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

Final Audit Report

AUDIT OF THE FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM OPERATIONS AT UNITEDHEALTHCARE INSURANCE COMPANY, INC.

Report Number 2022-CRAG-037
October 30, 2023

EXECUTIVE SUMMARY

Audit of the Federal Employees Health Benefits Program Operations at UnitedHealthcare Insurance Company, Inc.

Report No. 2022-CRAG-037 **October 30, 2023**

Why Did We Conduct the Audit?

The primary objective of the audit was to determine if UnitedHealthcare Insurance Company, Inc. (the 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 2949, the Office of the Inspector General (OIG) completed a performance audit of the FEHBP premium rate developments for contract years 2019 through 2021. We conducted our audit fieldwork remotely from September 26, 2022, through March 22, 2023.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

We determined that the Plan did not comply with the provisions of its contract and the laws and regulations governing the FEHBP for contract years 2019 through 2021 for plan code KT. All of the issues we identified in our audit are designated as procedural in this report. Specifically, our audit identified the following.

- There was a discrepancy within the 2020 FEHBP benefit brochure related to the emergency room copayment ($150 versus $200).
- There were variances in the Adjusted Community Rating (ACR) claims and membership data.
- The Plan did not provide sufficient supporting documentation to verify that pharmacy rebates were removed from pharmacy claims in the 2019 through 2021 FEHBP premium rate developments.
- Our review of a judgmental sample of medical claims determined a claim system configuration issue, a record retention issue, copayment errors, an out of network providers issue, and a coordination of benefits error.
- The Plan did not comply with guidance issued by the OPM OIG Administrative Sanctions Group for managing provider suspension and debarment for the FEHBP.
- The Plan's procedures for verifying ineligible family members were insufficient.
- ***During the audit, the Plan did not provide data we requested in a timely manner, and in some cases, not at all.***

ABBREVIATIONS

ACR	**Adjusted Community Rating**
ASG	**Administrative Sanctions Group**
CFR	**Code of Federal Regulations**
CL	**FEHBP Carrier Letter**
Contract	**OPM Contract CS 2949**
ER	**Emergency Room**
FEHB	**Federal Employees Health Benefits**
FEHBAR	**Federal Employees Health Benefits Acquisition Regulations**
FEHBP	**Federal Employees Health Benefits Program**
FWA	**Fraud, Waste, and Abuse**
Guidelines	**Guidelines for Implementation of Federal Employees Health Benefits Program Debarment and Suspension Orders**
MLR	**Medical Loss Ratio**
NFR	**Notice of Finding and Recommendations**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
PHI	**Protected Health Information**
PII	**Personally Identifiable Information**
Plan	**UnitedHealthcare Insurance Company, Inc.**
SFTP	**Secure File Transfer Protocol**
USC	**United States Code**

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I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at UnitedHealthcare Insurance Company, Inc. (Plan), plan code KT. The audit was conducted pursuant to the provisions of Contract CS 2949 (Contract); 5 United States Code (USC) 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.

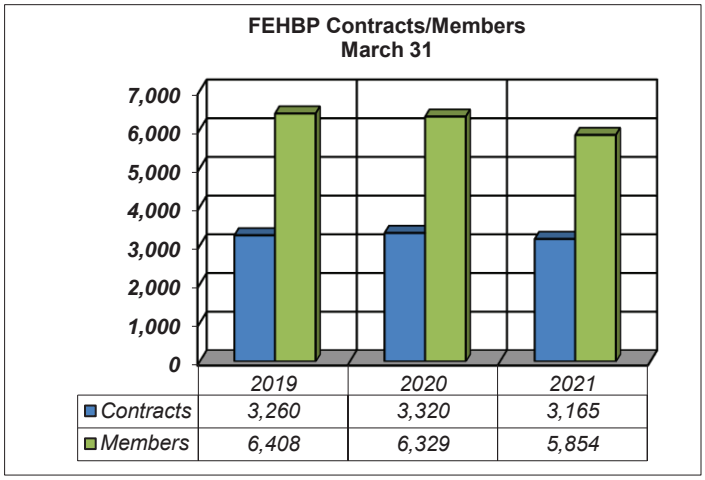
The FEHBP was established by the Federal Employees Health Benefits Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for Federal employees, annuitants, and dependents, and is administered by the OPM Healthcare and Insurance Office. The 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 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 below.



The Plan has participated in the FEHBP with plan code KT since 2016 and provides health benefits to FEHBP members in Arizona (Phoenix and Tucson), Colorado, Nevada, Oregon, and Washington.

This was the first audit of the Plan's premium rates for plan code KT as it was new to the FEHB Program in 2016. A prior MLR audit of UnitedHealthcare Insurance Company, Inc. was conducted by our office, which covered a different plan code, CY, for contract years 2013 through 2015. The prior audit identified defective pricing due to an overstated MLR credit in contract year 2013 and understated MLR credits in 2014 and 2015. The Plan agreed with the findings 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 (NFR) process. Due to the Plan's delayed response in providing documentation until after the issuance of the draft report, we were unable to communicate all of the findings in this report through the NFR process. (See Finding C.) The Plan's comments 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

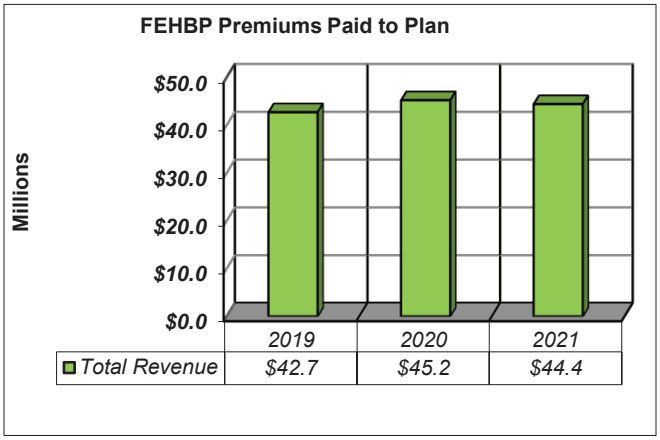
OBJECTIVES

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 $132.3 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 September 26, 2022, through March 22, 2023.

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 was developed in accordance with the requirements of 48 CFR, Chapter 16, and the Contract. We determined that the Plan's 2019 through 2021 Certificates of Accurate Pricing for plan code KT were defective due to the Plan not providing sufficient source documentation for several of the rating components and due to non-compliance with various sections of the Contract. The monetary findings associated with the record retention issues were immaterial to the overall premium rate calculations for all years of the audit scope; therefore, our findings are procedural in nature.

1. Emergency Room Copayment Discrepancy — Procedural

During our review of the Plan's 2020 FEHBP benefits brochure, we identified a discrepancy between the emergency room (ER) copayment listed as a change for the 2020 year and the ER copayment listed in the Emergency Services/Accidents benefits section.

The Plan's emergency room copayment discrepancy in the benefit brochure resulted in at least one OPM OIG Hotline complaint.

Contract Section 1.13(a) states "The Carrier bears full responsibility for the accuracy of its FEHB brochure." Additionally, Section 2.2(a), requires the Plan to provide benefits described in the FEHBP benefit brochure. OPM Contract Section 5.64, states that "(c) … The Contractor shall establish the following within 90 days after the contract award. … (2) An internal control 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."

The 2020 FEHBP benefits brochure, Section 2 – Changes for 2020, lists the copayment for an emergency room visit as increasing from $150 to $200. However, in Section 5(d), Emergency Services/Accidents, of the 2020 FEHBP benefits brochure, the copayment for an emergency room visit is listed as $150. The discrepancy between Section 2 and Section 5(d) created confusion for FEHBP members, which resulted in at least one OPM OIG Hotline complaint. The Plan did not have an adequate review process in place to ensure that the FEHBP benefits brochure was clearly stating the ER copayment to FEHBP members. Furthermore, it resulted in FEHBP members possibly overpaying their ER copayments

because the increased copayment was updated within the Plan's claim system but was not updated within Section 5(d) of the FEHBP benefits brochure.

Recommendation 1

We recommend that the Plan research its ER copayments from 2020 to determine the extent to which members were negatively impacted by the discrepancy and rectify any member overpayments.

Recommendation 2

We recommend that the Plan strengthen its internal controls to ensure that the FEHBP benefits brochure clearly and accurately states copayment amounts to its members.

Plan Response:

The Plan agreed with the finding and recommendations. It acknowledged the error and stated that a new electronic version of the FEHBP benefit brochure was created in February 2020, but it was never uploaded to the OPM.gov website. Further, the Plan is researching the issue for the members and will provide that information to the OIG.

OIG Comment:

We will review any additional information provided by the Plan throughout the resolution process. We will also continue to follow up on this issue during any future audits.

2. ACR Claims and Membership Variances **Procedural**

We identified a variance between the 2021 Adjusted Community Rating (ACR) data submission to the OPM OIG and the 2021 medical and pharmacy claims reported in the Plan's support for the FEHBP rate development submission. Furthermore, we identified variances between the Plan's reported membership totals used in the FEHBP rate development submission for contract years 2019 through 2021 and the Plan's system report membership totals.

Carrier Letter (CL) 2020-13 requires large carriers using an ACR methodology to submit claims data for FEHBP Program rates for 2021. Additionally, it states, "The claims data for the FEHB Program ***should be [emphasis added]*** downloaded from a central database at the time the rates are developed." Contract Section 5.64 states, "(c) … The Contractor shall establish the following within 90 days after the contract award … . (2) An internal control system. … (A) Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the business ethics awareness and compliance program and internal control system."

We requested an explanation and supporting documentation for the Plan's medical and pharmacy claims variance that existed with the 2021 data. The Plan responded that both the timing and source for the data-pull were different. The Plan confirmed that the claims data for the rate development was pulled from the system in April and the claims data for the ACR submission was pulled in July or August using a different system. Although it was determined to be immaterial for the 2021 contract year, it could significantly impact other year's claims amounts used in the FEHBP rate development and the Plan's ability to support its claims. Furthermore, the Plan is not in compliance with CL 2020-13.

Recommendation 3

We recommend that the Plan comply with CL 2020-13 and download its ACR claims data at the time the FEHBP rates are developed.

Recommendation 4

We recommend that the Plan strengthen its internal policies and procedures to ensure that it eliminates variances in its FEHBP rate development components.

Plan Response:

The Plan agreed with the finding and recommendation 3 but disagreed with recommendation 4.

The Plan stated, "the goal is to assure alignment and mitigate or eliminate discrepancies when possible. However, due to the nature of operational needs, various data sources and application of those sources will vary. The slight discrepancies that exist as a result are constantly reviewed for opportunities to adjust where applicable."

It also noted that it takes its contractual obligations seriously and administers the FEHBP in good faith to comply with all laws, regulations, and guidance.

OIG Comment:

We acknowledge the Plan's response to recommendation 4 and recognize that there may be slight variances of the data. However, the Plan's policies and procedures should be modified to comply with CL 2020-13, which will help eliminate potential future material variances in the claims data.

3. Pharmacy Rebates **Procedural**

The Plan could not provide support for the pharmacy rebates in the 2019 through 2021 FEHBP premium rate developments. Additionally, we were unable to verify if the pharmacy rebates were removed from the pharmacy claims amount.

The Plan was unable to provide supporting documentation for its pharmacy rebates.

Contract Sections 1.11(b) and 3.4 require that records be maintained for a retention period specified in the FEHBAR, 48 CFR 1652.204-70, which is a period of six years for the rate development submissions. Furthermore, the OPM rating instructions state that the Plan "must keep on file all data necessary to justify the ACR rate … ."

OPM rating instructions stipulate that "claims must be reduced by income attributed to the FEHBP group enrollees from all other sources such as prescription drug rebates" for the premium rate developments.

Although requested, the Plan was unable to furnish supporting documentation for our review. Therefore, we were unable to confirm that pharmacy rebates were removed from the pharmacy claims. As a result, we were unable to determine if the Plan applied pharmacy rebates to the applicable pharmacy claims within the FEHBP premium rate developments in 2019 through 2021.

Recommendation 5

We recommend that the Plan strengthen its internal policies and procedures to ensure that pharmacy rebates are properly allocated to the FEHBP and removed from the pharmacy claims in the premium rate development.

Plan Response:

The Plan did not respond to the finding or recommendation.

4. Medical Claims Review — Procedural

We reviewed a judgmental sample of 75 medical claims from the contract years 2019 and 2020 to determine if the Plan priced and paid its claims for eligible members in accordance with the applicable criteria. Based on our review, we identified several issues, which are noted below. Although the claims issues were immaterial, if the Plan does not address the deficiencies that led to the issues noted below, the issues may result in material errors in future years.

a. Claims System Policies and Procedures

Our review identified that the Plan's claims system configuration allowed 5 of the 75 sampled claims to be split into unique, suffixed, claim lines, which resulted in separate claim numbers. This separation of claims resulted in pricing issues with the contracted fee schedules and issues with the application of copayments.

The Plan split claim lines for some samples resulting in separate, unique, claim numbers that added a suffix (i.e., 01, 02, 03) to the claim number. For the samples in our review that included split claim lines, we were unable to verify the correct copayments and pricing on the claims due to the added suffix. The Plan stated that its claim system assigns a claim number to each claim prior to processing, although the action of splitting claims was not addressed in the Plan's claims processing policies and procedures.

OPM's Contract Section 5.64(c), requires the Plan to establish an internal control system sufficient to meet the terms of the Contract.

We concluded that the Plan did not have adequate policies and procedures in place to ensure all claim lines associated with a claim number can be tied together.

Recommendation 6

We recommend the Plan update its system and procedural controls for its claims processing system.

b. Claim Pricing

The Plan did not provide adequate supporting documentation to re-price 20 of the 75 sampled claims.

OPM's Contract Section 1.11(b) requires insurance carriers to maintain all records relating to the contract. Furthermore, the OPM rating instructions state that the Plan "must keep on file all data necessary to justify the ACR rate … ."

The Plan did not provide sufficient supporting documentation to confirm the pricing for 20 sampled claims.

Our review discovered multiple issues with the Plan's supporting documentation, including:

- contracts that were not fully executed and/or contracts that were not in effect until after the date of service on the claim;
- contracts provided that did not correspond to the servicing provider on the claim;
- payment remittance advices that were provided that had procedure codes or claim numbers not associated with the ACR claims data for the sample;
- fee schedules provided with contracts that did not list the amount billed on the claim;

- procedure codes priced off of the Plan's internal fee schedules that were not provided;

- a claim based on Medicare Part B pricing when the member was not enrolled in Medicare Part B; and

- copayments related to specialist servicing providers.

As a result, we determined that the Plan did not have sufficient internal controls in place to ensure adequate support documentation was maintained.

Recommendation 7

We recommend that the Plan ensures it maintains adequate supporting documentation in accordance with its Contract and the OPM rating instructions.

c. Copayment Error

The Plan did not apply an applicable copayment for 8 of the 75 sampled claims.

OPM's Contract Section 2.2(a) requires the Plan to provide benefits defined in the FEHBP benefits brochure. The Plan's 2019 and 2020 FEHBP benefit brochures list member copayments based on the benefits provided.

The 2019 and 2020 FEHBP benefit brochures note that the member is responsible for copayments, including a specific copayment amount for outpatient visits, specialists, labs, x-rays, and other diagnostic tests. Our review found that the Plan did not apply an applicable copayment for procedures that involved an outpatient visit, a specialist, a lab, x-rays, and an ultrasound. The Plan stated that a copayment was not required for an outpatient visit that also had an x-ray. However, we identified that a copayment was not applied on the entire outpatient visit, which is required per the benefits brochure. We identified one claim where only a partial copayment was applied. The Plan stated that the remaining copayment was withheld on a separate claim, although we were not provided with support documentation showing that the remaining copayment was withheld. The Plan also stated that the procedures for some of the sampled claims were for the professional component and that no copayment was required, although the Plan could not provide support that a technical component was completed on the sampled claims, which would have showed the copayment was applied.

Based on the issues noted, we determined that the Plan did not have adequate internal controls in place to ensure that appropriate copayments were applied as defined in the FEHBP benefit brochures.

Recommendation 8

We recommend that the Plan ensure that appropriate copayments are applied to claims as defined in the FEHBP benefit brochure.

d. Out of Network Providers

During our review, we determined that the Plan paid claims to out of network providers for 2 of the 75 sampled claims.

OPM's Contract Section 2.2(a) requires the Plan to provide benefits defined in the FEHBP benefits brochure. The 2019 and 2020 FEHBP benefit brochures state that a provider must be a participating provider in its network for services to be covered.

The Plan erroneously paid claims to out of network providers.

For one of our sampled claims, the Plan initially stated that the provider was out of network, but later explained that the provider was a participating provider. However, a contract was never provided by the Plan to confirm the provider was a participating provider. On the other sample claim, we requested a contract and fee schedule to support the pricing on the claim and the Plan responded that the provider was out of network, however the claim was still paid. By paying the out of network provider claims, the Plan was not in compliance with the terms of its Contract or the benefits stated in the 2019 and 2020 FEHBP benefit brochures.

Recommendation 9

We recommend that the Plan ensure claims are not processed for out of network providers as stated in the FEHBP benefit brochure.

e. Coordination of Benefits Error

The Plan did not properly coordinate benefits with Medicare for 2 of the 75 sampled claims.

OPM's Contract Section 2.6(a) requires the carrier to "coordinate the payment of Benefits ... with the payment of Benefits under Medicare ... ."

Per the 2019 and 2020 FEHBP benefit brochures, when Medicare Part A is primary, Medicare processes the claim first and the Plan provides secondary benefits for covered services. For one of the claims, the member was a retiree who was enrolled in Medicare Part A prior to the date of service of the claim. The claim was processed as an inpatient hospital stay for anesthesia services. According to Medicare Part A, anesthesia, when you are an inpatient in a hospital, is a covered service. The Plan stated that the claim was

for professional charges, which do not fall under Medicare Part A. This overlooks the fact that anesthesia is specifically covered under Part A when it is done during an inpatient hospital stay.

The 2019 and 2020 FEHBP benefit brochures state that with double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. For the second claim, the member was enrolled in Medicare Part B prior to the date of service of this claim, and the Plan did not coordinate with Medicare. The Plan stated that at the time the claim was processed, it did not have a Medicare Part B effective date. The Plan should have retroactively coordinated the claim with Medicare since the member was eligible for Part B on the date of service for the claim.

We determined that the Plan was not in compliance with its Contract because it did not properly coordinate applicable claims with the payment of benefits under Medicare.

Recommendation 10

We recommend that the Plan ensure that benefits are properly coordinated, when applicable, with Medicare benefits.

Plan Response:

Recommendations 6 through 10 and the associated findings were based on information the Plan provided in response to the draft report. As a result, there is no plan response for these recommendations.

OIG Comment:

The Plan did not provide supporting documentation for 62 of the 75 sampled claims timely. These findings were developed based on the Plan's response to the claims requests that were provided after the draft report response.

B. Internal Controls Review

We determined that the Plan's internal control systems over the FEHBP enrollment and claims processing did not sufficiently meet the contractual criteria. Per Contract Section 5.64, Contractor Code of Business Ethics and Conduct, "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

The Plan's internal controls were not sufficient to meet the contractual requirements.

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. Non-Compliance with OPM OIG Debarment and Suspension Guidelines

Our audit identified that the Plan did not comply with guidance issued by the OPM OIG Administrative Sanctions Group (ASG) for managing FEHBP provider suspension and debarment.

Per 5 CFR 890, Subpart J, a system of administrative sanctions is to be managed by OPM for health care providers who have committed certain violations. Furthermore, it gives OPM the authority to prescribe regulations regarding services or supplies furnished by debarred providers. The operation of FEHBP Administrative Sanctions was delegated to the OIG from the Director of OPM. In March 2004, ASG issued the "Guidelines for Implementation of Federal Employees Health Benefits Program Debarment and Suspension Orders" (Guidelines) to supplement applicable regulations and to provide comprehensive instructions on all aspects of health insurance carriers' responsibilities. Subsequently, ASG issued additional guidance to all carriers on specific aspects of the administrative sanctions program. According to 48 CFR 1609.7001(a), carriers are required to meet the requirements of 5 USC 89 and 5 CFR 890, from which the ASG Guidelines are based. Additionally, 48 CFR 1609.7001(b)(1) and (3) state that the carriers must comply with OPM instructions and directives, as well as the terms of the Contract, regulations, and statutes.

In 2020, ASG notified the Plan that its procedures did not comply with several established requirements of the Guidelines. Based on our review, gaps in the Plan's procedures to address ASG's guidance persist and may relate to a lack of adequate internal controls to establish processes that address customer-specific requirements. Specifically, we identified the following areas of noncompliance with ASG's guidance.

a. Enrollee Requests for Exceptions

Per the Guidelines, Chapter 2, Section B.3, the Plan's sanctions implementation program must contain certain requirements at a minimum, to include a description of how the Plan processes enrollee requests for an exception to a provider's debarment. However, the Plan stated that it had not established a process for handling exception requests from enrollees, because to its knowledge, it had never received such a request. Without an established process for handling these requests in compliance with the Guidelines, requests that members send to the Plan in the future may not be handled timely or appropriately, leaving the member at risk of not receiving necessary health care coverage.

b. Notifications to ASG When Debarred Providers Continue to Submit Claims

The Guidelines, Chapter 2, Sections E.6, and F.1 require carriers to provide ASG with documentation of claims for services submitted after the effective date of a provider's suspension or debarment in addition to the reporting the Plan is required to do as part of its semiannual report to ASG. Although the Plan's procedures address review of claims paid after debarment, it does not address the review of claims submitted but not paid, nor does it include instructions to notify ASG of the claims when the Plan identified them. Without timely notifications from the Plan when debarred and suspended providers continue to submit claims, ASG is unable to take additional appropriate measures to further sanction the providers to discourage continued violations.

c. Exceptions to Allow Certain Claim Payments to Debarred Providers

Chapter 3 of the Guidelines specifies exceptions under which claim payments may be made to providers, even after they are debarred or suspended "to protect the financial and health care interests of FEHBP enrollees." We determined that the Plan's procedures did not address scenarios in which claims should be allowed per this guidance, nor did it address how the Plan ensures that these claims would still be paid. By not having procedures in place to ensure that allowable exceptions are considered, the Plan's members are at risk of not receiving appropriate heath care coverage.

d. Debarment and Suspension Referrals to ASG

After issuing the Guidelines, ASG issued supplemental guidance to Federal Employees Health Benefits (FEHB) carriers that required Plans to refer providers for debarment or suspension to ASG when they became aware of providers who met the qualifications for debarment, suspension, or sanction. During our review, the Plan noted that it only makes referrals to OPM OIG ASG in the case of suspected fraud, waste, and abuse (FWA). We found that the Plan's procedure for FWA referrals is outdated, as the FEHBP Carrier Letter (CL) upon which it is based was superseded by CL 2017-13. In addition, by only referring FWA cases, the Plan is not in compliance with guidance to refer providers for debarment or suspension directly to ASG. Without these referrals, ASG may not be able to take the appropriate steps to sanction applicable providers and prevent further potential FWA.

e. Use of the SFTP

The Plan's policies and procedures did not include use of the Secure File Transfer Protocol, as required by the Guidelines.

Supplemental guidance issued by ASG required that Plans use the OIG Secure File Transfer Protocol (SFTP) to communicate specific types of information to ASG when it includes personally identifiable information (PII) and protected health information (PHI). Specifically, Plans must use the SFTP to communicate referrals for debarment, semi-annual reporting on debarment activity, and notices of providers continuing to submit claims during their debarment. The Plan stated that it used the SFTP for quarterly reports, and ASG confirmed that it had received the semi-annual report via SFTP from the Plan. However, the Plan's documented procedure for the semi-annual report process did not discuss the SFTP and the Plan indicated that the reports were sent via secure email. Therefore, if the Plan's procedures were followed as written, the Plan risks noncompliance with ASG's guidance and could put members' PII and PHI at risk of improper disclosure. Additionally, as noted above, the Plan did not make the appropriate referrals for debarment nor did it notify ASG when providers continued to submit claims during debarment, which should also be submitted to ASG using the SFTP.

Recommendation 11

We recommend that the Plan develop a formal written policy to address FEHBP enrollee requests for exception to a provider's debarment in accordance with the Guidelines.

Recommendation 12

We recommend that the Plan develop formal written policies and procedures to notify ASG of claims submitted, whether paid or not, after a provider is debarred or suspended in accordance with the Guidelines.

Recommendation 13

We recommend that the Plan revise its written policies and procedures to ensure that claims are paid to debarred providers when they meet the specific exceptions defined in the Guidelines.

Recommendation 14

We recommend that the Plan update its FWA referral process to comply with CL 2017-13 and the supplemental guidance to the Guidelines.

Recommendation 15

We recommend that the Plan develop policies and procedures for using the SFTP to communicate information to ASG when PII or PHI is involved in accordance with the supplemental guidance to the Guidelines.

Plan Response:

The Plan agreed with the finding and recommendations. It provided a formal written policy that addresses member's requests for exception to a provider's debarment, and it stated that it is in the process of updating its relevant policies and procedures related to recommendations 11 through 15.

OIG Comment:

We acknowledge receipt of the Plan's provided written policy that addresses member's requests for exception to a provider's debarment and we will review the effectiveness of the policy during a future audit. We will also work with ASG as needed to ensure compliance.

2. Ineligible Family Member FEHBP Enrollment Procedures

Our review of the enrollment verification process identified that the Plan does not have adequate documented procedures to implement the steps outlined in CL 2020-16.

CL 2020-16, issued November 5, 2020, provides guidance to carriers on the process of verifying eligibility and removing ineligible family member enrollments. The CL includes specific guidance based on 5 CFR 890 related to requests for proof of family eligibility on existing enrollments, documents that may be used as proof of eligible enrollments to satisfy such requests, and actions to take based on enrollees' or their family members' responses to the requests. The CL is based on amendments to 5 CFR Part 890 to provide a process to remove family members who are determined to be ineligible from FEHB enrollments.

Although the Plan stated that it had implemented the verification process described in CL 2020-16, the procedure that it provided did not support the Plan's assertion. Specifically, the Plan's procedure provides an overview of how the Plan handles enrollment change requests from members, but it does not specifically address the type of enrollment verification and documentation requirements outlined in the CL. The CL does state that the regulation is not meant to require carriers to perform a full audit of FEHB enrollments and advises caution on

the timing of carrier verification requests to avoid inundating employing offices. However, the Plan should have procedures in place to address all the steps outlined in the CL. Without adequate procedures to perform the verification process described in the CL, the Plan leaves the FEHBP at risk of covering health care costs for ineligible members.

Recommendation 16

We recommend that the Plan strengthen its procedures for requesting proof of family member eligibility and removing ineligible family member enrollments as outlined in CL 2020-16.

Plan Response:

The Plan agreed with the finding and recommendation, although it did state that an obstacle to verifying the information is current subscriber contact information and employing agency information. It plans to partner with employing agencies and OPM to confirm subscriber's information as well as specific employing agency information.

OIG Comment:

We acknowledge the Plan's response and will review the Plan's process for partnering with OPM and the employing agencies during future correspondence and reviews.

C. Timely Access to Supporting Documents

Contract section 5.64(c)(2)(ii)(G) states that at a minimum, the Plan's internal control system shall provide for full cooperation with Government agencies responsible for audits. Additionally, Contract section 5.64(a) defines "full cooperation" as providing timely and complete responses to the OIG's request for documents.

During this audit, the Plan did not provide requested data in a timely manner, and in some cases, not at all. We issued information requests throughout the audit to obtain information and support. For many of the information requests, there were extension requests, and some information was never received (i.e., support for the claims samples). The OIG met with the OPM contracting officer during the audit to alert them of the issue. At the time of our draft report issuance, the OIG issued an additional information request attempting to obtain missing claim sample supporting documentation for 62 of the 75 claims in our sample.

The Plan responded to the draft report but did not respond to the claims support request. When the audit team met with the Plan and asked about the status of the claims support, the Plan stated that it was working on getting the information. All of these delays in receiving information greatly impacted the audit and delayed the issuance of this final report. Furthermore, the Plan's failure to make available the records timely was a direct violation of its Contract.

Recommendation 17

We recommend that the contracting officer require the Plan to comply with the terms of its Contract, provide its full cooperation to the OIG in all future audits, and ensure it provides complete and accurate documentation, as requested, in a timely manner.

Plan Response:

The Plan did not have an opportunity to respond to this finding or recommendation.

OIG Comment:

Due to the fact that the OIG audit team continued to have issues receiving supporting documentation from the Plan even after the draft report response was received, we included this finding and recommendation in this final audit report.

EXHIBIT

UnitedHealthcare Insurance Company, 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?
Incurred Medical Claims from 3/1/2019 through 2/29/2020 used in the 2021 Claims Experience	151,890	$34,222,163	Used the RAT-STATS[1] statistical software program (with the following parameters: a 90% Confidence Level, a 50% Anticipated Rate of Occurrence, and a 20% Desired Precision Range) to select 75 random claims from SAS EG[2] as a sample.	75	$25,031	No

[1] A statistical software package that assists users in selecting random samples.
[2] SAS Enterprise Guide is a software program used to analyze data allowing users to access and manipulate data quickly.

APPENDIX

June 09, 2023

Deleted by OIG – Not Relevant to the Final Report
US Office of Personnel Management
Office of Inspector General
1900 E Street, N.W.
Washington, DC 20415

RE: Comments to the Draft Audit Report on UnitedHealthcare Insurance Company, Plan Code KT, Report No. 2022-CRAG-037

Dear **Deleted by OIG – Not Relevant to the Final Report**:

On May 10, 2023, the United States Office of Personnel Management, Office of the Inspector General ("OPM/OIG") submitted to the Plan a "Draft Report" (2022-CRAG-037) ("Draft Report"), detailing the results of its audit of the Federal Employees Health Benefits Program ("FEHBP") operations of the UnitedHealthcare Insurance Company ("UHIC"), rate code KT (the "Plan"), for contract years 2019 – 2021. Upon submission, OPM/OIG requested the Plan to provide comment to the Draft Report.

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Internal Controls Review

Deleted by OIG – Not Relevant to the Final Report

Recommendation

We recommend that the Plan develop a formal written policy to address FEHBP enrollee requests for exception to a provider's debarment in accordance with the Guidelines.

Recommendation

We recommend that the Plan develop formal written policies and procedures to notify AST of claims paid after a provider is debarred or suspended in accordance with the Guidelines.

Recommendation

We recommend that the Plan revise its written policies and procedures to ensure that claims are paid to debarred providers when they meet the specific exceptions defined in the Guidelines.

Recommendation

We recommend that the Plan update its FWA referral process to comply with CL 2017-13 and the supplement guidance to the Guidelines.

Recommendation

We recommend that the Plan develop policies and procedures for using the SFTP to communicate information to ASG when PII or PHI is involved in accordance with the supplemental guidance to the Guidelines.

In the Plan's response to the recommendations **Deleted by OIG – Not Relevant to the Final Report**, the Plan provided a formal written policy that addresses member's requests for exception to a provider's debarment **Deleted by OIG – Not Relevant to the Final Report** and the Plan committed to updating its relevant policies and procedures related to Recommendations **Deleted by OIG – Not Relevant to the Final Report**.

Deleted by OIG – Not Relevant to the Final Report

Ineligible Family Member FEHBP Enrollment Procedures

Recommendation

We recommend that the Plan strengthen its procedures for requesting proof of family member eligibility and removing ineligible family member enrollments as outlined in CL 2020-16.

The Plan agrees with this recommendation and noted to OIG that an obstacle to verifying the information is the fact that current subscriber contact information and employing agency information available to the Plan is not always current. However, the Plan will develop a process and make a reasonable effort to partner with employing agencies and OPM to confirm subscriber's information as well as specific employing agency information.

Emergency Room Copayment Discrepancy

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Recommendation

We recommend that the Plan research its ER copayments from 2020 to determine the extent to which members were negatively impacted by the discrepancy and rectify any member overpayments.

Recommendation

We recommend that the Plan strengthen its internal controls to ensure that the FEHBP benefits brochure clearly and accurately states copayment amounts to its members.

The Plan acknowledges the error and provided OIG with the information showing that while the error was corrected in the electronic version of the benefits brochure in February of 2020, the corrected electronic version was never uploaded to the OPM.gov website. The Plan is researching the impact (if any) to its members because of the discrepancy identified. **Deleted by OIG – Not Relevant to the Final Report**

ACR Claims and Membership Variances

Deleted by OIG – Not Relevant to the Final Report

Recommendation

We recommend that the Plan comply with CL 2020-13 and download its ACR claims data at the time the FEHBP rates are developed.

Recommendation

We recommend that the Plan strengthen its internal policies and procedures to ensure that it eliminate variances in its FEHBP rate development components.

As indicated in the Draft Report, the Plan agreed with Recommendation **Deleted by OIG – Not Relevant to the Final Report** but disagreed with Recommendation **Deleted by OIG – Not Relevant to the Final Report**. The Plan stated "the goal is to assure alignment and mitigate or eliminate discrepancies when possible. However, due to the nature of operational needs, various data sources and application of those sources will vary. The slight discrepancies that exist as a result are constantly reviewed for opportunities to adjust where applicable."

The OIG commented "*We acknowledge the Plan's response to Recommendation* **Deleted by OIG – Not Relevant to the Final Report** *and recognize that there may be slight variances of the data. However, the Plan's policies and procedures should be modified to comply with CL 2020-13, which will help eliminate material variances in the claims data.*

The Plan takes its contractual obligation very seriously and administers the FEHBP in good faith to comply with all federal regulations, contractual provisions and OPM instructions.

Deleted by OIG – Not Relevant to the Final Report

Respectfully,

Deleted by OIG – Not Relevant to the Final Report

Report Fraud, Waste, and Mismanagement

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

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