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

Final Audit Report

AUDIT OF THE FEDERAL EMPLOYEE HEALTH BENEFIT OPERATIONS AT GEISINGER HEALTH PLAN

Report Number 1C-GG-00-20-025
June 15, 2021

EXECUTIVE SUMMARY

Audit of the Federal Employees Health Benefits Program Operations at Geisinger Health Plan

Report No. 1C-GG-00-20-025 **June 15, 2021**

Why Did We Conduct the Audit?

The primary objective of the audit was to determine if Geisinger Health 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) and whether the Plan met the Medical Loss Ratio (MLR) requirements and thresholds established by OPM.

What Did We Audit?

Under Contract CS 2911, the Office of the Inspector General (OIG) completed a performance audit of the FEHBP premium rate developments and FEHBP MLR submissions for contract years 2014 through 2016. We conducted our audit fieldwork remotely from July 20, 2020, through December 17, 2020.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

We determined that portions of the 2014 through 2016 FEHBP premium rate developments and MLR filings were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM. As such, this report questions $553,257 for defective pricing in contract years 2014 through 2016, including $68,567 for related lost investment income. The reduction in premium rates, as well as additional reporting errors identified, led to understated MLR penalties of $60,203 and $59,593 in contract years 2015 and 2016, respectively. Specifically, our audit identified the following:

- The Plan used inaccurate completion factors, erroneous benefit adjustment factors, and unallowable capitation costs in its 2014 through 2016 rate developments.
- The Plan did not remove FEHBP members who have primary Medicare coverage when calculating the Transitional Reinsurance Fee (TRF) in the 2014 through 2016 rate developments.
- The Plan incorrectly allocated unallowable expenses to the FEHBP MLR.
- The Plan reported incorrect medical and pharmacy claims expenses in its MLR.
- The Plan allocated capitation expenses to the FEHBP MLR rather than reporting actual expenses.
- The Plan did not calculate the Patient Centered Outcome Research Institute and TRF taxes reported on its FEHBP MLR in accordance with applicable criteria.
- The Plan incorrectly processed and paid FEHBP medical claims.
- The Plan did not have sufficient internal controls over the FEHBP MLR and premium rate developments.
- The Plan provided an incorrect 2014 premium rate development to the auditors as the basis for their initial analysis, upon which we performed significant audit work.

ABBREVIATIONS

ACA	**Affordable Care Act**
ACR	**Adjusted Community Rate**
CFR	**Code of Federal Regulations**
Contract	**Contract CS 2911**
DME	**Durable Medical Equipment**
FEHBAR	**Federal Employee Health Benefits Acquisition Regulation**
FEHBP	**Federal Employees Health Benefits Program**
FFS	**Fee-for-Service**
GL	**General Ledger**
IBNR	**Incurred but Not Reported**
LII	**Lost Investment Income**
LOB	**Line of Business**
MLR	**Medical Loss Ratio**
OIG	**Office of the Inspector General**
OOP	**Out-of-Pocket**
OPM	**U.S. Office of Personnel Management**
PCORI	**Patient Centered Outcome Research Institute**
PCP	**Primary Care Physician**
Plan	**Geisinger Health Plan**
PMPM	**Per Member Per Month**
QHI	**Quality Health Improvement**
SSSG	**Similarly-Sized Subscriber Group**
TRF	**Transitional Reinsurance Fee**

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I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at Geisinger Health Plan (Plan). The audit was conducted pursuant to the provisions of Contract CS 2911 (Contract); 5 United States Code Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract years 2014 through 2016, 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 proportion of FEHBP premiums collected by a carrier that is spent on clinical services and quality health improvements.

The MLR was established to ensure that health plans are meeting specified thresholds for spending on medical care and health care quality improvement measures, and thus limiting spending on administrative costs, such as executive salaries, overhead, and marketing of the health plan. However, in our opinion the FEHBP MLR is not as transparent as intended and does not provide an assessment of the fairness of the premium paid for benefits received. As this continues to be a significant Program concern for us, we are addressing this issue with OPM through other channels.

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

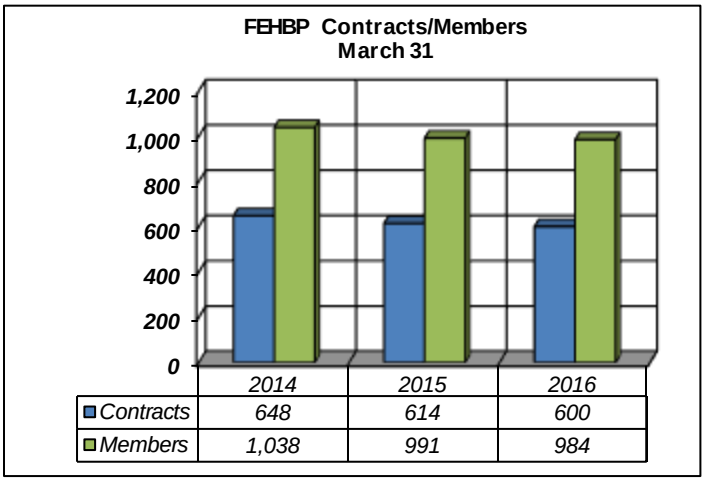
Starting with the pilot program in 2012 and for all non-traditional community-rated FEHBP carriers in 2013, OPM required the carriers to submit an FEHBP-specific MLR. This FEHBP-specific MLR calculation required carriers to report information related to earned premiums and expenditures in various categories, including reimbursement for clinical services provided to enrollees, activities that improve health care quality, and all other non-claims costs. If a carrier

fails to meet the FEHBP-specific MLR threshold, it must make a subsidization penalty payment to OPM within 60 days of notification of amounts due.

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

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

The number of FEHBP contracts and members reported by the Plan as of March 31 for each contract year audited is shown in the chart to the right.



The Plan has participated in the FEHBP since 2007 and provides health benefits to FEHBP members in the Northeastern, Central, and South Central regions of Pennsylvania. It is a health maintenance organization that offers FEHBP members a standard enrollment choice. This is the first audit of the Plan's MLR submissions; however, a previous premium rate audit of contract years 2008, 2009, 2011 and 2012 identified inappropriate health benefit charges to the FEHBP for contract years 2008, 2011, and 2012. The final audit report was issued in May of 2014, and all issues were resolved by OPM. These issues were considered in the planning and completion of this audit.

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

II. OBJECTIVES, SCOPE, AND METHODOLOGY

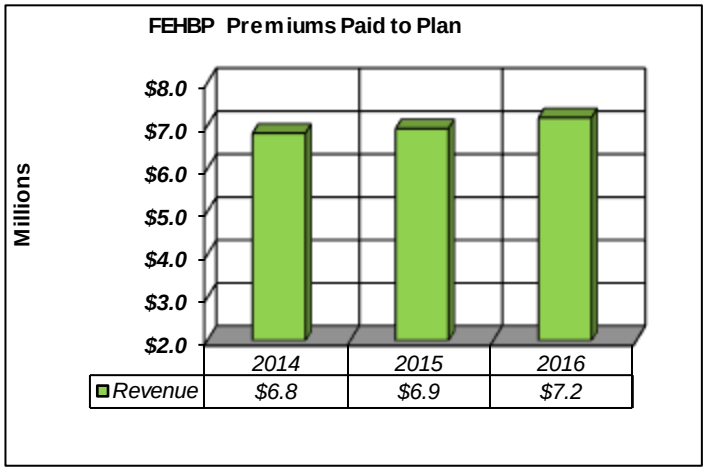
OBJECTIVES

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

SCOPE

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

This performance audit covered contract years 2014 through 2016. For these years, the FEHBP paid approximately $20.9 million in premiums to the Plan.



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

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

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

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

the available data was sufficient to achieve our audit objectives. Except as noted above, the audit was conducted in accordance with generally accepted government auditing standards, issued by the Comptroller General of the United States.

We remotely conducted our audit fieldwork from July 20, 2020, through December 17, 2020.

METHODOLOGY

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

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

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

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. Premium Rate Review

Carriers proposing rates to OPM are required to submit a Certificate of Accurate Pricing certifying that the cost or pricing data submitted in support of the FEHBP rates were developed in accordance with the requirements of 48 CFR, Chapter 16 and the Contract. During our premium rate review, we found that the Certificates of Accurate Pricing that the Plan signed for contract years 2014 through 2016 were defective. In accordance with Federal regulations, the FEHBP is, therefore, due a rate reduction for contract years 2014 through 2016 of $484,690 and Lost Investment Income (LII) of $68,567, for a total amount due to OPM of $553,257 (see Exhibit B).

1. Defective Pricing $484,690

During our review of the Plan's 2014 through 2016 premium rate developments, we identified issues that resulted in a lower audited premium rate than the Plan submitted. This resulted in defective pricing in each year, as illustrated in Table I.

Table 1 – Defective Pricing

Year	Plan's Premium	Audited Premium	Defective Pricing
2014	$6,836,572	$6,639,687	$196,885
2015	$6,867,717	$6,723,296	$144,421
2016	$7,173,589	$7,030,206	$143,384
		Total Defective Pricing	**$484,690**

The specific issues that resulted in the defective pricing findings under the provisions of Contract Section 3.3 are discussed in paragraphs A.1.a through A.1.d of this report.

a. Inaccurate Completion Factors

In response to the draft audit report, the Plan stated that an incorrect version of the 2014 FEHBP rate development workbook was provided to the audit team during the audit as support for the premium rates. The Plan provided an updated version of the 2014 FEHBP rate development workbook as part of its response to the draft report.

The FEHBP completion factors were overstated due to the Plan erroneously adjusting for an increase in retirees and age and gender factors.

Within the updated version of the 2014 FEHBP rate development workbook, the completion factors were higher than those shown in the originally provided version. Part of our review of the updated version of the 2014 rate development workbook included selecting two large group plans that used the same experience period as the FEHBP and were rated around the same time as the FEHBP for the 2014 calendar year to ensure consistent application of the rating model factors. Based on our review, we determined

the inpatient, outpatient, and professional completion factors applied to the FEHBP's recent experience period medical claims were higher than the other large group completion factors.

The 2014 Community Rating Guidelines stipulate that carriers using a claims-based adjusted community rate (ACR) method must follow certain rules, including that any method used to convert paid claims to incurred claims must be consistent for all claims-based ACR rated groups.

The Plan explained that it increased the completion factors applied to the recent experience period in the 2014 rate development to account for an increase in retirees and an increase in the age and gender factor that was applicable to the FEHBP. The Plan noted that there was no specific place in the 2014 renewal calculation to reflect this change in risk, so the completion factors were adjusted.

The Plan's rate development does utilize an age and gender factor; however, that factor is used in the manual rating of the FEHBP, which is not applicable to the rates since the FEHBP is 100 percent ACR rated. Further, the Plan's manual rating of the FEHBP shows a lesser rate, including the age and gender factor, than that reflected by the FEHBP experience rating. In addition, the rate development template utilized by the Plan for all large groups does not include a formula to escalate the completion factors calculated on the book of business for such things as a change in age and gender factors or an increase in retirees. In fact, it is unclear how the Plan would derive a completion factor that accurately accounts for such a change.

As a result, we adjusted the Plan's completion factors for inpatient, outpatient, and professional claims applicable to the recent experience period used in the 2014 rate development. These factors were adjusted to be consistent with the other large groups that are rated using a 100 percent claims-based ACR rate model.

b. <u>Erroneous Benefit Adjustments</u>

The Plan erroneously adjusted the FEHBP premium rates in contract years 2014 through 2016 to account for benefit adjustments that did not occur. Specifically, the Plan applied a benefit adjustment factor to the claims experience used in the FEHBP rate developments to adjust for an increased out-of-pocket (OOP) maximum.

Federal Employees Health Benefits Acquisition Regulation (FEHBAR) Part 1602.170-2(b) states that the ACR is a prospective community rate that is adjusted for the expected use of medical resources.

Based on the FEHBP benefit brochures, the OOP maximum did not increase in these years. The Plan made this prospective adjustment under the mistaken assumption that the

OOP maximum had changed for all groups, including the FEHBP, and it did not have sufficient internal controls over the rate development process to detect the errors.

As a result, the Plan inflated the FEHBP premium rates for contract years 2014 through 2016.

c. Unsupported and Unallowable Capitation Expenses

The Plan included unallowable capitation expenses as part of the total 2014 net claims experience used in the Plan's 2016 rate development. As a result of the issues, which will be discussed in paragraphs A.1.c.i through A.1.c.iii below, we determined approximately 85.6 percent of the reported capitations in the 2014 claims experience were allowable and supported. We applied the 85.6 percent rate of allowance from the results of our review of the 2014 capitation experience period to the experience periods used in each rate development and determined the total audited questioned capitations for each year, as detailed in Table II.

Table II – Unallowable Capitation Expenses

Rating Period	Experience Period	Capitations Expense in Rate Development	Audit Calculated Capitations	Variance
2014	2/1/11 – 1/31/12	$296,969	$254,206	$42,764
	2/1/12 – 1/31/13	$231,078	$197,803	$33,275
2015	1/1/12 – 12/31/12	$288,558	$247,006	$41,552
	1/1/13 – 12/31/13	$327,063	$279,966	$47,097
2016	1/1/13 – 12/31/13	$319,276	$273,300	$45,976
	1/1/14 – 12/31/14	$349,064	$298,659	$50,404

i. Unallowable Capitation Expenses

The Plan included capitation expenses for a high-end radiology vendor that represented payment for an administrative expense for utilization management, not for provision of services or payment of claims. Providers within the Plan's network rendered the high-end radiology services, and the Plan paid the claims, which were captured in the fee-for-service (FFS) medical claims data used for the rate development.

OPM Carrier Letter 2015-09 allows Plans to include claims expenses and administrative expenses when determining premium rates. However, administrative expenses are identified as a loading separate from claims expenses.

The Plan elected to report the high-end radiology payments as capitation expenses because the costs were based on a per member per month (PMPM) rate, which aligns with traditional capitation expenses. Due to the claims for high-end radiology being included in the FFS claims data used in the rate development, the Plan should not have included the payments as capitation expenses in the rate developments.

The Plan included payments to a high-end radiology vendor that represented payment for an administrative expense, which overstated the FEHBP premium rates.

The Plan's inclusion of the capitated expenses for this provider overstated the FEHBP premium rates.

ii. Unallowable Non-FEHBP Benefits

The Plan included capitation expenses for the Healthy Lifestyle Reimbursement program and the ConnectYourCare vendor, which administers HRAs, HSAs, and FSAs, despite the FEHBP benefit brochure stating that these programs are not part of the member's premium or benefits, respectively.

OPM Contract Section 2.2(a) states, "The Carrier shall provide the Benefits as described in the agreed upon brochure text … ." The FEHBP benefit brochure confirmed that the healthy rewards reimbursement and the flexible spending account program were not part of the member's premium or benefits.

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

As a result, the Plan inflated the FEHBP premium rates for contract years 2014 through 2016.

iii. Unallowable Non-Claims Cost

The Plan included expenses paid to its reinsurance provider as a capitation expense in its 2014 claims experience. Per the 2014 through 2016 OPM Rate Instructions, premium rates should be developed based on actual FEHBP claims data. Reinsurance premiums are not direct paid claims and do not represent compensation for or reimbursement of covered services provided to an enrollee. Therefore, reinsurance premiums should not be included in the claims data used in the Plan's rate model.

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

As a result, the Plan inflated the FEHBP premium rates for contract years 2014 through 2016.

d. Medicare Primary Members in TRF Calculation for Premium Rates

The Plan did not remove FEHBP members who have Medicare as their primary coverage when calculating the PMPM rate for the Transitional Reinsurance Fee (TRF) in the 2014 through 2016 rate developments.

OPM's Reconciliation Instructions for 2014, 2015, and 2016 require a carrier to adjust its TRF loading to recognize that the TRF is not applicable for those FEHBP members whose Medicare coverage was primary.

The Plan erroneously included Medicare primary members in its TRF calculation for the years 2014 through 2016.

The Plan was not aware that the TRF is not applicable to members who have primary Medicare coverage. As a result, the Plan was not in compliance with OPM's Reconciliation Instructions. In addition, the inclusion of FEHBP members with Medicare as primary in the calculation of the tax expense that is not applicable to those members may lead to an overstated premium.

Recommendation 1

We recommend that the Contracting Officer require the Plan to return $484,960 to the FEHBP for defective pricing in contract years 2014 through 2016.

Plan Response:

The Plan disagreed with the recommendation and provided contracts applicable to its reinsurance provider to support the reinsurance expense included in the capitations used in the 2016 rate development.

OIG Comment:

We reviewed the Plan's reinsurance contracts and recalculated the applicable expense to the FEHBP. However, the Plan did not address that the capitated reinsurance expenses are not claims costs. In addition, due to the very general description of what is incorporated into the administrative factor applied in the rate development, we are unable to determine if the reinsurance expense is also reflected in that charge. Therefore, we continue to question the reinsurance expense included in the Plan's capitations. The Plan did not address the other findings that led to Recommendation 1.

Recommendation 2

We recommend that the Plan develop written procedures to ensure that only applicable benefit adjustments are made to the FEHBP rate developments.

Plan Response:

The Plan agreed with the recommendation and noted that there was an error in the rating worksheet used for the 2014 through 2016 rate renewals, which was corrected for the 2017 rate renewals. The Plan also noted that the Underwriting Manager will review the FEHBP rates with the Underwriter to ensure erroneous adjustments are not applied to the FEHBP rates.

OIG Comment:

We agree the Plan should ensure the Underwriting Manager reviews the FEHBP rates with the Underwriter to ensure no adjustments were applied in error. Multi-level reviews are a welcome control to ensure erroneous items have a greater chance of being identified and corrected during the review process. Also, we urge the Plan to document the enhancements to the process in a written policy or procedure, which should also list the unique requirements of the FEHBP rates to ensure compliance with applicable criteria. Documenting the process in a policy or procedure would ensure that an Underwriter or Underwriting Manager were aware of the process and the requirements of the FEHBP, even if they were not part of the FEHBP rate development process during previous years. It would also ensure continuity of operations in the event of staffing turnover. The OPM OIG will review the 2017 renewal rating models during a future audit.

Recommendation 3

We recommend that the Plan develop written policies and procedures over the FEHBP rate development process that will strengthen process controls and assist in detecting and preventing errors, as well as ensure compliance with all applicable criteria when preparing the FEHBP rates.

Plan Response:

The Plan agreed with the recommendation. It noted that the Underwriter will meet with the Underwriting Manager and any other responsible parties to ensure erroneous adjustments are not applied to the FEHBP rates.

OIG Comment:

We agree the Plan should ensure the Underwriting Manager reviews the FEHBP rates with the Underwriter to ensure no adjustments were applied in error. Also, we urge the Plan to document the enhancements to the process in a written policy or procedure, which should

also list the unique requirements of the FEHBP rates to ensure compliance with applicable criteria. Documenting the information in a policy or procedure would ensure that an Underwriter or Underwriting Manager was aware of the process and the requirements of the FEHBP, even if they were not part of the FEHBP rate development process during previous years.

Recommendation 4

We recommend that the Plan ensure its FEHBP completion factors are consistent with other groups that are also claims-based ACR rated, as required by OPM's Community Rating Guidelines.

Plan Response:

The Plan agreed with the recommendation and noted that it will ensure the completion factors applied to the FEHBP are consistent with those used for its other claims-based ACR rated groups.

2. Lost Investment Income $68,567

In accordance with the FEHBP regulations and the Contract, the FEHBP is entitled to recover LII on the defective pricing findings in contract years 2014, 2015, and 2016. We determined that the FEHBP is due $68,567 for LII, calculated through May 31, 2021 (see Exhibit D). In addition, the FEHBP is entitled to LII for the period beginning June 1, 2021, until all defective pricing finding amounts have been returned to the FEHBP.

The FEHBP is due $68,567 for Lost Investment Income resulting from the defective pricing issues.

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

Recommendation 5

We recommend that the Contracting Officer require the Plan to return $68,567 to the FEHBP for LII, calculated through May 31, 2021. We also recommend that the Contracting Officer

recover LII on amounts due for the period beginning June 1, 2021, until all defective pricing amounts have been returned to the FEHBP.

Plan Response:

The Plan disagreed with some of the findings that led to the application of the LII remedy.

OIG Comment:

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

B. Medical Loss Ratio Review

The Certificates of Accurate MLR signed by the Plan for contract years 2014 through 2016 were defective. The Certificate of Accurate MLR states that the FEHBP-specific MLR is accurate, complete, and consistent with the methodology in Sec. 1615.402(c)(3)(ii). In accordance with Federal regulations and the OPM Community Rating Guidelines, our audit identified the following issues:

1. No Credit or Penalty Due

During the 2014 MLR filing period, the Plan calculated an MLR ratio of 86.66 percent, which fell within OPM's prescribed threshold. No penalty was due to OPM nor was a credit due to the Plan. However, our review of the Plan's FEHBP MLR submission disclosed issues within the MLR calculation, such as inaccurate allocation methods, inclusion of unallowable expenses, and the overstatement of premiums discussed in Section A, above. Our audited MLR ratio of 85.45 percent was due to reportable adjustments, although these adjustments were not significant enough to result in a penalty due to OPM or a credit due to the Plan.

2. Understated MLR Penalties

During the 2015 and 2016 FEHBP MLR filing periods, the Plan filed MLRs of 78.78 percent and 75.91 percent, respectively, which were below OPM's prescribed threshold of 85 percent and resulted in a penalty due to OPM. However, our review of the Plan's FEHBP MLR submissions identified issues that resulted in lower audited MLRs than the Plan's original FEHBP MLRs filed with OPM. Our audited MLR ratios were 77.74 percent in 2015 and 74.86 percent in 2016. This resulted in an increase to the Plan's MLR penalties in 2015 and 2016, as illustrated in Table III.

Table III - Understated MLR Penalty					
Year	Plan's MLR Ratio	Audited MLR Ratio	Plan's Current Penalty	Audited Penalty	Understated Penalty
2015	78.78%	77.74%	$424,839	$485,042	$60,203
2016	75.91%	74.86%	$645,834	$705,427	$59,593

Although Table III illustrates MLR variances due to the defective pricing findings, these values are specifically related to the amounts documented in this report. All penalty adjustments will be calculated by OPM after the defective pricing findings are resolved and collected. Any adjustments to the defective pricing findings in this report will also impact the penalty due. The specific issues that led to the penalty adjustments and defective Certificates of Accurate MLR are discussed throughout the remainder of the report.

Recommendation 6

We recommend that the Contracting Officer adjust the Plan's MLR penalty for contract years 2015 and 2016 once the defective pricing findings discussed in this report are resolved.

Plan Response:

The Plan agreed with the recommendation.

3. Inaccurate Allocation Methodologies

The Plan allocated Quality Health Improvement (QHI) expenses, pharmacy rebates, Affordable Care Act (ACA) other medical expenses, and litigation expenses to the FEHBP MLR in 2014 through 2016. Details of the allocations are presented below.

The Plan did not use allocation methodologies that yielded the most accurate results and inaccurately reported its 2014 claims.

a. Quality Health Improvement Expenses

The Plan allocated its QHI expenses to the FEHBP MLR in 2014 through 2016 from the entire book of business using a member month ratio.

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

The Plan surveyed its departments to determine the percentage of its employees' time that related to QHI expenses and identified those QHI expenses during a monthly close-out process. It used these activity-based administrative percentages to allocate the QHI expenses for the entire book of business to its line of business segments. However, the

Plan did not track administrative expenses to the FEHBP. Accordingly, it allocated QHI to the FEHBP MLR based on a member month ratio using the FEHBP member months to total member months. The FEHBP group is part of the large group segment, which is the lowest distinct segment tracked by the Plan. Therefore, it is more accurate to allocate the large group QHI expense, rather than the expense from the entire book of business, using a ratio of FEHBP member months to the large group member months.

Consequently, the Plan did not comply with applicable criteria, which led to FEHBP MLR QHI expenses that were overstated by $100,235 in 2014, $55,936 in 2015, and $44,542 in 2016. These overstated QHI expenses resulted in overstated MLR numerators in each year.

b. Pharmacy Rebates

The Plan allocated its pharmacy rebates based on a member month ratio.

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

The Plan was unable to track pharmacy rebates at the FEHBP level because pharmaceutical companies made adjustments to the claims eligible for rebates after they were submitted by the Plan. However, pharmacy rebates were directly related to pharmacy claims, so an allocation based on pharmacy claims would have been a more accurate methodology.

We recalculated the pharmacy rebates attributable to the FEHBP based on a pharmacy claim allocation and determined the rebates reported in the FEHBP MLR were understated by $29,357 in 2014, $60,730 in 2015, and $44,347 in 2016, which overstated the Plan's claims expenses in the FEHBP MLR numerator.

c. ACA Other Medical Expenses

The Plan allocated other medical expenses from its commercial general ledger, which included ACA individual and ACA small group expenses, to the FEHBP MLR in 2014 through 2016. The allocation methodology was based on a member month ratio that included both ACA individual and ACA small group members.

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

The Plan's allocation methodology did not utilize the lowest level of accounting detail to allocate to the FEHBP MLR. The inclusion of ACA Exchange lines of business in its allocation of other medical expenses to the FEHBP MLR caused the expense to be misstated. Although the misstatement was not material to the FEHBP MLR calculation

in our audited years, the Plan was not in compliance with the applicable criteria. Furthermore, the inclusion of the additional lines of business in the allocation may lead to material misstatements in future years.

d. Allocation of Direct Claims Expense

The Plan allocated direct claims paid to providers as settlement for litigation in its "other medical expense" account in 2014.

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

The Plan stated that it reported the claims in the commercial general ledger (GL) because they were part of a settlement of litigation related to commercial claims for covered services. However, based on documentation provided by the Plan, we were unable to determine whether the allocated claims from the "other medical expense" account were for FEHBP members. While the expense allocated to the FEHBP was not material to the FEHBP MLR calculation, by allocating direct claims to the FEHBP, the Plan was not in compliance with applicable criteria and misstated the claims expense in its 2014 FEHBP MLR.

Recommendation 7

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

Plan Response:

The Plan agreed with the recommendation. It noted that its methodology was updated for the 2019 FEHBP MLR and provided a copy of its 2019 MLR procedures.

Recommendation 8

We recommend that the Plan ensure direct claims are reported, not allocated, on the FEHBP MLR in accordance with 45 CFR 158.140.

Plan Response:

The Plan agreed with this recommendation and stated that it enhanced its FEHBP MLR procedures effective February 2021.

4. Unallowable Expenses

Our audit identified several expenses that were either not allowable or not allocable to the FEHBP, but were reported in the Plan's 2014 through 2016 FEHBP MLR submissions. Details of these expenses are discussed below.

The Plan included unallowable and non-allocable expenses in the FEHBP MLR in 2014 through 2016.

a. Incurred but Not Reported

The Plan allocated incurred but not reported (IBNR) GL expense accounts to the 2014 FEHBP MLR.

The Plan included the IBNR accounts in its allocation of other medical expenses "in order to tie back to the total medical expense in the GL. Since IBNR applies across all lines of business, these expenses were included in the allocation."

OPM Carrier Letter 2013-11 specifies that no completion factor may be applied to the claims in the MLR calculation.

As a result of including the IBNR, the Plan overstated its claims by $52,933 in 2014, which in turn overstated the MLR numerator. Furthermore, the Plan was not in compliance with the applicable criteria due to the inclusion of IBNR.

b. Reinsurance

The Plan allocated reinsurance expenses and reinsurance adjustments to the FEHBP MLR incurred claims. Reinsurance expenses and reinsurance adjustments are not direct paid claims and do not represent compensation or reimbursement for covered services provided to an enrollee.

45 CFR 158.140(b)(3) states that amounts paid to third party vendors for secondary network savings, network development, administrative fees, claims processing, utilization management, and amounts paid to providers for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee must not be included in the incurred claims.

The Plan lacked adequate internal controls to ensure the GL accounts allocated to the FEHBP MLR contained only allowable expenses.

Due to the inclusion of unallowable reinsurance expenses and adjustments, the Plan overstated its expenses in the FEHBP MLR numerator by $25,935 in 2014, $25,822 in 2015, and $35,034 in 2016 and its capitation expense in 2016 by $4,227. In addition, the Plan was not in compliance with 45 CFR 158.140(b)(3).

c. Capitated Vendor Fee

The Plan included a capitated payment that represented an administrative fee for utilization management in its 2014 through 2016 MLR submissions.

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

The capitated payments that represented an administrative fee were for high-end radiology services provided by in-network providers. The Plan paid the claims as FFS medical claims, which were reported in the MLR. As a result, we determined this capitated payment was not representative of actual claims costs.

The Plan did not have documented policies and procedures to identify and remove administrative expenses that were incorporated as capitation expenses in its MLR submissions.

As a result, the Plan overstated its incurred claims reported in the MLR numerator by $11,649 in 2014, $7,594 in 2015 and $32,294 in 2016 for expenses related to the administrative capitated expense.

d. Unallowable Non-Capitated Expense

The Plan allocated a vendor's non-capitated payments from the commercial GL account as other medical expenses to the MLR in 2014 through 2016, even though all of the vendor's non-capitated payments related to the ACA line of business (LOB).

FAR 31.201-4 states, "A cost is allocable if it is assignable or chargeable to one or more cost objectives on the basis of relative benefits received or other equitable relationship."

The Plan explained that both the capitated and non-capitated expenses for the vendor were allocated to the FEHBP because both the capitated and non-capitated expenses apply to the commercial LOB. Since the FEHBP is part of the commercial LOB, the FEHBP was assigned an allocation of those expenses. Due to the fact that the non-capitated payments related to the ACA LOB, we determined it should not have been allocated to the FEHBP.

As a result, the Plan was not in compliance with applicable regulations, which resulted in an overstated other medical expense in the FEHBP MLR of $24,772 in 2014, $28,304 in 2015, and $21,494 in 2016 due to the inclusion of the vendor's non-capitated expenses.

Recommendation 9

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

Plan Response:

The Plan agreed with the recommendation and noted that IBNR was no longer included as of 2015, reinsurance was excluded beginning in 2020, and the vendor that was paid the unallowable non-capitated expense is no longer applicable. In addition, the Plan enhanced its FEHBP MLR procedures effective February 2021.

OIG Comment:

We verified that IBNR was not allocated to the 2015 or 2016 MLR calculation. We will assess if reinsurance was excluded beginning in 2020 and if the vendor that was paid the unallowable non-capitated expense is no longer a vendor during future audits. Additionally, since the Plan enhanced its FEHBP MLR procedures as a result of our audit and outside the audit scope, we will evaluate the effectiveness of any FEHBP MLR process improvements during future audits.

5. MLR Claims Total Variance

The Plan used incorrect medical and pharmacy claim amounts in the 2014 and 2016 MLR submissions.

The Plan had a mapping issue, which created a small variance between the data used to populate the MLR submission and the claims data submitted to the OPM Office of the Inspector General (OIG). The Plan stated that it had corrected the mapping issue in 2017 and that the data submitted to the OPM OIG is the correct claims data.

Per the 2014 and 2016 OPM Community Rating Guidelines, "Only FEHBP claims associated with benefits covered in the plan's FEHB contract may be included in the MLR calculation." Additionally, FEHB claims incurred during the calendar year and paid through June 30th of the following year must be included in the MLR calculation, and other claims will not be considered.

As a result of the error, the Plan's 2014 medical and pharmacy claims were overstated by $4,775[1], and the 2016 pharmacy claims were understated by $5,072.

[1] The medical claims were overstated by $136 and the pharmacy claims were overstated by $4,639.

Recommendation 10

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

Plan Response:

The Plan agreed with the recommendation and noted that the issue was corrected in 2017. The Plan also stated that it enhanced its FEHBP MLR procedure effective February 2021.

OIG Comment:

Since the Plan enhanced its FEHBP MLR procedures as a result of our audit and outside the audit scope, we will evaluate the effectiveness of any FEHBP MLR process improvements during future audits.

6. Application of Defective Pricing Findings to the MLR

As discussed in Section A of this draft report, our audit identified defective pricing findings related to the Plan's premium rates in contract years 2014 through 2016, totaling $484,690. The Community Rating Guidelines state that the denominator of the FEHBP MLR calculation will be equal to the OPM supplied premium income or carrier supplied premium income less any amount recovered from the carrier due to an audit. Therefore, we have removed from the 2014 through 2016 premium amounts $196,885; $144,421; and $143,384, respectively. This in turn reduced the MLR denominators, as illustrated in the variance column in Table I on page 1 of this report.

Recommendation 11

We recommend that the Contracting Officer reduce the Plan's MLR premiums by $196,885 in 2014, $144,421 in 2015, and $143,384 in 2016 for the questioned costs identified in this audit.

Plan Response:

The Plan disagreed with this recommendation based on the disputed premium pricing under recommendation 1.

OIG Comment:

The Plan provided additional support and documentation, which was reviewed as part of the individual findings and recommendations that led to recommendation 1 (see section A.1. of this report). The premium reductions in Recommendation 11 were updated in accordance with our review in section A.1. of this report.

7. Allocated Capitations

The Plan did not report direct capitation expenses in its 2014 through 2016 MLR submissions.

The Plan allocated its capitation expenses reported on the FEHBP MLR because the FEHBP's membership size is insignificant compared to total membership and the Plan does not record data at the FEHBP-specific level.

45 CFR 158.140(a) states that the MLR submissions "must include direct claims paid to or received by providers, including under capitations contracts ... ."

As a result, the total claims reported in the MLR numerator are misstated, which ultimately impacted the accuracy of the FEHBP MLR percentage.

(For additional details, see finding D.1. – Capitated Rates Not Adjusted for Benefits)

Recommendation 12

We recommend that the Plan report direct FEHBP capitation expenses on its future MLR submissions in accordance with 45 CFR 158.140(a).

Plan Response:

The Plan agreed with the recommendation and noted that it tracked capitation expenses at the FEHBP level beginning in 2020.

8. Regulatory Fee Calculation Errors

a. PCORI and TRF Covered Lives Calculation

The Plan did not use an approved method for computing covered lives at the FEHBP level when calculating the Patient Centered Outcome Research Institute (PCORI) and Transitional Reinsurance Fee (TRF) for the 2015 and the TRF for the 2016 FEHBP MLR submissions.

Per 26 CFR 46.4375-1 paragraph (c), the PCORI fee is the average covered lives under the policy for the policy year multiplied by the applicable dollar amount. Determining the average covered lives must follow one of the four methodologies listed in the regulation. 45 CFR 153.405 refers to the covered lives methodology for calculation of the TRF and specifies a choice of several procedures for counting covered lives that the health insurance issuer must follow.

The Plan did not use an approved method for calculating covered lives used in the calculation of PCORI and TRF for its 2015 and 2016 MLR submissions.

The Plan explained it followed the snapshot method for GL reporting purposes, but did not calculate the FEHBP-specific covered lives using the same method. Per 26 CFR 46.4375-1(c)(2)(iv), the snapshot method allows an issuer to determine the average number of lives covered by adding the totals of lives covered on a date during the first, second, or third month of each quarter then dividing that by the number of dates on which a count is made. Although it followed this methodology at the GL level, the Plan simply took its membership multiplied by the applicable fee to determine the FEHBP level expenses.

The Plan did not comply with applicable criteria in its methodology to calculate the 2015 PCORI and TRF taxes and the 2016 TRF tax for the FEHBP.

b. <u>Medicare Primary Members in TRF Calculation</u>

The Plan calculated its TRF for the 2015 and 2016 FEHBP MLR submissions based on a membership report that included all FEHBP members. The Plan did not exclude those FEHBP members who have Medicare as their primary insurance.

45 CFR 153.400(a)(1) states that, "reinsurance contributions are required for major medical coverage that is considered to be part of a commercial book of business, but are not required to be paid more than once with respect to the same covered life. … a contributing entity must make reinsurance contributions for lives covered … except to the extent that … coverage applies to individuals with respect to which benefits under Title XVIII of the Act (Medicare) which are primary under the Medicare Secondary Payor rules ... ."

Furthermore, OPM FEHB Program Carrier Letter No 2013-15 states that "the transitional reinsurance fee will be an allowable cost to the FEHBP … [and that] Carriers are not required to make fee payments for individuals who are enrolled in any part of Medicare if Medicare … coverage (Part A, Part B, or both) is primary."

The Plan stated that it misinterpreted Medicare COB guidance, which states that large group employers, such as the FEHBP, are primary over Medicare. The Plan's interpretation, for the purpose of the tax calculation to the FEHBP, was that the Plan is primary for all FEHBP members. The Plan did not take into account that when an FEHBP member retires and has Medicare, Medicare becomes the primary insurer.

The Plan overstated its TRF on the 2015 and 2016 FEHBP MLR submissions by including FEHBP members who had Medicare as their primary coverage. While the overall impact of the error was immaterial to the MLR calculation in those years, the

error may lead to a material misstatement in future years if a large number of FEHBP members with Medicare as primary coverage are included in the TRF calculation.

Recommendation 13

We recommend that the Plan update its policies and procedures to ensure tax expenses on the FEHBP MLR submission are calculated in accordance with applicable regulations.

Plan Response:

The Plan agreed with the recommendation and noted that it enhanced its FEHBP MLR procedure effective February 2021.

OIG Comment:

Since the Plan enhanced its FEHBP MLR procedures as a result of our audit and outside the audit scope, we will evaluate the effectiveness of any FEHBP MLR process improvements during future audits.

Conclusion-MLR Review

Per the issues discussed above, adjustments were made to the FEHBP MLR submissions. These adjustments resulted in an increase to the Plan's penalty of $60,203 for contract year 2015 and $59,593 in contract year 2016. The adjustments for contract year 2014 were not significant enough to result in a penalty due to OPM or a credit due to the Plan. All penalty adjustments will be calculated by OPM after the defective pricing findings are resolved and collected. Any adjustments to the defective pricing findings in this report will also impact the penalty due.

C. Medical Claims Review

We reviewed a statistical sample of 75 medical claims from 2014 to determine if the Plan priced and paid the claims for eligible members in accordance with applicable criteria. Based on our review, we identified several issues, which are noted below. None of the errors proved to be material enough to remove in the audited premium or MLR reviews, although if left unaddressed, the issues may have a material impact in future years.

1. Emergency Room Copayment Error

The Plan inappropriately applied copayments for six emergency room claims. Specifically, the Plan applied amounts greater than the copayment responsibility listed in the 2014 FEHBP benefit brochure.

Contract Section 2.2(a) requires the Plan to provide benefits defined in the FEHBP benefits brochure. The 2014 FEHBP benefit brochure notes that the member is responsible for copayments, along with a specific copayment amount for emergency room visits.

When the claim covered multiple days of service, the Plan's claims processing system was unable to apply one copayment for the entire claim. Its claim processors performed a manual adjustment to the claim to appropriately apply the copayment. The claim processors did not correctly adjust six claims in 2014.

By applying an incorrect copayment on the claims, the Plan understated its incurred medical claims in 2014, which consequently misstated the MLR numerator and the claims used in the rate developments. In addition, the Plan was not in compliance with Contract Section 2.2(a) and the FEHBP benefit brochure. Furthermore, FEHBP members may have overpaid their copayments for emergency room visits. Without additional information, we cannot determine the full impact to the affected FEHBP members, nor if the claims were subsequently adjusted to reflect the correct payment.

2. Inpatient Coinsurance Error

The Plan incorrectly paid one primary care physician (PCP) inpatient service claim without a member coinsurance responsibility.

The Plan's policy for any PCP ancillary service, including physician evaluations during an inpatient hospital stay, was to pay the claim with no member coinsurance. This is the Plan's policy for all commercial solutions groups.

Contract Section 2.2(a) requires the Plan to provide benefits defined in the FEHBP benefit brochure. The FEHBP benefit brochure notes that the member is responsible for coinsurance. For physician services during an inpatient hospital stay, the applicable coinsurance is 20 percent after deductible, per visit.

By not applying the appropriate coinsurance, the Plan was not in compliance with its Contract. In addition, the Plan overstated its 2014 incurred medical claims, which consequently overstated the MLR numerator and the claims used in the rate developments.

3. Coverage for Disposable Durable Medical Equipment

The Plan paid claims for non-covered disposable durable medical equipment (DME); specifically, electrical stimulator leads and insulin infusion sets.

Contract Section 2.2(a) requires the Plan to provide benefits defined in the FEHBP benefit brochure. The 2014 FEHBP benefit brochure states that, "Disposable items such as incontinent pads, electrodes, ace bandages, elastic stockings, and dressings" are not covered by the Plan.

The Plan stated that it covers DME supplies that are necessary and directly related to the DME. By covering all charges for disposable DME, the Plan overstated its 2014 incurred medical claims, which consequently misstated the MLR numerator and the claims used in the

rate developments. In addition, the Plan was not in compliance with Contract Section 2.2(a) and the 2014 FEHBP benefit brochure.

4. Lesser of Billed and Allowed Claim Payments

The Plan erroneously adjudicated a facility claim that was based on a fee schedule amount that was greater than what was billed by the provider. This contradicted what was stated in the Plan's contract with the Provider.

Contract Section 2.3(g) states, "It is the Carrier's responsibility to proactively identify overpayments through comprehensive, statistically valid reviews and a robust internal control program. 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 … ."

The Plan's claim system was unable to properly price facility claims using the "lesser of" logic.

Additionally, the Plan's contract with certain providers contains language that stipulates the provider shall receive payment from the Plan for services rendered in accordance with the "lesser of" the provider's billed charge or the reimbursement rates set forth on the Plan's payment schedule.

The Plan explained that its claim system during the scope of the audit did not have the capability to apply the "lesser of" logic automatically to facility claims. By paying more than the provider's billed charge, the Plan overstated its 2014 incurred medical claims, which consequently misstated the MLR numerator and the claims used in the rate developments. Also, the Plan was not in compliance with Contract Section 2.3(g) and its own contract with its provider.

Recommendation 14

We recommend that the Plan verify that its current claim processing system is configured to process claims in accordance with its Contract and the FEHBP benefit brochure.

Plan Response:

The Plan agreed with the recommendation. To ensure it is processing claims in accordance with its contract with OPM, the Plan stated that its Quality Assurance team will conduct an FEHBP auto-adjudicated claims audit and refine the criteria used to select the manual claims it reviews.

Recommendation 15

We recommend that the Plan research emergency room copayments from 2014 through 2016 to determine which members were negatively impacted by the error and rectify any member overpayments.

Plan Response:

The Plan disagreed with the recommendation and noted that its contracts with most of its providers have time limits on claim adjustments.

OIG Comment:

While the OIG understands contractual agreements with the Plan's participating providers may limit the amount of time the Plan has to recoup overpayments from the providers, the Plan can and should still research the extent of the overpayments made by FEHBP members and refund any overpayments. It was the Plan's system limitations that resulted in such overpayments and the members should not be negatively impacted by the Plan's inability to identify the errors and recoup overpayments in a timely manner.

Recommendation 16

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

Plan Response:

The Plan agreed with the recommendation and noted that as of January 1, 2021, the FEHBP benefit brochure was updated to reflect that there is no member cost share for PCP ancillary services.

Recommendation 17

We recommend that the Plan strengthen its system controls, processes, and procedures to ensure that claims are priced in accordance with the terms in its provider contracts.

OIG Comment:

The Plan responded to the draft report and provided further documentation to support that a certain provider contract did not contain the same "lesser of" clause referenced in the draft audit finding. Based upon our analysis of the response, we updated the finding and recommendation for the final report. As a result, the response to this draft report recommendation was no longer relevant to the final audit report.

Recommendation 18

We recommend that the Plan strengthen its controls to proactively identify and promptly recover erroneous claim payments in accordance with Section 2.3(g) of its contract with OPM.

OIG Comment:

The Plan responded to the draft report and provided further documentation to support that a certain provider contract did not contain the same "lesser of" clause referenced in the draft audit finding. Based upon our analysis of the response, we updated the finding and recommendation for the final report. As a result, the response to this draft report recommendation was no longer relevant to the final audit report.

D. Internal Control Review

Per Contract Section 5.64, Contractor Code of Business Ethics and Conduct, "(c) … The Contractor shall establish the following within 90 days after the contract award … . (2) An internal controls system. (i) The Contractor's internal control system shall--(A) Establish standards and procedures to facilitate timely discovery of improper conduct in connection with Government contracts; and (B) Ensure corrective measures are promptly instituted and carried out. (ii) At a minimum, the Contractor's internal control system shall provide for … (A) Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the business ethics awareness and compliance program and internal control system."

We determined that the Plan's internal control system did not sufficiently meet the contractual criteria. Specifically, we found the issues noted below.

1. Capitated Rates Not Adjusted for Benefits

The Plan developed its capitated rates based on the collective experience of the commercial group and did not account for FEHBP utilization or benefit adjustments when developing the rates.

Contract Section 2.2(a) states, "The Carrier shall provide the benefits as described in the agreed upon brochure text ... ."

The Plan did not develop its capitated rates for FEHBP members based on the benefits offered to them.

The Plan does not have policies and procedures for developing capitated vendor and provider rates. The Plan's process is to calculate capitation rates at the commercial line of business, regardless of the varying benefit levels.

As a result, the FEHBP may be subsidizing or being subsidized by other groups. In addition, the Plan may be paying capitated expenses for services that are not covered by the FEHBP. It is understood that capitated arrangements are usually a fixed payment rate, however the overall rates should account for total community benefits and utilization data when possible.

Recommendation 19

We recommend that the Plan develop capitation rates that account for the specific benefits offered in the FEHBP benefit brochure to ensure the FEHBP is not subsidizing other groups nor paying for benefits that are not covered by the FEHBP benefit brochure.

Plan Response:

The Plan agreed with the recommendation. It also noted that its sales, underwriting, actuarial, finance and vendor relations teams will coordinate to ensure capitation rates applied to the FEHBP account for the specific benefits outlined in the FEHBP benefits brochure.

2. Early Termination of Coverage for Overage Dependents

The Plan did not terminate coverage for dependent members in compliance with the requirements stated in the 2014 through 2016 FEHBP benefit brochures.

The FEHB Facts Sections of the 2014 through 2016 FEHBP benefit brochures state that dependent children are eligible to receive coverage until their 26th birthday. The brochures also state that members "will receive an additional 31 days of coverage … when … [they] are no longer eligible for coverage."

The Plan terminated coverage for dependent members as of the last day of the month in which they turned 26, which did not allow for the 31-day run-out of coverage. This is the Plan's policy for terminating overage dependent's coverage, regardless of specifications for individual group requirements. Due to the Plan terminating these members' coverage in advance of the 31-day run-out permitted by the brochures, the members do not receive the full benefits due to them.

Recommendation 20

We recommend that the Plan amend its policy for overage dependents to include 31 days of coverage for FEHB program dependent members beginning on the dependent's 26th birthday.

Plan Response:

The Plan agreed with the recommendation and noted that it will create a weekly report to identify FEHBP terminations, which will be used to update eligibility in the claims

processing system, as appropriate. "The 31-day extension of coverage will be applicable for all terminations except cancelations."

3. Incorrect Audit Documentation

As stated in section A.1.a, the Plan identified that an incorrect version of the 2014 FEHBP rate development workbook was provided to the OIG during the audit.

Contract section 1.11(b) states that "The Contractor shall make available at its office at all reasonable times those books and records for examination and audit for the record retention period… ."

The Plan initially provided an incorrect 2014 rate development workbook, which was audited during fieldwork.

In response to the OIG's draft report, the Plan informed us that it had provided an incorrect 2014 FEHBP rate development workbook from which we had audited and developed our initial results. Based on the fact that the audit team had numerous questions regarding the incorrect rate development, as well as the fact that we based the initial audit results on the analysis of the incorrect development, the correct 2014 rate model was not provided for examination in a reasonable time. We held a meeting with the Plan during which Plan personnel explained that the version of the 2014 rate development workbook that was submitted to the OIG during the audit was not the correct version that had been used to determine the rates. The workbook provided to the OIG was a version updated by an internal underwriter who did not work on the FEHBP account. It is unclear why this version of the workbook was created or maintained by the Plan. We audited the updated workbook after receiving it, which eliminated issues that were included in the draft report, and added an additional issue explained above in section A.1.a.

On March 18, 2021, the OIG emailed the Plan to elicit a response for the finding stated above. The Plan stated that a formal response would be submitted to the OIG, however none was ever provided to the audit team.

Recommendation 21

We recommend that the Plan provide complete and accurate documentation for all audits, as requested, in a timely manner.

Plan Response:

The Plan did not respond to the recommendation.

4. Debarment and Suspension Review

Our review of the Plan's debarment policies and procedures identified that the Plan did not adequately address all of its responsibilities under the FEHBP administrative sanctions program during the scope of our audit. For example, the Plan's template letters to notify FEHBP members when a provider is debarred or suspended do not disclose that the provider was debarred or suspended, do not contain instructions on how members can request exceptions, and do not disclose to the member the 15-day grace period for payment of claims to the provider. Additionally, the Plan does not have procedures for contacting OPM regarding partial potential debarred provider matches or written procedures for reporting to OPM semiannually on debarment activity.

During our review, we also became aware that the Plan's Debarment contact used a shared login and password to access the OPM Debarment webpage during the scope of our audit.

The Plan lacked internal controls to comply with the required FEHBP administrative sanctions program.

Per OPM OIG Administrative Sanctions Department's Guidelines for Implementation of FEHBP Debarment and Suspension Orders, FEHBP carriers have specific responsibilities to fully implement the administrative sanctions program. Chapter 2 of the Guidelines provides specific instructions regarding the actions that carriers must take in each of those areas:

A. Designate a Point of Contact with OIG

B. Develop a Sanctions Implementation Plan

C. Establish a Sanctions Database and Update It Monthly

D. Notify Enrollees Who Receive Services from Debarred/Suspended Providers

E. Preclude Payment of FEHBP Funds to Debarred/Suspended Providers

F. Report to OPM Semiannually on Debarment Activity

Generally, FEHBP payments to debarred or suspended providers are prohibited for services furnished on or after the effective date of the sanction. However, there are certain specific situations in which such payments may be made, notwithstanding a provider's debarment or suspension. Chapter 3 of the OPM OIG Administrative Sanctions Department's Guidelines for Implementation of FEHBP Debarment and Suspension Orders describes specific exceptions where payment can be made to debarred or suspended providers, most of which are administered directly by FEHBP carriers, without case-by-case approval by OPM; however, one requires OPM to approve an individual's request for continuation of services for or on behalf of an FEHBP enrollee.

In addition, Chapter 4 of the OPM OIG Administrative Sanctions Department's Guidelines for Implementation of FEHBP Debarment and Suspension Orders specifically limits access to the OPM OIG Debarment webpage to one specific named individual designated by the Plan in order to maintain the security of the providers' personal and sensitive information.

The Plan did not have strong internal controls over its processes related to FEHBP debarred providers. In addition, a misunderstanding that login/password information was department-wide led to the sharing of login and password information to access the OPM Debarred Provider Listing on the OPM Debarment Webpage.

As a result, the Plan was not in compliance with the OPM OIG Administrative Sanctions Department's Guidelines for Implementation of FEHBP Debarment and Suspension Orders. This non-compliance could lead to the payment of FEHBP member claims to providers who are debarred or suspended from participation in the FEHBP, as well as pose a risk to the security of providers' personal and sensitive information.

Recommendation 22

We recommend that the Plan ensure its written policy and procedure at a minimum meets the requirements set forth in OPM OIG Administrative Sanctions Department's Guidelines for Implementation of FEHBP Debarment and Suspension Orders.

Plan Response:

The Plan agreed with the recommendation and noted that it "believes the Sanctioned and Debarred Provider Desk Level Procedure satisfies this recommendation."

OIG Comment:

Since the Plan introduced the desk level procedures as a result of our audit, we will evaluate the effectiveness of any debarment and suspension process improvements during future audits.

Recommendation 23

We recommend that the Plan ensure the login information to access OPM's Debarred Provider Listing is not shared between employees. In addition, the Plan should notify OPM of any change in designated contact, so that OPM can provide a specific username and password for the sole use of the new designated contact.

Plan Response:

The Plan agreed with the recommendation. It noted that its Debarment policy was updated in January 2021 to prohibit the sharing of login information for accessing

OPM's Debarred Provider Listing and to stipulate that OPM should be notified of a change in designated contact.

EXHIBIT A

Geisinger Health Plan

Medical Claims Sample Selection Criteria and Methodology

Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Medical claims incurred from 1/1/2014 through 12/31/2014	15,125 Claims	$4,327,564	Utilized RAT-STATS[2] (90% Confidence Level/50% Anticipated Rate of Occurrence/20% Desired Precision Range), which generated a sample size of 75. Then utilized SAS[3] to randomly select 75 incurred, unadjusted medical claims.	Statistical	No

[2] RAT-STATS is a statistical software designed by the U.S. Department of Health and Human Services OIG to assist in selecting random samples.

[3] SAS Enterprise Guide is a software used to analyze data allowing users to access and manipulate data quickly.

EXHIBIT B

Geisinger Health Plan

Summary of Defective Pricing Questioned Costs

Contract Year 2014	$196,885
Contract Year 2015	$144,421
Contract Year 2016	$143,384
Total Defective Pricing Questioned Costs	**$484,690**
Lost Investment Income	$68,567
Total Amount Due to OPM	**$553,257**

EXHIBIT C

Geisinger Health Plan

Defective Pricing Questioned Costs by Contract Year

Contract Year 2014

	Self	**Family**	Total
FEHBP Line 5 - Reconciled Rate	$282.31	$649.32	
FEHBP Line 5 - Audited Rate	$274.18	$630.62	
Bi-weekly Overcharge	$8.13	$18.70	
To Annualize Overcharge:			
March 31, 2014 Enrollment	430	218	
Pay Periods	26	26	
2014 Defective Pricing	**$90,893**	**$105,992**	**$196,885**

Contract Year 2015

	Self	Family	Total
FEHBP Line 5 - Reconciled Rate	$300.47	$691.08	
FEHBP Line 5 - Audited Rate	$294.15	$676.55	
Bi-weekly Overcharge	$6.32	$14.53	
To Annualize Overcharge:			
March 31, 2015 Enrollment	403	207	
Pay Periods	26	26	
2015 Defective Pricing	**$66,221**	**$78,200**	**$144,421**

EXHIBIT C (continued)

Geisinger Health Plan

Defective Pricing Questioned Costs by Contract Year (continued)

Contract Year 2016

	Self	Self +1	Family	Total
FEHBP Line 5 - Reconciled Rate	$313.92	$722.03	$722.03	
FEHBP Line 5 - Audited Rate	$307.65	$707.59	$707.59	
Bi-weekly Overcharge	$6.27	$14.44	$14.44	
To Annualize Overcharge:				
March 31, 2016 Enrollment	389	4	209	
Pay Periods	26	26	26	
2016 Defective Pricing	**$63,415**	**$1,502**	**$78,467**	**$143,384**

EXHIBIT D

Geisinger Health Plan

Lost Investment Income

	2014	2015	2016	2017	2018	2019	2020	2021	Total
Defective Pricing:	$196,885	$144,421	$143,384	$0	$0	$0	$0	$0	$484,690
Cumulative Totals:	$196,885	$341,306	$484,690	$484,690	$484,690	$484,690	$484,690	$484,690	$484,690
Average Interest Rate (per year):	2.0625%	2.2500%	2.1875%	2.438%	3.0625%	3.1250%	1.6250%	0.8750%	
Interest on Prior Year Finding	$0	$4,430	$7,466	$11,814	$14,844	$15,147	$7,876	$1,767	$63,344
Current Year Interest	$2,030	$1,625	$1,568	$0	$0	$0	$0	$0	$5,223
Total Cumulative Interest Calculated through May 31, 2021:	$2,030	$6,055	$9,034	$11,814	$14,844	$15,147	$7,876	$1,767	**$68,567**

EXHIBIT E

Geisinger Health Plan

Summary of Medical Loss Ratio Adjustments

Contract Year 2014	
Penalty Calculated	$0
Penalty Received	$0
Total 2014 Adjustment	**$0**
Contract Year 2015	
Penalty Calculated	$485,042
Penalty Received	$424,839
Total 2015 Credit Adjustment Due to Plan	**$60,203**
Contract Year 2016	
Penalty Calculated	$705,427
Penalty Received	$645,834
Total 2016 Credit Adjustment Due to Plan	**$59,593**

EXHIBIT F

Geisinger Health Plan

2014 Medical Loss Ratio Adjustment

	Plan	Audited
2014 FEHBP MLR Lower Corridor (a)	85%	85%
2014 FEHBP MLR Upper Corridor (b)	89%	89%
Claims Expense		
Adjusted Incurred Medical and Pharmacy Claims	$5,678,912	$5,678,912
Less: Understated Pharmacy Rebates		$29,357
Less: Overstated IBNR		$52,933
Less: Overstated Reinsurance		$25,935
Less: Capitated Vendor Fee		$11,649
Less: Overstated Other Medical Expenses		$24,772
Less: Overstated Medical Claims		$136
Less: Overstated Pharmacy Claims		$4,639
Plus: Quality Health Improvement Expenses	$168,908	$168,908
Less: Overstated Quality Health Improvement Expenses		$100,235
Total MLR Numerator	**$5,847,820**	**$5,598,164**
Premium Income	$6,822,080	$6,822,080
Less: Premium Rate Defective Pricing Questioned Costs		$196,885
Less: Taxes and Regulatory Filing Fees	$73,842	$73,842
Total MLR Denominator (c)	**$6,748,238**	**$6,551,353**
FEHBP Medical Loss Ratio (d)	**86.66%**	**85.45%**
FEHBP Contract Months	7,836	7,836
Small Group Adjustment[4] (e)	3.03%	3.03%
FEHBP Adjusted MLR[5] (f)	**89.68%**	**88.48%**
Penalty Calculation (If (d) is less than (a), ((a-f)*c)	$0	$0
Credit Calculation (If (d) is greater than (b), ((d-b)*c)	$0	$0
Total MLR Adjustment		**$0**

[4] The Small Group Adjustment (e) is calculated as (18,000 – number of FEHB contract months) / 16,800 * 5.0%. The Small Group Adjustment (e) is only used to calculate a penalty, not a credit.
[5] FEHBP Adjusted MLR (f) is calculated by adding the FEHBP Medical Loss Ratio (d) with the Small Group Adjustment (e).

EXHIBIT F (continued)

Geisinger Health Plan

2015 Medical Loss Ratio Adjustment

	Plan	Audited
2015 FEHBP MLR Lower Corridor (a)	85%	85%
2015 FEHBP MLR Upper Corridor (b)	89%	89%
Claims Expense		
Adjusted Incurred Medical and Pharmacy Claims	$5,021,887	$5,021,887
Less: Understated Pharmacy Rebates		$60,730
Less: Overstated Reinsurance		$25,822
Less: Capitated Vendor Fee		$7,594
Less: Overstated Other Medical Expenses		$28,304
Plus: Quality Health Improvement Expenses	$140,035	$140,035
Less: Overstated Quality Health Improvement Expenses		$55,936
Total MLR Numerator	**$5,161,922**	**$4,983,537**[6]
Premium Income	$6,926,888	$6,926,888
Less: Premium Rate Defective Pricing Questioned Costs		$144,421
Less: Taxes and Regulatory Filing Fees	$99,789	$99,789
Total MLR Denominator (c)	**$6,827,099**	**$6,682,678**
FEHBP Medical Loss Ratio (d)	**75.61%**	**74.57%**
FEHB Contract Months	7,356	7,356
Small Group Adjustment[7] (e)	3.17%	3.17%
FEHBP Adjusted MLR[8] (f)	**78.78%**	**77.74%**
Penalty Calculation (If (d) is less than (a), ((a-f)*c)	$424,839	$485,042
Total Penalty Reduction		**$60,203**

[6] Due to rounding the FEHBP MLR percentages, the total penalty amount does not mathematically tie.
[7] The Small Group Adjustment (e) is calculated as (18,000 – number of FEHB contract months) / 16,800 * 5.0%.
[8] FEHBP Adjusted MLR (f) is calculated by adding the FEHBP Medical Loss Ratio (d) with the Small Group Adjustment (e).

EXHIBIT F (continued)

Geisinger Health Plan

2016 Medical Loss Ratio Adjustment

	Plan	Audited
2016 FEHBP MLR Lower Corridor (a)	85%	85%
2016 FEHBP MLR Upper Corridor (b)	89%	89%
Claims Expense		
Adjusted Incurred Medical and Pharmacy Claims	$5,044,542	$5,044,542
Less: Understated Pharmacy Rebates		$44,347
Less: Overstated Reinsurance		$39,261
Less: Capitated Vendor Fee		$32,294
Less: Overstated Other Medical Expenses		$21,494
Plus: Understated Pharmacy Claims		$5,072
Plus: Quality Health Improvements	$117,574	$117,574
Less: Overstated Quality Health Improvements		$44,542
Total MLR Numerator	**$5,162,116**	**$4,985,251**[9]
Premium Income	$7,184,638	$7,184,638
Less: Premium Rate Defective Pricing Questioned Costs		$143,384
Less: Taxes and Regulatory Filing Fees	$83,524	$83,524
Total MLR Denominator (c)	**$7,101,114**	**$6,957,730**
FEHBP Medical Loss Ratio (d)	72.69%	71.65%
FEHB Contract Months	7,212	7,212
Small Group Adjustment[10] (e)	3.21%	3.21%
FEHBP Adjusted MLR[11] (f)	75.91%	74.86%
Penalty Calculation (If (d) is less than (a), ((a-f)*c)	$645,834	$705,427[12]
Total Penalty Reduction		**$59,593**[13]

[9] Due to rounding, the total does not mathematically tie.
[10] The Small Group Adjustment (e) is calculated as (18,000 – number of FEHB contract months) / 16,800 * 5.0%. The Small Group Adjustment (e) is only used to calculate a penalty, not a credit.
[11] FEHBP Adjusted MLR (f) is calculated by adding the FEHBP Medical Loss Ratio (d) with the Small Group Adjustment (e).
[12] Due to rounding the FEHBP MLR percentages, the total penalty amount does not mathematically tie.
[13] Due to rounding, the total does not mathematically tie.

APPENDIX

FEHB MLR Audit Combined Response – Received February 17, 2021

Recommendations	Agree/ Disagree	Plan Response
FEHB MLR Audit Recommendation 1 - We recommend that the contracting officer require the Plan to return $954,782 to the FEHBP for defective pricing in contract years 2014 through 2016	Disagree	The Plan disagrees with this recommendation. Upon further review, the wrong renewal rating workbook was sent for the 2014 rating of FEHBP. Underwriting found the experience rating model that matches the experience rating model that was submitted in the RFP Responses for 2014. The Plan also provided a response and supporting documentation regarding capitation payments, surcharges and other calculations.
FEHB MLR Audit Recommendation 2 - We recommend that the Plan put procedures in place to ensure that only applicable benefit adjustments are made to the FEHBP rates.	Agree	Benefit Adjustment was applied due to a rating worksheet error on the 2014 through 2016 renewal rating models. Error was corrected beginning with 2017 renewal rating models. Underwriter will also review rating of FEHBP with Underwriting Manager to ensure that no adjustments are applied erroneously to the rating of the group.
FEHB MLR Audit Recommendation 3 - We recommend that the Plan develop policies and procedures over the FEHBP rating process that will strengthen process controls and assist in detecting and preventing errors, as well as ensure compliance with all applicable criteria when preparing the FEHBP rates.	Agree	Underwriter will schedule a meeting with underwriting manager and all other responsible parties to ensure that no erroneous adjustments are made in the rating of FEHBP.
FEHB MLR Audit Recommendation 4 – **Deleted by the OIG – Not Relevant to the Final**		
FEHB MLR Audit Recommendation 5 - We recommend that the contracting officer require the Plan to return $132,452 to the FEHBP for LII, calculated through January 31, 2021. We also recommend that the	Disagree	The Plan disagrees with this recommendation based on the additional information provided under Recommendation 1.

contracting officer recover LII on amounts due for the period beginning February 1, 2021, until all defective pricing amounts have been returned to the FEHBP.		
FEHB MLR Audit Recommendation 6 - We recommend that the contracting officer require the Plan to return $132,452 to the FEHBP for LII, calculated through January 31, 2021. We also recommend that the contracting officer recover LII on amounts due for the period beginning February 1, 2021, until all defective pricing amounts have been returned to the FEHBP.	Agree	The plan agrees with this recommendation.
FEHB MLR Audit Recommendation 7 - We recommend that the Plan create, implement, and document internal control policies and procedures to ensure that expenses are allocated to the FEHBP MLR based on a methodology that yields the most accurate results, as required by 45 CFR 158.170(b)(1).	Agree	The plan agrees with this recommendation. The Plan updated methodology in 2019 FEDS MLR reporting. Please see the 2019 FEDS MLR Calculation Procedures.
FEHB MLR Audit Recommendation 8 - We recommend the Plan ensure direct claims are reported, not allocated, on the FEHBP MLR in accordance with 45 CFR 158.140.	Agree	The plan agrees with this recommendation. The Plan Enhanced FEDS MLR policy and procedure effective 2/9/2021. See 2019 FEDS MLR Calculation Procedures document.

FEHB MLR Audit Recommendation 9 - We recommend the Plan create, implement, and document internal control policies and procedures to ensure that only allowable and allocable expenses are included in the FEHBP MLR submissions, in accordance with applicable regulations.	Agree	The plan agrees with this recommendation. The Plan excluded IBNR effective 2015. Excluded Reinsurance starting in 2020. NIA is no longer applicable. The Plan Enhanced FEDS MLR policy and procedure effective 2/9/2021. See 2019 FEDS MLR Calculation Procedures document.
FEHB MLR Audit Recommendation 10 - We recommend that the Plan institute a more stringent MLR review process to identify reporting errors prior to submitting the MLR to OPM.	Agree	The Plan agrees with this recommendation. Rx claims had immaterial variance ($136, $4,639, $5,072) compared to OPM claims data submission. This was corrected in 2017. The Plan Enhanced FEDS MLR policy and procedure effective 2/9/2021. See 2019 FEDS MLR Calculation Procedures document.
FEHB MLR Audit Recommendation 11 - We recommend the Contracting Officer reduce the 2014 through 2016 MLR premiums by $399,909 in 2014, $268,272 in 2015, and $286,601 in 2016 for the questioned premium costs identified in this audit.	Disagree	The plan disagrees with this recommendation based on the disputed premium pricing under Recommendation 1.
FEHB MLR Audit Recommendation 12 - We recommend the Contracting Officer reduce the 2014 through 2016 MLR premiums by $399,909 in 2014, $268,272 in 2015, and $286,601 in 2016 for the questioned premium costs identified in this audit.	Agree	The plan agrees with this recommendation. Starting with plan year 2020, drill down capitation expenses at FEDS level.
FEHB MLR Audit Recommendation 13 - We recommend that the Plan update its policies and procedures to ensure tax	Agree	The plan agrees with this recommendation. The Plan Enhanced FEDS MLR policy and procedure effective 2/9/2021. See 2019 FEDS MLR Calculation Procedures document.

expenses on the FEHBP MLR submission are calculated in accordance with applicable regulations.		
FEHB MLR Audit Recommendation 14 - We recommend that the Plan verify that its current claim processing system is configured to process claims in accordance with its contract with OPM and the FEHBP benefit brochure.	Agree	The plan agrees with this recommendation. Effective April 2021, the QA team will implement an FEHBP auto adjudicated claims audit as well as revise the criteria used in selecting the manual FEHBP claims to ensure we are processing claims in accordance with its contract with OPM and the FEHBP benefit brochure.
FEHB MLR Audit Recommendation 15 - We recommend that the Plan research ER copayments from 2014 through 2016 to determine which members were negatively impacted by the error and rectify any member overpayments.	Disagree	The plan disagrees with this recommendation. The claims department does not recommend adjusting claims from 2014 as most of our provider contracts have time limits on our ability to make claim adjustments. Providers close their books on claim payments two years back from the current date, so we would only adjust claims January of 2019.
FEHB MLR Audit Recommendation 16 - We recommend that the Plan strengthen its system controls and claims processing procedures to ensure its compliance with the group-specific benefits and member cost-sharing responsibilities as outlined in the FEHBP benefit brochure.	Agree	The plan agrees with this recommendation. This recommendation is due to a member being charged a PCP copay when she was seen by her PC during an inpatient hospital stay. The benefit brochure stated members should have been charged coinsurance for physician services during a hospital stay. Effective 1/1/2021, the benefits brochure was updated so there is $0 cost share for all PCP ancillary services. Please see the highlighted text on page 54 of the 2021 brochure.

FEHB MLR Audit Recommendation 17 - We recommend that the Plan strengthen its system controls, processes, and procedures to ensure that claims are priced in accordance with the terms in its provider contracts.	Disagree	**Deleted by the OIG – Not Relevant to the Final**
FEHB MLR Audit Recommendation 18 - We recommend that the Plan strengthen its controls to proactively identify and promptly recover erroneous claim payments in accordance with Section 2.3(g) of its contract with OPM.	Disagree	**Deleted by the OIG – Not Relevant to the Final**
FEHB MLR Audit Recommendation 19 - We recommend that the Plan develop capitation rates that account for the specific benefits offered in the FEHBP benefit brochures to ensure the FEHBP is not subsidizing other groups nor paying for benefits that are not covered by the FEHBP benefit brochure.	Agree	The plan agrees with this recommendation. The Sales, Underwriting, Actuarial, Finance and Vendor Relations teams will communicate and coordinate to ensure that we apply capitation rates that account for the specific benefits offered in the FEHBP benefit brochures. This will ensure the FEHBP is not subsidizing other groups nor paying for benefits that are not covered by the FEHBP benefit brochure. The target completion date is 4/1/2021.

FEHB MLR Audit Recommendation 20 - We recommend that the Plan amend its policy for overage dependents to include 31 days of coverage for FEHB program dependent members beginning on the dependent's 26th birthday.	Agree	The plan agrees with this recommendation. The Enrollment team will create a weekly report to identify terminations which will then be reviewed, and eligibility will be updated in our claims processing system as appropriate. The 31-day extension of coverage will be applicable for all terminations except cancelations. This report will be implemented by 3/31/2021.
FEHB MLR Audit Recommendation 21 - We recommend that the Plan ensure its written policy and procedure at a minimum meets the requirements set forth in OPM OIG Administrative Sanctions Department's Guidelines for Implementation of FEHBP Debarment and Suspension Orders.	Agree	The plan agrees with this recommendation. GHP believes The Sanctioned and Debarred Provider Desk Level Procedure satisfies this recommendation. It has been included.
FEHB MLR Audit Recommendation 22 - We recommend that the Plan ensure the login information to access OPM's Debarred Provider Listing is not shared between employees. In addition, the Plan should notify OPM of any change in designated contact, so that OPM can provide a specific username and password for the sole use of the new designated contact.	Agree	The plan agrees with this recommendation GHP updated its Debarment policy on 1/27/21 to specify sharing login information to OPM's Debarred Providers is prohibited. It also instructs employees to notify OPM for any change in our designated contact. Please see the Updated Debarment Policy. Page 1, Section 2a is highlighted for your convenience.

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Signature of Plan Official

Deleted by the OIG – Not Relevant to the Final
Title of Plan Official

[Related to the audit issue identified in section A.1.a, the Plan provided the following response.]

Deleted by the OIG – Not Relevant to the Final

Geisinger Health Plan understands and agrees with the findings. We will ensure that the completion factors that are used for FEHBP will be consistent with other claims-based ACR rated groups.

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Finding:

During the audit, the Plan explained the completion factors applied to the FEHBP group claims were based on the commercial book of business. Part of the OIG's review of the correct version of the 2014 rate developments included selecting two large group plans that used the same experience period as the FEHBP and were rated around the same time as the FEHBP for the 2014 calendar year. Based on our review, we determined the completion rates applied to the FEHBP's medical claims were higher than those applied to other large groups.

The 2014 Community Rating Guidelines stipulate that carriers using a claims-based adjusted community rate method must follow certain rules, including: Any method used to convert paid claims to incurred claims must be consistent for all claims-based ACR rated groups.

The Plan explained that it increased the completion factors applied to the 2/1/12 - 1/31/13 experience period in the 2014 rate development to account for an increase in retirees and an increase in the age/sex factor that was applicable to the FEHBP. The Plan noted there was no specific place in the 2014 renewal calculation to reflect this change in risk, so the completion factors were adjusted.

The Plan's rate development does utilize an age/sex factor; however, that factor is used in the manual rating of the FEHBP, which is not applicable to the rates since the FEHBP is 100% credible. Further, the Plan's manual rating of the FEHBP shows a lesser rate, including the age/sex factor, than that reflected by the FEHBP experience rating. In addition, the rate development template utilized by the Plan for all large groups does not include a formula to escalate the completion factors calculated on the book of business for such things as a change in age/sex factors or an increase in retirees. In fact, it is unclear how the Plan would derive a completion factor that accurately accounts for such a change.

As a result, we adjusted the Plan's completion factors for inpatient, outpatient, and professional claims, applicable to the newer experience period used in the 2014 rate development to those that were calculated on the Plan's book of business. We confirmed these were also applied to the other sampled large group, which was rated around the same time as the FEHBP and is 100% credible.

Recommendation:

We recommend the Plan ensure its FEHBP completion factors are consistent with other groups that are also claims-based ACR rated, as required by OPM's Community Rating Guidelines.

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