterprise level and allocating that total downstream to its business segments. Aetna's process for calculating one HIF for its wholly owned legal entities accounts for the weight of all customers and develops an appropriate factor to account for the cost for the overall operation of the FEHB business and all applicable plan sponsors in a fair and equitable manner.

We look forward to discussing this finding in more detail before the final audit report's completion.



Report Fraud, Waste, and Mismanagement

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