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

Final Audit Report

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

Report Number 2022-CRAG-008
December 19, 2022

Executive Summary

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Report No. 2022-CRAG-008 **December 19, 2022**

Why Did We Conduct the Audit?

The primary objective of the audit was to determine whether Humana Health Plan, Inc. (Plan) complied with the provisions of its contract and the laws and regulations governing the Federal Employees Health Benefits Program (FEHBP). To accomplish this objective, we verified whether the FEHBP premium rates were developed in accordance with contract regulations and rating instructions established by the U.S. Office of Personnel Management (OPM).

What Did We Audit?

Under Contract CS 1570, the Office of the Inspector General completed a performance audit of the FEHBP premium rate developments for contract years 2019 through 2021. We conducted our audit fieldwork remotely from January 24, 2022, through September 19, 2022.

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Assistant Inspector General for Audits

What Did We Find?

We found that portions of the 2019 through 2021 FEHBP premium rate developments were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM. As such, this report questions $334,761 for defective pricing in contract years 2020 and 2021. In addition, the FEHBP is due lost investment income of $13,083 on the premium overpayments. Specifically, our audit identified the following:

- Defective pricing of the premium rate developments occurred due to the 2020 premium rate development including improperly loaded special benefit loadings, which then caused the 2021 premium rate development to include incorrect plan adjustment factors.
- The Plan's 2019 morbidity, demographic, and cost share factors were not properly supported in the FEHBP rate development.
- The Plan did not maintain adequate supporting documentation for overage dependents as required by applicable criteria.
- Our review of sampled claims from 2020 identified that the Plan did not properly configure its claims system to price and pay claims based on the terms of the provider contracts and fee schedules. Also, a claim was processed and paid with an incorrect Explanation of Medicare Benefits, and another claim was paid after a member's termination date.
- The 2018 family rate for the standard option plan was incorrectly stated in the 2018 benefit brochure.

Abbreviations

BCT	**Benefit Comparison Tool**
CFR	**Code of Federal Regulations**
CLER	**Centralized Enrollment Clearinghouse System**
COB	**Coordination of Benefits**
Contract	**Contract CS 1570**
DCN	**Document Control Number**
EOMB	**Explanation of Medicare Benefits**
FEHBAR	**Federal Employees Health Benefits Acquisition Regulations**
FEHBP	**Federal Employees Health Benefits Program**
LII	**Lost Investment Income**
MLR	**Medical Loss Ratio**
MOPS	**Market Operational & Professional Standards**
NFR	**Notice of Findings and Recommendations**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**Humana Health Plan, Inc.**
SSSG	**Similarly-Sized Subscriber Group**

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I. Background

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at Humana Health Plan, Inc. (Plan), plan codes 75 and RW. The audit was conducted pursuant to the provisions of Contract CS 1570 (Contract); 5 United States Code Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract years 2019 through 2021 and was conducted remotely by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG) staff.

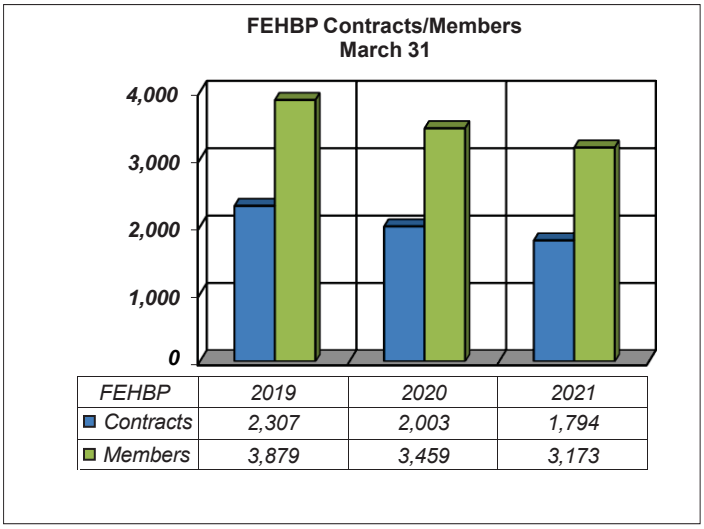
The FEHBP was established by the Federal Employees Health Benefits Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for Federal employees, annuitants, and dependents, and is administered by the OPM Healthcare and Insurance Office. The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

In April 2012, OPM issued a final rule establishing an FEHBP-specific Medical Loss Ratio (MLR) requirement to replace the similarly-sized subscriber group (SSSG) comparison requirement for most community-rated FEHBP carriers (77 Federal Register 19522). The MLR was established to ensure that health plans are meeting specified thresholds for spending on medical care and health care quality improvement measures, and thus limiting spending on administrative costs, such as executive salaries, overhead, and marketing of the health plan. The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act (P.L. 111-148) and defined by the U.S. Department of Health and Human Services in 45 CFR Part 158.

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

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

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



FEHBP	2019	2020	2021
Contracts	2,307	2,003	1,794
Members	3,879	3,459	3,173

The Plan has participated in the FEHBP since 1975 and provides health benefits to FEHBP members in the Chicago, Illinois metropolitan area.

A prior SSSG audit of the Plan covered contract year 2012. The audit found that the FEHBP premium rates were developed in accordance with OPM's rules and regulations for contract year 2012 and did not identify any questioned costs. A prior MLR audit of the Plan covered contract years 2013 and 2014 and identified defective Certificates of Accurate MLR Calculations. Specifically, the Plan had included claims for unsupported and ineligible overage disabled dependents in the 2013 and 2014 claims data, the Plan allocated a negative tax liability in 2014, and the Plan adjusted the FEHBP's 2013 and 2014 MLR calculations, based on a Centers for Medicare and Medicaid Services audit, to limit the allowable fraud reduction expenses. We confirmed that the related audit recommendations have been closed.

The preliminary results of this audit were communicated to Plan officials during the Notice of Finding and Recommendations (NFR) process as well as the draft report. The Plan's comments, if any, to both the NFR's and draft report were considered in preparation of this report and are included, as appropriate, in the report. Additionally, we discussed the issues outlined in this report with Plan officials during the Exit Conference.

II. Objectives, Scope, and Methodology

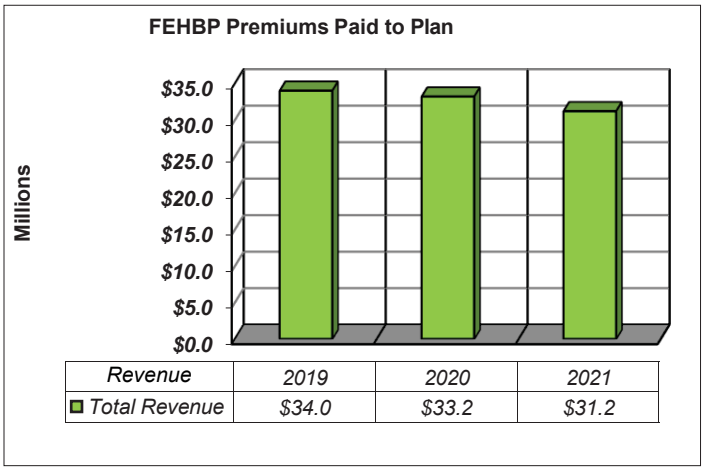
Objectives

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

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 2019 through 2021. For these years, the FEHBP paid approximately $98 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 premium rate calculations were accurate, complete, and valid;
- medical claims were processed accurately;
- appropriate allocation methods were used; and
- any other costs associated with its premium rate calculations were appropriate.

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

We remotely conducted our audit fieldwork from January 24, 2022, through September 19, 2022.

Methodology

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

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

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 FEHBP Contract CS 1570 (Contract). We determined that the Plan's 2020 and 2021 Certificates of Accurate Pricing were defective for plan codes 75 and RW. As such, this report questions $334,761 for defective pricing in 2020 and 2021. In addition, the FEHBP is due Lost Investment Income (LII) of $13,083 on the premium overpayments.

1. Defective Pricing: $334,761

During the 2020 and 2021 contract years, the Plan submitted premium rates for the FEHBP with High, Standard, and Basic benefit options; however, we identified several defective pricing issues that resulted in lower audited premium rates than what was submitted by the Plan (see Exhibit B). Specifically, application of the defective pricing remedy shows that the FEHBP is due $334,761 for contract years 2020 and 2021 (see Exhibit A).

Table I – Defective Pricing				
Year	**High**	**Standard**	**Basic**	**Total**
2020	($69,328)	$142,974	$137,991	$211,637
2021	$41,251	$61,330	$20,543	$123,124
			Total Overcharged Premium	**$334,761**

The specific issues that resulted in a monetary rate reduction of the FEHBP premium rates under the provisions of the Contract Section 3.3 are discussed in detail in paragraphs A.1.a through A.1.b of this report.

Recommendation 1:

We recommend that the Plan return $334,761 to the FEHBP for defective pricing in contract years 2020 and 2021.

Plan's Response:

The Plan agreed with the 2020 defective pricing total of $211,637 but did not provide any comment on the 2021 defective pricing total of $123,124.

a. Special Benefit Loadings

During our review of the 2020 rate year, we determined that there was a discrepancy between the special benefit loadings listed in the 2020 rate development and those shown in the 2020 FEHBP benefit brochure.

Per the 2020 Reconciliation Instructions, "If the special benefit is offered only to FEHB enrollees and the cost was approved by OPM in the 2020 proposal, it cannot be changed in the reconciliation."

Also, "Pursuant to Contract clause 3.4, Contractor Records Retention (FEHBAR 1652.204-70), OPM requires all carriers to maintain documentation to support all calculations and statements pertaining to the reconciliation. … For carriers using an ACR method, this includes detailed reports (including the database) supporting all data (e.g., claims data) used to derive the rates … ."

The Plan inadvertently used incorrect special benefit loadings within its 2020 premium rate development.

The Plan explained that during the 2020 pricing cycle, there were proposed benefit changes that the Plan initially filed with OPM. A smaller rate increase was requested by OPM, so it asked the Plan to adjust its benefit changes. The final changes, which were approved by OPM, were correctly listed in the 2020 Benefit Closeout Letter and the FEHBP benefit brochure. However, the Plan did not capture the approved changes within the development of the premium rates nor did OPM identify the error. Therefore, the incorrect special benefit loadings were inadvertently used in the proposal and reconciliation.

The Plan used a benefit comparison tool (BCT) to develop and document necessary special benefit loadings and/or plan adjustment factors. For 2020, the Plan was able to provide the factors, but not the actual documentation from the BCT. We applied the updated factors provided by the Plan for the correct special benefit loadings to obtain audited premium rates for 2020.

Based on the results, the Plan understated the High option premium rates and overstated the Standard and Basic option premium rates in 2020. Further, the incorrect special benefit loadings from the 2020 premium rate had a direct impact on the 2021 pricing. The incorrect 2020 adjustments were included in the plan adjustment factor formulas applied to the current and prior claims experiences for 2021. We applied the updated 2021 plan adjustment factors and determined that the Plan overcharged the 2021 High, Standard, and Basic option premium rates.

Recommendation 2:

We recommend that the Plan comply with the applicable criteria and only include related special benefit loadings that were approved by OPM.

Plan's Response:

The Plan agreed with the finding.

b. Incorrect Provider Contract

Our review of the sampled 2020 claims identified that the Plan did not properly configure its claims system to price and pay a sampled claim based on the terms in its provider contracts and fee schedules.

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

The Plan's claim system was not properly configured to pay claims in accordance with the terms in its provider contracts and fee schedules.

The Plan explained that "Based on the provider's contract this claim should have processed at [redacted] of the Medicare allowed amount after the [Multiple Procedure Payment Reduction]. However, the claim incorrectly processed at [redacted] of the Medicare allowed amount due to a contract load error, causing this claim to be overpaid." The Plan stated that "The contract load error was corrected in August 2021 [and] [a]ny impacted claims will be corrected.

We queried the 2020 and 2021 experience period medical claims universe for plan codes 75 and RW to determine if there were additional claims related to this provider. We noted three additional claims related to this provider.

Based upon the provided documentation, we were unable to confirm that the contract load error was corrected as of August 21, 2021, or if the impacted claims have been repriced or corrected. Therefore, we removed these claims, totaling $19,304, from the 2020 and 2021 premium rate claims experience because it inflated the incurred claims total. The Plan lacked adequate controls to ensure its claim system was updated and claims were processed in accordance with the provider contract.

Recommendation 3:

We recommend that the Plan ensure appropriate internal controls are in place to detect and correct claim overpayments in accordance with Contract Section 2.3(g).

Recommendation 4:

We recommend that the Plan ensure appropriate procedures and controls are in place to update its claims processing systems to reflect the most current provider pricing agreements.

Plan's Response:

The Plan agreed with the finding.

The Plan stated that it "audited the Provider group and found that the incorrect record was loaded into the contract information system effective January 1, 2018. A correction was made to the [claim system] on August 12, 2021 to correct the record [and] update the fee schedule from [redacted]] … ." Humana will not recoup the claim overpayments because the contract overpayments issued more than 18 months from the original paid date cannot be recovered. "The review and correction of additional claims impacted by the provider contract pricing oversight are in progress."

The process to load a contract into the contract information system has been updated to include additional auditing prior to approval of the record in the system. "The Plan updated its processes to track through a single database instead of each associate submitting their own files and tracking their own documentation. Additionally, [the Plan] implemented a process called Outcome Based Reviews that validates the desired outcome was met during the execution of the provider update."

OIG Comment:

Within the draft report we requested additional documentation related to the audit issue, however, the Plan did not provide any further comment, correction, or documentation. Therefore, it is still our position that the incorrectly priced claims should not be included in the pricing data and should be removed from the audited rate. A total of $19,304 was removed from the claim experience related to the 2020 and 2021 premium rates.

2. Lost Investment Income: $13,083

In accordance with the FEHBP regulations and the Contract, the FEHBP is entitled to recover LII on the defective pricing finding in contract years 2020 and 2021. We determined that the FEHBP is due $13,083 for LII, calculated through November 30, 2022 (see Exhibit C). In addition, the FEHBP is entitled to LII for the period beginning December 1, 2022, until all defective pricing finding amounts have been returned to the FEHBP.

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 semiannual cost of capital rates.

Recommendation 5:

We recommend that the Plan return $13,083 to the FEHBP for LII, calculated through November 30, 2022. We also recommend that the Plan return LII on amounts due for the period beginning December 1, 2022, until all defective pricing finding amounts have been returned to the FEHBP.

Plan's Response:

The Plan agreed with the finding.

B. Internal Controls Review

Based on errors identified during our audit and discussed throughout this report, we determined that the Plan's internal controls over the FEHBP premium rate development process were insufficient. 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."

Specifically, we found the issues noted below.

1. Overage Dependent Documentation: Procedural

The Plan did not maintain adequate documentation for all of its disabled dependents and was unable to retrieve documentation to support its eligibility determination.

The Plan did not maintain adequate documentation for its disabled dependents in accordance with the FEHBP benefit brochures, its contract, or its own policy, which was created based on a prior OIG audit.

In a previous OIG MLR audit of the Plan, there was a finding related to overage disabled dependents whose status was not fully supported. An overage dependent is defined as a disabled child age 26 or older, who is incapable of self-support because of a physical or mental disability that existed before their 26th birthday. As a part of the audit resolution, the Plan provided an updated disabled dependent policy. The policy stated that once the Plan received and verified the information, the overage dependent is updated/flagged in the enrollment system, then the 2089 form and documentation supporting the disability is scanned and assigned a document control number (DCN). The DCN is tied or matched to the subscriber's profile and enrollment record. We performed a review of the updated policy to assess its implementation and effectiveness.

The Plan's 2020 and 2021 FEHBP benefit brochures state that it covers dependents age 26 and over when they are deemed disabled and incapable of self-support prior to age 26. Furthermore, the FEHBP Handbook states that it is the responsibility of the subscriber's employing office to provide documentation for disabled dependents, and the Plan is responsible for maintaining the documentation per Contract Section 1.11(b). This contract clause requires insurance carriers to maintain all records relating to the Contract and to make these records available for a period of time specified by FEHBAR 1652.204-70. FEHBAR 1652.204-670 is incorporated into the Contract at Section 3.4, which requires the carrier to maintain individual enrollee and/or patient claim records "for six years after the end of the contract term to which the claim records relate."

We selected a judgmental sample of five overage dependents from the 2020 medical claims data for plan code 75 to determine if the Plan properly adhered to its new disabled dependent policy described above. We verified if the supporting documentation for the sampled dependents was available. The results of our dependent eligibility review noted two overage

dependents whose status was not fully supported in compliance with the Plan's policy and the applicable criteria. As a result, we expanded our judgmental sample with an additional five overage dependents from the 2020 and 2021 medical claims for both plan codes 75 and RW. Based on our review, we determined there was one additional overage dependent for which the Plan was unable to provide supporting documentation.

The Plan is not in compliance with the contractual and regulatory requirements for the maintenance of records. As a result, we isolated all the medical and pharmacy claims for contract years 2020 and 2021 for the unsupported overage dependents and determined the monetary impact of the claims was immaterial in this instance.

Recommendation 6:

We recommend that the Plan maintain adequate documentation from the responsible employing offices for designated FEHBP overage disabled dependents in accordance with the applicable criteria.

Recommendation 7:

We recommend that the Plan review its written policies and procedures to assess the effectiveness in complying with the Contract's records retention requirements, specifically as it relates to designated FEHBP overage disabled dependents.

Plan's Response:

The Plan agreed with the finding.

2. Morbidity, Demographic, and Cost Share Impact Factor: Procedural

During the review of the 2019 FEHBP premium rate, we determined that an FEHB-specific factor used to reflect additional morbidity, demographics, and cost share impacts based on historical and future projections was applied to the rate. The factor was labeled as "Morbidity/Demographics/Cost Share Impacts" to account for (a) incremental morbidity beyond the standard, (b) demographics (aging) adjustment in addition to what is standardly assumed on a commercial group renewal, and (c) increases annually in the amount of coordination of benefits (COB) recoveries resulting from the group encountering higher allowed claim cost offsets due to an increasing number of enrollees carrying dual coverage with Medicare Parts A and B.

We noted that the morbidity, demographic, and cost share impact factors were updated from the proposal to the reconciliation for the contract year 2019 premium rate. The Plan stated that it overwrote the file used to calculate the factors in the proposal and it did not have a

copy of the original documentation. The original factors were created using data paid through March 2018. The Plan did provide an updated file for the 2019 reconciliation process, but the file used to calculate the factors was updated with data paid through April 2018. The methodology used to calculate the factors is the same, but due to the change in the data, the factors are different from what was used in the proposal. Since the Plan did not maintain adequate supporting documentation for the factors, we were unable to support the original morbidity, demographic, and cost share factors.

Documentation to support the morbidity, demographic, and cost share factors was not maintained by the Plan.

Based on the description of the morbidity factor, it is based on group-specific demographics. Per the Community Rating Instructions, "If group-specific demographic assumptions … were used in the proposal, the same figures must be used in the reconciliation." As a result, the morbidity, demographic, and cost share factor from the 2019 proposal was applied to the 2019 reconciliation.

Additionally, "Pursuant to contract clause 3.4, Contractor Records Retention (FEHBAR 1652.204-70), OPM requires all carriers to maintain documentation to support all calculations and statements pertaining to the reconciliation. … For carriers using an ACR method, this includes detailed reports (including the database) supporting all data (e.g., claims data) used to derive the rates … ."

While the impact of adjusting the 2019 morbidity, demographic, and cost share factor to what was used in the proposal was immaterial, the Plan lacked adequate system controls to ensure necessary demographic documentation was maintained.

Recommendation 8:

We recommend that the Plan comply with the record retention requirements of its Contract.

Plan's Response:

The Plan agreed with the finding that more robust documentation and document retention standards were needed in 2018 and 2019 to support the original morbidity, demographic, and cost share factors. "In November 2021, the Large Group Forecasting and Special Accounts team implemented new process and documentation standards called Market Operational & Professional Standards (MOPS). Within the MOPS are standards on Email Guidelines & Etiquette, Folder Maintenance, Peer Review, Model & Workbook Layout. The Email Guidelines & Etiquette section requires all incoming and outgoing emails to be saved within a folder that is

appropriately named for the work being completed. All of the work accompanying the outgoing emails must be saved or linked within the folder system that houses the outgoing email. MOPS guides the work that is completed by [the Plan's] team and ensures [they] are completing quality work and retaining sufficient documentation of all of [their] work."

OIG Comment:

The Plan stated it has implemented a new process and developed documentation standards. We will review the effectiveness of the process and documented standards during a future audit.

3. Incorrect Explanation of Medicare Benefits: Procedural

During our review of a sample of 25 judgmentally selected medical claims, we identified that there was a claim processed and paid with the incorrect Explanation of Medicare Benefits (EOMB).

The Plan did not follow its own internal reimbursement policies for COB claims, nor did it maintain appropriate documentation.

OPM's Contract Section 1.11(b) requires insurance carriers to maintain all records relating to the contract and to make these records available for a period of time specified by FEHBAR, 48 CFR 1652.204-70. The referenced clause is incorporated into the contracts at Section 3.4, which requires the carrier to maintain "all records applicable to a contract term ... for a period of six years after the end of the contract term to which the claim records relate."

The Plan stated that it did not attempt to obtain an updated EOMB because there was not an indication or dispute of an incorrect payment. Furthermore, the Plan's COB claim process provides instruction for reviewing the accuracy of the EOMB information that is submitted.

The process advises the claims adjuster to deny a claim with incorrect, missing, or invalid information. However, this claim was processed and paid incorrectly due to human error. Leadership has been notified, and the specific claims adjuster will receive additional training.

While the impact of the claim was immaterial, the Plan lacked adequate system controls to ensure its own reimbursement policies were followed and the necessary documentation was maintained in accordance with its Contract.

Recommendation 9:

We recommend that the Plan comply with the requirements of its Contract related to internal controls and record retention.

Plan's Response:

The Plan "acknowledges that the incorrect explanation of Medicare benefits was used for the claim sample in question. The claim involved [a COB] in which the [FEHBP] policy was secondary to Medicare. The provider submitted an incorrect [EOMB] which did not match the billed services or charges for the submitted claim." The Plan stated that it "has an established process in place for an Adjuster to follow when an incorrect EOMB is submitted." The Plan provided policies and procedures which outline the specific Adjuster step actions when an incorrect EOMB is received. The Plan also provided its Record Retention policy.

However, the Plan disagrees with remainder of the findings and recommendation. The Plan's "internal controls include quality auditing for oversite of claim processing accuracy. … Upon receipt of a dispute, correspondence, or correction of a claim appropriate action is taken as warranted."

OIG Comment:

We recognize that this claim was processed incorrectly due to human error and have reviewed the Plan's policies and procedures outlining the specific Adjuster step actions when an incorrect EOMB is received. We have also reviewed the Plan's Record Retention policy. We will further evaluate the effectiveness of these policies and procedures during a future audit. However, we still recommend that the Plan comply with its Contract related to internal controls and record retention to ensure similar situations do not occur in the future.

4. Claims Paid After Termination Date: Procedural

During our review of the sampled claims, we identified a claim that was paid after the member's termination date.

The Plan paid a claim for a member after their termination date and could not support that the claim payment was retracted.

The FEHBP benefit brochure mentions that if enrollment continues after a member is no longer eligible for coverage and premiums are not paid, the member will be responsible for all benefits paid during the period in which premiums were not paid.

The claim in question had a date of service of June 7, 2018, was received on July 5, 2018, and was processed on July 18, 2018. However, on October 17, 2018, the Plan received notification to terminate the policy retroactively to May 31, 2018.

We inquired if the claim paid after the termination was retracted. In the Plan's response, it mentioned that the claim in question should not have been paid based on the termination date. It stated that it notified the provider of the overpayment and requested the provider reimburse it for the overpayment, although we were unable to verify if the overpayment was requested or if the payment was returned for the claim in question.

The Plan did not address our inquiry if any other claims paid after the termination date were retracted or reversed. Therefore, we reviewed the 2020 and 2021 medical and pharmacy claims universe to determine if this member had any additional claims paid after the termination date. We noted that there were a total of eight medical claims and one pharmacy claim. It appears that these claims were incorrectly paid, and we were not provided documentation to show that they were retracted.

The Plan could not provide the necessary documentation to show that the claims for the member were retracted, which not only potentially overstated its incurred claims amount, but the Plan also is not in compliance with its Contract and the regulatory requirements.

Recommendation 10:

We recommend that the Plan strengthen its internal controls around terminated members and retracting payments for ineligible claims that were paid in accordance with its Contract.

Recommendation 11:

We recommend that the Plan ensure all members are accurately terminated in accordance with the applicable guidance.

Plan's Response:

The Plan agreed with the finding. The Plan was able to obtain refunds for some claims, however, claims were written off where the Plan did not receive a refund. "The

member was terminated effective May 31, 2018, per the third quarter Centralized Enrollment Clearinghouse System ('CLER') discrepancy. The member was not eligible for an extension of coverage as they moved to another carrier as shown in the CLER."

"The Plan will monitor its process to ensure all members are accurately terminated in accordance with the guidance in the [Contract] and [FEHBP] benefit brochure. Member enrollment is updated quarterly in the CLER system, and a specialist processes all enrollment, changes, and terminations. Member updates may result in retroactive terminations, and the Plan does not deny any retroactive terminations as enrollment must match the CLER system."

OIG Comment:

We acknowledge the Plan's response, but it did not provide any additional comments or documentation. It is still our position that these claims should not have been included in the FEHBP experience period claims to calculate the premium rates.

5. Benefit Brochure Inaccuracy: Procedural

The Plan had a misstatement of the standard option biweekly family rate in its 2018 FEHBP benefit brochure.

OPM Contract section 1.13 states that the Plan "bears full responsibility for the accuracy of its FEHB brochure."

The 2018 FEHBP benefit brochure misstated the standard option family enrollee premium amount.

During our review of the 2019 FEHBP premium rate, we determined that in order to obtain the necessary rate increase, the 2018 rate must be used as part of the calculation. We reviewed the previous year's rates in the 2018 FEHBP brochure and noted that there was an error with the listed standard option biweekly family enrollee premium amount. This error distorted the total 2018 family rate. The FEHBP benefit brochure's biweekly amount was $363.81, but the premium shown on OPM's website was the correct rate of $393.81. We reached out to the OPM Actuaries and determined that the biweekly enrollee share in the brochure appeared to be a typographical error. The enrollees of the standard option family plan may have had confusion about the amount of their biweekly rates, and the Plan was not in compliance with Contract Section 1.13.

Recommendation 12:

We recommend that the Plan ensure that FEHBP benefit brochures are complete and accurate in accordance with its Contract.

Plan's Response:

The Plan agreed with the finding.

Exhibit A

Humana Health Plan, Inc.
Summary of Defective Pricing Questioned Costs

Contract Year 2019	$0
Contract Year 2020	$211,637
Contract Year 2021	$123,124
Total Defective Pricing Questioned Costs	**$334,761**
Lost Investment Income	$13,083
Total Amount Due to OPM	**$347,844**

Exhibit B

Humana Health Plan, Inc.
2020 Defective Pricing Questioned Costs

Contract Year 2020

High Option	**Self**	**Self+1**	**Family**
FEHBP Line 5 – Reconciled Rate	$610.92	$1,313.48	$1,374.57
FEHBP Line 5 – Audited Rate	$614.63	$1,321.46	$1,382.92
Bi-weekly Undercharge	$3.71	$7.98	$8.35
To Annualize Undercharge:			
March 31, 2020 Enrollment	489	21	82
Pay Periods	26	26	26
Subtotal	$47,168.94	$4,357.08	$17,802.20

Standard Option	**Self**	**Self+1**	**Family**
FEHBP Line 5 – Reconciled Rate	$469.38	$1,009.17	$1,056.10
FEHBP Line 5 – Audited Rate	$465.43	$1,000.68	$1,047.23
Bi-weekly Overcharge	$3.95	$8.49	$8.87
To Annualize Overcharge:			
March 31, 2020 Enrollment	735	12 5	173
Pay Periods	26	26	26
Subtotal	$75,484.50	$27,592.50	$39,897.26

Basic Option	**Self**	**Self+1**	**Family**
FEHBP Line 5 – Reconciled Rate	$332.06	$713.93	$747.13
FEHBP Line 5 – Audited Rate	$322.79	$694.00	$726.28
Bi-weekly Overcharge	$9.27	$19.93	$20.85
To Annualize Overcharge:			
March 31, 2020 Enrollment	216	79	83
Pay Periods	26	26	26
Subtotal	$52,060.32	$40,936.22	$44,994.30

Total 2020 Defective Pricing **$211,637**

Exhibit B (Cont.)

Humana Health Plan, Inc.
2021 Defective Pricing Questioned Costs

Contract Year 2021

High Option	**Self**	**Self+1**	**Family**
FEHBP Line 5 – Reconciled Rate	$675.97	$1,453.34	$1,520.93
FEHBP Line 5 – Audited Rate	$673.38	$1,447.77	$1,515.11
Bi-weekly Undercharge	$2.59	$5.57	$5.82
To Annualize Undercharge:			
March 31, 2021 Enrollment	428	20	63
Pay Periods	26	26	26
Subtotal	$28,821.52	$2,896.40	$9,533.16

Standard Option	**Self**	**Self+1**	**Family**
FEHBP Line 5 – Reconciled Rate	$516.15	$1,109.72	$1,161.34
FEHBP Line 5 – Audited Rate	$514.17	$1,105.47	$1,156.89
Bi-weekly Overcharge	$1.98	$4.25	$4.45
To Annualize Overcharge:			
March 31, 2021 Enrollment	660	102	139
Pay Periods	26	26	26
Subtotal	$33,976.80	$11,271	$16,082.30

Basic Option	**Self**	**Self+1**	**Family**
FEHBP Line 5 – Reconciled Rate	$363.97	$782.54	$818.93
FEHBP Line 5 – Audited Rate	$362.58	$779.54	$815.80
Bi-weekly Overcharge	$1.39	$3.00	$3.13
To Annualize Overcharge:			
March 31, 2021 Enrollment	228	68	86
Pay Periods	26	26	26
Subtotal	$8,239.92	$5,304	$6,998.68

Total 2021 Defective Pricing	**$123,124**

Exhibit C

Humana Health Plan, Inc. Lost Investment Income

Lost Investment Income	2019	2020	2021	30-Nov-22	Total
Defective Pricing:	$0	$211,637	$123,124	$0	$334,761
Cumulative Totals:	$0	$211,637	$334,761	$334,761	$334,761
Average Interest (per year):	3.125%	1.625%	1.000%	2.8125%	
Interest on Prior Years Findings:	$0	$0	$2,116	$8,631	$11,531
Current Years Interest:	$0	$1,720	$616	$0	$2,336
Total Cumulative Interest Calculated Through November 30, 2022:	$0	$1,720	$2,732	$8,631	**$13,083**

Exhibit D

Humana Health Plan, Inc
Medical Claims Sample Selection Criteria and Methodology

Universe Criteria	Universe of Unique Claims (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Number	Sample (Dollars)	Results Projected to the Universe?
2020 Incurred Medical Claims	58,156 Claims	$39,252,444	Judgmental – utilized SAS EG[1] to select 5 random claims greater than $10,000 and 20 random claims less than $10,000	25	$181,484	No

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

Appendix A

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Chief, Community-Rated Audits Group
United States Office of Personnel Management

Deleted by the OIG – Not Relevant to the Final Report

Company Response: Draft Report - Humana Health Plan, Inc. - Chicago, Plan Codes 75 and RW – Received by the OIG on October 24, 2022

The Plan reviewed the reported draft findings and offers no additional commentary or corrections. The Plan continues to disagree with components of finding 3 related to the effectiveness of internal controls monitoring the quality of claim processing.

The Plan requests the responses to recommendations 2, 5-7, 12, **Deleted by the OIG – Not Relevant to the Final Report** be updated to reflect "The Plan agreed with the finding and will consider the recommendation."

Deleted by the OIG – Not Relevant to the Final Report

Sincerely, Digital Signature

Deleted by the OIG – Not Relevant to the Final Report

Deleted by the OIG – Not Relevant to the Final Report, Associate Director
Regulatory Compliance, Audit Coordination

500 W Main Street
Louisville, KY 40207

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Appendix B

Below are the Plan's responses to the Notice of Findings and Recommendations that were issued during the audit fieldwork, as applicable to the final report.

Plan's Response to NFR #1 – Received by the OIG on July 1, 2022

Recommendation

We recommend that the Plan maintain adequate documentation from the responsible employing offices for designated FEHBP overage disabled dependents.

Recommendation

We recommend that the Plan review its written policies and procedures to assess the effectiveness in complying with the Contract's records retention requirements, specifically as it relates to designated FEHBP overage disabled dependents.

Auditee Response

Plan Management concurs with the factual accuracy of the audit issues.

Plan Management concurs with recommendations.

Plan's Response to NFR #2 – Received by the OIG on July 1, 2022

Recommendation

We recommend that the Plan comply with the record retention requirements of its contract.

Auditee Response

Plan Management concurs with the factual accuracy of the audit issues.

Plan Management concurs with recommendation.

Additional Plan Comments:

The Plan acknowledges that the incorrect explanation of Medicare benefits was used for the claim sample in question. The claim involved Coordination of Benefits (COB) in which the Federal Employee's Health Benefit Program (FEHBP) policy was secondary to Medicare. The provider submitted an incorrect Explanation of Medicare Benefits (EOMB) which did not match

the billed services or charges for the submitted claim. Humana has an established process in place for an Adjuster to follow when an incorrect EOMB is submitted. This process was not followed.

However, the Plan respectfully disagrees with remainder of the OPM's findings and recommendation.

The Plan's internal controls include quality auditing for oversite of claim processing accuracy.

Upon receipt of a dispute, correspondence, or correction of a claim appropriate action is taken as warranted.

Plan's Response to NFR #3 – Received by the OIG on July 1, 2022 and July 11, 2022

Recommendation

We recommend that the Plan ensure appropriate procedures and controls are in place to update its claims processing systems to reflect the most current provider pricing agreements.

Auditee Response

Plan Management concurs with the factual accuracy of the audit issues.

Plan Management concurs with recommendation.

Additional Plan Comments:

Response to Recommendation:

The Plan audited the Provider group and found that the incorrect record was loaded into the contract information system effective January 1, 2018. A correction was made to the load on August 12, 2021 to correct the record to update the fee schedule from 93% to 90%. The original provider amendment used to load the contracted rates was reviewed and there was a loader error. The process to load a contract into the contract information system has since been updated so that additional auditing is done prior to approval of the record in the system.

Response to Recommendation: (Supplemental Response)

Based on the provider's contract an overpayment issued more than 18 months from the original paid date cannot be recovered. Humana will not recoup this overpayment amount.

The review and correction of additional claims impacted by the provider contract pricing oversight are in progress.

Response to Recommendation:

The Plan updated its process to track through a single database instead of each associate submitting their own files and tracking their own documentation. Additionally, we implemented a process called Outcome Based Reviews that validates the desired outcome was met during the execution of the provider update.

Plan's Response to NFR #4 – Received by the OIG on July 1, 2022

Recommendation

We recommend that the Plan provide the necessary documentation to support that claims after the retroactive termination were retracted and the member received the appropriate extension of coverage.

Recommendation

We recommend that the Plan provide its written policies and procedures to assess their effectiveness in meeting the Contract's member termination requirements specifically as it retroactively termed FEHBP members.

Recommendation

We recommend that the Plan monitor its process to ensure all members are accurately terminated in accordance with the guidance in the FEHBP contract and benefit brochure.

Auditee Response

Plan Management concurs with the factual accuracy of the audit issues.

Plan Management concurs with recommendations.

Additional Plan Comments:

Response to Recommendation:

Please note that claims were written off where the Plan did not receive a refund.

Response to Recommendation:

The member was terminated effective May 31, 2018 per the third quarter Centralized Enrollment Clearinghouse System ("CLER") discrepancy. The member was not eligible for an extension of coverage as they moved to another carrier as shown in the CLER.

Response to Recommendation:

The Plan will monitor its process to ensure all members are accurately terminated in accordance with the guidance in the FEHBP contract and benefit brochure. Member enrollment is updated quarterly in the CLER system, and a specialist processes all enrollment, changes, and terminations. Member updates may result in retroactive terminations, and the Plan does not deny any retroactive terminations as enrollment must match the CLER system.

Plan's Response to NFR #5 – Received by the OIG on August 9, 2022

Recommendation

We recommend that the Plan comply with the record retention requirements of its contract.

Auditee Response

Plan Management concurs with recommendation.

Additional Plan Comments:

More robust documentation and document retention standards were needed in 2018/2019 in order to support the original morbidity/demographic factors. In November 2021, the Large Group Forecasting and Special Accounts team implemented new process and documentation standards called Market Operational & Professional Standards (MOPS). Within the MOPS are standards on Email Guidelines & Etiquette, Folder Maintenance, Peer Review, Model & Workbook Layout. The Email Guidelines & Etiquette section requires all incoming and outgoing emails to be saved within a folder that is appropriately named for the work being completed. All of the work accompanying the outgoing emails must be saved or linked within the folder system that houses the outgoing email. MOPS guides the work that is completed by our team and ensures we are completing quality work and retaining sufficient documentation of all of our work.

Plan's Response to NFR #6 – Received by the OIG on August 26, 2022

Recommendation

We recommend that the Plan comply with the applicable criteria related to special benefit loadings.

Recommendation

We recommend that the contracting officer require the Plan to return $211,637 to the FEHBP for defective pricing in contract year 2020.

Auditee Response

Plan Management concurs with the factual accuracy of the audit issues.

Plan Management concurs with recommendations.

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