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Office of Audits

Final Audit Report

Audit of the Federal Employees Health Benefits Program Operations at Medical Mutual of Ohio

Report Number 2022-CRAG-032
August 21, 2023

Executive Summary

Audit of the Federal Employees Health Benefits Program Operations at Medical Mutual of Ohio

Report No. 2022-CRAG-032 **June XX, 2023**

Why Did We Conduct the Audit?

The primary objective of the audit was to determine if Medical Mutual of Ohio (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 1182, the Office of the Inspector General completed a performance audit of the FEHBP premium rate developments and FEHBP MLR submissions for contract years 2018 through 2020. We conducted our audit fieldwork remotely from September 27, 2022, through March 2, 2023.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

We determined that portions of the 2020 FEHBP premium rate development and the 2018 through 2020 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 $67,506 for defective pricing in contract year 2020. In addition, the FEHBP is due lost investment income of $4,423 on the premium overpayments. The reduction in premium rates, as well as additional reporting errors identified, led to an overstated MLR credit of $4,281 in 2018 and understated MLR penalties, totaling $649,974, in contract years 2019 and 2020. Specifically, our audit identified the following:

- The Plan used inaccurate trend factors in its 2020 rate reconciliation.
- The 2019 and 2020 MLR filings included incorrect plan code expenses.
- The MLR filings included duplicate Accountable Care Organization expenses in 2018 and 2019 and inaccurate Patient Centered Outcomes Research Institute expenses in contract years 2018 through 2020.
- Centralized Enrollment Clearinghouse System enrollment discrepancies were not resolved in a timely manner.
- Overage dependents were terminated early, and the Plan did not assess the applicability of the 31-day extension of coverage for FEHBP members that terminated due to a subscriber tier reduction.
- The Plan's internal controls over the FEHBP enrollment records and manual processing of claims were insufficient, resulting in unsupported termination dates and claims processing errors.
- The Plan lacked policies and procedures surrounding its same-day copay policies, which also conflicted with the FEHBP Benefits Brochure.

Abbreviations

ACO	**Accountable Care Organization**
CFR	**Code of Federal Regulations**
CL	**Carrier Letter**
CLER	**Centralized Enrollment Clearinghouse System**
CMS	**Corporate Membership System**
Contract	**OPM Contract CS 1182**
FEHBAR	**Federal Employees Health Benefits Acquisition Regulations**
FEHBP	**Federal Employees Health Benefits Program**
IRS	**Internal Revenue Service**
LII	**Lost Investment Income**
MLR	**Medical Loss Ratio**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
PCORI	**Patient-Centered Outcomes Research Institute**
Plan	**Medical Mutual of Ohio**
PMPY	**Per Member Per Year**
SSSG	**Similarly-Sized Subscriber Group**

Table of Contents

Page

Executive Summary i

Abbreviations ii

I. **Background** 1

II. **Objectives Scope and Methodology** 3

III. **Audit Findings and Recommendations** 5

A. Premium Rate Review 5

1. Defective Pricing 5
2. Lost Investment Income 6
3. Claims Data Requirement Issue 7

B. Medical Loss Ratio Review 7

1. FEHBP MLR Filing Requirement Noncompliance 8
2. Duplicate Accounting of ACO Fees 10
3. Inaccurate PCORI Fees 11
4. MLR Credit Adjustment and Additional Penalties Due 13

C. Internal Control Review 15

1. CLER 160 Errors 15
2. Extension of Coverage Not Applied 17
3. Enrollment Verification and Termination Issues 19
4. Incorrectly Priced and Paid FEHBP Claims 21
5. Same-Day Copay Policy Issue 23

Exhibit A (Summary of Defective Pricing Questioned Costs)

Exhibit B (Defective Pricing Questioned Costs)

Exhibit C (Lost Investment Income)

Exhibit D (Summary of Medical Loss Ratio Review)

Exhibit E (Medical Loss Ratio Review by Contract Year)

Exhibit F (Medical Claims Sample Selection Criteria and Methodology)

Appendix (Plan's April 5, 2023, response to the draft report)

Report Fraud, Waste, and Mismanagement

I. Background

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at Medical Mutual of Ohio (Plan), plan codes 64, UX, and X6. The audit was conducted pursuant to the provisions of Contract CS 1182 (Contract); 5 United States Code Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract years 2018 through 2020 and was conducted remotely by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG) staff.

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

In April 2012, OPM issued a final rule establishing an FEHBP-specific Medical Loss Ratio (MLR) requirement to replace the similarly-sized subscriber group (SSSG) comparison requirement for most community-rated FEHBP carriers (77 Federal Register 19522). The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act (P.L. 111-148) and defined by the U.S. Department of Health and Human Services in 45 CFR Part 158. In 2012, community-rated FEHBP carriers could elect to follow the FEHBP-specific MLR requirements, instead of the SSSG requirements. Beginning in 2013, the MLR methodology was required for all community-rated carriers, except those that are state-mandated to use traditional community rating. State-mandated traditional community-rated carriers continue to be subject to the SSSG comparison rating methodology.

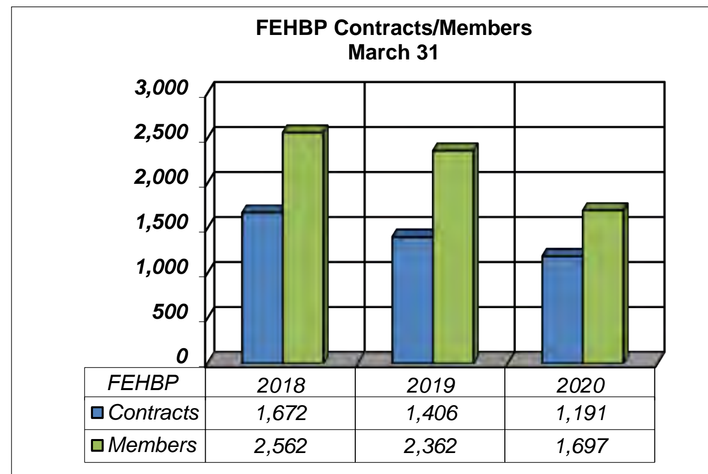
The MLR is the proportion of FEHBP premiums collected by a carrier that is spent on clinical services and quality health improvements. The MLR was established to ensure that health plans are meeting specified thresholds for spending on medical care and health care quality improvement measures, and thus limiting spending on administrative costs, such as executive salaries, overhead, and marketing of the health plan. 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.

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.

Additionally, 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	2018	2019	2020
Contracts	1,672	1,406	1,191
Members	2,562	2,362	1,697

In 2018, the Plan provided health benefits to FEHBP members in Northeast Ohio and offered a basic, standard, and high option. In 2019, the Plan added the Northwest Ohio service area and removed the high option benefit.

This is the first audit of the Plan's MLR submissions. Medical Mutual of Ohio acquired the HealthSpan Integrated Care FEHBP contracts through a novation. A prior audit of HealthSpan Integrated Care's premium rates for contract year 2010 through 2013 identified inappropriate health benefit charges to the FEHBP. The final audit report was issued in May of 2014, and all issues were resolved by OPM.

Some of the preliminary results of this audit were communicated to Plan officials during the Notice of Finding and Recommendations process. The Plan's comments were considered in preparation of this report and are included, as appropriate, in the report. Additionally, we discussed all of the issues outlined in this report with Plan officials during the Exit Conference.

II. Objectives, Scope, and Methodology

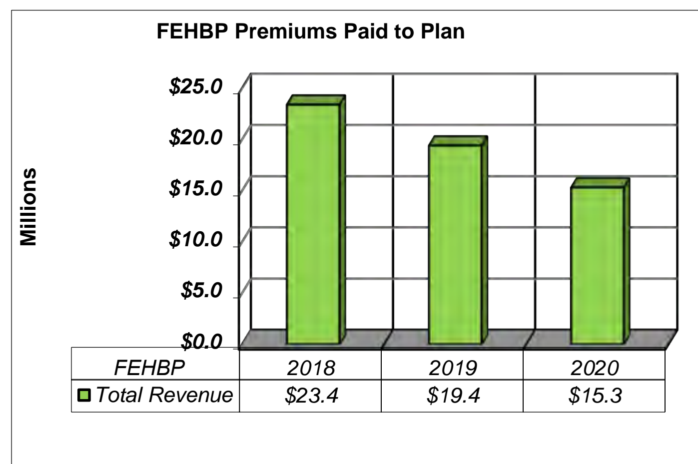
Objectives

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 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 2018 through 2020. For these years, the FEHBP paid approximately $58.1 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;
- appropriate allocation methods were used;
- any other costs associated with its MLR and premium rate calculations were appropriate;
- FEHBP medical claims were processed accurately;
- FEHBP members received the 31-day extension of coverage when coverage was lost, as applicable; and

- Centralized Enrollment Clearinghouse System (CLER) “160” error codes were resolved timely.

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 September 27, 2022, through March 2, 2023.

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 F 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 FEHBP Contract CS 1182 (Contract). We determined that the Plan's 2020 Certificate of Accurate Pricing for plan codes 64, UX, and X6 were defective due to non-compliance with OPM's Community Rating Guidelines. In accordance with Federal regulations, the FEHBP is, therefore, due overpaid premiums of $67,506 for contract year 2020. In addition, the application of the defective pricing remedy shows that the FEHBP is also due Lost Investment Income (LII) of $4,423 on the premium overpayment for a total amount due to OPM of $71,929 (see Exhibit A).

1. Defective Pricing: $67,506

During our review of the Plan's 2020 FEHBP premium rate development for Plan Codes 64, UX, and X6, we determined that an annual trend was not properly applied to the FEHBP rate. Although the Plan applied the annual trend factor by using its trend factor table, the table used and labeled "for groups Effective 01/01/2020 and Prepared on or after 01/10/2020" did not meet OPM's 2020 Community Rating Guidelines. Specifically, OPM's guidelines state, "[o]nly factors that are changed for all claims-based Adjusted Community Rating groups before January 1 of the contract period may be updated in the reconciliation." As such, the Plan should have used the previous trend factor table labeled "for groups Effective 01/01/2019 and Prepared on or after 09/14/2018." During the audit, the Plan acknowledged an error in the application of the trend factor.

The Plan did not follow OPM's Community Rating Guidelines, resulting in defective pricing in 2020.

As a result, we adjusted the annual trend factors during the recalculation of the 2020 FEHBP premium rate development using the factors in the Plan's trend factor table labeled "for groups Effective 01/01/2019 and Prepared on or after 09/14/2018." The audit calculated rates resulted in audited premium rates that were $67,506 lower than what was submitted by the Plan.

Recommendation 1:

We recommend that the Plan return $67,506 to the FEHBP for defective pricing.

Plan Response:

The Plan agreed with the finding and recommendation.

Recommendation 2:

We recommend that the Plan develop written FEHBP-specific policies and procedures to address the appropriate application of factors in the FEHB premium rate development per OPM's Community Rating Guidelines.

Plan Response:

The Plan stated that "Starting 2024 policy year, the FEHBP premium rating will be transferred from Actuarial department to Underwriting department. Underwriting department utilize[s] Stepwise system for rating purpose." The Plan also attached a policy and procedure for the StepWise rating system, which was updated based on the recommendation from the audit report.

OIG Comment:

The Plan's policy and procedure is not FEHBP-specific, nor does it allude to FEHBP-specific rating regulations. However, it does require any changes to the large group rating factors to be reviewed for compliance with FEHBP rating requirements. In addition, it requires the underwriter assigned to the FEHBP account to be notified in writing of any changes. The assigned underwriter then must approve those changes in writing before they can be implemented. It appears the policy may be sufficient to address the intent of Recommendation 2; however, it would require the Plan to separately track and verify the specific requirements contained in each year's Carrier Letter. The effectiveness of the policy will be reviewed during future audits to ensure they are working as intended.

2. Lost Investment Income: $4,423

In accordance with the FEHBP regulations and the contract between OPM and the Plan, the FEHBP is entitled to recover LII on the defective pricing finding in contract year 2020. We determined that the FEHBP is due $4,423 for LII, calculated through May 31, 2023 (See Exhibit C). In addition, the FEHBP is entitled to LII for the period beginning June 1, 2023, until all defective pricing finding amounts have been returned to the FEHBP.

The Federal Employee Health Benefits Acquisition Regulation (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 3:

We recommend that the Plan return $4,423 to the FEHBP for LII, calculated through May 31, 2023. We also recommend that the Plan return LII on amounts due for the period beginning June 1, 2023, until all defective pricing finding amounts have been returned to the FEHBP.

Plan Response:

The Plan agreed to LII on the questioned costs by providing its own calculated figure.

OIG Comment:

We reviewed the Plan’s LII figure and noted it did not take into account the months leading up to the issuance of this report. We recalculated the LII on the questioned costs of $67,506 through May 2023. The results are indicated in the finding above.

3. Claims Data Requirements Issue

Per OPM’s Data Requirements for All Community-Rated HMOs, Carrier Letter (CL) 2019-07, carriers that submit rates as large carriers and use an Adjusted Community Rating methodology must submit the claims data in support of the 2020 premium rate development to OPM OIG by the specified date. During the audit, we noted the Plan was not in compliance with CL 2019-07; however, the Plan was compliant with subsequent data requirement submissions. As such, we are not making a recommendation related to this issue as it has already been resolved.

B. Medical Loss Ratio Review

The Certificates of Accurate MLR signed by the Plan for contract years 2018 through 2020 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. FEHBP MLR Filing Requirements Noncompliance

During our review of the Plan's 2019 through 2020 FEHBP MLR calculations, we determined that the Plan included Plan Codes 64, UX, X6, and YF in the same calculation even though plan codes X6 and YF were to be calculated and filed separately on two additional FEHBP MLR forms. Specifically, OPM's Community Rating Guidelines require that "[t]he carrier must aggregate by Plan as defined in Appendix 1" when completing its MLR calculations. Appendix 1 states that "Plan" is defined as "all options offered by a carrier within a contractually defined area. Normally this will be a single rate code however multiple rate codes may apply."

The Plan did not follow OPM's Community Rating Guidelines, which led to incorrect FEHBP MLR reporting in 2019 and 2020.

The Plan's 2019 and 2020 FEHBP benefit brochures specify the following plan code coverage areas:

Table I: Medical Mutual of Ohio 2019-2020 Coverage Areas by Plan Code		
Plan Code	**Contract Years 2019 - 2020 Coverage Areas**	**OPM Contract No.**
64	**Northeast Ohio Counties**: Ashland, Ashtabula, Columbiana, Cuyahoga, Erie, Geauga, Huron, Lake, Lorain, Mahoning, Medina, Portage, Richland, Stark, Summit, Trumbull, and Wayne	CS 1182
UX		
X6	**Northwest Ohio Counties**: Allen, Defiance, Fulton, Henry, Lucas, Ottawa, Putnam, Sandusky, Seneca and Wood	
YF	**Southwest Ohio Counties**: Brown, Butler, Champaign, Clark, Clermont, Green, Hamilton, and Montgomery	CS 2957

Based on OPM's definition of "Plan" and the defined coverage areas, Plan Codes 64 and UX should be filed together on one FEHBP MLR form as they cover the same Northeast Ohio counties and are under the same contract. Plan code X6 should be individually filed on a separate FEHBP MLR form as it covers the Northwest Ohio counties, even though it is on the same contract as Plan Codes 64 and UX. Additionally, plan code YF should be filed separately on its own FEHBP MLR form as it covers the Southwest Ohio counties on a separate contract.

In our audited recalculation of the Plan's 2019 and 2020 FEHBP MLR, we included claims and other allowable expenses for Plan Codes 64 and UX in the numerator, aligning with OPM's reported premium denominator which includes only Plan Codes 64 and UX. Per OPM's 2019 and 2020 Community Rated Guidelines, Plan Code X6 was not subject to filing an FEHBP MLR based on its income of less than $750,000. As such, we did not recalculate a 2019 and 2020 FEHBP MLR for plan code X6. Additionally, Plan Code YF is

under OPM contract number 2957, which is separate from Plan Codes 64, UX, and X6, and thus was not recalculated as it is not within the scope of this audit.

Recommendation 4:

We recommend that the Plan develop written FEHBP-specific policies and procedures to ensure an FEHBP MLR calculation is completed and filed with OPM for each “Plan” as specified in OPM’s Community Rating Guidelines, Appendix I.

Plan Response:

“The Plan agreed with the finding and recommendation.” It provided a policy and procedure to address the recommendation.

OIG Comment:

We agree the Plan provided a new policy and procedure that appears to address the recommendation. Its effectiveness will be reviewed during future audits to ensure they are working as intended.

Recommendation 5:

We recommend that the Plan assess its FEHBP MLR filing methodology for contract year 2021 and discuss refiling options with the OPM Contracting Officer, if applicable.

Plan Response:

“The Plan agreed with the finding and recommendation.” It noted that "the filing methodology for contract year 2021 did consider the plan codes appropriately.”

OIG Comment:

Since the 2021 MLR submission is not in the scope of this audit we did not verify the Plan’s assertion. However, the 2021 MLR filing may be reviewed during a future audit.

2. Duplicate Accounting of ACO Fees

During our review of the Plan's 2018 and 2019 FEHBP MLR calculations, we determined that the Plan reported Accountable Care Organization (ACO) fees in both the incurred claims total (MLR form line 2.1b) and the medical incentive pools and bonuses total (MLR form line 2.11). The duplicate accounting of the ACO fees resulted in the overstatement of FEHBP claims of $3,733 and $17,535 for MLR filing years 2018 and 2019, respectively (See Table II). The Plan recognized that it included the ACO expenses in the incurred claims data prior to filing the 2020 FEHBP MLR. As such, the Plan removed the ACO fees from the 2020 FEHBP incurred claims data and correctly accounted for the ACO expenses on line 2.11 of the 2020 FEHBP MLR form.

This issue appears to stem from the inclusion of ACO fees in the Plan's data submission to OPM and the OIG. As discussed above in A.3., OPM issues a Claims Data Requirements for All Community-Rated HMOs CL mandating that community-rated carriers filing an FEHBP MLR form submit FEHBP claims data used in the FEHBP MLR calculation to the OIG. Specifically for the scope of our audit, CLs 2019-07, 2020-13, and 2021-17 state, "[t]he data should include FEHB claims incurred during calendar year [MLR filing year] and paid through June 30 [following year]. No other claims will be considered, and completion factors should not be applied to this data. Only FEHB claims associated with benefits covered may be included in the MLR claims."

Table II: Medical Mutual of Ohio's Overstated ACO Fees by Plan Code					
Year	ACO Fees (64)	ACO Fees UX	ACO Fees X6	ACO Fees YF[1]	Plan's Line 2.1b Total ACO Fees
2018	$3,534.00	$239.00	$0.00	$0.00	$3,773.00
2019	$15,152.00	$2,171.00	$140.50	$71.50	$17,535.00

Per the CL requirements, ACO fees do not qualify for inclusion in the MLR claims submission to the OIG as they are not claims associated with covered benefits. As such, in our audited recalculation of the Plan's 2018 and 2019 FEHBP MLR, we excluded the ACO fees from incurred claims reported on line 2.1b and accounted for the ACO fees once on line 2.11, medical incentive pools and bonuses.

[1] Although YF is not part of our audit scope, it is included here due to the Plan's MLR filing requirement noncompliance discussed in Section B.1. of the report.

Recommendation 6:

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

Plan Response:

"The Plan agreed with the finding and recommendation." It provided a new FEHBP MLR Filing policy and procedure.

OIG Comment:

Although the Plan's policy and procedure includes instructions for completing each line of the FEHBP MLR, it does not discuss an FEHBP MLR review process. As a result, the Plan's response does not meet the intent of the recommendation. We continue to recommend the Plan institute a more stringent FEHBP MLR review process, to include a second level review and approval of the submission, in order to identify reporting errors prior to submission to OPM.

Recommendation 7:

We recommend that the Plan implement procedures to ensure that it complies with OPM's annual Claims Data Requirements for All Community-Rated HMOs carrier letter and only include FEHB claims associated with covered benefits.

Plan Response:

The Plan stated it "updated the code/logic to exclude ACO Payments going forward."

OIG Comment:

We will test the effectiveness of the Plan's updated process related to the exclusion of ACO payments during a future audit.

3. Inaccurate PCORI Fees

During our review of the Plan's 2018 through 2020 FEHBP MLR calculations, we determined that the Plan did not utilize the Internal Revenue Service (IRS) guidance for calculating the Patient-Centered Outcomes Research Institute (PCORI) fee, resulting in inaccurate reporting of the PCORI fee in all three audit scope years. Specifically, the Plan did not utilize the required per member per year (PMPY) PCORI fee for the applicable policy year as published by the IRS. Additionally, in contract years 2019 and 2020, the Plan

erroneously included enrollment from Plan Codes X6 and YF in its calculation of the average number of lives, used to determine the total PCORI fee.

Per 26 CFR 46.4375, the PCORI fee applies to health insurance policies ending on or after October 1, 2012, and before October 1, 2019. Additionally, the Further Consolidated Appropriations Act, 2020 (Pub. L. 116-94), signed into law on December 20, 2019, extended the PCORI fee for an additional 10 years, through 2029. The IRS issued guidance providing PCORI fee filing due dates, applicable rates for the fee's lifespan, and calculation instructions, including four options for determining the average number of lives.

The Plan indicated that it used a PCORI Fee of $2.53 PMPY, $2.45 PMPY, and $2.63 PMPY to calculate the 2018 through 2020 fees, respectively; however, these PMPY fees did not correspond to the IRS guidance by policy year. Additionally, the average covered lives were overstated in contract years 2019 and 2020 due to the erroneous inclusion of plan codes X6 and YF (See Tables III and IV).

Table III. 2018 through 2020 PCORI Fee Comparison

FEHBP Policy Effective Dates	1. IRS PCORI Fee (PMPY)	2. Audited Average Covered Lives	3. Plan Applied PCORI Fee (PMPY)	4. Plan Average Covered Lives
1/1/2018 through 12/31/2018	$2.45	2,570	$2.53	2,570
1/1/2019 through 12/31/2019	$2.54	2,234	$2.45	2,283
1/1/2020 through 12/31/2020	$2.66	1,635	$2.63	1,729

Table IV. PCORI Fee Comparison

PCORI Fee Comparison	IRS PCORI Fee (PMPY) * Audited Average Covered Lives	Audited PCORI Fee	Plan Applied PCORI Fee (PMPY) * Plan Average Covered Lives	Plan Calculated PCORI Fee	PCORI Fee Variance
2018	$2.45 * 2,570	$6,296	$2.53 * 2,570	$6,501	$205
2019	$2.54 * 2,234	$5,673	$2.45 * 2,283	$5,593	-$80
2020	$2.66 * 1,635	$4,348	$2.63 * 1,729	$4,754	$406

We recalculated the PCORI fee attributable to the FEHBP in contract years 2018 through 2020 utilizing the guidance provided by the IRS and data provided by the plan for plan codes 64 and UX, resulting in the variances illustrated in Table III. We will include our audited calculations of the FEHBP PCORI fee in our overall review of the FEHBP MLR submissions for contract years 2018 through 2020.

Recommendation 8:

We recommend that the Plan ensure its FEHBP PCORI expenses are calculated in accordance with Federal regulations and guidance provided by the IRS.

Plan Response:

"The Plan agreed with the finding and recommendation." It provided an updated FEHBP MLR filing policy and procedure.

OIG Comment:

We agree that the Plan's updated policy and procedure includes a directive to calculate the FEHBP MLR PCORI fee in accordance with Federal regulations and guidance provided by the IRS for the applicable year. The effectiveness of the policy and procedure will be reviewed during future audits to ensure it is working as intended.

4. MLR Credit Adjustment and Additional Penalties Due

The results of our review of the Plan's FEHBP MLR for contract years 2018 through 2020, including the issues presented above, are as follows:

The Plan's 2018 FEHBP MLR credit was reduced and the Plan owes additional FEHBP MLR penalties in 2019 and 2020.

- In contract year 2018, the Plan calculated an FEHBP MLR of 106.71 percent, resulting in a credit due the Plan of $4,313,627. We recalculated the 2018 FEHBP MLR by removing the duplicate accounting of ACO fees and utilizing the IRS instructions to calculate the PCORI fee. We determined that the 2018 FEHBP MLR was 106.70 percent, resulting in a credit of $4,309,346. As such, a credit reduction of $4,281 is applicable for contract year 2018.

- In contract year 2019, the Plan calculated an FEHBP MLR of 74.29 percent, resulting in a penalty due OPM of $1,971,532. This penalty was offset by previously accumulated FEHBP MLR credits per OPM's Community Rating Guidelines. We recalculated the 2019 FEHBP MLR by excluding expenses, enrollment, and other data related to plan codes X6 and YF, which were to be filed on separate FEHBP MLR forms. Additionally, we removed the duplicate ACO fees and recalculated the PCORI fee utilizing the IRS instructions. We determined that the 2019 FEHBP MLR was 73.33 percent, resulting in a penalty of $2,150,036. As such, the Plan owes an additional penalty of $178,504 to OPM for contract year 2019.

- In contract year 2020, the Plan calculated an FEHBP MLR of 80.69 percent, which included a small group adjustment of .92 percent, resulting in a penalty due OPM of $608,452. This penalty was offset by previously accumulated FEHBP MLR credits, as specified in OPM's community rating guidelines. We recalculated the 2020 FEHBP MLR by excluding expenses related to plan codes X6 and YF, which were to be filed on separate FEHBP MLR forms. Additionally, we recalculated the PCORI fee utilizing the IRS instructions and reduced the MLR denominator by the 2020 premium rate questioned costs discussed in section A. of this report. The incorporation of these adjustments resulted in a 2020 FEHBP MLR of 77.32 percent, which included a 1.12 percent small group adjustment. The calculated penalty was $1,079,922. As such, the Plan owes an additional penalty of $471,470 to OPM for contract year 2020.

Per the 2018 through 2020 OPM Community Rating Guidelines, "[i]f the plan's Adjusted FEHB MLR is 85.0 [percent] … or higher no penalty is due OPM. If the plan's Adjusted FEHB MLR is below 85.0 [percent], the carrier pays a penalty equal to the difference between the 85.0 [percent] and plan's actual Adjusted FEHB MLR, multiplied by the denominator of the plan's FEHB MLR calculation. If the plan's Unadjusted FEHB MLR is above 89.0 [percent], the plan receives a credit equal to the difference between the plan's Unadjusted FEHB MLR and 89.0 [percent] multiplied by the denominator of the plan's FEHB MLR calculation. This credit can only be used to offset future FEHB MLR penalties." The use of credits to offset future penalties is limited to the years specified in OPM's Community Rating Guidelines by contract year.

Recommendation 9:

We recommend that the OPM Contracting Officer reduce the Plan's 2018 FEHBP MLR credit by $4,281 and offset the Plan's 2019 and 2020 FEHBP MLR penalties of $178,504 and $471,470, respectively, by FEHBP MLR credits from previous contract years.

Plan Response:

The Plan agreed with the reasonableness of the calculation.

C. Internal Control Review

We determined that the Plan's internal control systems over the FEHBP in the following areas did not sufficiently meet the contractual criteria. 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.

The Plan lacked sufficient controls to consistently administer FEHBP enrollment, benefits, and claims per the terms of the Contract.

1. CLER 160 Errors

During our review of the Plan's enrollment process and related FEHBP requirements for contract years 2018 through 2020, we identified that the Plan lacked sufficient internal controls, including written policies and procedures, necessary to resolve Centralized Enrollment Clearinghouse System (CLER) "160" errors within one year of the initial error as required by Contract Section 1.9(a)(j). Specifically, the Contract states, "[t]he Carrier shall not have any CLER records with a 160-error code and a fail count of four or higher. A "160" error is when a Carrier reports an enrollment but no agency or Tribal Employer reports that enrollment."

The CLER enrollment reconciliation process, required in Contract Section 1.5, is conducted quarterly; therefore, each CLER fail count for discrepancy code 160 is attributable to 3 months of FEHBP coverage that may not be applicable. The accumulation of four or more fail counts equates to a year or more of FEHBP coverage of individuals that may be ineligible to receive coverage. To resolve this type of issue, 5 CFR 890.308 (a)(1) and (2) provides, "a carrier that cannot reconcile its record of an individual's enrollment with agency enrollment records or does not receive documentation necessary to resolve the discrepancy from the employing office within 31 days of a request must provide written notice to the individual that the employing office of record does not show him or her as enrolled in the carrier's plan and that he or she will be disenrolled 31 calendar days after the date of the notice unless the enrollee provides appropriate documentation to resolve the discrepancy. … (2) If the carrier does not receive documentation required under paragraph (a)(1) of this section within the specified timeframe, the carrier should disenroll the individual, without further notice."

To test the Plan's processes related to the resolution of CLER discrepancy code 160, we selected a sample of 12 enrollment discrepancies, with five or more fail counts for discrepancy code 160, from the first quarter 2020 listing of CLER enrollment discrepancies provided by the Plan. Our review of those samples indicated that the Plan is not in compliance with the Contract or 5 CFR 890.308(a)(1) and (2). Specifically, we found one sample in which the CLER "160" member was not terminated from the Plan because the Plan requested documentation through CLER to terminate the member but did not receive a response back with a termination date nor did it receive documentation from the agency to terminate the member. On six of the samples, the Plan stated it sent letters to the member to confirm their enrollment status, but based on the dates provided by the Plan, the letters were not sent until well after the member had reached the maximum allowed "160" fail counts. On one specific sample, the fail count reached 13 in the first quarter of 2020, but the Plan stated the letter was not sent until the fourth quarter of 2020.

The Plan did not identify the reason the CLER "160" fail counts exceeded the contract limit before the Plan terminated the applicable members; however, it is evident the Plan lacked adequate internal controls, including written policies and procedures, to ensure timely review and resolution of CLER "160" errors identified in the quarterly CLER reports. Therefore, the Plan is not compliant with Contract Section 5.64, which requires Plans to establish procedures to administer a sufficient internal control program to meet the terms of the Contract.

Recommendation 10:

We recommend that the Plan implement adequate internal controls, including updating the written policies and procedures effective in July of 2022, to ensure the resolution of CLER "160" error code discrepancies before the quarterly fail count for those errors exceeds the threshold specified in the Contract with OPM.

Plan Response:

The Plan provided an updated procedure in response to the recommendation.

OIG Comment:

The Plan's updated procedure appears to address the intent of the recommendation. However, we recommend that the Plan further modify the procedure to clearly state that the "160" error code must be resolved before it exceeds the threshold of three fail counts. We will test the effectiveness of the Plan's updated policy during a future audit.

Recommendation 11:

We recommend that the Plan follow the processes and time limitations provided in 5 CFR 890.308 when addressing FEHBP member disenrollment.

Plan Response:

The Plan provided an updated procedure in response to the recommendation.

OIG Comment:

The Plan's updated procedure does not appear to address the intent of the recommendation. The updated procedure requires review of the CLER "160" code discrepancies only upon reaching a fail count of two. However, 5 CFR 890.308 requires that the Plan reconcile its enrollment or obtain the necessary documentation from the employing office within 31 days. If the Plan is unable to reconcile the enrollment after the 31 days, the Plan must send written communication to the member notifying them that they will be disenrolled if the necessary documentation is not provided. Since the procedure directs the Plan to wait until the second discrepancy and the discrepancy reports are done on a quarterly basis, the procedure, as written, would not ensure compliance with the time limitations noted in the regulation. We continue to recommend the Plan follow the processes and time limitations provided in 5 CFR 890.308 to ensure compliance with the regulation.

2. Extension of Coverage Not Applied

During the scope of the audit, the Plan lacked policies and procedures to assess and apply the 31-day extension of coverage (EOC) for eligible FEHBP dependent members terminating due to reaching the maximum dependent coverage age of 26 and members terminating due to a benefit coverage tier reduction (e.g., change from a family coverage to self only coverage, etc.).

Per the FEHBP Benefits brochure, which is part of the Plan's Contract with OPM, FEHBP members are entitled to an additional 31 days of coverage, for no additional premium, when enrollment ends or when the subscriber or member is no longer eligible for coverage. In addition, 5 CFR Subpart D section 890.401(a) (1) states that "An enrollee ... and a covered family member whose coverage is terminated other than by cancellation of the enrollment or discontinuance of the plan ... is entitled to a 31-day extension of coverage ... without contributions by the enrollee or the Government ... ."

Regarding the aging out dependents, the Plan confirmed it terminated dependents at the end of the month in which they turned 26 and did not apply the 31-day extension of coverage as required. The Plan provided a group benefit summary that showed the standard option

benefit policy is to terminate a dependent member at the end of the month in which they turn 26. Additionally, for members that lost coverage due to a tier change, the Plan relied on the OPM payroll offices to calculate and communicate the extension of coverage to the Plan, if applicable. The Plan noted it would have no way to know if the date provided by the FEHBP included the 31-day EOC[2]; however, this does not preclude them from coordinating with the payroll offices to determine if a member that is removed via a tier reduction is eligible for the 31-day EOC as required under the terms of contract.

Contract Section 5.64 specifies that the Plan must establish an internal control system to facilitate timely discovery of contract compliance issues and promptly institute and carry out corrective action. Since the Plan is not assessing and applying the 31-day EOC requirement to FEHBP members due to lacking and undocumented processes, it is apparent that there is a lack of controls over the Plan's FEHBP member enrollment and termination processes. If updated and enhanced FEHBP-specific policies and procedures are not implemented to strengthen controls, the Plan will continue to be in non-compliance with the Contract and FEHBP members may be denied benefits when they are eligible for FEHBP coverage.

Recommendation 12:

We recommend that the Plan develop internal controls to ensure it assesses and properly applies the 31-day extension of coverage for all eligible FEHBP members that are terminated from the Plan, in accordance with applicable regulations and the Contract.

Plan Response:

The Plan provided a new policy in response to the recommendation.

OIG Comment:

The policy provided by the Plan appears to address the intent of the recommendation. We will test the effectiveness of the Plan's policy during future audits.

Recommendation 13:

We recommend that the Plan update its FEHBP group benefit summary and any other internal policies, procedures, or system configurations to ensure aging-out dependent

[2] See OPM OIG Audit Report 2022-CRAG-0010 at oig.opm.gov, in which OPM OIG reported on the OPM FEHBP enrollment process issues that inhibit Carriers from determining the proper 31-day EOC application for dependent (i.e., spouse, children) terminations resulting from a benefit selection for tier reductions.

members receive the full 31-day extension of coverage they are entitled to as required by the Contract.

Plan Response:

The Plan stated that it "currently has guidance in our FEHB brochures and SBC documents that notifies FEHBP members of their right to receive the full 31-day extension of coverage they are entitled to as required by the FEHB Contract." The Plan provided its 2023 Basic and Standard Option FEHBP Benefits Brochure, as well as the Basic and Standard Option Summary of Benefits and Coverage (SBC) document.

OIG Comment:

We acknowledge that the Plan's Basic and Standard Option FEHBP Benefits Brochure and SBC outline the extension of coverage entitlements. However, during the audit the Plan provided an FEHBP "Group Benefit Summary Report" document that contained inaccurate information regarding termination of coverage for overage FEHBP dependents. We continue to recommend the Plan ensure the FEHBP "Group Benefit Summary Report" and any other internal documentation for the FEHBP plans accurately reflect the 31-day extension of coverage applicable to terminating overage dependents.

3. Enrollment Verification and Termination Issues

During our review of the Plan's dependent termination records, we identified that the Plan retroactively adjusted members' coverage effective dates in its Corporate Membership System (CMS) when it canceled the members as "never effective," even though the "never effective" member was identified in the FEHBP claims data. Further, because of the way the Plan retroactively terminates its members, the actual dates documented in CMS may not be representative of the actual coverage start or end dates, and there's no way to determine when or if the FEHBP member was enrolled in the Plan.

In our review of the dependent termination samples, we identified one dependent sample where the subscriber's coverage start and end dates were the same day, January 7, 2015, three of the subscriber's dependents showed coverage start and end dates of January 8, 2017, and a fourth dependent had coverage start and end dates a week earlier than the other three, on January 1, 2017. The Plan explained that this subscriber and related dependents were from the Plan's assumed responsibility of HealthSpan's enrollment file in 2016. The subscriber did not have coverage and was added and canceled effective January 8, 2017. It further explained that "when we cancel someone never effective and it's the only segment the contract holder has on TOPPS [the Plan's claims processing system][,] the record is back dated 2 years." Regarding the dependents, the Plan explained that the termination dates reflected that the member canceled due to being overage (i.e., turned age 26 and lost

eligibility); however, we found that the dependent's coverage date of January 8, 2017, was approximately a year after their 26th birthday, January 17, 2016. Although the Plan provided an Excel spreadsheet with subscriber and dependent information in the enrollment file, there were no coverage start dates listed in that file to determine the date of enrollment in the Plan or if the member was enrolled at all.

Based on the explanations provided by the Plan, the subscriber and dependents were never covered under the FEHBP; however, the data in CMS does not provide sufficient evidence to verify when coverage, if any, was applicable. In addition, we could not determine why the dependent member appeared in our 2018 universe of claims data if the dependent member never had coverage. Although we determined the Plan did not pay claims for the dependent member in 2018 based on the claims data provided, it is clear that the member was listed as covered even in 2018. Due to the limited data contained in the enrollment screens provided, we could not determine how long the subscriber and members may have been erroneously listed as enrolled in the Plan. Additionally, based on the Plan's explanation that the subscriber record is back-dated two years, it's possible the coverage cancel date would pre-date the effective date of the subscriber's coverage and make the enrollment information completely inaccurate.

Recommendation 14:

We recommend that the Plan establish written policies and procedures to strengthen internal controls over the maintenance and integrity of FEHBP enrollment records, including but not limited to the manual entry of termination dates and the validation of enrollee effective dates in CMS.

Plan Response:

The Plan provided a written system policy in response to the recommendation.

OIG Comment:

This policy does not address the accurate capture of the member's effective and termination dates in the system; rather, it explains why the dates are back-dated two years when a member is canceled as never effective. As such, further enhancement of the policy is needed to address the recommendation and ensure effective and termination dates are accurate in the system.

Recommendation 15:

We recommend that the Plan enhance the controls around CMS to ensure that any retro-active adjustment to the FEHBP members' effective start date is captured in its system records.

Plan Response:

The Plan provided a written system policy in response to the recommendation.

OIG Comment:

This policy does not include information related to ensuring the subscriber's original effective date is memorialized in the system. As such, it does not address the recommendation. We continue to recommend that the Plan ensure each member's effective date is accurately reflected in the enrollment system.

4. Incorrectly Priced and Paid FEHBP Claims

As part of our audit of the Plan's FEHBP 2018 through 2020 premium rates and MLR, we selected a sample of 28 medical claims from contract year 2018 to verify if contracted benefits were received by eligible FEHBP members and that those services were priced and paid per the provider contracts and the Contract held with OPM. Through our claims review, we identified one claim priced and paid outside the terms of the applicable provider contract and one high dollar claim incorrectly priced due to the exclusion of the member copayment. The Plan indicated that both issues were due to processor error. Additionally, based on the Plan's process, the high dollar claim should have received a second review by the Plan for accuracy but was not identified as being priced and paid in error. As such, we determined that the root cause of these errors stem from internal control weaknesses, resulting in the incorrect payment of claims and the use of inaccurate claims data in the 2018 FEHBP MLR calculation and 2020 FEHBP premium rate development.

In our review of a skilled nursing claim, we identified that the Plan did not update its claims system with the correct skilled nursing rate for one of the sampled claims' providers. The updated skilled nursing rate was more than the prior rate, resulting in the underpayment of claims for this skilled nursing provider. When the Plan identified the error, it reprocessed the impacted provider claims but failed to reprocess the sampled claim we reviewed. The Plan was unable to determine the exact reason the claim was missed, but noted that it was a claims processor error.

Additionally, during the review of one high dollar inpatient medical claim, we found that the Plan did not apply a copayment during the pricing of the claim, resulting in overpayment of the claim. Per the 2018 FEHBP Benefits Brochure, the high option copayment for inpatient stays was $250; however, the claims processor did not apply a member copayment. Additionally, the claim met the criteria for another pricing accuracy review as an institutional claim above $25,000; however, the high dollar review process did not identify the errors. The Plan indicated that this claim was also incorrectly processed due to human error.

As a result of these claims pricing errors and weak controls surrounding the high dollar claim review, the Plan was not in compliance with Contract Section 2.3 which states, "(g) Erroneous Payments. 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 to the Member from the Member or, if to the provider, from the provider. …. (h) All erroneous claim payments by the Carrier must be correctly adjusted in the Carrier's FEHBP rate development and/or Medical Loss Ratio calculation."

As such, we adjusted the applicable 2018 claims data, used in the 2018 MLR calculation and the 2020 Premium Rate Development, to account for the incorrect payments, and found the overall impact to be immaterial. However, if the Plan does not correct the claims review process weaknesses, there is the potential that incorrect FEHBP claims pricing and payments will continue and may materially impact future FEHBP premium rate developments and the FEHBP MLR calculations. Also, without corrective action, the Plan will continue to be noncompliant with Contract Section 2.3 as well as Contract Section 5.64.

Recommendation 16:

We recommend that the Plan enhance controls over its manual processing of claims to ensure accurate copayments are applied to FEHBP member claims.

Plan Response:

The Plan stated its "[c]laims area will limit access to FEHBP processing to processors who have exceptional quality. Refresher training will be provided to selected individuals on manual adjudication and FEHBP benefits."

OIG Comment:

We will test the effectiveness of any internal control improvements during a future audit.

Recommendation 17:

We recommend that the Plan enhance controls over the high dollar claims accuracy review to ensure all aspects of the claim are considered, including member copays.

Plan Response:

The Plan stated it "will explore opportunities to audit high dollar manual adjudication claims specific to FEHBP and claims will be passed to our Corporate Disbursements System for a second post adjudication review prior to release of payment."

OIG Comment:

We will test the effectiveness of any internal control improvements during a future audit.

Recommendation 18:

We recommend that the Plan enhance controls surrounding the reprocessing and review of claims in cases where new provider rates are implemented after the effective date of the rate.

Plan Response:

The Plan agreed and stated it "will explore opportunities for improvement that include:
- **Report storage and documentation of activities**
- **Reporting to identify claims missed by processors[.]"**

OIG Comment:

We agree with the Plan's approach and recommend that the Plan pay particular attention to the controls related to the reprocessing of claims, whether manually or automatically adjudicated, when new provider rates are implemented after the effective date of the rate. We will review any enhancements to the Plan's internal controls during a future audit.

5. Same-Day Copay Policy Issue

During the scope of the audit, the Plan lacked written policies and procedures to document its FEHBP-specific policies regarding the application of same-day copayments. In addition, the 2018 FEHBP Benefits Brochure did not reflect the specific policies the Plan stated were in place. Specifically, during our claims sample review, we identified three claims where the Plan did not apply a copayment because of its same-day copayment policies.

For two of the three samples, the Plan explained that the lack of copayment was due to its policy to apply only one copayment per provider per day, which applies to the first service processed for the date of service. The Plan stated the policy was a legacy HealthSpan billing process, which was adopted by the Plan as requested by the Office of Personnel Management (OPM). Specifically, the Plan noted that prior to HealthSpan's FEHB membership transition to the Plan as of January 1, 2017, it "received guidance from OPM to align FEHB benefits with the benefits that were previously in place with HealthSpan in 2016. The intent was to minimize member disruption during the transition." Although the Plan provided email correspondence from HealthSpan to the Plan, supporting the one copay per provider per day policy, it did not provide communication from OPM regarding a directive, nor did it provide a documented policy or procedure.

Additionally, we found that one of the three samples was an air ambulance claim, which was also not priced with a member copayment. The Plan stated the copayment was collected on another same-day ambulance claim. We verified the ambulance services were not with the same provider. The Plan explained that its policy was to apply only one ambulance copayment per day; however, it did not provide any written policy or procedure to support its claim. In addition, the 2018 FEHBP Benefits Brochure explicitly states the ambulance copayment is a per trip amount, not a per day amount.

Contract Section 5.64 requires the Plan to establish an internal control system sufficient to meet the terms of the Contract. Further, Section 2.2(a) of the Contract states "[t]he Carrier shall provide the Benefits as described in the agreed upon brochure text found in Appendix A."

The Plan's inability to provide policies or procedures highlight an internal control weakness. Further, the Plan priced and paid claims contrary to the 2018 FEHBP Benefit Brochure, which did not explicitly list the same-day copayment limitations. As a result, the Plan is not compliant with the terms of the Contract, and we could not determine if the Plan priced the copayment for 3 of the 28 claim samples correctly. In addition, FEHBP members would not have been aware of the same-day copayment policies the Plan asserted were in place.

Recommendation 19:

We recommend that the Plan develop written policies and procedures to document its same-day copayment policies for its FEHBP plans.

Plan Response:

The Plan proposed aligning its FEHBP copayment policy with its standard copayment policy for the Standard Option, noting that the high option was terminated on December 31, 2018. It also noted that it "will ensure that ambulance copay for the Standard Option is administered on a per trip basis as stated in the existing FEHB brochure."

OIG Comment:

The Plan should discuss the proposed Standard Option office visit copay change with OPM Contracting to gain input and approval. The Plan should also ensure that the details of the benefit are adequately disclosed to its members in the FEHBP Benefits Brochure. We continue to recommend that the Plan memorialize its same-day copayment policies in a written policy or procedure.

Recommendation 20:

We recommend that the Plan ensure the FEHBP Benefits Brochure clearly and accurately communicates the same-day copayment policies to its FEHBP members.

Plan Response:

The Plan proposed aligning its FEHBP copayment policy with its standard copayment policy for the Standard Option, noting that the high option was terminated on December 31, 2018. It also noted that it "will ensure that ambulance copay for the Standard Option is administered on a per trip basis as stated in the existing FEHB brochure."

OIG Comment:

We agree with the Plan's approach and will review the Plan's updated brochure language during a future audit.

Exhibit A

Medical Mutual of Ohio
Summary of Defective Pricing Questioned Costs

Contract Year 2018	$0
Contract Year 2019	$0
Contract Year 2020	$67,506
Total Defective Pricing Questioned Costs	**$67,506**
Lost Investment Income	$4,423
Total Amount Due to OPM	**$71,929**

Exhibit B

Medical Mutual of Ohio
2020 Defective Pricing Questioned Costs

Plan Code 64 (Standard Option)				
Contract Year 2020	**Self**	**Self+1**	**Family**	**Total**
FEHBP Line 5 - Reconciled Rate	$467.35	$1,028.17	$1,121.64	
FEHBP Line 5 - Audited Rate	$465.44	$1,023.95	$1,117.04	
Bi-weekly Overcharge	$1.91	$4.22	$4.60	
To Annualize Overcharge:				
March 31, 2018 Enrollment	728	96	101	
Pay Periods	26	26	26	
Total 2020 Defective Pricing – Plan Code 64 (Standard Option)	**$36,152**	**$10,533**	**$12,080**	**$58,765**

Plan Code UX (Basic Option)				
Contract Year 2020	**Self**	**Self+1**	**Family**	**Total**
FEHBP Line 5 - Reconciled Rate	$189.77	$417.50	$455.45	
FEHBP Line 5 - Audited Rate	$188.92	$415.63	$453.41	
Bi-weekly Overcharge	$0.85	$1.87	$2.04	
To Annualize Overcharge:				
March 31, 2018 Enrollment	158	54	30	
Pay Periods	26	26	26	
Total 2020 Defective Pricing – Plan Code UX (Basic Option)	**$3,492**	**$2,625**	**$1,591**	**$7,708**

Exhibit B (continued)

Medical Mutual of Ohio
2020 Defective Pricing Questioned Costs (Continued)

Plan Code X6 (Standard Option)				
Contract Year 2020	**Self**	**Self+1**	**Family**	**Total**
FEHBP Line 5 - Reconciled Rate	$366.11	$805.44	$878.65	
FEHBP Line 5 - Audited Rate	$364.61	$802.12	$875.04	
Bi-weekly Overcharge	$1.50	$3.32	$3.61	
To Annualize Overcharge:				
March 31, 2018 Enrollment	6	1	1	
Pay Periods	26	26	26	
Total 2020 Defective Pricing – Plan Code X6 (Standard Option)	**$234**	**$86**	**$94**	**$414**

Plan Code X6 (Basic Option)				
Contract Year 2020	**Self**	**Self+1**	**Family**	**Total**
FEHBP Line 5 - Reconciled Rate	$189.70	$417.34	$455.27	
FEHBP Line 5 - Audited Rate	$188.85	$415.47	$453.23	
Bi-weekly Overcharge	$0.85	$1.87	$2.04	
To Annualize Overcharge:				
March 31, 2018 Enrollment	7	3	6	
Pay Periods	26	26	26	
Total 2020 Defective Pricing – Plan Code X6 (Basic Option)	**$155**	**$146**	**$318**	**$619**

Exhibit C

Medical Mutual of Ohio

Lost Investment Income

Lost Investment Income	**2020**	**2021**	**2022**	**31-May-23**	**Total**
Defective Pricing:	$67,506	$0	$0	$0	$67,506
Cumulative Totals:	$67,506	$67,506	$67,506	$67,506	$67,506
Average Interest (per year):	1.625%	1.000%	2.813%	4.625%	
Interest on Prior Years Findings:	$0	$675	$1,899	$1,301	$3,875
Current Years Interest:	$548	$0	$0	$0	$548
Total Cumulative Interest Calculated Through May 31, 2023:	$548	$675	$1,899	$1,041	**$4,423**

Exhibit D

Medical Mutual of Ohio
Summary of Medical Loss Ratio Review

Contract Year 2018	
Credit Calculated	$4,309,346
Credit Received	$4,313,627
Total 2018 Credit Reduction	**($4,281)**
Contract Year 2019	
Penalty Calculated	$2,150,036
Penalty Received	$1,971,532
Total 2019 Penalty Increase	**$178,504**
Contract Year 2020	
Penalty Calculated	$1,079,922
Penalty Received	$608,452
Total 2020 Penalty Increase	**$471,470**

Exhibit E

Medical Mutual of Ohio
2018 Medical Loss Ratio Adjustment

2018 Medical Loss Ratio Adjustment	Plan	Audited
2018 FEHBP MLR Lower Threshold (a)	85%	85%
2018 FEHBP MLR Upper Threshold (b)	89%	89%
Claims Expense		
Plan Code 64 & UX Incurred Medical and Pharmacy Claims	$26,974,458	$26,970,685
Paid Medical Incentives Pools and Bonuses	$3,773	$3,773
Healthcare Receivables	$1,092,029	$1,092,029
Plus: Quality Health Improvement Expenses	$101,207	$101,207
Total MLR Numerator	**$25,987,409**	**$25,983,636**
Premium Income	$23,438,815	$23,438,815
Less: Taxes and Regulatory Filing Fees	($913,749)	($914,320)
Total MLR Denominator (c)	**$24,352,564**	**$24,353,135**
FEHBP Medical Loss Ratio (d)	106.71%	106.70%
FEHBP Contract Months	21,036	21,036
Small Group Adjustment (e)	0.00%	0.00%
FEHBP Adjusted MLR (f)	106.71%	106.70%
Penalty Calculation (If (d) is less than (a), ((a-f) *c)	$0	$0
Credit Calculation (If (d) is greater than (b), ((d-f) *c)	$4,313,627	$4,309,346
Total MLR Credit Reduction		**$4,281**

Exhibit E (continued)

Medical Mutual of Ohio
2019 Medical Loss Ratio Review

2019 Medical Loss Ratio Adjustment	Plan	Audited
2019 FEHBP MLR Lower Threshold (a)	85%	85%
2019 FEHBP MLR Upper Threshold (b)	89%	89%
Claims Expense		
Plan Code 64 & UX Incurred Medical and Pharmacy Claims	$14,504,741	$14,504,741
Plan Code X6 & YF Incurred Medical and Pharmacy Claims	$184,158	$0
Plus: Paid Medical Incentive Pools and Bonuses	$17,535	$17,323
Less: Healthcare Receivables	$1,114,360	$1,097,175
Plus: Allowable Fraud Reduction Expense	$2,490	$85,476
Plus: Quality Health Improvement Expenses	$87,178	$85,476
Total MLR Numerator	**$13,681,742**	**$13,512,806**
Premium Income	$19,246,588	$19,246,588
Less: Taxes and Regulatory Filing Fees	$830,971	$819,715
Total MLR Denominator (c)	**$18,415,617**	**$18,426,873**
FEHBP Medical Loss Ratio (d)	74.29%	73.33%
FEHBP Contract Months	18,840	18,476
Small Group Adjustment (e)	0.00%	0.00%
FEHBP Adjusted MLR (f)	74.29%	73.33%
Penalty Calculation (If (d) is less than (a), ((a-f) *c)	$1,971,532	$2,150,036
Credit Calculation (If (d) is greater than (b), ((d-f) *c)	$0	$0
Total MLR Penalty Increase		**$178,504**

Exhibit E (continued)

Medical Mutual of Ohio
2020 Medical Loss Ratio Review

2020 Medical Loss Ratio Adjustment	Plan	Audited
2020 FEHBP MLR Lower Threshold (a)	85%	85%
2020 FEHBP MLR Upper Threshold (b)	89%	89%
Claims Expense		
Plan Code 64 & UX Incurred Medical and Pharmacy Claims	$11,570,508	$11,570,508
Plan Code X6 & YF Incurred Medical and Pharmacy Claims	$550,733	
Plus: Paid Medical Incentive Pools and Bonuses	$17,978	$17,465
Less: Healthcare Receivables	$928,666	$916,381
Plus: Quality Health Improvement Expenses	$52,929	$50,525
Total MLR Numerator	**$11,263,481** [3]	**$10,722,117**
Premium Income	$14,994,277	$14,994,277
Less: Premium Rate Defective Pricing Questioned Costs Plan Code 64		$58,765
Less: Premium Rate Defective Pricing Questioned Costs Plan Code UX		$7,708
Less: Taxes and Regulatory Filing Fees	$874,230	$857,517
Total MLR Denominator (c)	**$14,120,047**	**$14,070,282**
FEHBP Medical Loss Ratio (d)	79.77%	76.20%
FEHBP Contract Months	14,904	14,234
Small Group Adjustment (e)	0.92%	1.12%
FEHBP Adjusted MLR (f)	80.69%	77.32%
Penalty Calculation (If (d) is less than (a), ((a-f) *c)	$608,452	$1,079,922
Credit Calculation (If (d) is greater than (b), ((d-f) *c)	$0	$0
Total MLR Penalty Increase		**$471,470**

[3] Variance due to rounding.

Exhibit F

Medical Mutual of Ohio

Medical Claims Sample Selection Criteria and Methodology

Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Sample (Dollars)	Results Projected to the Universe?
FEHBP Plan Code #64 Medical claims incurred from 1/1/2018 through 12/31/2018	53,554 Claims	$21,378,887	Isolated claims with "inpatient" place of service codes. Selected all claims with paid totals greater than $70,000.	10	$1,089,160	No
			Isolated claims with "outpatient" place of service codes. Selected all claims with paid totals greater than $40,000.	7	$364,234	
			Isolated claims with all other place of service codes (excluding "inpatient" and "outpatient"). Selected all claims with paid totals greater than $11,000.	11	$177,458	
			Total Claims Samples	**28**	**$1,630,852**	

Appendix

MMO Response for FEHBP Audit Report

Plan response submitted to OIG: April 5, 2023

A. PREMIUM RATE REVIEW

1. Defective Pricing

Recommendation 1

Response: MMO did the same calculation and Deleted by the OIG – Not Relevant to the Final Report shared with OPM and OPM agreed with the number and will update it in the final report.

Recommendation 2

Response: Starting 2024 policy year, the FEHBP premium rating will be transferred from Actuarial department to Underwriting department. Underwriting department utilize Stepwise system for rating purpose. Please see the attached file named " StepWise Rate Doc and Stop Loss Rating Factors Update and Testing Protocol Updt 1.17.2023" for policy and procedures. It's updated recently based on the recommendation from the audit report.

2. Lost Investment Income for defective pricing

Recommendation 3

Response: **Deleted by the OIG – Not Relevant to the Final Report** The revised lost investment income is calculated as **Deleted by the OIG – Not Relevant to the Final Report**.

B. Medical Loss Ratio Review

1. FEHBP MLR Filing Requirements Noncompliance

Recommendation 4

Response: The Plan agreed with the finding and recommendation. The policy and procedure has been completed. Please see the attached file named "FEHB MLR Filing Policy and Procedure_2021". The filing methodology for contract year 2021 did consider the plan codes.

Recommendation 5

Response: The Plan agreed with the finding and recommendation. The filing methodology for contract year 2021 did consider the plan codes appropriately.

2. Duplicate Accounting of ACO Fees

Recommendation 6

Response: The Plan agreed with the finding and recommendation. A policy and procedure has been completed. Please see the attached file named" FEHB MLR Filing Policy and Procedure_2021".

Recommendation 7

Response: The MMO team has updated the code/logic to exclude ACO Payments going forward.

3. Inaccurate PCORI Fees

Recommendation 8

Response: The Plan agreed with the finding and recommendation. A policy and procedures has been updated. Please see the attached file named “FEHB MLR Filing Policy and Procedure_2022”.

4. MLR Credit Adjustment and Additional Penalties Due

Recommendation 9

Response: The Plan found that the calculations were reasonable.

C. Internal Control Review

1. CLER 160 Errors

Recommendation 10

Response: Please see the attached file named “FEHB Reconciliation Procedure 160”.

Recommendation 11

Response: Please see the attached file named “FEHB Reconciliation Procedure 160”.

2. Extension of Coverage Not Applied

Recommendation 12

Response: Please see the attached file named “FEHB 31 day extension”.

Recommendation 13

Response: Medical Mutual currently has guidance in our FEHB brochures and SBC documents that notifies FEHBP members of their right to receive the full 31-day extension of coverage they are entitled to as required by the FEHB Contract. Please see page 4 of the attached Basic and Standard Option SBC’s for details. Additionally, our FEHB brochures include language regarding the 31-day extension of coverage on page 10. Please see the attached documents for additional details.

3. Enrollment Verification and Termination Issues

Recommendation 14

Response: Please see the attached file named” Canceled never effective in TOPPS”.

Recommendation 15

Response: Please see the attached file named” Canceled never effective in TOPPS”.

4. Incorrectly Priced and Paid FEHBP Claims

Recommendation 16

Response: The MMO Claims area will limit access to FEHBP processing to processors who have exceptional quality. Refresher training will be provided to selected individuals on manual adjudication and FEHBP benefits.

Recommendation 17

Response: Medical Mutual will explore opportunities to audit high dollar manual adjudication claims specific to FEHBP and claims will be passed to our Corporate Disbursements System for a second post adjudication review prior to release of payment. Our post adjudication review is conducted for appropriateness and accuracy. High dollar post adjudication claims are currently audited prior to release for payment with the following thresholds:

- Professional Payable Claims $5,000
- Institutional Payable Claims $25,000

Recommendation18

Response: The Medical Mutual Claims and Contracting teams will explore opportunities for improvement that include:

- Report storage and documentation of activities
- Reporting to identify claims missed by processors

5. Same-Day Copay Policy Issue

Recommendation 19

Response: Medical Mutual is proposing to align our office visit copay protocol for FEHB with Medical Mutual's standard copay policy on a going forward basis for the Standard Option. Additionally, we will ensure that ambulance copay for the Standard Option is administered on a per trip basis as stated in the existing FEHB brochure.
It should be noted that the High Option was terminated on December 31, 2018. Thus, modification of the High Option plan design is not required at this time since the plan is no longer offered to FEHB members.

Recommendation 20

Response: Medical Mutual will conduct a detailed review of all the current copay language contained in the FEHB brochures and revise the 2024 FEHB brochure to include additional language regarding how copays are administered.

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