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 GROUP HEALTH COOPERATIVE

Report Number 1C-54-00-18-015
February 6, 2019

EXECUTIVE SUMMARY

Audit of the Federal Employees Health Benefits Program Operations at Group Health Cooperative

Report No. 1C-54-00-18-015 **February 6, 2019**

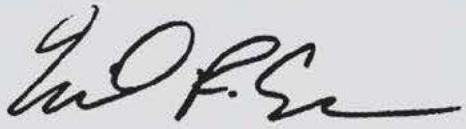
Why Did We Conduct The Audit?

The primary objective of the audit was to determine whether Group Health Cooperative (Plan) was in compliance 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 Plan met the Medical Loss Ratio (MLR) requirements established by the U.S. Office of Personnel Management (OPM).

Because of Program changes resulting from OPM's roll-out of its MLR methodology, we are no longer performing a review of the FEHBP's rates. Consequently, this change to our audit process only allows us to verify whether the calculated percentage of the premium paid that is spent on patient-related health care expenses meets the MLR threshold. It does not allow us to assess the fairness of the premium paid for benefits received.

What Did We Audit?

Under Contract CS 1043, the Office of the Inspector General (OIG) completed a performance audit of the FEHBP MLR submissions to OPM for contract years 2013 through 2016. Our audit fieldwork was conducted from March 26, 2018, through September 11, 2018, at the Plan's office in Seattle, Washington, and our OIG offices.



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Assistant Inspector General for Audits

What Did We Find?

The Certificates of Accurate MLR signed by the Plan in all years were defective, resulting in MLR credit reductions of $1,345,290 for 2014, $1,086,940 for 2015, and an understated MLR credit of $14,727,560 for 2016. Finally, although the Plan met the MLR threshold in 2013, there were also errors in that year's MLR calculation.

Specifically, our audit identified the following:

- The Plan included medical and pharmacy claims not allowed by the FEHBP in the incurred claims total for all years (2013 through 2016).
- The Plan inadvertently omitted pharmacy rebates for all years (2013 through 2016).
- The Plan incorrectly reported Healthcare Receivables in 2013.
- The Plan overstated its 2013 MLR premium by not removing a third party's dental premium.
- The Plan overstated its 2016 Medicare Subsidy Received.
- The Plan incorrectly reported tax expenses in 2013 and 2014.
- The Plan did not have sufficient internal controls over the FEHBP MLR process.

Our audit did not disclose any findings related to the Plan's procedures for quality health improvement expenses.

ABBREVIATIONS

B&O	**Business and Occupancy**
CAP	**Corrective Action Plan**
CFR	**Code of Federal Regulations**
COB	**Coordination of Benefits**
Contract	**U.S. Office of Personnel Management Contract CS 1043**
CMS	**Centers for Medicare and Medicaid Services**
CRU	**Clinic Review Unit**
FEHBAR	**Federal Employees Health Benefits Acquisition Regulations**
FEHBP	**Federal Employees Health Benefits Program**
KFHPW	**Kaiser Foundation Health Plan of Washington**
MLR	**Medical Loss Ratio**
OIG	**Office of the Inspector General**
OPM	**US Office of Personnel Management**
QHI	**Quality Health Improvement**
Plan	**Group Health Cooperative**
SSSG	**Similarly-Sized Subscriber Group**
WDS	**Washington Dental Services**

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I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at Group Health Cooperative (Plan). The audit was conducted pursuant to the provisions of Contract CS 1043 (Contract); 5 United States Code Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract years 2013 through 2016, and was conducted at the Plan's offices in Seattle, Washington.

Effective February 1, 2017, an acquisition of the Plan was finalized. Consequently, the Plan's legal name is now Kaiser Foundation Health Plan of Washington (KFHPW), which is a regional subsidiary of Kaiser Foundation Health Plan, Inc. As a result of this acquisition, all reports and recommendations will be directed to KFHPW.

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 U.S. Office of Personnel Management's (OPM) Healthcare and Insurance Office. The provisions of the Federal Employees Health Benefits Act are implemented by OPM through regulations codified in 5 CFR Chapter 1, Part 890. Health insurance coverage is provided through contracts with health insurance carriers who provide service benefits, indemnity benefits, or comprehensive medical services.

In April 2012, OPM issued a final rule establishing an FEHBP-specific Medical Loss Ratio (MLR) requirement to replace the similarly-sized subscriber group (SSSG) comparison requirement for most community-rated FEHBP carriers (77 FR 19522). The MLR is the proportion of FEHBP premiums collected by a carrier that is spent on clinical services and quality health improvements. The MLR for each carrier is calculated by dividing the amount of dollars spent for FEHBP members on clinical services and health care quality improvements by the total amount of FEHBP premiums collected in a calendar year.

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. For example, the threshold of 85 percent requires carriers to spend 85 cents of every premium dollar on patient care and limits the amount that can go to administrative expenses and profit to 15 cents of every dollar. However, the MLR does not provide an assessment of the fairness of the premium paid for benefits received, only that the calculated percentage of the premium paid is spent on patient-related health care expenses.

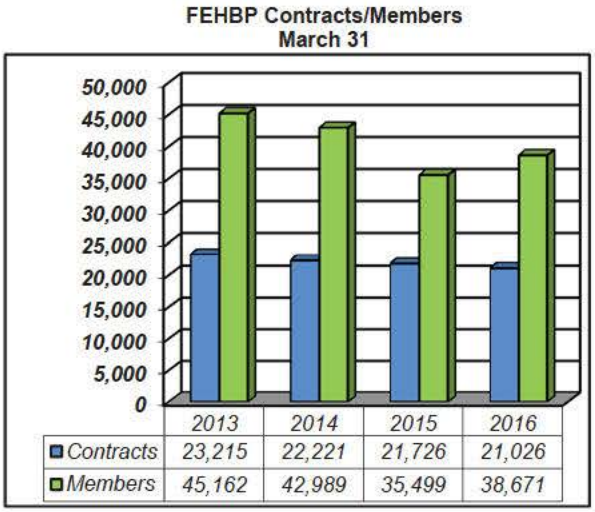
The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act (P.L. 111-148) and defined by the U.S. Department of Health and Human Services in

45 CFR Part 158. In 2012, community-rated FEHBP carriers could elect to follow the FEHBP-specific MLR requirements, instead of the SSSG requirements. Beginning in 2013, however, the MLR methodology was required for all community-rated carriers, except those that are state-mandated to use traditional community rating. State-mandated traditional community-rated carriers continue to be subject to the SSSG comparison rating methodology.

Starting with the pilot program in 2012 and for all non-traditional community-rated FEHBP carriers in 2013, OPM required the carriers to submit an FEHBP-specific MLR. This FEHBP-specific MLR calculation required carriers to report information related to earned premiums and expenditures in various categories, including reimbursement for clinical services provided to enrollees, activities that improve health care quality, and all other non-claims costs. If a carrier fails to meet the FEHBP-specific MLR threshold, it must make a subsidization penalty payment to OPM within 60 days of notification of amounts due.

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.



	2013	2014	2015	2016
Contracts	23,215	22,221	21,726	21,026
Members	45,162	42,989	35,499	38,671

The Plan has participated in the FEHBP since 1960 and provides health benefits to FEHBP members in most of Washington State and Northern Idaho.

A prior audit of the Plan covered contract years 2009 through 2012. The audit did not identify any findings or questioned costs, and no corrective action was necessary. In 2015, the OPM OIG Information Systems Audits Group issued a Final Audit Report of Information Systems General and Application Controls at Group Health Cooperative and KPS Health Plans. The scope of this audit centered on the information systems used by the Plan and KPS Health Plan to process medical insurance claims for FEHBP members, with a primary focus on the claims adjudication applications. All recommendations related to this audit have been addressed.

The preliminary results of this audit were discussed with Plan officials at an exit conference and

in subsequent correspondence. A draft report was also provided to the Plan for review and comment. The Plan's comments were considered in preparation of this report and are included, as appropriate, as an Appendix to the report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The primary objective of this performance audit was to determine whether the Plan complied with the provisions of its Contract and the laws and regulations governing the FEHBP. Specifically, we verified whether the Plan met the MLR requirements and thresholds established by OPM and paid the correct amount to the Subsidization Penalty Account, if applicable. We also performed additional testing to determine whether the Plan complied with the provisions of other applicable laws and regulations.

Our audits of the MLR submission filed with OPM are completed in accordance with the criteria expressed in OPM's rating instructions. The MLR audit evaluation includes an assessment of key components of the MLR calculation, including allowable claims, capitations, health care expenses, and quality health improvements (numerator), and the premium received, excluding applicable tax expenses (denominator). The result of the MLR calculation must meet OPM's prescribed thresholds. If the calculation falls below the threshold, the health plan must pay a penalty determined by the variance between the actual MLR ratio and the established threshold.

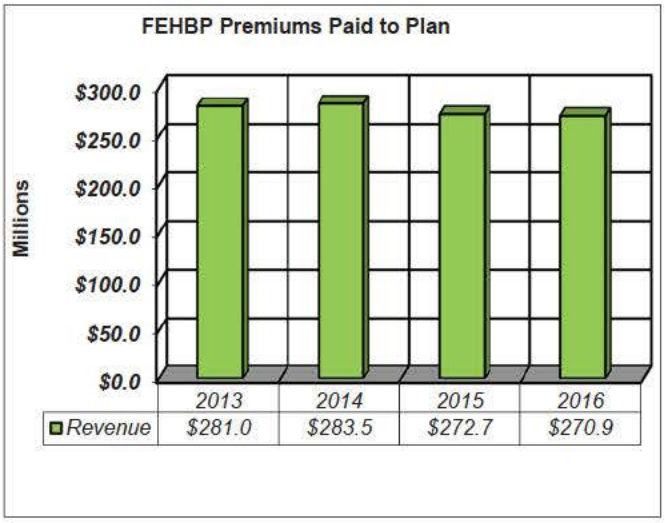
Although the FEHBP premiums used in the MLR calculation are ultimately determined by the premium rates proposed by the Plan and certified and paid by OPM, the OPM rating instructions no longer provide sufficient criteria to evaluate the fairness of those rates against the standard market value of similarly-sized groups. Furthermore, per the OPM rating instructions, health plans can utilize OPM's total reported premium, as the denominator in the MLR calculation, which when utilized is not subject to audit. Since the majority of health plans choose this option, the premiums utilized in the MLR calculation are very frequently not available for audit and the fairness of the FEHBP premium rates cannot be evaluated.

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 2013 through 2016. For these years, the FEHBP paid approximately $1.1 billion in premiums to the Plan.

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



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

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

The audit fieldwork was performed from March 26, 2018, through September 11, 2018, at the Plan's offices in Seattle, Washington, as well as in our offices in Cranberry Township, Pennsylvania; Jacksonville, Florida; and Washington, D.C.

METHODOLOGY

We examined the Plan's MLR calculations and related documents as a basis for validating the MLR. Further, we examined claim payments, quality health expenses, taxes and regulatory fees, and any other applicable costs to verify that the cost data used to develop the MLR was accurate, complete, and valid. We also examined the methodology used by the Plan in determining the premium in the MLR calculations. Finally, we used the Contract, the Federal Employees Health

Benefits Acquisition Regulations (FEHBAR), and the rate instructions to determine the propriety of the Plan's MLR calculations.

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

We determined the basis for the premium amount used in the MLR calculation for all years of the audit scope and verified the accuracy and acceptability based on HHS and OPM regulations and instructions.

We derived the percentage of quality health improvement (QHI) expenses to total claims cost for all years of the audit scope, and determined whether the expenses for QHI activities, included in the plan's MLR calculation, were in accordance with HHS regulations and OPM regulations and instructions. Next, we obtained the Plan's methodology for identifying and allocating QHI costs to the FEHB program and evaluated whether the costs were allowed under HHS and OPM regulations. Finally, we evaluated the allocation methods to ensure the FEHB was receiving an equitable allocation of the QHI expense.

We obtained and reviewed supporting documentation for the tax amounts reported on the Plan's FEHBP MLR form. We verified that the tax amount allocated to the consumer groups was equal to the actual tax paid.

The tests performed for the medical and pharmacy claims, along with the methodology, are detailed in Exhibits F and G at the end of this report.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. Medical Loss Ratio Review

The Certificates of Accurate Medical Loss Ratio (MLR) that the Plan signed for contract years 2013 through 2016 were defective. In accordance with Federal regulations and the U.S. Office of Personnel Management's (OPM) Community Rating Guidelines, our audit identified the following issues:

1. No Credit or Penalty Due $0

During the 2013 MLR filing period, the Plan calculated an MLR ratio that fell within OPM's prescribed threshold. However, our review of the Plan's MLR submission disclosed issues within the MLR calculation, such as payments for non-covered benefits, claim payments for overage dependents, and the overstatement of premiums due to the inclusion of third-party pass-through payments. These adjustments, while reportable, were not significant enough to result in a penalty due to OPM or a credit due the Plan.

2. Overstated MLR Credits $2,432,230

The Plan's non-compliance with Program requirements and its inability to support its MLR calculations resulted in a total overstated MLR credit of $2,432,230 for contract years 2014 and 2015.

During the 2014 MLR filing period, the Plan calculated an MLR ratio of 92.49 percent, resulting in a credit due to the Plan of $11,047,338. However, during our review of the Plan's MLR submission, we identified issues that resulted in a lower audited MLR than that calculated by the Plan. As a result, we determined that the Plan's MLR credit should be reduced by $1,345,290 for this year. Table I on page 8 illustrates the variances that generated the credit adjustment due to OPM. The specific issues that led to the credit adjustments, listed in Table I, will be discussed throughout the report.

During the 2015 MLR filing period, the Plan calculated an MLR ratio of 95.06 percent, resulting in a credit due to the Plan of $18,601,722. However, during our review of the Plan's MLR submission, we identified issues that resulted in a lower audited MLR than that calculated by the Plan. As a result, we determined that the Plan's MLR credit should be reduced by $1,086,940 for contract year 2015. Table I below illustrates the variances that generated the credit adjustment due to OPM. The specific issues that led to the credit adjustments, listed in Table I, will be discussed throughout the report.

Table I – Overstated MLR Credit					
Year	Plan's MLR Ratio	Audited MLR Ratio	Plan's Current Credit	Audited Credit	Credit Reduction to OPM
2014	92.49%	92.07%	$11,047,338	$9,702,048	$1,345,290
2015	95.06%	94.70%	$18,601,722	$17,514,782	$1,086,940
				Total Reduction	$2,432,230

3. Understated MLR Credit **$14,727,560**

During the 2016 MLR filing period, the Plan calculated an MLR ratio of 88.26 percent, which fell within OPM's prescribed thresholds. However, during our review of the Plan's MLR submission, we identified issues that resulted in a higher audited MLR than that calculated by the Plan, resulting in a credit of $14,727,560 due to the Plan. Table II illustrates the variances that generated the credit due to the Plan. The specific issues that led to the credit adjustment, listed in Table II, will be discussed throughout the report.

Table II – Understated MLR Credit					
Year	Plan's MLR Ratio	Audited MLR Ratio	Plan's Current Penalty/Credit	Audited Credit	Credit Due to Plan
2016	88.26%	93.77%	$0	$14,727,560	$14,727,560

Recommendation 1

We recommend that the Contracting Officer reduce the Plan's MLR credit by $1,345,290 for contract year 2014.

Recommendation 2

We recommend that the Contracting Officer reduce the Plan's MLR credit by $1,086,940 for contract year 2015.

Recommendation 3

We recommend that the Contracting Officer apply a credit of $14,727,560 due to the Plan in contract year 2016.

Plan Response:

"The Carrier agrees with recommendations 1, 2 and 3. We have confirmed the values for the recommended reductions and credits for years 2014-2016 with no issue."

4. MLR Claims Data

a. Dependent Eligibility

According to the Federal Employees Health Benefits Program (FEHBP) benefit brochure, dependents are only eligible to be covered after age 26 if the dependent is disabled or incapable of self-support. OPM Contract CS 1043 Section 1.11(b) requires insurance carriers to maintain all records relating to the contract and to make these records available for a period of time specified by FEHBAR 1652.204-70. The referenced clause is incorporated into the contracts at Section 3.4, which requires the carrier to maintain individual enrollee and/or patient claim records "for six years after the end of the contract term to which the claim records relate." However, since the member's employing office certifies via letter a disabled child's dependent status, that letter, and any subsequent correspondence related to their disabled status, should be maintained in the member's eligibility records for as long as they are a member of the health plan to ensure compliance with the Contract's records retention requirements and that claims incurred by these overage dependents are allowable.

A lack of supporting documentation resulted in claim payments totaling $1,669,213 for unsupported overage dependent members.

As part of our dependent eligibility review, we used SAS statistical analysis software to identify dependent members equal to or over the age of 26 who incurred claims in contract years 2013 through 2016 and provided our sample to the Plan for review. In responding to our sample, the Plan explained that the reason they were unable to support these members' disabled status was due to their interpretation of Contract Section 3.4 above, which only requires that supporting documentation be maintained for six years. However, by not maintaining eligibility documents for active members that incurred claims, the Plan is not in compliance with contractual and regulatory requirements for the maintenance of records. Consequently, we cannot determine whether the following claim payments are for valid incurred claims:

Table III - Unallowable Claims Paid - Disabled Dependent Review				
Year		**Dependents**	**Claims Count**	**Unallowable Claims Paid Amount**
2013	Medical	58	1,013	$212,542
	Pharmacy	52	837	$55,422
	Total	110	1,850	**$267,964**
2014	Medical	59	1,123	$797,050
	Pharmacy	43	738	$62,547
	Total	102	1,861	**$859,597**
2015	Medical	51	1,076	$273,932
	Pharmacy	48	1,073	$59,547
	Total	99	2,149	**$333,479**
2016	Medical	45	799	$164,789
	Pharmacy	35	1,782	$43,384
	Total	80	2,581	**$208,173**
Grand Total				**$1,669,213**

Furthermore, OPM's MLR Instructions state that only claims "associated with benefits covered in the Plan's FEHBP contract may be included in the MLR calculation." Therefore, the Plan also inflated their MLR calculation by including unsupported claims in the claims totals used to calculate the MLR.

Recommendation 4

We recommend that the Plan maintain supporting documentation for FEHBP dependents that have been designated as disabled.

Plan Response:

"Consistent with the recommendation, the Carrier will maintain supporting documentation for FEHBP dependents, designated as entitled to dependent coverage because of a disability, 'for six years after the end of the contract term to which the claim records relate.'…

Going forward, records related to dependents with disabilities will be electronically uploaded directly into the Carrier's internal systems. This will allow the Carrier to promptly retrieve records up to 6 years after the end of the contract term of any given disabled dependent, consistent with OPM Contract CS 1043 Section 1.11(b) and Federal Employee Health Benefit Acquisition Regulation 1652.204-70.

Although the Carrier does not contest the current findings and resulting adjustments to its MLR submission, we believe that doing so fails to reflect the important role that OPM and other Federal agencies play in administering benefits for dependents with disabilities. Carriers depend on OPM and other agencies to process and transmit eligibility information concerning these dependents, and often encounter significant obstacles in obtaining and maintaining documentation."

OIG Comment:

We acknowledge the Plan's intent to begin storing records electronically for dependents designated as disabled and maintaining them for six years after the end of the contract term. This would meet the record retention requirement outlined in Section 3.4 of the Contract. However, the implementation of this new electronic record keeping process occurred outside the scope of our audit and we cannot comment on its effectiveness.

b. Non-Covered Benefits

For our review of the non-covered benefit claims samples, we reviewed the Plan's Benefit Brochures to determine non-covered services, drugs, or supplies. We then used SAS to select a sample of non-covered abortion medical claims for all years in the audit scope (2013-2016) and sent this sample to the Plan for review.

During the first quarter of 2014, the Plan's Compliance department discovered errors in their FEHBP claims processing for abortion services. The following three issues were identified in March 2014:

For contract years 2013 through 2015, the Plan processed and paid claims totaling $5,811 for non-covered abortion benefits.

- The incurred abortion claims were not [redacted]
- The incurred abortion claims were not [redacted] and
- Although a Health Plan Services Administration Claims policy was in place advising of the FEHBP criteria for abortion coverage, a corresponding [redacted] was not created.

Through ongoing compliance monitoring in 2016, an additional error was discovered. When Coordination of Benefits (COB) is present and the Plan is secondary, the FEHBP abortion services claims were [redacted]. The COB team did not [redacted]

[redacted]. The secondary payment was based on [redacted]

All of these errors, in combination, resulted in the improper payment of $5,811 ($4,715 in 2013, $50 in 2014, and $1,046 in 2015) for non-covered abortions. Consequently, we removed $4,715, $50, and $1,046 from the 2013, 2014, and 2015 MLR calculations, respectively. We also reviewed the medical claims universe to confirm there were no other associated claims with the non-covered abortion sample (See Table IV below).

Table IV - Non-Covered Benefits - Voluntary Pregnancy Termination Claims

Year		Universe		Identified Members	Claims Count	Unallowable Claims Paid Amount
		Members	Claims			
2013	Medical	15	27	5	6	$4,715
2014	Medical	17	26	1	1	$50
2015	Medical	22	32	3	4	$1,046
					TOTAL	**$5,811**

Recommendation 5

We recommend that the Contracting Officer verify that the Plan has implemented proper [redacted] to prevent the payment for non-covered benefits.

Plan Response:

"The Carrier agrees with the Report's findings as they relate to non-covered medical claims for abortion services. …

During the 2014 FEHBP renewal, the same non-covered abortion medical claim issues described in this report for 2014 were discovered. In response, the Carrier promptly implemented a corrective action plan (CAP) targeting those errors. That CAP took effect the first quarter of 2014. Evidenced by reports shared during this audit, the 2014 CAP has shown to be effective in addressing all identified errors.

After the first quarter of 2014, only claims subject to coordination of benefits (COB) inadvertently [redacted] established in the CAP for FEHBP abortion claims. The Carrier self-disclosed this COB-related issue during the on-site portion of the audit. The Carrier then immediately implemented a CAP to address this issue. These actions have been effective."

OIG Comment:

We acknowledge the Plan has implemented a corrective action plan (CAP) as it relates to abortion for FEHBP members. The CAP was implemented beginning in April 2018 and consists of the following areas:

- Identify any FEHBP abortion claims submitted between January 1, 2016, and March 31, 2018, that paid in error and [redacted]. This work will continue prospectively, as necessary.
- Assure [redacted]
- Verify that staff in all areas potentially affected (i.e., Claims, Member Services, Review Services, and Appeals) have access to policy, procedure, and desk level resources and have been trained on the correct processes.
- Continue to monitor FEHBP abortion claims on a quarterly basis. These claims will be monitored quarterly until there is evidence that 24 months have passed without an error. After 24 months of error free claims processing have passed, spot-check monitoring will be performed.

While these steps all strengthen the controls over the non-covered benefits related to abortion claims, the implementation of these procedures and controls occurred outside the scope of our audit and we cannot comment on their effectiveness.

c. Pharmacy Rebates

The Plan omitted $2,158,122 in pharmacy rebates from the FEHBP MLR for the scope of the audit, inflating incurred claims in each year.

45 Code of Federal Regulations (CFR) 158.140(b)(i) states the prescription drug rebates received by the issuer must be deducted from incurred claims. During our audit, the Plan noted that the external pharmacy rebates were inadvertently omitted from the FEHBP MLR calculations for the scope of this audit. This resulted in an understatement of external pharmacy rebates of $253,678 in 2013, $579,080 in 2014, $752,415 in 2015, and $572,949 in 2016. These understatements also contributed to the Plan's overstatement of the incurred claims amount in each year's MLR calculation.

Recommendation 6

We recommend that the Plan develop written, standardized policies and procedures over the pharmacy rebates calculation and reporting process.

Recommendation 7

We recommend that the Contracting Office request the 2017 external pharmacy rebate amount from the Plan in order to verify the effectiveness of any CAP implemented by the Plan.

Plan Response:

"The Carrier agrees with the findings related to Pharmacy Rebates.

The Carrier self-disclosed this omission during the on-site portion of the audit. The Carrier has created and implemented a CAP to ensure that: (1) external pharmacy rebates are identified and [redacted]; and (2) external pharmacy rebates are netted out of the claims paid amount on line 2.1b of the FEHBP MLR Submission and the supporting data files.

These corrective actions are now part of the Carrier's [redacted] and annual FEHBP MLR production processes.

To help evaluate the effectiveness of the CAP, the Carrier is willing to submit documentation to support its external pharmacy rebate amount for 2017 upon request."

OIG Comment:

Starting in February 2018, the Plan began to implement a CAP, as it relates to accounting for the prescription rebates on their FEHBP MLR form. This plan includes the following steps:

- Documentation of region specific [redacted] to ensure external pharmacy rebates are included in MLR filings.
- Formalization of secondary review/ongoing monitoring and accountability, including documentation to ensure accuracy and completeness of work performed.

While these steps all strengthen the controls related to the accounting of prescription rebates on the FEHBP MLR form, the implementation of these procedures and controls occurred outside the scope of our audit and we cannot comment on their effectiveness.

d. Healthcare Receivables

During our review of the 2013 healthcare receivables, the Plan provided documentation to support $2,093,798 in healthcare receivables incurred in 2013 and paid through June 30, 2014. However, the Plan inadvertently miscalculated the amount included in the 2013 MLR calculation, only reporting a total amount of $841,753. This resulted in a variance of $1,252,045 that overstated the incurred claims in the 2013 MLR Form.

Recommendation 8

We recommend that the Plan develop written, standardized policies and procedures over the healthcare receivables calculation and reporting process.

Plan Response:

"The Carrier agrees with findings related to the calculations of the 2013 healthcare receivables.

This error, discovered and self-disclosed by the Carrier during the on-site portion of the audit, was corrected starting with data year 2014. The correction has been documented and is now reflected in the Carrier's standard process materials."

OIG Comment:

In addition to the corrective action mentioned above, the Plan also implemented a standard process of using [redacted]. Based on the results of our reviews of the FEHBP MLR forms for contract years 2014 through 2016, this process had the intended effect of reporting the correct healthcare receivable amount on the FEHBP MLR form. While the process appears to be working correctly, a written document was not provided which would formally establish the process for Plan personnel.

5. Quality Health Improvements Review

Our review determined that the Plan's quality health improvements included in its MLR filings were allowable and equitably allocated to the FEHBP-specific MLR form using a reasonable allocation methodology.

6. Premium Review

The Plan improperly included third party dental and CMS subsidies in some premium totals causing misstatements of the applicable MLR percentages.

During our premium income review, we noted that OPM's Community Rating Guidelines state, "OPM will provide to carriers the incurred premium to be used in the MLR calculation from the OPM subscription income reports. The OPM-supplied subscription income is not subject to audit. If the carrier believes the OPM subscription income is incorrect, the carrier may use its own premium income amount. The carriers' supplied premium income is subject to audit and must be justified with supporting documentation at the time of audit." The Plan opted to use OPM's subscription income in the FEHBP MLR calculation. We confirmed that the Plan accurately reported OPM's subscription income in the FEHBP MLR submission, however the following issues were noted:

a. Washington Dental Service Premium

For contract year 2013, the Plan received monthly premium payments from Washington Dental Service (WDS) and included the annual amount of $7,876,863 in its 2013 MLR premium income. However, this premium amount is a [redacted], and should not have been included in the MLR calculation. This amount should have been excluded because the dental coverage is [redacted], and because the dental claims are not [redacted]. Removal of this amount from the MLR calculation resulted in a $7,876,863 overstatement of the premium income, thereby understating the MLR percentage.

b. Medicare Subsidy Received from CMS for Medicare Advantage

The Plan also receives revenue from the Centers for Medicare and Medicaid Services (CMS) in the form of a monthly capitation amount. This monthly capitation, along with the premium dues submitted by OPM, constitutes the total Medicare premium in the Plan's general ledger, which is recognized as premium in the FEHBP MLR filing.

For contract year 2016, the CMS Capitation Revenue reported in the Plan's general ledger was $51,876,629. However, we found that the Plan included $72,024,566 in medical subsidies received from CMS in their FEHBP MLR calculation, thereby overstating this premium amount by $20,147,937. The Plan explained that this error occurred due to inadvertently [redacted] which they had already included within the FEHBP group premium amount.

Recommendation 9

We recommend that the Plan develop written, standardized policies and procedures over the accounting for premium revenue as part of the MLR calculation and reporting process.

Plan Response:

"The Carrier agrees with findings related to the inclusion of 2013 dental premiums resulting in an overstatement of premiums for the 2013 MLR calculation.

This error, discovered and self-disclosed by the Carrier during the on-site portion of the audit, has been fully and effectively remediated. Beginning with the Carrier's 2015 submission, a validation review of the WDS premium (Pt 1, Item 1.6 of the MLR) has been a fundamental step in the Carrier's review process for completing the MLR submission. This additional review step ensures the Carrier's reported amounts are accurate and substantiated. …

The Carrier agrees with findings related to the 2016 premium overstatement for CMS medical subsidies received.

This error, discovered and self-disclosed by the Carrier during the on-site portion of the audit, has been fully addressed through a corrective action plan (CAP). Through the CAP process, [redacted] were created, [redacted] were put in place, [redacted] has been installed and additional resources are allocated for ongoing compliance around premium accounting."

OIG Comment:

We acknowledge the Plan implemented a corrective action plan beginning in 2014 to properly exclude the third party dental premiums from the FEHBP MLR form. Our MLR reviews in contract years 2014 through 2016 found the Plan to have correctly excluded these premiums. Based on these results, we have increased confidence that the newly implemented controls are correctly excluding the dental premium.

In March 2018, the Plan began implementing a corrective action plan to ensure that the Medicare Advantage subsidy is correctly reported in the FEHBP MLR form. The Plan implemented the following steps:

- Leveraging how this is handled on a Plan-wide level, to create and document region specific [redacted].

- Formalizing and documenting the performance of [redacted].
- Consulting with additional national Kaiser Permanente MLR subject matter experts to conduct detailed reviews and to determine best practices for filing activities and processes. Additional supporting key controls and improvements will be identified and implemented as needed.

While these steps all strengthen the controls over the reporting of the CMS subsidy on the FEHBP MLR form, the implementation of these procedures and controls occurred outside the scope of our audit and we cannot comment on their effectiveness.

7. Federal and State Taxes and Licensing or Regulatory Fees

45 CFR 158.161 and 158.162 require that taxes and regulatory fees be broken out and excluded from the total amount of premium revenue when calculating an issuer's MLR. Based on our review of the Plan's support for Federal income tax and other tax-related expenses, we identified the following issues[1]:

a. 2013 Tax Expenses

Our review of Part 3 of the 2013 MLR form detected a $1,003,296 material overstatement of the total Federal and state taxes and fees to be excluded from premium. This included a miscellaneous administrative expense totaling $994,440 that was included in Line 3.4 in error, and the Washington State Office of Insurance Commission assessments totaling $8,856 which were included in the Patient Centered Outcomes Research Initiative total.

b. 2014 Tax Expenses

During our review of the 2014 tax expense, we determined a variance of $104,986 between what was reported in the tax category expenses and what was reported on the MLR form. Upon closer review, we found that the [redacted] was not updated to reflect the 2014 balance and, instead, the 2013 amount was carried forward. Consequently, the FEHBP expenses were understated. We applied the appropriate 2014 [redacted] expenses of $142,495 to the MLR form, instead of the original expenses of $37,509

The Plan's overstatement of Tax Expenses in 2013 and 2014 resulted in inflated MLRs each year.

[1] There were no recommendations for the tax expense findings as the results were incorporated in the Medical Loss Ratio Review findings in III.A.1 and III.A.2 above.

applied by the Plan. As a result, the Plan understated the tax expense used in the 2014 MLR denominator calculation by $104,986.

Plan Response:

The Plan did not respond to this audit issue.

8. Conclusion

We made adjustments to the FEHBP MLRs as indicated above. The results of these adjustments show that the Plan overstated the MLR credit in 2014 by $1,345,290 and in 2015 by $1,086,940. For 2016, the Plan understated the credit by $14,727,560. Finally, even though the 2013 MLR submission required adjustments due to the above-mentioned audit issues, there was no financial impact to the MLR that was submitted to OPM.

B. Internal Controls Review

The Plan did not have adequate written policies and procedures to govern the MLR process and was unable to provide all of the necessary supporting documentation during the audit. In addition to not being in compliance with the Contract's records retention requirements, this lack of internal controls over the MLR process resulted in significant discrepancies in the MLRs that were filed with OPM in each year and required material changes to the credit amounts claimed, as discussed above.

Section 5.64(c)(2)(ii)(A) of the Contract states that the Contractor's internal control system will at a minimum provide for "Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the … internal control system." The Contract further states at Section 5.64(c)(2)(ii)(C)(1), (2) and (3) that the Contractor's internal control system should provide "Periodic reviews of company business practices, procedures, policies, and internal controls for compliance with … the special requirements of Government contracting, including--

A lack of sufficient policies and procedures over the MLR process resulted in significant discrepancies to the FEHBP-specific MLR forms filed with OPM.

(1) Monitoring and auditing to detect criminal conduct;

(2) Periodic evaluation of the effectiveness of the … internal control system, especially if criminal conduct has been detected; and

(3) Periodic assessment of the risk of criminal conduct, with appropriate steps to design, implement, or modify … the internal control system as necessary to reduce the risk of criminal conduct identified through this process."

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

Finally, due to a lack of adequate written policies and procedures to govern and oversee MLR data collection, allocation, and reporting of the MLR process, we were unable to determine if the Plan had sufficient oversight over its MLR calculation for our audit scope. Consequently, the Plan is at risk for continued reporting inconsistences and errors that may have material impacts on the MLR calculation.

Recommendation 10

We recommend that the Plan establish Internal Control policies and procedures to govern and oversee the MLR data collection, allocation, and reporting process.

Plan Response:

"The Carrier agrees with the objective … regarding Internal Control policies and procedures. The Carrier has and will continue to augment existing policies and procedures to govern and oversee the MLR data collection, allocation, and reporting process.

The Carrier has implemented additional levels of review." These levels of review are specified in the Plan's Response and OIG Comments listed in the findings above.

"In addition, subject matter experts at the Kaiser Permanente Program level now conduct a concurrent review of the medical loss ratio development to supplement the regional review. This national review includes reasonability checks and reconciliation of relevant entries to the Carrier's Supplemental Health Care Exhibit.

The Carrier has also implemented a more rigorous [redacted]

OIG Comments:

While we agree that the Plan has taken steps in implementing corrective action plans to address many of the issues raised in this report, most were either implemented outside the scope of our audit or were not formalized so that we could review the [redacted]. Consequently, we cannot comment on their effectiveness. Any future OPM OIG audits will be responsible for determining whether the implementation of these corrective action plans and new internal controls have the intended effect of improving the accuracy of the FEHBP MLR form submissions. See each individual section in the Findings and Recommendations section of this report for further analysis.

Exhibit A

Group Health Cooperative
Summary of MLR Credit Adjustments

Contract Year 2013

Plan's filed 2013 Credit Calculation	$0
Audited 2013 Credit Calculation	$0
2013 Overstated Credit	$0

Contract Year 2014

Plan's filed 2014 Credit Calculation	$11,047,338
Audited 2014 Credit Calculation	$9,702,048
2014 Overstated Credit	$1,345,290

Contract Year 2015

Plan's filed 2015 Credit Calculation	$18,601,722
Audited 2015 Credit Calculation	$17,514,782
2015 Overstated Credit	$1,086,940

Contract Year 2016

Plan's filed 2016 Credit Calculation	$0
Audited 2016 Credit Calculation	$14,727,560
2016 Understated Credit	($14,727,560)

Exhibit B

Group Health Cooperative
2013 MLR Credit Adjustment

	Plan	Audited
2013 FEHBP MLR Lower Corridor (a)	85%	85%
2013 FEHBP MLR Upper Corridor (b)	89%	89%
Claims Expense		
Medical Incurred Claims	$247,190,842	$247,190,842
Pharmacy Incurred Claims	$31,448,271	$31,448,271
Less: Incorrectly Paid Medical Dependent Claims		($212,542)
Less: Incorrectly Paid Pharmacy Dependent Claims		($55,422)
Less: Pharmacy Rebates		($253,678)
Less: Non Covered Benefits		($4,715)
Adjusted Incurred Claims	**$278,639,113**	**$278,112,756**
Paid Medical Incentive Pools and Bonuses	$3,667,358	$3,667,357
Less: Healthcare Receivables	$841,753	$2,093,798
Allowable Fraud Reduction Expenses	$0	$0
Adjusted Incurred Claims	$281,464,718	$279,686,315
Quality Health Improvement Expenses	$3,988,528	$3,988,528
Total MLR Numerator	**$285,453,246**	**$283,674,843**
Premium Income	$333,834,829	$325,957,966
Less: Taxes and Regulatory Fees	$6,261,105	$5,257,809
Total MLR Denominator	**$327,573,724**	**$320,700,157**
FEHBP Unadjusted Medical Loss Ratio Calculation (d)	87.14%	88.45%
Credit Calculation (If (d) is greater than (b), ((d-b)*c)	$0	$0
Credit Adjustment Due To Plan		**$0**

Exhibit C

Group Health Cooperative
2014 MLR Credit Adjustment

	Plan	Audited
2014 FEHBP MLR Lower Corridor (a)	85%	85%
2014 FEHBP MLR Upper Corridor (b)	89%	89%
Claims Expense		
Medical Incurred Claims	$252,761,503	$252,761,503
Pharmacy Incurred Claims	$34,898,442	$34,898,442
Less: Incorrectly Paid Medical Dependent Claims		($797,050)
Less: Incorrectly Paid Pharmacy Dependent Claims		($62,547)
Less: Non-Covered Benefits		($50)
Less: Pharmacy Rebates		($579,080)
Adjusted Incurred Claims	**$287,659,945**	**$286,221,218**
Paid Medical Incentive Pools and Bonuses	$1,515,576	$1,515,576
Less: Healthcare Receivables	$373,007	$373,007
Allowable Fraud Reduction Expenses	$0	$0
Adjusted Incurred Claims	$288,802,514	$287,363,787
Quality Health Improvement Expenses	$3,866,621	$3,866,621
Total MLR Numerator	**$292,669,135**	**$291,230,408**
Premium Income	$326,407,297	$326,407,297
Less: Taxes Regulatory Fees	$9,978,312	$10,083,298
Total MLR Denominator	**$316,428,985**	**$316,323,999**
FEHBP Unadjusted Medical Loss Ratio Calculation (d)	92.49%	92.07%
Credit Calculation (If (d) is greater than (b), ((d-b)*c)	$11,047,338	$9,702,048
Overstated Credit		**$1,345,290**

Exhibit D

Group Health Cooperative
2015 MLR Credit Adjustment

	Plan	Audited
2015 FEHBP MLR Lower Corridor (a)	85%	85%
2015 FEHBP MLR Upper Corridor (b)	89%	89%
Claims Expense		
Medical Incurred Claims	$250,796,392	$250,796,392
Pharmacy Incurred Claims	$37,774,119	$37,774,119
Less: Incorrectly Paid Medical Dependent Claims		($273,932)
Less: Incorrectly Paid Pharmacy Dependent Claims		($59,547)
Less: Non-Covered Benefits		($1,046)
Less: Pharmacy Rebates		($752,415)
Adjusted Incurred Claims	**$288,570,511**	**$287,483,571**
Paid Medical Incentive Pools and Bonuses	$1,462,692	$1,462,692
Less: Healthcare Receivables	$258,586	$258,586
Allowable Fraud Reduction Expenses	$0	$0
Adjusted Incurred Claims	$289,774,617	$288,687,677
Quality Health Improvement Expenses	$2,231,094	$2,231,094
Total MLR Numerator	**$292,005,711**	**$290,918,771**
Premium Income	$317,104,212	$317,104,212
Less: Taxes and Regulatory Fees	$9,908,720	$9,908,720
Total MLR Denominator	**$307,195,492**	**$307,195,492**
FEHBP Unadjusted Medical Loss Ratio Calculation (d)	95.06%	94.70%
Credit Calculation (If (d) is greater than (b), ((d-b)*c)	$18,601,722	$17,514,782
Overstated Credit		**$1,086,940**

Exhibit E

Group Health Cooperative
2016 MLR Credit Adjustment

	Plan	Audited
2016 FEHBP MLR Lower Corridor (a)	85%	85%
2016 FEHBP MLR Upper Corridor (b)	89%	89%
Claims Expense		
Medical Incurred Claims	$243,412,895	$243,412,895
Pharmacy Incurred Claims	$40,991,261	$40,991,261
Less: Incorrectly Paid Medical Dependent Claims		($43,384)
Less: Incorrectly Paid Pharmacy Dependent Claims		($164,789)
Less: Pharmacy Rebates		($572,949)
Adjusted Incurred Claims	**$284,404,156**	**$283,623,034**
Paid Medical Incentive Pools and Bonuses	$1,783,159	$1,783,159
Less: Healthcare Receivables	$599,096	$599,096
Allowable Fraud Reduction Expenses	$0	$0
Adjusted Incurred Claims	$285,588,219	$284,807,097
Quality Health Improvement Expenses	$4,692,253	$4,692,253
Total MLR Numerator	**$290,280,472**	**$289,499,350**
Premium Income	$337,728,383	$317,580,446
Less: Taxes and Regulatory Fees	$8,848,098	$8,848,098
Total MLR Denominator	**$328,880,285**	**$308,732,348**
FEHBP Unadjusted Medical Loss Ratio Calculation (d)	88.26%	93.77%
Credit Calculation (If (d) is greater than (b), ((d-b)*c)	$0	$14,727,560
Understated Credit		**$14,727,560**

Exhibit F

Medical Claims Sample Selection Criteria and Methodology

Medical Claims Sample

Medical Claims Review Area	Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe ?
Dependent Eligibility	Dependent Members age >=26 who incurred medical claims in 2013, 2014 and 2016. Dependent Member =26 who incurred medical claims in 2015.	515 members	N/A	103 members	Random Sample	No
Non-Covered Benefits	All Elective Abortion Codes paid in 2013 through 2016	13 claims	$7,424	Selected entire universe; 13 claims	Judgmental	No

Exhibit G

Pharmacy Claims Sample Selection Criteria and Methodology

Pharmacy Claims Sample

Pharmacy Claims Review Area	Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Dependent Eligibility	Dependent Members age >=26 who incurred pharmacy claims in 2013, 2015, and 2016. Dependent Member =26 who incurred pharmacy claims in 2014.	381 members	N/A	107 members	Random Sample	No

APPENDIX

November 14, 2018

[redacted]
Chief, Community Rated Audits Group
U.S. Office of Personnel Management
Office of the Inspector General, Office of Audits
1900 E Street, NW
Washington, DC 20415

RE: Kaiser Foundation Health Plan of Washington (f/k/a Group Health Cooperative)
Response to Draft of a Proposed Report (1C-54-00-18-015) (October 16, 2018)

Dear [redacted]

On behalf of Kaiser Foundation Health Plan of Washington, formerly known as Group Health Cooperative (the "Carrier"), this letter responds to your correspondence of October 16, 2018, which enclosed a Draft Audit Report based on "…whether Group Health Cooperative (Plan) was in compliance with the provisions of its contract and the laws and regulations governing the Federal Employees Health Benefits Program (FEHB)." Draft Report, p. 1. This response addresses recommendations in the Draft Report. Where appropriate, it also references corrective actions that have been taken by the Carrier based on the recommendations.

I. SUMMARY OF DRAFT REPORT RECOMMENDATIONS

As described in the Draft Report, the Office of Inspector General ("OIG") identified several opportunities for improvement and made (9) recommendations with regard to the Carrier's FEHB-specific medical loss ratio (MLR) submissions for contract years 2013 through 2016. In brief, the Draft Report made the following recommendations:

1) Reduce the Carrier's MLR credit by $1,345,290 for contract year 2014
2) Reduce the Carrier's MLR credit by $1,086,940 for contract year 2015
3) Apply a credit of $14,727,560 due to the Carrier in contract year 2016
4) Maintain supporting documentation for FEHBP dependents that have been designated as disabled
5) Verify the Carrier has implemented proper system edits to prevent the payment for non-covered benefits
6) Develop written, standardized policies and procedures over the pharmacy rebates calculation and reporting process
7) Develop written, standardized policies and procedures over the Healthcare Receivables calculation and reporting process
8) Develop written, standardized policies and procedures over the accounting for premium as part of the MLR calculation and reporting process
9) Establish Internal Control policies and procedures to govern and oversee the MLR data collection, allocation, and reporting process

II. RESPONSE TO DRAFT REPORT FINDINGS

The Carrier generally agrees to the findings outlined in the Draft Report and acknowledges the positive working experience had with the audit team throughout the entire audit process. Though navigating the audit process offers challenges for both sides, we sincerely hope that our unwavering commitment to providing compliant FEHBP MLR submissions to OPM was visible through both our transparency and eagerness to act on opportunities for improvement. Additionally, the Carrier wishes to reiterate certain facts which we believe clarify or place in context a number of the findings in the Draft Report. The Carrier has fully implemented a remediation process for each of the opportunities addressed in the Draft Report's recommendations and are providing additional details in the discussion below. The Carrier would be pleased to provide any additional information that would help satisfy concerns noted in the Draft Report.

Recommendation 1-3 (MLR adjustment recommendations)

Recommendation 1
We recommend the Contracting Officer reduce the Plan's MLR credit by $1,345,290 for contract year 2014.

Recommendation 2
We recommend the Contracting Officer reduce the Plan's MLR credit by $1,086,940 for contract year 2015.

Recommendation 3
We recommend the Contracting Officer apply a credit of $14,727,560 due to the Plan in contract year 2016.

Carrier Response:
The Carrier agrees with recommendations 1, 2 and 3. We have confirmed the values for the recommended reductions and credits for years 2014-2016 with no issue.

Recommendation 4 (Dependent Eligibility)

Recommendation 4
We recommend that the Plan maintain supporting documentation for FEHBP dependents that have been designated as disabled.

Carrier Response:
Consistent with the recommendation, the Carrier will maintain supporting documentation for FEHBP dependents, designated as entitled to dependent coverage because of a disability, "for six years after the end of the contract term to which the claim records relate."

Deleted by OIG – Not Relevant to the Final Report

Going forward, records related to dependents with disabilities will be electronically uploaded directly into the Carrier's internal systems. This will allow the Carrier to promptly retrieve records up to 6 years after the end of the contract term of any given disabled dependent, consistent with OPM Contract CS 1043 Section 1.11(b) and Federal Employee Health Benefit Acquisition Regulation 1652.204-70.

Although the Carrier does not contest the current findings and resulting adjustments to its MLR submission, we believe that doing so fails to reflect the important role that OPM and other Federal agencies play in administering benefits for dependents with disabilities. Carriers depend on OPM and other agencies to process and transmit eligibility information concerning these dependents, and often encounter significant obstacles in obtaining and maintaining documentation.

Deleted by OIG – Not Relevant to the Final Report

Recommendation 5 (Non-Covered Benefits)

Recommendation 5
We recommend that the Contracting Officer verify that the Plan has implemented proper [redacted] to prevent the payment for non-covered benefits. We acknowledge that the Plan provided a corrective action plan related to address this recommendation, however, we have not evaluated its effectiveness.

Carrier Response:
The Carrier agrees with the Report's findings as they relate to non-covered medical claims for abortion services.

Deleted by OIG – Not Relevant to Final Report

During the 2014 FEHBP renewal, the same non-covered abortion medical claim issues described in this report for 2014 were discovered. In response, the Carrier promptly implemented a corrective action plan (CAP) targeting those errors. That CAP took effect the first quarter of 2014. Evidenced by reports shared during this audit, the 2014 CAP has shown to be effective in addressing all identified errors.

After the first quarter of 2014, only claims subject to coordination of benefits (COB) inadvertently [redacted] established in the CAP for FEHBP abortion claims. The Carrier self-disclosed this COB-related issue during the on-site portion of the audit. The Carrier then immediately implemented a CAP to address this issue. These actions have been effective.

Recommendation 6 (Pharmacy Rebates)

Recommendation 6
We recommend that the Plan develop written, standardized policies and procedures over the pharmacy rebates calculation and reporting process. We acknowledge the Plan has provided a

corrective action plan to address this recommendation, however, we have not evaluated its effectiveness.

Carrier Response:
The Carrier agrees with the findings related to Pharmacy Rebates.

The Carrier self-disclosed this omission during the on-site portion of the audit. The Carrier has created and implemented a CAP to ensure that: (1) external pharmacy rebates are identified and [redacted] and (2) external pharmacy rebates are netted out of the claims paid amount on line 2.1b of the FEHBP MLR Submission and the supporting data files.

These corrective actions are now part of the Carrier's [redacted] and annual FEHBP MLR production processes.

To help evaluate the effectiveness of the CAP, the Carrier is willing to submit documentation to support its external pharmacy rebate amount for 2017 upon request.

Recommendation 7 (Healthcare Receivables)

Recommendation 7
We recommend that the Plan develop written, standardized policies and procedures over the Healthcare Receivables calculation and reporting process. We acknowledge the Plan has provided a corrective action plan to address this recommendation, however, we have not evaluated its effectiveness.

Carrier Response:
The Carrier agrees with findings related to the calculations of the 2013 healthcare receivables.

This error, discovered and self-disclosed by the Carrier during the on-site portion of the audit, was corrected starting with data year 2014. The correction has been documented and is now reflected in the Carrier's standard process materials.

Recommendation 8 - Premium Review

Recommendation 8
We recommend that the Plan develop written, standardized policies and procedures over the accounting for premium as part of the MLR calculation and reporting process. We acknowledge the Plan has provided a corrective action plan to address this recommendation, however, we have not tested its effectiveness.

Carrier Response:
Washington Dental Services Premium
The Carrier agrees with findings related to the inclusion of 2013 dental premiums resulting in an overstatement of premiums for the 2013 MLR calculation.

This error, discovered and self-disclosed by the Carrier during the on-site portion of the audit, has been fully and effectively remediated. Beginning with the Carrier's 2015 submission, a validation review of the Washington Dental Service premium (Pt 1, Item 1.6 of the MLR) has been a fundamental step in the Carrier's review process for completing the MLR submission. This additional review step ensures the Carrier's reported amounts are accurate and substantiated.

Medicare Subsidy Received from CMS for Medicare Advantage
The Carrier agrees with findings related to the 2016 premium overstatement for CMS medical subsidies received.

This error, discovered and self-disclosed by the Carrier during the on-site portion of the audit, has been fully addressed through a corrective action plan (CAP). Through the CAP process, [redacted] were created, [redacted] were put in place, [redacted] has been installed and additional resources are allocated for ongoing compliance around premium accounting.

Recommendation 9 (Internal Controls Review)

Recommendation 9
We recommend that the Plan establish Internal Control policies and procedures to govern and oversee the MLR data collection, allocation, and reporting process.

Carrier Response:
The Carrier agrees with the objective underpinning Recommendation 9 – regarding Internal Control policies and procedures. The Carrier has and will continue to augment existing policies and procedures to govern and oversee the MLR data collection, allocation, and reporting process.

The Carrier has implemented additional levels of review. The Carrier's corrective action plans (CAP) described in Recommendations 5, 6, 7 and 8 specify some of the additional controls that have been implemented.

In addition, subject matter experts at the Kaiser Permanente Program level now conduct a concurrent review of the medical loss ratio development to supplement the regional review. This national review includes reasonability checks and reconciliation of relevant entries to the Carrier's Supplemental Health Care Exhibit.

The Carrier has also implemented a more rigorous [redacted]

III. CONCLUSION

We appreciate this opportunity to respond to the Draft Report, and urge you to give due consideration to the information provided in this letter.

This response contains commercial and financial information that is proprietary and confidential to the Carrier. Disclosure of this information would cause substantial harm to the Carrier's competitive position. OPM is requested to treat this document as confidential. This material is exempt from disclosure under Section 552(b)(4) of Title 5 of the United States Code.

Please do not hesitate to contact me if you have any questions or need any additional information. You can reach me at [redacted]. Thank you.

Sincerely,

[redacted]

CC:

[redacted]

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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Washington Metro Area: (202) 606-2423

By Mail:
Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, NW
Room 6400
Washington, DC 20415-1100

– CAUTION –

Report No. 1C-54-00-18-015