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

Final Audit Report

AUDIT OF THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM OPERATIONS AT DEAN HEALTH PLAN

Report Number 2023-CRAG-011
January 12, 2024

EXECUTIVE SUMMARY

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

Report No. 2023-CRAG-011 **January 12, 2024**

Why Did We Conduct the Audit?

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

What Did We Audit?

Under Contract CS 1966 (Contract), the Office of the Inspector General completed a performance audit of the FEHBP premium rate developments for contract years 2020 through 2022. We conducted our audit fieldwork remotely from February 13, 2023, through September 13, 2023.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

We determined that portions of the Plan's 2020 through 2022 FEHBP premium rate developments were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM. The issues we identified in our audit are designated as procedural, including the following:

- The Plan's internal controls over the FEHBP premium rate development were insufficient in the following areas:
    - Claim Reductions,
    - Catastrophic Claims,
    - Benefit Factors (FEHBP Plan Medical Per Member Per Month Rate),
    - Health Insurance Providers Fee, and
    - Brochure Inaccuracies.
- The Plan did not provide sufficient oversight to third party vendors responsible for claims repricing.
- The Plan's claims system did not process non-participating provider and secondary payer claims in accordance with the terms of the Contract.
- The Plan had insufficient FEHBP termination policies and procedures to effectively administer FEHBP enrollment during contract years 2020 through 2022.
- The Plan's claims data submissions to the Office of the Inspector General did not meet the requirements of Carrier Letters 2021-17 and 2022-14.

ABBREVIATIONS

ACR	**Adjusted Community Rating**
CFR	**Code of Federal Regulations**
CL	**Carrier Letter**
CLER	**Centralized Enrollment Clearinghouse System**
Contract	**OPM Contract CS 1966**
DHP	**Dean Health Plan**
FEHBP	**Federal Employees Health Benefits Program**
MLR	**Medical Loss Ratio**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
PCP	**Primary Care Provider**
Plan	**Dean Health Plan**
PMPM	**Per Member Per Month**
SPC	**Specialist**

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I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at Dean Health Plan (Plan), plan codes WD and AG. The audit was conducted pursuant to the provisions of Contract CS 1966 (Contract); 5 United States Code Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract years 2020 through 2022 and was conducted remotely by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG) staff.

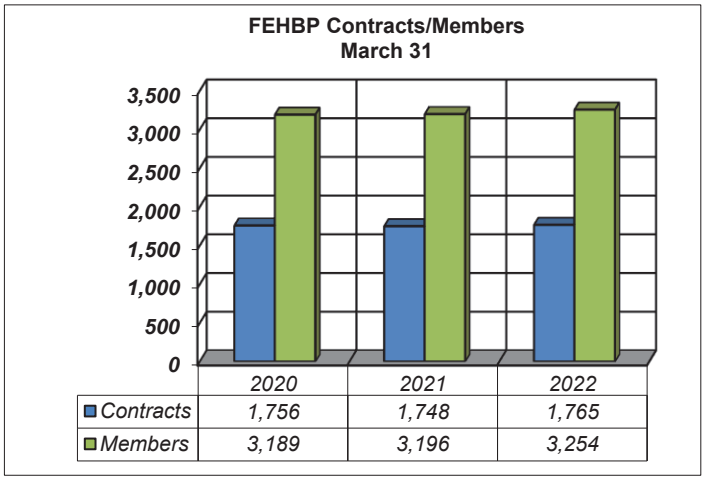
The FEHBP was established by the Federal Employees Health Benefits Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for Federal employees, annuitants, and eligible dependents, and is administered by the OPM Healthcare and Insurance Office.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

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 is 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.



	2020	2021	2022
Contracts	1,756	1,748	1,765
Members	3,189	3,196	3,254

In 2020 through 2022, the Plan provided health benefits to FEHBP members in South Central Wisconsin, offering a standard and high option, designated as FEHBP plan code WD. In 2021, the Plan added the basic option, FEHBP plan code AG, and continued to carry that basic option in 2022. Enrollment in the basic option was limited to enrollees that lived or worked in the Wisconsin counties of Dane, Dodge, Fond du Lac, Green, Rock, or Sauk and utilized the Dean Focus provider network for all services.

A prior audit of the Plan's premium rates for contract years 2012 and 2013 did not identify issues with the premium rates; however, the audit identified issues related to the MLR. Specifically, the Plan did not use the correct FEHBP claims data for the 2012 and 2013 MLR calculations. Additionally, the Plan did not reduce the claims for both years by the change in health care receivables, incorrectly included taxes on investment income, and did not use the correct premium income. The final audit report was issued in March of 2016, and all issues were resolved by OPM.

The preliminary results of this audit were communicated to Plan officials during the Notice of Finding and Recommendations process and the exit conference. The Plan's comments were considered in the preparation of this report and are included, as appropriate, in the report.

II. OBJECTIVES, SCOPE AND METHODOLOGY

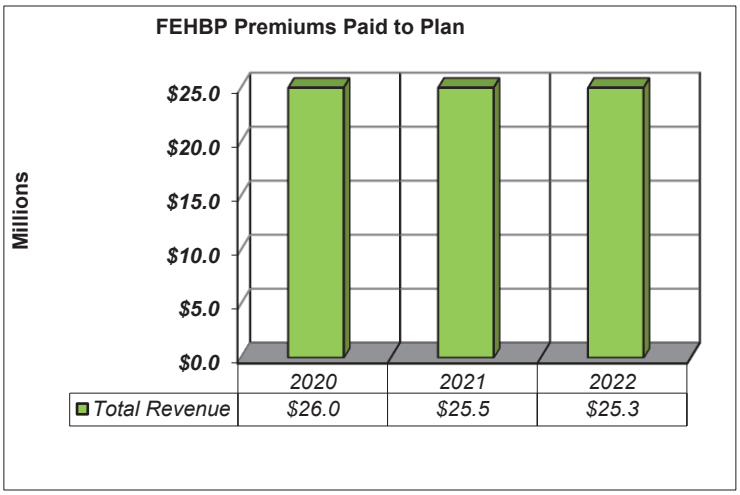
OBJECTIVES

The primary objective of this performance audit was to determine whether the Plan complied with the provisions of its Contract and the laws and regulations governing the FEHBP. Specifically, we 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 2020 through 2022. For these years, the FEHBP paid approximately $76.8 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:

- Adjusted Community Rating (ACR) claims data was submitted in accordance with Carrier Letter requirements;
- FEHBP premium rate calculations were accurate, complete, and valid;
- FEHBP medical claims were processed accurately; and
- FEHBP Enrollment transactions are processed in accordance with the terms of the Contract.

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 February 13, 2023, through September 13, 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, 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 and claims policies and procedures. We also interviewed appropriate Plan officials regarding the controls in place to ensure that the premium rate calculations and claims pricing were completed accurately and appropriately. Other auditing procedures were performed as necessary to meet our audit objectives.

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

III. AUDIT FINDINGS AND RECOMMENDATIONS

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 1966 (Contract). We determined that the Plan's 2020 through 2022 Certificates of Accurate Pricing for plan codes WD and AG were defective because portions of the Plan's 2020 through 2022 FEHBP premium rate developments were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM. We recalculated the Plan's premium rates, as discussed throughout the report, utilizing OPM's community-rating guidelines and applicable regulations. The net result did not identify any questioned costs; however, we found several instances of internal control issues, designated in this report as procedural findings.

Specifically, we determined that the Plan's internal control systems over FEHBP premium rate developments, medical claims processing and enrollment 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 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."

A. PREMIUM RATE REVIEW

1. Claim Reduction Non-Compliance

The Plan did not reduce the reported claims totals by pharmacy rebates and subrogation costs in the certified 2020 through 2022 FEHBP premium rate developments, as required by OPM's Rate Instructions and Community Rated Guidelines, communicated in FEHB Program Carrier Letters 2019-06, 2020-09, and 2021-07. Specifically, "FEHBP claims must be reduced by income attributed to FEHBP group enrollees from all other sources such as drug subscription rebates, coordination of benefits, subrogation, and settlements."

As we conducted fieldwork, the Plan advised that pharmacy rebates and subrogation costs are part of the underwriting adjustment that is applied to the final premium rate; however, this method of application is not outlined in any policy or procedure document nor is it disclosed on the proposal/reconciliation questionnaires submitted to OPM. The Plan noted on the questionnaires that "[t]he Calculated Rate ***may be*** [emphasis added] adjusted further by an Underwriting Adjustment, Plan Shift/Subsidy and/or a Business Discount factor depending on

the market conditions and financial targets in place," never indicating that the required reductions for the pharmacy rebates, subrogation, etc. were typically accounted for in the underwriting adjustment. The Plan applied underwriting adjustments in the premium rate proposals to the High and Standard options in 2020, and to the Standard and Basic options for 2021 and 2022. OPM requires that the underwriting adjustments in the rate reconciliations be (at least) what was reported by the Plan in the proposals, as they are considered to be Federal Employees Health Benefits (FEHB) discounts.

It's unclear why the Plan did not disclose to OPM that the underwriting adjustment includes items that are explicitly required by OPM's Community Rated Guidelines to be applied as a reduction to claims, especially since the Plan noted that the 2020 rate proposal was resubmitted to achieve a final rate and the Plan modified the underwriting adjustment to attain that final rate. If the modified underwriting adjustment in this scenario did include pharmacy rebates and subrogation costs, the Plan did not advise OPM of how those costs were impacted. Further, claims components, such as pharmacy rebates and subrogation costs, should adjust the actual claims experience from which they originated. By the Plan not reducing the ACR claims experience with the required reductions attributable to that claims experience, subsequent loadings in the premium rate development will be inflated and the premium rates will not be current, accurate, and complete as required in Contract, Section 3.3.

This issue appears to stem from insufficient policies and procedures for the development of FEHBP premium rates, including compliance with OPM's Carrier Letters. As required in the Minimum Standards for Health Benefit Carriers, 48 CFR Part 1609.7001(b)(1), FEHBP carriers must perform the contract held with OPM in accordance with prudent business practices, including but not limited to timely compliance with OPM instructions and directives. As such, sufficient controls, including written policies and procedures, should be in place to ensure that the Plan complies with guidance provided by OPM, including instruction provided via Carrier Letter. If updated and enhanced FEHBP-specific policies and procedures are not implemented to strengthen controls, the Plan will continue to not properly reduce claims in the premium rate developments.

Recommendation 1

We recommend that the Plan establish written policies and procedures to strengthen internal controls over the process for implementing OPM Carrier Letter guidance in accordance with 48 CFR Part 1609.7001(b)(1).

Plan Response:

The Plan stated, "[w]hile we maintain that our process is Actuarially sound, and our rates are current, accurate, and complete due to including [pharmacy] rebates and subrogation

within the Underwriting Adjustments, we agree that transparency around claims adjustments can be improved.

We will implement distinct rows in the Rate Development Spreadsheet for Rx Rebates and Subrogation. These items will no longer be included in the Underwriting Adjustments row. We will implement the recommended updates to our policies and procedures documentation to ensure proper implementation of OPM Carrier Letter guidance in accordance with 48 CFR Part 1609.7001(b)(1).”

OIG Comment:

We recognize that the Plan intends to add distinct rows in the premium rate development to account for pharmacy rebates and subrogation; however, it is unclear where in the premium rate development the distinct rows will be added and in which contract year these changes will take effect. Additionally, we were not provided with the updated policy and procedure documents that address how the Plan will track and implement OPM Carrier Letter Guidance. As such, we cannot comment on the potential effectiveness of these actions to address the recommendation at this time.

2. Unsupported Catastrophic Claims Adjustment

The Plan’s documentation did not support the catastrophic claims adjustment amounts in the 2020 to 2022 rate developments. The Plan provided spreadsheets with amounts that differed from the rate development amounts and did not use the claims data submitted to the OIG for their calculations. Further, the Plan noted in multiple responses that a “Medical Diagnosis” report was used to assess the member’s medical condition(s) to see if the conditions were ongoing and would provide additional risk to the Plan. However, the Plan was unclear how this report was incorporated into the methodology for determining the catastrophic claims adjustment or how it impacted the rate developments. Lastly, the Plan’s Large Renewal Processing document does not discuss the Plan’s process of truncating catastrophic claims at [redacted].

According to Carrier Letters 2019-06, 2020-09, and 2021-07, once the experience period and claims are set in the proposal, they cannot be changed after the proposal is submitted. Therefore, the Plan should have used the submitted claims data to calculate the factors in the rate development. Per the Plan’s Contract with OPM and the Community Rated Guidelines, the Plan must use a standard rating methodology within the rate development. Specifically, per Contract Section 3.2, all community rated plans must develop the FEHBP’s rates using their State-filed rating methodology, or if not required to file with the State, their standard written and established rating methodology. Further, the Community Rating Guidelines state the rating method must be completely and clearly explained. Lastly, Contract Section 3.4, Contractor

Records Retention states, "Notwithstanding the provisions of Section 5.7 (FAR 52.215-2(f)) *Audit and Records – Negotiation,* the Carrier will retain and make available all records applicable to a contract term that support the annual statement of operations and, for contracts that equal or exceed the threshold at FAR 15.403-4(a)(1), the rate submission for that contract term for a period of six years after the end of the contract term to which the records relate."

This issue occurred because the Plan did not maintain documentation to support or clearly document the methodology used for the catastrophic claims adjustment within the 2020 through 2022 rate developments. As a result, the Plan cannot adequately support, and the OIG cannot confirm that the catastrophic claims amounts used within the 2020 through 2022 rate developments are accurate.

Recommendation 2

We recommend that the Plan revise and update established policies and procedures to ensure a standard rating methodology is used for the FEHB premium rate development in accordance with 48 CFR Part 1609.7001(b)(3).

Recommendation 3

We recommend the Plan maintain documentation to support the rate submissions as required by Contract CS 1966.

Plan Response:

The Plan disagreed with the finding and stated, "[w]hen a group renewal is pulled into Stepwise, the catastrophic claims that are pulled for the rate development are extracted through logic built in the tables that support the Stepwise rating engine. Stepwise is programmed to identify claims by member that exceed the pooling level in each experience period. Any dollar value over the pooling amount will be credited (Line 8 of Experience Exhibit) through a PMPM adjustment. The Medical Diagnosis report is a report that is pulled into Excel from a separate Stepwise data table and is used for evaluation by the Underwriter [to] determine future ongoing medical conditions. This evaluation will never alter the pooled claims PMPM located in Line 8 of the Experience Exhibit rather the Medical Diagnosis report is an aid, along with other reports, to help the Underwriter determine what he/she may decide to recommend for a renewal increase. Desk procedure, 'Large Group Renewal Processing,' will accompany this response to show that we do have procedures in place that we use for the renewal build-up. This process is used for all large group renewals."

OIG Comment:

Although not specifically stated in its response, it appears that the Plan provided us with an updated "Large Group Renewal Processing" document, as the content varies from the version supplied to us during fieldwork. It is unclear though when either version of this document became effective because the origination, review, and approval dates are not annotated on either copy. Further, the "last revised" date on both document copies shows the same reviewer and a date of "7/2021." As such, we cannot discern what "Large Group Renewal Processing" document was in place during all scope years of the audit.

The most recent version of the "Large Group Renewal Processing" document, provided in response to the Draft report, contains the following language, "[t]he Underwriter will evaluate the person's medical history to see what has occurred to create higher claims and make a determination if the condition appears to be ongoing. **This evaluation will not change the pooled out claims on the experience exhibit but will rather assist the Underwriter in determining what renewal increase to set the group at** [emphasis added] … ." We recognize that this additional language confirms that the Underwriter will not change the pooled claims in Stepwise when evaluating the person's medical history; however, it does not specify what reports will be used in this process, including the previously designated "Medical Diagnosis" report. Moreover, the "Large Group Renewal Processing" document does not clearly indicate the Plan's pooling methodology, including truncating high dollar claims at the applicable pooling level and dividing by member months.

Finally, both versions of the "Large Group Renewal Processing" document that we received note that the Plan Underwriter should save Catastrophic claim summary and detail information from Stepwise when completing the rate renewal. However, the saved information provided to us in support of the 2020 through 2022 FEHBP rate developments did not match what was actually used to determine the premium rates. If these "Large Group Renewal Processing" documents were in effect during the audit scope rate renewal periods, it is unclear why the Plan did not retain the records as required by the Contract.

Due to these remaining issues, we continue to recommend that the Plan update and implement its "Large Group Renewal Processing" document to clearly define its premium rate renewal process and ensure all supporting documents are retained as required by the Contract.

3. Benefit Factors Variances

The Plan did not develop accurate and complete benefit factors used in the certified 2020 through 2022 FEHBP Premium Rate Developments in accordance with the terms of the Contract Section 3.3. Specifically, we reviewed the Plan-provided Managed Care Rate Model (MCRM) benefit inputs, which the Plan used to develop the FEHBP Plan Medical (Plan Med)

per member per month (PMPM) output values in the FEHBP premium rate development benefit factors and found that the MCRM output values were not developed based on the explicit FEHBP benefits and actual cost-sharing stipulations outlined in the FEHBP brochures. The Plan's MCRM, which is a common industry-purchased rate model, is populated with respective group benefits (e.g., deductibles, coinsurance, and copays) to create Plan Med PMPM values, which are used to develop benefit factors that adjust experience claims from prior to current benefit levels (Plan's Attachment A). However, the Plan does not have adequate documented policies and sufficient controls surrounding MCRM benefit inputs for the FEHBP, resulting in improper cost-sharing inputs that lead to deficient Plan Med PMPM values used in the Plan's Attachment A benefit factor calculations.

As we compared the provided experience period rate model screen shots to the respective FEHBP brochures, we identified numerous rate model cost-sharing inputs that differ from the amounts clearly defined in the FEHBP benefit brochures, including the Plan identified 2021 copay MCRM input error relating to the urgent care benefit under the basic option. The MCRM input errors are summarized in Table I and subsequent report sections A.3.a. through A.3.d.

Table I: Benefit Comparison - FEHBP Brochure vs. MCRM

MCRM Benefit Description	Benefit Year(s)	Plan Option	FEHBP Brochure Copay/Coinsurance Amount	MCRM Copay/Coinsurance Amount
a. Glasses/Contacts	2017 - 2022	High and Standard	Nothing (child)/Not Covered (adult)	[redacted] coinsurance
b. Outpatient: Psychiatric and Alcohol/Drug Abuse	2017 - 2022	High	$20	[redacted] coinsurance
c. Outpatient: Psychiatric and Alcohol/Drug Abuse	2021 and 2022	Basic	$40	[redacted]
d. Allergy Testing and Immunotherapy	2017 - 2022	High	$20 Primary Care Provider (PCP)/$40 Specialist (SPC)	[redacted] coinsurance
e. Allergy Testing and Immunotherapy	2021 and 2022	Basic	$0/$80	[redacted]
f. Vision Exams	2021 and 2022	High and Standard	$40 SPC	[redacted] SPC
g. Vision Exams	2019 and 2020	High and Standard	$40	[redacted] SPC
h. Vision Exams	2021 and 2022	Basic	$80 SPC	[redacted] SPC
i. Hearing Exams	2021 and 2022	Basic	$40	[redacted]
j. Urgent Care	2021	Basic	$40	[redacted]

a. Improper 10 Percent Coinsurance Inputs

The Plan's methodology was to input a [redacted] in-network coinsurance within MCRM for benefits that are not explicitly listed in the brochure. The specific benefits shown above for *a., b.,* and *d.* can be directly traced from the MCRM screenshots to the FEHBP brochures, which stipulate explicit cost-sharing provisions that differ from the Plan's 10 percent coinsurance inputs. As such, the Plan's improper use of the in-network [redacted] coinsurance MCRM inputs versus the actual cost-sharing provisions, outlined in the FEHBP brochures, resulted in deficient Plan Med PMPM values and invalid benefit factors.

b. Improper [redacted] Copay Inputs

The Plan's methodology was to input an [redacted] specialist care copay amount for copay-only plan benefits within MCRM that are not explicitly listed in the brochure. The specific benefits shown above for *c.* and *i.* can be directly traced from the MCRM screenshots to the brochures, which stipulate explicit cost-sharing provisions that differ from the Plan's [redacted] copay-only plan inputs. As such, the Plan's improper use of the [redacted] copay-only MCRM input versus the actual cost-sharing provisions, outlined in the FEHBP brochures, resulted in deficient Plan Med PMPM values and invalid benefit factors.

c. Improper PCP Copay Inputs

The Plan's methodology was to input the primary care provider (PCP) copay for the benefits shown above, *e.* through *h.*, within MCRM. The Plan noted that the allergy immunotherapy benefit for letter *e.* is not explicitly listed in the brochure, warranting the lower primary care copay input, and the vision benefits for *g.* through *k.* refer only to the standard routine vision exam performed by the PCP/Optometry, also warranting the lower primary care copay input. However, the specific benefits shown above for *e.* through *k.* can be directly traced from the MCRM screenshots to the brochures, which stipulate explicit cost-sharing provisions that differ from the Plan's default PCP copay inputs. As such, the Plan's improper use of the PCP copay MCRM inputs versus the actual cost-sharing provisions, outlined in the FEHBP brochures, resulted in deficient Plan Med PMPM values and invalid benefit factors.

d. Improper 2021 Basic Urgent Care Copay Input

The Plan identified that the urgent care copay for the basic option for benefit year 2021 was misstated within MCRM at [redacted] versus the actual FEHBP brochure copay amount

of $40 as illustrated above in letter *j*. The Plan advised that this error occurred because the MCRM model was referencing an outdated version of the Basic Benefit Plan design. It was also noted by the Plan in a separate response that the final benefit factor for the basic option, including the corrected copay amount, resulted in the same benefit factor for the 2022 basic option, and that the overall impact is immaterial. Nonetheless, the Plan's improper MCRM urgent care copay input of [redacted] versus the actual copay amount of $40, outlined in the FEHBP brochures, resulted in a deficient Plan Med PMPM value and invalid benefit factor.

4. <u>Plan Med PMPM Variances</u>

As noted above, the Plan developed a Plan Med PMPM value that is based on rate model inputs attributable to group benefits. The dollar value rate model output was provided in screenshots for each experience period benefit option and labeled within the screenshot as "Total Plan Med PMPM (Premium less Rx PMPM)." The Plan Med PMPM value is a line item incorporated into the benefit factor calculation, as demonstrated on the Plan's Attachment A schedules. We compared the Attachment A schedule Plan Med PMPM values to the rate model output values and noted several variances. The Plan noted that the larger variances (approximately $[redacted] to $[redacted] PMPM) present in premium rate year 2020 experience periods were due to an [redacted] and that the smaller variances occurred due to [redacted] (approximately $[redacted] to $[redacted] PMPM). It is unclear why the hard-coded Plan Med PMPM Attachment A schedule values would not directly reconcile to the source model Plan Med PMPM values since there would be no additional formulas between the rate model output and the hard-coded Attachment A values, only the potential for human error or discretion when inputting the source data.

To ensure the accuracy of future benefit adjustments applied in the FEHBP premium rate developments, the Plan should address the internal control issues discussed above, including memorializing written and detailed policies and procedures, to mitigate future benefit errors when developing the FEHBP premium rates. Although the Plan indicated that it has policies and procedures in place, adequate documentation was not provided to corroborate their existence. Furthermore, based on the various benefit issues identified above and the Plan's own admission that an outdated benefit design was erroneously used, it is evident that the current policies and procedures are insufficient. Should the Plan not immediately remedy the issues identified, it risks being noncompliant with Contract Section 5.64(c), which states that Plans shall establish an internal controls system that ensures corrective measures are promptly instituted and carried out.

Recommendation 4

We recommend that the Plan establish written policies and procedures to strengthen internal controls over the development of the Plan Med PMPM values and FEHBP benefit factor calculations reported on Attachment A schedules.

Recommendation 5

We recommend that the Plan implement a quality assurance review related to MCRM inputs to ensure that the actual contracted FEHBP Brochure benefits are used to develop the benefit factors in the premium rate calculations.

Recommendation 6

We recommend that the Plan establish written policies and procedures to strengthen internal controls over consistency amongst Attachment A Plan Med PMPM values and Rate Model Plan Med PMPM values.

Plan Response:

The Plan agreed with the findings and recommendations. Specifically, the Plan stated, "[w]e agree with the factual accuracy of the audit issue although the benefit variances between the MCRM and benefit brochure produce benefit factor are minimal and immaterial in the context of Underwriting review, marketplace/competitive pricing, and management decision elements of the rate development process.

We will implement the recommended updates to our policies and procedures documentation to strengthen internal controls over the development of the Plan Med PMPM values and FEHBP benefit factor calculations reported on Attachment A schedules. We will also implement additional policies and procedures to strengthen internal controls over consistency amongst Attachment A Plan Med PMPM values and Rate Model Plan Med PMPM values.

Finally, we will implement a quality assurance review related to MCRM inputs to ensure that the actual contracted FEHBP Brochure benefits are used to develop the benefit factors in the premium rate calculations."

OIG Comment:

We recognize that the Plan intends to address the recommendations through the implementation of new/updated policies and procedures and by adding a quality assurance review related to MCRM usage. Prior to the issuance of this report, the updated policies and procedures were not provided for our review. Additionally, it is unclear when the quality assurance review will be implemented. As such, we cannot comment on the potential effectiveness of these actions to address the recommendations at this time.

5. Overstated Health Insurers Providers Fee

The Plan applied a Health Insurance Providers Fee (HIPF) to the 2020 premium rates that was greater than the HIPF attributable to the FEHBP. Specifically, the Plan applied a [redacted] percent HIPF loading to the FEHBP premium rate developments, both High and Standard Options, for 2020; however, using the Internal Revenue Service Letter 5067C, Annual Fee on Health Insurance Providers for 2020 and the 2020 Office of Personnel Management (OPM) Subscription Income report, we determined the FEHBP portion of the Health Insurance Providers Fee was materially less. According to the Plan, it calculates the HIPF rate loading by [redacted]. The percentage of HIPF to commercial premium is then [redacted], but the calculation itself was unsupported, contained discretionary adjustments, and was not specific to FEHB business.

Per Carrier Letter 2013-14, OPM determined that the portion of the section 9010 Providers Fee paid that is attributable to its FEHB business will be an allowable cost to the FEHB Program as an expense to the "overall operation of the business" of providing health insurance according to the FEHB Contract Section 3.2(b)(2)(iii). Therefore, the Plan's rate development should only include the portion of the fee that is applicable to the FEHBP.

This issue appears to stem from insufficient policies and procedures for implementing OPM's Carrier Letter guidance. As required in the Minimum Standards for Health Benefit Carriers, 48 CFR Part 1609.7001(b)(1), FEHBP carriers must perform the contract held with OPM in accordance with prudent business practices, including but not limited to timely compliance with OPM instructions and directives. As such, sufficient controls, including written policies and procedures, should be in place to ensure that the Plan complies with guidance provided by OPM, including instruction provided via Carrier Letter, as required by Contract Section 5.64. If updated and enhanced FEHBP-specific policies and procedures are not implemented to strengthen controls, the Plan may incorrectly load unallowable costs within the FEHB rate.

Recommendation 7

We recommend that the Plan establish written policies and procedures to strengthen internal controls over the process for implementing OPM Carrier Letter guidance in accordance with 48 CFR Part 1609.7001(b)(1).

Plan Response:

"While we maintain that a proper HIPF fee amount was applied to the rate development spreadsheet based on our sound projection methodology and additional income tax loading, to improve transparency, we agree to implement written policies and procedures to strengthen internal controls over the process for implementing OPM Carrier Letter guidance in accordance with 48 CFR Part 1609.7001(b)(1)."

OIG Comment:

We recognize that the Plan intends to address the recommendation through the implementation of policies and procedures pertaining to OPM Carrier Letter guidance. Prior to the issuance of this report, the new policies and procedures were not provided for our review. As such, we cannot comment on the potential effectiveness of these actions to address the recommendation at this time.

6. Brochure Inaccuracies

The Plan did not ensure the accuracy of the copayments listed in the 2021 and 2022 FEHBP brochures for the High and Standard Options. Specifically, we found inaccurate Urgent Care copayment amounts listed in some sections within the brochures. Since Urgent Care is listed in multiple sections of the brochures, we verified each section had the correct copayment amount of $20 as agreed to in an OPM Letter dated July 24, 2020.

Within the 2021 and 2022 FEHBP brochures, Section 5(a), Medical Services and Supplies Provided by Physicians and Other Health Care Professionals - Diagnostic and Treatment Services – Professional Services of Physicians in urgent care, the copay is listed as $40. Additionally, the 2021 and 2022 FEHBP brochures, Section 5, High and Standard Option Benefits Overview - High Plan Overview, a $40 copay is listed for Urgent Care. Per the Contract Section 1.13, Information and Marketing Materials, the Carrier bears full responsibility for the accuracy of its FEHB brochure.

This issue appears to stem from the Plan's lack of oversight when ensuring accuracy of the FEHB Plan brochure. As required in the Minimum Standards for Health Benefit Carriers, 48 CFR Part 1609.7001(b)(3), FEHBP carriers must perform the contract held with OPM in accordance with prudent business practices, including compliance with the terms of the FEHBP contract, regulations and statutes. If FEHBP-specific policies and procedures are not implemented to strengthen controls, FEHBP members may be overpaying their member responsibility.

Recommendation 8

We recommend that the Plan establish policies and procedures to ensure accuracy of the FEHBP brochures in accordance with 48 CFR Part 1609.7001(b)(3).

Plan Response:

The Plan proposed that Section 5(a) of the High and Standard benefit brochures include language to specify that the urgent care center copay was applicable per visit. OPM approved the change, which is included in the 2024 FEHBP benefit brochures. Further, the Plan stated that a written document covering the brochure review process is to be developed.

OIG Comment:

We confirmed that OPM's Healthcare and Insurance Program Office approved the urgent care copay language that was implemented in the 2024 high and standard option (FEHBP plan code WD) benefit brochures. We recognize that the Plan intends to address the recommendation through the development of a written brochure review process document; however, prior to the issuance of the report we were not provided with the document for review. As such, we cannot comment on its potential effectiveness to address the recommendation.

B. MEDICAL CLAIMS REVIEW

1. Lack of Oversight of Third-Party Vendors

The Plan did not ensure claims repriced by third party vendors were priced in accordance with the contract terms. Specifically, for one of the sampled claims the Plan could not support the paid amount for the claim. The claim was for transplant services, which are repriced by a third-party vendor who holds the Provider agreements with the transplant

providers. We reviewed the third-party vendor's Plan Client Claim Detail Report for the claim, which identified the amount billed and the repriced claim amount but did not provide details or references to payment terms. According to the Plan, this claim was paid as an interim claim; however, per the claim and the Client Claim Detail Report, the member was discharged prior to payment of the claim and would not be considered an interim claim. Therefore, we repriced the claim using the rates in the contract. We found the claim was not paid per the contract terms and the provider was underpaid.

This occurred because the Plan does not have adequate controls in place to ensure third-party vendors were repricing claims per the contract terms. As a result, the Plan is not compliant with the terms of the Contract and Dean Health Plan (DHP) FEHBP members are subject to varying member cost share rules. As required in the Minimum Standards for Health Benefit Carriers, 48 CFR Part 1609.7001(b)(3), FEHBP carriers must perform the contract held with OPM in accordance with prudent business practices, including compliance with the terms of the FEHB contract, regulations, and statutes. If the Plan does not implement sufficient internal controls surrounding oversight of third-party vendors repricing FEHBP claims, the Plan risks improper payments to providers, which will ultimately impact the FEHBP premium rates and members.

Recommendation 9

We recommend that the Plan establish controls to ensure third-party vendors reprice claims in accordance with contract terms.

Plan Response:

"DHP has an existing oversight process for all claims that exceed $250,000 in Billed Charges (High Cost Claims Review process), which would include most of the claims from Optum for Transplants. The first level of that claim audit is handled by our claims team, which has access to the Optum Provider Contracts in the Optum Portal. The claims team then forwards their findings to DHP's Quality Auditor for Operations. The Quality Auditor reviews the claim audit the same day. If there are errors in the claims payment audit by the claims team, the error is noted and forwarded to the Claims Manager. If after review, the error is verified, the Claims Manager makes the necessary changes to the claims payment and releases the claim for payment.

Additionally, after reviewing the contract between Optum and UW Health Care with OPTUM representatives last week, we determined the reference to Interim Payment and Interim Claim did not have the same meaning. According to the contract

language, an 'Interim Payment' is not limited to claims submitted while the patient is Inpatient for transplant services. Instead, the 50 [percent] of billed charges Interim Payment is made for each claim submitted during the Transplant Case Period.

The Transplant Case Period begins the day of admission for the transplant procedure and ends 90 days following a patient's discharge from the hospital. Therefore, when the Inpatient claim was submitted and paid after the patient was discharged, it was paid at 50% of the billed charges as is required by the contract for Interim Payments. Please see the contract excerpt explaining the payment level for 'Interim Payments'. At the end of the Transplant Case Period, the billed charges for all of the claims during the Transplant Case Period are tallied, and the entire Transplant Case is paid at the percentage of billed charges required in the contract."

OIG Comment:

The Plan provided third-party contract excerpt supports interim payments, paid at 50 percent, are made for transplant claims like the one we discussed in the finding. However, the contract language goes on to state that "[t]o reconcile the final payment due for services rendered during the Case Rate period, Interim Payments will be subtracted from the final amount payable for the Case Rate period." The Plan did not supply the reconciliation of the interim payments made and/or any analysis of the final payment amount due for these services on the claim we reviewed. As such, we cannot discern if the claim questioned in the report was paid correctly or not.

Further, we find it concerning that the Plan did not have a clear understanding of the payment terminology (i.e., Interim Payment and Interim Claim) in its third-party contract until it initiated a review due to our audit inquiry, and that its "existing oversight process" only includes "most" of the third-party transplant claims. We continue to recommend that the Plan establish controls to ensure third-party vendors reprice claims in accordance with contract terms.

2. Non-Participating Providers Pricing Issue

During the scope of the audit, the Plan lacked written policies and procedures to document its FEHBP-specific policies regarding the processing of medical claims from non-participating (non-par) providers. Specifically, during our claims sample review, we identified two non-par claims where the Plan applied differing payment methodologies, resulting in various pricing payment and member responsibility amounts.

We noted the provider claim for one non-par provider was ultimately paid at [redacted] percent of billed charges, while another non-par provider claim was paid at [redacted] percent of billed charges. The Plan stated that its policy for the payment of non-par claims indicates that "[p]rofessional claims are reimbursed based on a [redacted] … This was a decision made by DHP on how a non-plan ... claim would be reimbursed, but there is no written policy/documentation of this. This reimbursement has been in place since the implementation of ... our claims platform back in 2012."

The Plan's inability to provide policies or procedures related to payment of non-par providers highlights an internal control weakness. As a result, the Plan is not compliant with the terms of the Contract and FEHBP members are subject to varying member cost share rules. Furthermore, FEHBP members would not have been aware of the varying non-par claims processing policies nor the resulting member responsibility.

As required in the Minimum Standards for Health Benefit Carriers, 48 CFR Part 1609.7001(b)(3), FEHBP carriers must perform the contract held with OPM in accordance with prudent business practices, including compliance with the terms of the FEHBP contract, regulations, and statutes. If the Plan does not implement sufficient internal controls surrounding non-par provider reimbursement, the Plan risks improper payments to providers, which will ultimately impact the FEHBP premium rates and members.

Recommendation 10

We recommend that the Plan develop written policies and procedures to document its non-participating provider claims processing policies for its FEHBP plans and ensure the FEHBP benefit brochures clearly communicate member responsibility when receiving Plan pre-authorized services from a non-par provider.

Plan Response:

The Plan disagreed with the finding and noted that previously supplied supporting documentation provided sufficient evidence that adequate controls were in place. However, the Plan also states, "we do agree that we could develop and implement written policies and procedures to further enhance these controls. We will draft and put those policies and/or procedures into production. Additionally, we will implement annual meetings to review Non-Participating Provider pricing.

Lastly, in reference to the recommendation on the FEHBP benefit brochure. Carriers in general, us included, are provided an FEHB Program Brochure template to follow. Any deviations must be approved by our FEHB Contract Specialist. The Health Plan uses the template language verbatim for the 'How we pay providers' section. We do not publicize our contracting reimbursement arrangements within the brochure as that is proprietary information. Finally, this is an HMO offering, meaning that members are restricted to use in-network plan providers (except for emergency/urgent care). In order to obtain services from a non-plan provider, the member must obtain an approved prior authorization. Once that is obtained, the services are treated the same as in-network, meaning the same copays, deductibles, etc. apply and the member cannot be balanced billed from the non-plan provider."

OIG Comment:

We agree with the Plan's statement that "[i]n order to obtain services from a non-plan provider, the member must obtain an approved prior authorization. Once that is obtained, the services are treated the same as in-network, meaning the same copays, deductibles, etc. apply and the member cannot be balanced billed from the non-plan provider." However, we did not find that the Plan followed this methodology in its processing of the non-par claim paid at 80 percent of billed charges. On that specific non-par claim, the FEHBP member received the Plan's authorization for pre-service coverage on Durable Medical Equipment (DME) benefits. Per the benefit brochure, DME benefits are covered by the Plan with an FEHBP member responsibility of 10 percent coinsurance, yet the Plan paid 80 percent of charges under its undocumented non-par claim pricing policy.

We recognize that the Plan intends to draft and implement policies and procedures and conduct annual meetings regarding its non-par provider pricing. Since we have not received a copy of the policies and procedures and the additional controls are being implemented outside the scope of our audit, we cannot comment on their potential effectiveness to address the recommendation.

C. ENROLLMENT REVIEW

1. 31-Day Extension of Coverage Application Issues

During our review of the Plan's FEHBP enrollment process, we identified that it lacked policies and procedures to assess and apply the 31-day extension of coverage (EOC) for eligible FEHBP dependent members terminating via either the OPM and Standard Form (SF) 2809 Health Benefits Election paper forms, the electronic OPM/SF 2809 Health Benefits

Election or the SF 2810 Notice of Change in Health Benefits Enrollment electronic 834 enrollment action file (2809/2810 834 file).

Per Contract Section 1.5, the Plan shall adhere to OPM issued guidance and criteria relating to enrollment reconciliation, including receiving the Centralized Enrollment Clearinghouse System (CLER) 2809/2810 834 file to update enrollment records and resolve discrepancies during the CLER enrollment reconciliation process. Pertaining to this process, we found that the Plan's FED 834 & Paper Enrollment Processing (CM093) procedure document discussed the requirement to review the 2809/2810 paper forms and the 2809/2810 834 file but lacked procedures for assessing the 31-day EOC for the 2809/2810 834 file and the 2809 paper forms. Although CM093 highlights the FEHBP practice of terminating dependent member coverage through omission on the 2809 834 file, it does not discuss how the Plan will assess and determine whether the 31-day EOC is warranted. Also, CM093 states that the Plan "will process the termination received making sure to confirm whether or not the 31-day coverage extension is checked" during the processing of paper 2809/2810 forms; however, only the 2810 paper form contains a checkbox for the 31-day EOC. The OPM and SF 2809 paper forms do not include a checkbox to indicate 31-day EOC applicability.

The Plan stated that it assumed the federal payroll offices included the 31-day EOC in the data sent via the 834 file and 2809 paper forms, but as outlined under the "FEHB Program Business Rules and Limitations" section of the 2809 Companion Guide, Federal agencies are not required to provide dependent information on the CLER 2809/834 file. As such, the use of the 834 file itself is limited in determining 31-day EOC for members being terminated. The companion guide is designed by default to permit a change in a benefit selection such as a tier reduction but does not provide any data on the dependent that is impacted by this tier reduction. The 2809/834 file does not provide adequate data to properly determine 31-day EOC applicability of the terminating dependent as required under the terms of the Contract.

In addition, as previously stated, the paper versions of the SF 2809 and the OPM 2809 Forms, that result in the termination of dependents, do not have all the necessary fields to indicate if the termed dependent is eligible for the 31-day EOC as required under the terms of Contract; however, this does not preclude the Plan from assessing if the terminated family member is eligible for the 31-day EOC benefit as specified under 5 CFR 890.308(g). Conversely, there may be instances where the member was removed because they were never eligible as a family member, and therefore, do not have the right to 31-day EOC as outlined under 5 CFR 890.401(1)(a).

Non-compliance with the Contract terms regarding the assessment and application of the 31-day EOC may result in early FEHBP terminations. As such, the Plan's CM093 procedure should be updated to include 31-day EOC review requirements for FEHBP members terminating via all forms of communication, including the paper forms and the 834 file. As for the 2809/834 transactions that are outlined in OPM Carrier Letter (CL) 2021-15, it is noted by OPM that the removed family member on the electronic 2809 will include a "Benefit End" date, and therefore, the Carriers will not add the 31-day EOC because that coverage was already granted by the data provider; however, the 2809/834 31-day EOC eligibility assessment reported within this finding relates to the family member that is omitted and terminated due to a tier reduction.

Recommendation 11

We recommend that the Plan update procedure CM093 to ensure it assesses and properly applies the 31-day extension of coverage for all eligible FEHBP members that are terminated from the Plan using the 2809/2810 834 file or the SF 2809 and OPM 2809 paper forms in accordance with applicable regulations and the Contract.

Plan Response:

"As noted in our [prior] response, we were actively seeking guidance from OPM on applying the 31-day extension. Upon receipt of that guidance from OPM, we updated our internal procedure to reflect that the extension should apply to all 2810 terminations, as well as those dependents dropped by file omission. We will cite that guidance and this audit in our internal documentation for future reference."

OIG Comment:

The Plan's response did not include the guidance provided by OPM or the Plan's updated internal procedures. As such, we cannot evaluate the potential accuracy and effectiveness of the guidance and resulting actions. However, the Plan should be aware that it is indicated within the CLER 2810 Companion Guide that the Value 349 equates to "Benefit End," which has a corresponding Companion Guide end note stipulating that the coverage for the terminated subscriber and any eligible family member is extended for an additional 31 days. We maintain that the Plan implement policies and procedures to ensure the enrollment transactions submitted via the 2810/834 files are properly processed to ensure that terminated members receive the 31-day extension of coverage in addition to the "Benefit End" date.

Conversely, the 2809/834 transactions that are outlined in OPM CL 2021-15 advise that the removed family member on the electronic 2809 will include a "Benefit End" date, and therefore, the Carriers *will not add the 31-day EOC* because that coverage was already granted by the data provider. The issue reported within this finding pertains to tier reduction enrollment transactions communicated via the 2809 834 files that are not discussed in OPM CL 2021-15 or processed through SF2809/OPM 2809 paper forms. We maintain that the Plan implement policies and procedures to assert if the omitted member terminated due to a tier reduction is eligible or not eligible for the 31-day extension of coverage as required under the terms of the Contract.

2. <u>Enrollment Verification Issues</u>

In addition to the 31-day EOC issues, we determined that the Plan's FED 834 and Paper Enrollment Processing procedure (CM093) does not speak to member eligibility verification as required by 5 CFR 890.105.308(e)(1) and the related guidance specified in the Office of Personnel Management's CL 2020-16, titled the FEHBP: Removal of Ineligible Family Members from Enrollments.

Specifically, the requirements and guidance are as follows:

- As provided in 5 CFR 890.308(e)(1), "A carrier may request verification of eligibility from the enrollee at any time of an individual who is covered as a family member of the enrollee in accordance with § 890.302. To verify eligibility, the carrier shall send the enrollee a request for appropriate documentation of the individual's relationship to the enrollee with a copy to the enrollee's employing office of record."

- Also, CL 2020-16 "provides guidance to FEHB Carriers on (1) the process for requesting proof of family member eligibility for existing enrollments; (2) what documents may be used as proof; and (3) what actions FEHB Carriers can take based on an enrollee's or family member's response to a request for verification of eligibility."

During the audit scope years, the Plan did not confirm eligibility for existing members nor implement a process to remove ineligible family members from FEHBP coverage based on the review of member eligibility. Upon inquiry, the Plan responded, "[o]ur understanding is that the recommendations related to verifying eligibility for existing members within Carrier Letter No. 2020-16 are not formal requirements and therefore did not need to be implemented. The Health Plan decided not to implement this as it would have caused an administrative lift, requiring us to send a mailing to all existing members to confirm eligibility, collect documentation, and then pass that documentation on to the appropriate

payroll office. We do not confirm eligibility for existing members for any of our clients as eligibility is determined at the point of enrollment."

As required in the Minimum Standards for Health Benefit Carriers, 48 CFR Part 1609.7001(b)(1), FEHBP carriers must perform the contract held with OPM in accordance with prudent business practices, including but not limited to timely compliance with OPM instructions and directives. As such, sufficient controls, including written policies and procedures, should be in place to ensure that the Plan complies with guidance provided by OPM, including instruction provided via Carrier Letter.

These issues appear to stem from insufficient policies and procedures addressing compliance with OPM's contract, regulations, and guidance (i.e., carrier letters). 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 runs the risk of providing FEHB coverage for non-eligible FEHBP members.

Recommendation 12

We recommend that the Plan establish written policies and procedures to strengthen internal controls over the maintenance and integrity of FEHBP enrollment records in accordance with 5 CFR 890.308 and Carrier Letter 2020-16.

Plan Response:

The Plan stated that it updated its policy and procedures to collect documentation to verify FEHBP eligibility upon receiving the Carrier Letter. Further, the Plan stated, "[w]e maintain our position and disagree that we are required to perform a full-scale audit for all dependents enrolled. The carrier letter indicates that this is recommended, but not required. Of note, we are currently sending the full eligibility files including all dependents to OPM on a monthly basis, per the OPM requirement. We are seeking guidance from OPM on what needs to be implemented to 'participate in this shared responsibility' … ."

OIG Comment:

As noted by the Plan in their response to the finding, Carriers are not required to perform a full-scale audit, but Carrier Letter 2020-16 does specify that "FEHB Carriers and employing offices have a shared responsibility to verify and confirm family member eligibility, recognizing that ineligible family members can result in the FEHB Program paying

erroneous or even fraudulent claims." We recognize that the Plan intends to update its policy and procedures and reach out to OPM regarding the shared responsibilities. However, the Plan did not provide any documentation to support that updated policies and procedures were put into place, nor support confirming correspondence with OPM soliciting guidance. As such, we cannot determine if these actions occurred and their potential effectiveness at addressing the recommendation.

3. CLER Process Issues

As previously discussed in section C.1. of this report, CLER provides information on electronic FEHBP enrollment data from health insurance carriers and Federal payroll offices. In CLER, carriers have a report option to create customized reports based on the enrollment information stored in CLER. Report 12, Carrier Discrepancy Listing, is one of these options that provides a list of carrier and payroll office enrollee records that match, as well as records marked with carrier warning and discrepancy codes by the carrier ID code. During our review of the Plan's enrollment process, we requested the CLER Report 12 for four quarters during the scope of our audit, Q3 and Q4 for 2020, and Q3 and Q4 for 2021. The CLER Report 12 disclosed five members with discrepancy error code 160 having 4 or higher fail counts. It is established under Contract Section 1.9, Plan Performance, letter (j), that "[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."

We held a meeting with OPM Enrollment and Member Support Group personnel to further our understanding of the fail count feature within CLER Report 12 and obtained additional data for members identified as having four or higher 160 discrepancy error code fail counts. We learned from OPM that fail counts remain with an FEHBP enrollee until they are resolved; therefore, as enrollees change Carriers, it's possible that the receiving Carrier will not have the ability to resolve the discrepancies independently that originated under the previous carrier. Additionally, fail counts can accumulate on any discrepancy code and continue to accumulate sequentially even if the discrepancy code changes. Although these issues exist within the CLER process, the FEHBP Carrier Handbook stipulates that Carriers are obligated to reconcile with payroll offices until all enrollment discrepancies are resolved. As such, we identified the following issues during our review of the Plan's CLER process:

- The Plan failed to resolve discrepancy error code 164 with 11 fail counts, recurring over a three-year period, which converted to discrepancy error code 160, with 12 fail counts, in Q4 of 2021. Also, the Plan did not address the Payroll Office Comments present in the

CLER, the Reconciliation Action field denoted with code 610 – Carrier Correction Required.

- Members included on the Report 12 with error code 160 were ultimately disenrolled and noted as "cancel enrollment due to group report" per the Plan's system screenshots; however, these members were confirmed as deceased by the OIG. The Plan terminated these members several weeks after the date of death and did not have any date of death documentation (i.e., OPM 2810, SF 2810, and other documentation).

Although it is unclear why the Plan did not resolve these CLER process issues timely, the root cause appears to be weak internal controls. The Plan's written policies and procedures, related to resolving CLER error fail counts, are insufficient to meet the terms of Contract Section 1.9 and do not adhere to Contract Section 5.64, which stipulates that Plans must establish procedures to timely identify Contract issues and administer a sufficient internal control program to meet the terms of the Contract.

Recommendation 13

We recommend that the Plan update its current policy document to ensure CLER warning and discrepancy codes are resolved as stipulated under Contract terms.

Recommendation 14

We recommend that the Plan update its current policy document to ensure FEHBP members are termed in accordance with OPM's requirements, and that the Plan's system reflects the reason for disenrollment.

Recommendation 15

We recommend that the Plan establish a documented process to coordinate with OPM to resolve code 160 errors prior to reaching the Contract threshold of four or higher.

Recommendation 16

We recommend that the Plan implement a quality assurance process to validate that the improved CLER policies are adequate and enhance internal controls.

Plan Response

"We have a Policy and Procedure for the CLER quarterly reconciliation. Upon further research during our current quarterly review, we discovered that a data translation table is not functioning correctly. This has a direct impact on the Enrollment Codes sent for members, causing repetitive 164 errors. This issue will be resolved with the 12/1/2023 full file submission. We have further updated our P&P with instructions regarding repetitive 164 errors.

With regard to 160 fail errors, we follow the process for reconciling these [as] prescribed by OPM: Report 13 is reviewed for payments. The 160 fail notification letter is sent to the member (with OPM language) requiring proof of eligibility to reinstate. If no payments are received, the member's coverage is terminated. Report 12 does not provide a member termination date or date of death information. The Health Plan is seeking further guidance and recommendations on this matter."

OIG Comment:

We recognize that the Plan has procedure "CM022_FED QUARTERLY MEMBERSHIP RECONCILIATION," which was provided for our review during fieldwork. However, we did not receive an updated version of this procedure that addresses the finding recommendations, including the new processes implemented to address the repetitive 164 errors as described by the Plan in its response. Further, it is unclear from whom the Plan is seeking further guidance and recommendations regarding the member termination date and date of death information. As noted in the finding, this information can be found on the OPM 2810, SF2810, and other documentation transmitted to the Plan during the CLER process. If the Plan sought OPM's guidance on the findings and recommendations, we were not provided with the related correspondence.

We recognize that the Plan intends to update its procedures; however, the Plan did not provide any updates in response to the draft report. Further, the Plan did not address the recommendation to implement a quality assurance process. As such, the findings and recommendations remain applicable.

4. Aging-Out Dependent Termination Issues

As part of our review of the Plan's FEHBP enrollment process, we analyzed the aging-out dependent process to verify that the Plan is properly terminating overage dependent members in accordance with the Contract and providing the 31-day EOC to eligible members.

Specifically, we selected a sample of 15 dependents who reached the maximum dependent age of 26 and generated claims which were included in the experience period of the 2021 premium rate development. Of those 15 aging-out dependents, we determined that 13 members were terminated one day beyond the 31-day EOC timeframe as established in the FEHBP Brochures. The Plan's FED 834 & Paper Enrollment Processing procedure (CM093) includes a section outlining the process for dependent terminations designated under the "Dependent Max Age Terminations," which appears to adequately ensure that dependents are terminated in accordance with the FEHBP Brochures. Specifically, this policy document stipulates, "All max age terminations are automatically extended 31 days from the date of birth. Eligibility ends at mid-night the [day the] dependent turns 26, so the 31-day extension of coverage should **begin** on the child's birthday," and therefore, complies with the requirements of 5 CFR 890.304(c). As such, it's unclear why these members received an additional day of coverage and were not termed in accordance with the Contract.

We also noted that the Plan's policy document does not indicate how it notifies aging-out FEHBP members of pending termination, which resulted in inconsistent notification practices. Specifically, in 14 of the 15 aging-out dependent samples we reviewed, the Plan sent letters to FEHBP members providing notice of pending termination due to age, but the timing of the notifications varied from 4 to 52 days prior to the dependents' 26th birthdays. The Plan's letter issuance dates do not adhere to the time-period stipulated in OPM Carrier Letter 2022- 15, which advises, "FEHB Carriers must provide written notice to the enrollee, at least 60 days before the child's birthday … ."

The Plan's insufficient internal controls surrounding the application of the 31-day EOC and varying letter issuance practices do not adhere to the regulations set forth under Contract Section 5.64, which stipulates that Plans must establish procedures to timely identify Contract issues and administer a sufficient internal control program to meet the terms of the Contract. As such, without sufficient policies and procedures to address the requirements of the FEHBP, including the assessment and application of the 31-day EOC for aging-out dependents, the Plan will not be able to fulfill the requirements of the Contract.

Recommendation 17

We recommend that the Plan determine the cause for the additional day of coverage and correct the deficiency to ensure that FEHBP aging-out dependents are properly terminated and receive the 31-day EOC in accordance with the contract and with the Plan's policy document CM093.

Recommendation 18

We recommend that the Plan update procedure CM093 to ensure it consistently notifies pending FEHBP aging-out dependent terminations in accordance with OPM Carrier Letter 2022-15 and the Contract.

Plan Response

"We have a separate Policy and Procedure for terminating max age dependents, which includes the 31 day extension and notification to the member of the termination. We don't believe that this document was previously shared, so it is being shared now – 'CM098_Monthly Termination Notices.'

The 31-day extension was an area of confusion for many carriers. We received clarification on calculating the 31-day extension for max age dependents in February 2021. Following receipt of that guidance, our procedure was updated.

For the aging out samples, the Health Plan will update our reporting and procedures to ensure we provide notice at a minimum of 60-days prior to the dependent's date of birth."

OIG Comment:

The Plan's response does not specifically address the issue that it is granting an EOC of 32 days, when 31 days is applicable. However, after reviewing "CM098_Monthly Termination Notices" which was provided in response to the draft report, we found that Section 1.1.6 of "CM098_Monthly Termination Notices" incorrectly states that "[t]erm date is 31 days past their birthdate EX: DOB on 5/12/1991, they would be termed 6/12/2017[.]" In that scenario, the Plan is not counting the FEHBP member's birthday as day 1 of the 31-day EOC. If the Plan is utilizing procedure document CM098 to process the EOC for FEHBP aging out dependents, it would explain why a 32-day EOC was granted to FEHBP members. However, it doesn't explain how the Plan's CM093 and CM098 procedure documents contain conflicting language for the application of the FEHBP aging out dependent 31-day EOC.

Additionally, the "CM098_Monthly Termination Notices" provided in response to the draft report has not been updated to ensure that FEHBP members receive notice of pending termination 60 days prior to the dependent's date of birth. Although the Plan states that it intends to update its procedures, we have not yet been provided with the revised procedures.

As such, we cannot comment on their potential effectiveness to resolve the recommendations.

D. CARRIER LETTER COMPLIANCE

1. Claims Data Requirement Issue

The Plan was not in compliance with the Federal Employee Health Benefits Program (FEHBP) Claims Data Requirements Carrier Letter (CL) 2021-17. The annual Claims Data Requirement CL requires that medical and pharmacy claims data used to develop the FEHBP premium rates and Medical Loss Ratio calculation is submitted to the Office of Personnel Management (OPM), Officer of the Inspector General (OIG). Specifically, CL 2021-17 required the claims data submissions by November 30, 2021; however, the Plan did not submit the 2022 FEHBP premium rate claims data and the 2020 MLR submission claims data until notified by the OPM OIG in January 2023 that the data was not received. Upon notification, the Plan submitted the data to the OIG, noting that the submission was missed because CL 2021-17 was not internally communicated between applicable personnel at the Plan.

Additionally, the claims data submitted to the OIG in response to CL 2021-17 and CL 2022-14 did not meet the requirements of the CLs. Specifically, CL 2021-17 claims data submission lacked discharge dates, which is a required field as specified in the CL. Also, the claims data submitted for CL 2022-14 (2021 MLR / 2023 Rates) [redacted] as required; therefore, the data could not be accepted and processed by the OPM OIG.

These issues appear to stem from insufficient policies and procedures addressing the review and compliance with OPM's Claims Data Requirements CLs. As required in the Minimum Standards for Health Benefit Carriers, 48 CFR Part 1609.7001(b)(1), FEHBP carriers must perform the contract held with OPM in accordance with prudent business practices, including but not limited to timely compliance with OPM instructions and directives. As such, sufficient controls, including written policies and procedures, should be in place to ensure that the Plan complies with guidance provided by OPM, including instruction provided via CL.

Recommendation 19

We recommend that the Plan strengthen its internal controls by implementing written policies and procedures that ensure compliance with OPM's annual Claims Data

Requirement Carrier Letter for the timely and complete submission of claims data to the OPM OIG.

Plan Response:

"We will implement the recommended updates to our policies and procedures documentation to strengthen internal controls to assure timely and complete submission of claims data to OPM OIG.

Additionally, the Health Plan has added an annual activity to the Regulatory Calendar to oversee the FEHB Claims Data Requirements for All Community-Rated HMOs. Notifications to appropriate business owners will be sent on an annual frequency to notify them that this is due and to complete timely."

OIG Comment:

Although the Plan provided a narrative response of internal processes, we have not yet received the updated policies and procedures, nor support for the annual activity on the regulatory calendar and notifications to the appropriate business owners. Therefore, we cannot comment on the potential effectiveness of these intended actions to address the recommendations.

EXHIBIT A

Dean Health Plan, Inc.
Medical Claims Sample Selection Criteria and Methodology

Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria	Sample (Number)	Sample (Dollars)	Results Projected to the Universe?
FEHBP Plan Code #WD Medical claims incurred from 2/1/2018 through 1/31/2020	120,380 Claims	$46,987,872	Isolated claims with "inpatient" place of service codes utilizing SAS EG[1]. Judgmentally selected all claims with paid totals greater than $100,000.	7	$2,683,506	No
			Isolated claims with "outpatient" place of service codes utilizing SAS EG. Judgmentally selected all claims with paid totals greater than $50,000.	6	$410,405	
			Isolated claims with all other place of service codes (excluding "inpatient" and "outpatient") utilizing SAS EG. Judgmentally selected all claims with paid totals greater than $20,000.	8	$230,692	
			Total Claims Samples	**21**	**$3,324,603**	

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

OIG Comment: Response received October 23, 2023.

Dean Health Plan (DHP) Response to Draft Report:

A. Premium Rate Review

1. Claims Reduction Non-Compliance

DHP Response: While we maintain that our process is Actuarially sound and our rates are current , accurate, and complete due to including RX rebates and subrogation within the Underwriting Adjustments, we agree that transparency around claims adjustments can be improved.

We will implement distinct rows in the Rate Development Spreadsheet for Rx Rebates and Subrogation. These items will no longer be included in the Underwriting Adjustments row. We will implement the recommended updates to our policies and procedures documentation to ensure proper implementation of OPM Carrier Letter guidance in accordance with 48 CFR Part 1609.7001(b)(1).

2. Unsupported Catastrophic Claims Adjustment

DHP Response: The plan disagrees with this finding. When a group renewal is [redacted]

3. Benefit Factors Variances

DHP Response: We agree with the factual accuracy of the audit issue although the benefit variances between the MCRM and benefit brochure produce benefit factor are minimal and immaterial in the context of Underwriting review, marketplace/competitive pricing, and management decision elements of the rate development process.

We will implement the recommended updates to our policies and procedures documentation to strengthen internal controls over the development of the Plan Med PMPM values and FEHBP benefit

factor calculations reported on Attachment A schedules. We will also implement additional policies and procedures to strengthen internal controls over consistency amongst Attachment A Plan Med PMPM values and Rate Model Plan Med PMPM values.

Finally, we will implement a quality assurance review related to MCRM inputs to ensure that the actual contracted FEHBP Brochure benefits are used to develop the benefit factors in the premium rate calculations.

4. Plan Med PMPM Rate Variances

DHP Response: See response for Section A-3 as it applies to this section as well.

5. Overstated Health Insurance Providers Fee

DHP Response: While we maintain that a proper HIPF fee amount was applied to the rate development spreadsheet based on our sound projection methodology and additional income tax loading, to improve transparency, we agree to implement written policies and procedures to strengthen internal controls over the process for implementing OPM Carrier Letter guidance in accordance with 48 CFR Part 1609.7001(b)(1).

6. Brochure Inaccuracies

DHP Response: As previously communicated, we confirmed the following:

1. Plan benefit configuration set up correctly.
2. Urgent care claims were processed correctly.
3. Agree Section 5/Benefits Overview mis-stated the urgent care copay. This section does not impact the benefit build/configuration and/or claims processing.

Actions Taken:

1. Clarified language to Section 5(a) Diagnostic & Treatment Services/Professional Services of Physicians in an Urgent Care Center was proposed and approved for the 2024 FEHB Program Brochures. Language added "$20 copayment per visit - Urgent Care Center".
2. Written brochure review process to be developed.

B. <u>Medical Claims Review</u>

1. Lack of Oversight of Third-Party Vendors

DHP Response: DHP has an existing oversight process for all claims that [redacted]

[redacted]

[redacted]

[redacted]

2. Non- Participating Providers Pricing Issue

DHP Response: The Health Plan still disputes this finding as we believe the supporting documentation provided following the NFR showed sufficient evidence that we have adequate controls in place.

However, we do agree that we could develop and implement written policies and procedures to further enhance these controls. We will draft and put those policies and/or procedures into production. Additionally, we will implement annual meetings to review Non-Participating Provider pricing.

Lastly, in reference to the recommendation on the FEHBP benefit brochure. Carriers in general, us included, are provided an FEHB Program Brochure template to follow. Any deviations must be approved by our FEHB Contract Specialist. The Health Plan uses the template language verbatim for the "How we pay providers" section. We do not publicize our contracting reimbursement arrangements within the brochure as that is proprietary information. Finally, this is an HMO offering, meaning that members are restricted to use in-network plan providers (except for emergency/urgent care). In order to obtain services from a non-plan provider, the member must obtain an approved prior authorization. Once that is obtained, the services are treated the same as in-network, meaning the same copays, deductibles, etc. apply and the member cannot be balanced billed from the non-plan provider.

3. Secondary Payer Issue

DHP Response: See attached for a procedure document that was not previously shared "EX Code 1IC - COMM Product and COMM Primary." This procedure includes instructions for instances when DHP pays as secondary.

C. Enrollment Review

1. 31-Day Extension of Coverage Application Issue

DHP Response: As noted in our NFR response, we were actively seeking guidance from OPM on applying the 31-day extension. Upon receipt of that guidance from OPM, we updated our internal procedure to reflect that the extension should apply to all 2810 terminations, as well as those dependents dropped by file omission. We will cite that guidance and this audit in our internal documentation for future reference.

2. Enrollment Verification Issues

DHP Response: Upon receipt of the Carrier Letter requiring eligibility verification of dependents enrolling directly with the carrier, we updated our Policy and Procedures to collect documentation to verify eligibility.

We maintain our position and disagree that we are required to perform a full-scale audit for all dependents enrolled. The carrier letter indicates that this is recommended, but not required. Of note, we are currently sending the full eligibility files including all dependents to OPM on a monthly basis, per the OPM requirement. We are seeking guidance from OPM on what needs to be implemented to "participate in this shared responsibility," as noted in OIG's response to our NFR comments.

3. CLER Process Issues

DHP Response: We have a Policy and Procedure for the CLER quarterly reconciliation. Upon further research during our current quarterly review, we discovered that a data translation table is not functioning correctly. This has a direct impact on the Enrollment Codes sent for members, causing repetitive 164 errors. This issue will be resolved with the 12/1/2023 full file submission. We have further updated our P&P with instructions regarding repetitive 164 errors.

With regard to 160 fail errors, we follow the process for reconciling these are prescribed by OPM: Report 13 is reviewed for payments. The 160 fail notification letter is sent to the member (with OPM language) requiring proof of eligibility to reinstate. If no payments are received, the member's coverage is terminated. Report 12 does not provide a member termination date or date of death information. The Health Plan is seeking further guidance and recommendations on this matter.

4. Aging Out Dependent Termination Issues

DHP Response: We have a separate Policy and Procedure for terminating max age dependents, which includes the 31 day extension and notification to the member of the termination. We don't believe that this document was previously shared, so it is being shared now - "CM098_Monthly Termination Notices."

The 31-day extension was an area of confusion for many carriers. We received clarification on calculating the 31-day extension for max age dependents in February 2021. Following receipt of that guidance, our procedure was updated.

For the aging out samples, the Health Plan will update our reporting and procedures to ensure we provide notice at a minimum of 60-days prior to the dependent's date of birth.

D. Carrier Letter Compliance

1. Claims Data Requirement Issue

DHP Response: We will implement the recommended updates to our policies and procedures documentation to strengthen internal controls to assure timely and complete submission of claims data to OPM OIG.

Additionally, the Health Plan has added an annual activity to the Regulatory Calendar to oversee the FEHB Claims Data Requirements for All Community-Rated HMOs. Notifications to appropriate business owners will be sent on an annual frequency to notify them that this is due and to complete timely

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Report No. 2023-CRAG-011