



**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
AETNA OPEN ACCESS
NORTHERN NEW JERSEY**

Report Number 1C-JR-00-15-046

July 15, 2016

-- CAUTION --

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EXECUTIVE SUMMARY

Audit of the Federal Employees Health Benefits Program Operations at Aetna Open Access – Northern New Jersey

Report No. 1C-JR-00-15-046

July 15, 2016

Why Did We Conduct the Audit?

The primary objective of the audit was to determine if Aetna Open Access – Northern New Jersey (Plan) was in compliance with the provisions of its contract and the provisions of the laws and regulations governing the Federal Employees Health Benefits Program (FEHBP). We verified whether the Plan met the Medical Loss Ratio (MLR) requirements established by the U.S. Office of Personnel Management. We also verified whether the Plan developed the FEHBP premium rates using complete, accurate and current data.

What Did We Audit?

Under Contract CS 2867, the Office of the Inspector General performed an audit of the FEHBP operations at the Plan. The audit covered the Plan's 2012 and 2013 FEHBP premium rate build-ups and MLR submissions. Our audit fieldwork was conducted from September 14, 2015 through September 24, 2015, at the Plan's office in Blue Bell,



Michael R. Esser
*Assistant Inspector General
for Audits*

What Did We Find?

We determined that portions of the 2012 and 2013 MLR calculation were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM. Specifically, our audit identified the following:

- The Plan's use of "Direct Premiums Written" in determining the large group premium ratio does not produce the most accurate results. The Plan should use "Direct Premiums Earned", which most accurately represents the premium specific to the calendar year.
- In contract years 2012 and 2013, the Plan did not use a fair and equitable allocation method to determine the federal income tax expense related to the FEHBP.
- The Plan included medical and pharmacy claims not allowed by the FEHBP in the incurred claims amount used in the 2013 MLR submission.

Although these findings affected the 2012 and 2013 MLR calculations, the findings did not result in a penalty for these contract years.

The audit also showed that the rating documentation provided was sufficient to support the 2012 and 2013 FEHBP premium rates.

ABBREVIATIONS

ACA	Affordable Care Act
CFR	Code of Federal Regulations
FEHBAR	Federal Employees Health Benefits Acquisition Regulations
FEHBP	Federal Employees Health Benefits Program
HHS	U.S. Department of Health and Human Services
MLR	Medical Loss Ratio
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
Plan	Aetna Open Access – Northern New Jersey
SSSG	Similarly-Sized Subscriber Group
TCR	Traditional Community Rating

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I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at Aetna Open Access – Northern New Jersey (Plan). The audit was conducted pursuant to the provisions of Contract CS 2867; 5 United States Code Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract years 2012 and 2013, and was conducted at the Plan’s office in Blue Bell, Pennsylvania.

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). 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 is important because it requires health insurers to provide consumers with value for their premium payments by limiting the percentage of premium dollars that can be spent on administrative expenses and profit. For example, an MLR threshold of 85 percent requires carriers to spend 85 cents of every premium dollar on claims and limits the amount that can be spent on administrative expenses and profit to 15 cents of every dollar.

The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act (ACA, P.L. 111-148) and defined by the U.S. Department of Health and Human Services (HHS) 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 (TCR). State-mandated TCR carriers continue to be subject to the SSSG comparison rating methodology.

Starting with the pilot program in 2012 and for all non-TCR FEHBP carriers in 2013, OPM required the carriers to submit an FEHBP-specific MLR. This FEHBP-specific MLR calculation

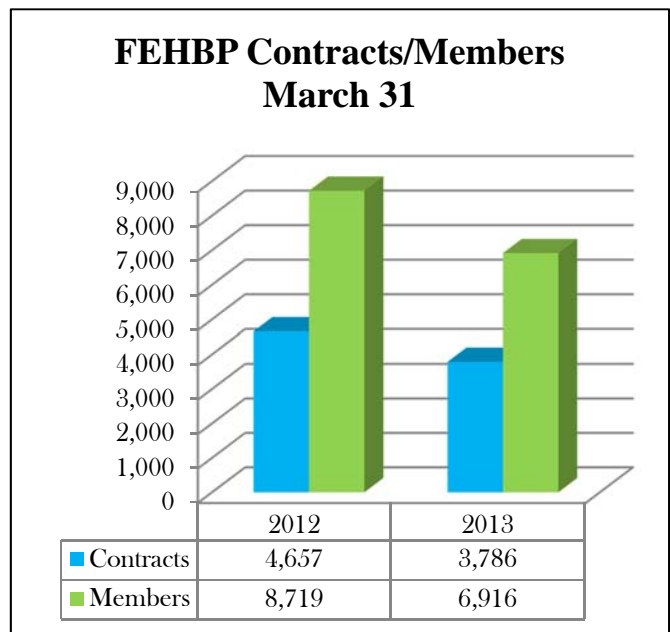
required carriers to report information related to earned premiums and expenditures in various categories, including reimbursement for clinical services provided to enrollees, activities that improve health care quality, and all other non-claims costs. If a carrier fails to meet the FEHBP-specific MLR 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 Plan reported 4,657 contracts and 8,719 members as of March 31, 2012, and 3,786 contracts and 6,916 members as of March 31, 2013, as shown in the chart below.

In contracting with community-rated carriers, OPM relies on carrier compliance with appropriate laws and regulations and, consequently, does not negotiate base rates. OPM negotiations relate primarily to the level of coverage and other unique features of the FEHBP.

The Plan has participated in the FEHBP since 2002 and provides health benefits to FEHBP members in Northern New Jersey. A prior audit of the Plan covered contract year 2011. There were no findings or questioned costs identified in that audit.



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 was in compliance with the provisions of its contract and the laws and regulations governing the FEHBP. Specifically, we verified whether the Plan met the MLR requirements established by OPM and paid the correct amount to the Subsidization Penalty Account, if applicable. Additional tests were also performed to determine whether the Plan was in compliance with the provisions of other applicable laws and regulations.

Scope

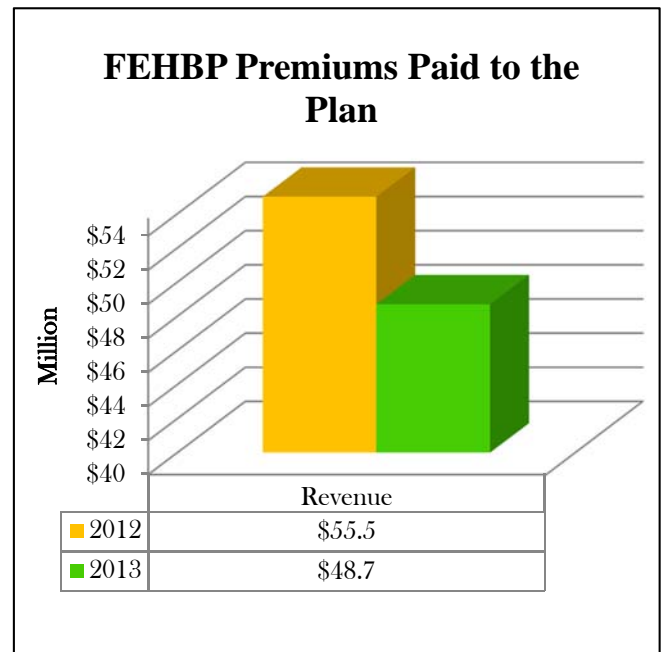
We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. 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 2012 and 2013. For contract years 2012 and 2013, the FEHBP paid approximately \$55.5 million and \$48.7 million in premiums to the Plan, respectively.

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. However, the audit included such tests of the Plan's rating system and such other auditing procedures considered necessary under the circumstances. Our review of internal controls was limited to the procedures the Plan has in place to ensure that:

- The rates charged to the FEHBP were developed in accordance with the Plan's standard rating methodology and the claims, factors, trends, and other related



adjustments were supported by complete, accurate, and current source documentation; and

- The FEHBP MLR calculations were accurate, complete, and valid; claims were processed accurately; appropriate allocation methods were used; and, that 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 September 14, 2015 through September 24, 2015, at the Plan's office in Blue Bell, Pennsylvania.

Methodology

We examined the Plan's MLR calculations and related documents as a basis for validating the MLR. Further, we examined claim payments and quality health expenses 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 in the Plan's claims processing system, we reviewed the Plan's claims processing policies and procedures and interviewed appropriate Plan officials regarding the controls in place to ensure that claims were processed accurately. Other auditing procedures were performed as necessary to meet our audit objectives.

The tests performed, along with the methodology, are detailed below by Medical and Pharmacy claims:

Medical Claims Sample Selection Criteria/Methodology

Medical Claims Review Area	Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Abortion 2013	Medical claims with procedure codes 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 59866, 59870, S0190, S0191, S0199, S2260, S2265, S2266, S2267.	█	\$█	Selected all claims from the universe.	N/A	No
Coordination of Benefits (COB) – Medicare 2013	Medical claims amount paid greater than \$15,000 for members greater than age 64.	█	\$█	Selected all claims from the universe.	N/A	No
Dependent Eligibility 2013	Members over age 26 who are not the subscriber or a spouse.	█	\$█	Selected the 10 highest claims paid, totaling \$24,906.	Judgmental	No
Chiropractic Copay 2013	Medical claims with procedure codes 98940, 98941, 98942 and 98943 and copay does not equal \$35.	█ of the █ had a \$0 copay)	\$█	Selected all claims where the copay amount does not equal \$0. The 16 selected claims totaled \$█.	Judgmental	No
Gender Specific – Male Only Procedures Paid for Females 2013	Medical claims for females ran against a list of 226 procedure codes identified as male only procedures.	█	\$█	Selected the highest paid claim from each of the following procedure codes: 54150 and 76870. The 2 selected claims totaled \$710.	Judgmental	No

Medical Claims Review Area	Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Gender Specific – Female Only Procedures Paid for Males 2013	Medical claims for males ran against a list of 451 procedure codes identified as female only procedures.	█	\$█	Selected the highest paid claim from each of the following procedure codes: 11980, 84702, 84703, 88104, 88108, 88161, 88172, 88173, 88184, 88185, 88187, 88188, and 88189. The 13 selected claims totaled \$4,916.	Judgmental	No
Non-Covered Benefits Review 2013	Medical claims containing non-covered benefit procedure codes (total of 1,209 non-covered procedure codes).	█	\$█	Selected the highest paid claim from each of the 32 procedure codes in the universe results. The 32 selected claims totaled \$9,534.	Judgmental	No
Eyeglasses and Contacts 2013	Medical claims containing vision related procedure codes (total of 121 vision related procedure codes).	█	\$█	Selected all claims from the universe where the claim payment was greater than the member allowance of \$100 for the high option or \$200 for the basic option. Total sample included 5 claims totaling \$█.	Judgmental	No

Pharmacy Claims Sample Selection Criteria/Methodology

Pharmacy Claims Review Area	Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
High Dollar Prescriptions 2013	Pharmacy claims greater than or equal to \$10,000.	■	\$ ■■■■■	Randomly selected 14 claims totaling \$234,277.	Random	No
High Quantity Dispensed 2013	All pharmacy claims with a quantity dispensed greater than 1,000 units.	■	\$ ■■■■■	Selected all claims from the universe.	N/A	No
Dependent Eligibility 2013	Members over age 26 who are not the subscriber or a spouse.	■	\$ ■■■■■	Selected the first 12 highest paid claims from the universe, totaling \$11,771.	Judgmental	No

We also examined the rate build-up of the Plan's 2012 and 2013 Federal rate submissions and related documents as a basis for validating the Plan's standard rating methodology. We verified that the factors, trends, and other related adjustments used to determine the FEHBP premium rates were sufficiently supported by source documentation. We used the contract, the FEHBAR, and the rate instructions to determine the propriety of the FEHBP premiums and the reasonableness and acceptability of the Plan's rating system.

Finally, we examined the Plan's financial information and evaluated the Plan's financial condition and ability to continue operations as a viable ongoing business concern.

III. AUDIT FINDINGS AND RECOMMENDATIONS

1. Medical Loss Ratio

Procedural

Aetna Open Access – Northern New Jersey (Plan) elected to participate in the 2012 Medical Loss Ratio (MLR) pilot program offered to certain Federal Employees Health Benefits Program (FEHBP) carriers. The MLR pilot program replaced SSSG requirements with an MLR threshold. Simply stated, the MLR is the ratio of FEHBP incurred claims (including expenses for health care quality improvement) to total premium revenue determined by the U.S. Office of Personnel Management (OPM).

For contract year 2012, the OPM-established MLR threshold for MLR pilot program carriers was 89 percent. Therefore, 89 cents of every health care premium dollar must have been spent on health care expenses. If the MLR was less than 89 percent, a carrier will owe a subsidization penalty equal to the difference between the threshold and the carrier's actual MLR.

For contract year 2013, OPM changed the MLR threshold to 85 percent and created an MLR corridor. If carriers met the MLR threshold, no penalty is due. If the MLR was over 89 percent, the carrier receives a credit equal to the difference between the carrier's reported MLR and 89 percent, multiplied by the denominator of the MLR. This credit can be used to offset any future MLR penalty and is available until it is used up by the Plan or the Plan exits the FEHBP.

The Plan calculated an MLR of [REDACTED] percent for contract year 2012, and [REDACTED] percent for contract year 2013. However, during our review of the Plan's MLR submissions, we found the following issues.

Direct Premiums Earned

The Plan allocated non-income related taxes, regulatory fees, quality health improvement expenses, and fraud reduction expenses that were applicable to the FEHBP by using a premium ratio allocation method. The premium ratio was calculated by dividing the FEHBP premium by total large group sector premium on the HHS grand total MLR filing, designated as "Direct Premiums Written." However, we believe the Plan's use of "Direct Premiums Written" in determining the large group premium ratio does not produce the most accurate results. Instead, "Direct Premiums Earned" should be the basis for the allocation since it more accurately represents the premiums earned by the Plan for the calendar year.

“Direct Premiums Earned” is calculated by taking the “Direct Premiums Written” amount, adding the difference of unearned premium in the prior and current year, and then subtracting premium balances written off for the calendar year. The result, “Direct Premiums Earned,” is the actual premium the Plan received. Since the actual FEHBP paid premium is used for the FEHBP portion of the ratio, we believe that the actual or “Direct Premiums Earned” amount should be used for the large group portion of the ratio. The Plan’s FEHBP premium ratios using “Direct Premiums Written,” were 8.6041 percent and 9.4878 percent for 2012 and 2013, respectively. However, our audited FEHBP premium ratios using “Direct Premiums Earned,” were 8.6126 percent and 10.0037 percent for 2012 and 2013 respectively.

Plan Response:

The Plan disagrees with the use of direct premiums earned as the basis for allocating expenses. For components of the FEHBP MLR filing that are not addressed by OPM’s instructions, the Plan contends that OPM’s instructions refer plans back to the HHS rules. Therefore, since the Plan allocated expenses on the HHS filing using a direct premium written ratio, they applied the same methodology to the FEHBP MLR filing. The Plan states that allocating the FEHBP expenses on a direct premium earned ratio is not only inconsistent with the HHS expense allocations but is also in direct contrast to OPM’s instructions which refer plans back to using the HHS rules.

The Plan also informed us that they have moved to a date of service premium on their HHS filing which will eliminate the need to report unearned premium adjustments starting in 2014. The method of calculating the date of service premium is consistent with the OPM subscription income calculation and will not need any further adjustments.

OIG Comment:

We agree with the Plan that the FEHBP MLR regulations instruct plans to refer back to the HHS rules when they do not provide specific instructions for components of the MLR filing. However, the HHS rules do not explicitly state direct premiums written should be used when allocating expenses. The regulations state that, “HHS has not prescribed a standardized method for allocating costs and all costs must be allocated according to generally accepted accounting methods which yield the most accurate results and are well documented.” Our audit tests of “Direct Premiums Earned” yields the most accurate result for FEHBP MLR purposes.

The Plan also states they allocate expenses in the HHS filing using a “Direct Premium Written” ratio and the same methodology should apply when allocating expenses to the FEHBP MLR calculation. However, the intent of OPM’s instructions was to include

calendar year revenue, incurred claims and expenses. “Direct Premiums Earned” is calculated in the same manner as OPM subscription income, by incorporating the written annual premium for the year and adjusting by unearned premium in the prior and current years. “Direct Premiums Written” does not take into account adjustments for unearned premium in the prior and current years and does not present an accurate premium amount for the calendar year period. Therefore, we disagree with the Plan’s position and assert that “Direct Premiums Earned” should be used when calculating the premium allocation ratio.

As to the Plan’s move to a date of service premium methodology to derive its premium allocation ratios beginning in 2014, we tentatively agree that this move should address this issue going forward. However, we will need to analyze this methodology on a future audit before we can offer a full opinion. Because of the Plan’s move to this methodology, we are not making a recommendation to address this issue in this final report. That being said, we maintain that “Direct Premiums Earned” continues to represent the most accurate premium amount for allocation purposes, and we will continue to question this issue, where applicable, on any unaudited Aetna plan year prior to 2014.

Tax Allocation

Pursuant to the provision of U.S. Department of Health and Human Services (HHS) 45 Code of Federal Regulations (CFR) § 158, Plans are allowed to reduce the premium used in the MLR calculation by taxes and regulatory fees paid, excluding Federal income taxes paid on investment income and capital gains. The Plan allocated non-income related taxes, regulatory fees, quality health improvement expenses, and fraud reduction expenses that were applicable to the FEHBP by using a premium ratio allocation method. The premium ratio was calculated by dividing the FEHBP premium by the total large group sector premium on the HHS grand total MLR filing, of which the FEHBP is included. However, for State and Federal income taxes, the Plan attempted to calculate the gain or loss on the FEHBP as if it was its own entity. The result was a State Income tax allocation of \$ [REDACTED] and \$ [REDACTED] and a Federal Income tax allocation of \$ [REDACTED] and \$ [REDACTED] to the FEHBP for contract years 2012 and 2013, respectively.

HHS 45 CFR § 158.170 requires that the Plan’s allocation method be based on a generally accepted accounting method. However, we found that the Plan’s method used to allocate the Federal income taxes to the FEHBP is not applied proportionately, appropriately, and is not based on a generally accepted accounting method. Also, it is not suitable to treat the FEHBP as if it were its own entity since expenses are not tracked at the group level and the method is not related to actual expenses incurred. A more appropriate method, which the Plan used for several other expenses in its MLR calculation, is the premium ratio allocation method. This method yields a more accurate result and is supportable (i.e., well documented).

Therefore, we recalculated the Federal income tax allocation using the premium ratio method and determined that the FEHBP's portion of State income tax owed was \$ [REDACTED] and \$ [REDACTED], for contract years 2012 and 2013 respectively. Additionally, we determined that the FEHBP's portion of Federal income tax due was \$ [REDACTED] and (\$ [REDACTED]), for contract years 2012 and 2013, respectively. As a result, we reduced the premium in our audited MLR calculations by \$ [REDACTED] in 2012 and \$ [REDACTED] in 2013.

Plan Response:

The Plan disagrees with the OIG's Federal income tax allocation in the 2012 and 2013 MLR calculations. The Plan contends that their methodology of calculating the FEHBP net income and applying the applicable tax rate is a more accurate representation of the FEHBP federal income tax expense. The Plan states that net income, not premium, should be used to allocate income taxes since income and losses are what determines the tax expense. Additionally, the Plan maintains that its income tax allocation method for the FEHBP conforms to generally accepted accounting principles. Finally, it asserts that the method used for its FEHBP Federal income tax allocation is the same method used for its HHS MLR filing.

OIG Comment:

The OIG disagrees with the Plan and asserts that the Plan's method used to calculate the FEHBP Federal and State income tax does not conform to HHS 45 CFR § 158, which states, "All costs reported by issuers must be *allocated* according to generally accepted accounting methods that yield the most accurate results and are well documented." The Plan did not allocate a portion of the Federal and State income tax expense that was reported on the Plan's statutory financial statements, but instead calculated an FEHBP net income value that is not well documented. Ultimately, the Plan's FEHBP net income calculation is unverifiable and is not an equitable basis to determine the FEHBP Federal and State income tax expense.

The HHS regulations require a portion of taxes be allocated to each of the MLR health insurance markets (e.g., individual, small group, large group, etc.), which the Plan refers to as MLR pools. To determine each pool's Federal and State income tax amount, including that of the HHS large group pool, the Plan calculated the net income for the large group pool, divided by the net income for the entire company and multiplied by the Federal and State income taxes reported on the annual statement. This methodology adheres to the HHS regulation by allocating a portion of the Federal income taxes reported by the Plan on their statutory financial statements.

However, the Plan did not consistently use this method to determine the Federal and State income tax attributable to the FEHBP, which is part of the HHS large group pool. Instead of

allocating a portion of the reported Federal and State income tax to the FEHBP as required by HHS 45 CFR § 158, the Plan calculated the FEHBP net income and multiplied the amount by a corporate tax rate of 35 percent and state tax rate of 9 percent. This method is inconsistent with the Plan's Federal and State income tax allocation for the HHS MLR pools and is not well documented, since the FEHBP's net income cannot be verified.

The Plan's removal of expenses in the FEHBP net income calculation also distorts the expenses reported for the HHS large group pool. Since the FEHBP is part of the large group sector, those expenses should be removed from the large group net income calculation as well. If they are not removed, then the expenses are spread out amongst the rest of the large group sector which will understate the amount of taxes allocated to the large group pool. Since the Plan cannot track expenses on a group level, contractual exclusions or variances in contractual expenses cannot be accurately tracked, rendering it impossible to determine any one group's net income.

Consequently, it is our position that the premium ratio allocation method yields a more accurate result to determine the FEHBP Federal income tax expense, since it adheres to the HHS regulation and was used by the Plan in several other MLR cost allocation areas. Therefore, we recalculated the Federal and State income tax allocation using the premium ratio method. We determined that the FEHBP's portion of Federal income tax was \$ [REDACTED] and (\$ [REDACTED]), for contract years 2012 and 2013, respectively. The FEHBP's portion of State income tax was \$ [REDACTED] and \$ [REDACTED], for contract years 2012 and 2013, respectively. We reduced the premium in our audited MLR calculations to account for these amounts.

MLR Claims Data

During our review of the Plan's MLR submission for contract year 2013, we determined that the incurred claims amount included in the Plan's MLR calculation was incorrect. Specifically, the Plan included medical and pharmacy claim amounts not allowed by the FEHBP.

According to the FEHBP certificate of coverage, dependent coverage ends once the dependent turns 26 years of age. During our review of the 2013 medical claims data, we identified two ineligible members who exceeded the dependent age limit and generated 54 medical claims which were incorrectly paid. Our review of the 2013 pharmacy claims data also identified five ineligible members who exceeded the dependent age limit and generated five pharmacy claims which were incorrectly paid.

Additionally, the 2013 FEHBP benefit brochure states that members enrolled in the High Option plan receive a \$100 allowance towards the purchase of corrective eyeglasses and frames or contact lenses every 24 months. Members enrolled in the Basic Option receive a

\$200 allowance for corrective eyeglasses and frames or contact lenses per 24 month period. We reviewed medical claims relating to eyeglasses and contacts to verify that members were receiving the appropriate allowances. Our review identified two members enrolled in the High Option plan who received a higher allowance than what was allowed in the benefit brochure. Both members received a \$200 allowance instead of a \$100 allowance, increasing the claims cost by \$100 for each member.

We also identified procedure codes which are typically only paid for male or female members in the 2013 medical claims data and ran queries on both sets of procedure codes against the opposite sex, to determine if there were any claims paid. We found no instances of claims being paid for female members from our male only procedure code list. However, we did find one female procedure code which was paid in eight separate instances for six different male members.

Finally, we identified procedure codes which are defined as non-covered benefits per the benefit brochure and queried this list of procedure codes against the 2013 medical claims data. The results of our query and review disclosed three different procedure codes that were improperly paid.

Plan Response:

The Plan agrees with the findings for medical and pharmacy claims paid on ineligible members. The Plan is currently working with the OIG and OPM to implement an appropriate action plan to address this finding going forward.

The Plan agrees with the findings for inappropriate eyeglass allowances. The Plan intends to provide refresher training instructions via a memorandum for claims processors to address this mistake going forward.

The plan agrees with the findings for gender specific claims paid on ineligible members. The Plan intends to provide refresher training instructions via a memorandum for claims processors to address this mistake going forward.

The plan agrees with the findings for non-covered benefits. The Plan intends to provide refresher training instructions via a memorandum for claims processors to address this mistake going forward.

Conclusion

We recalculated the Plan's 2012 and 2013 MLR submissions using direct premiums earned for allocation of expenses. We also adjusted the income tax expenses on a premium ratio

basis. Finally, we removed the incorrectly paid medical and pharmacy claims from the numerator of the MLR calculation. The results show our audited MLR calculations were higher than the OPM prescribed thresholds of 89 percent and 85 percent in contract years 2012 and 2013, respectively, and, consequently, resulted in no subsidization penalty for both years.

Recommendation 1

We recommend that the contracting officer require the Plan to either calculate the FEHBP's State and Federal income tax allocation using the premium ratio method or utilize a method which is well documented and supported.

Recommendation 2

We recommend that the contracting officer verify that the Plan submits an appropriate action plan to address the payment of medical and pharmacy claims for ineligible members.

Recommendation 3

We recommend that the contracting officer verify that the Plan issued the training instruction memorandums to their claims processors to correct the claims processing errors identified in this report.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

COMMUNITY-RATED AUDITS GROUP

[REDACTED], Auditor-in-Charge

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED], Senior Team Leader

[REDACTED], Group Chief

APPENDIX



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March 28, 2016

[REDACTED]
Chief, Community-Rated Audits Group
U.S. Office of Personnel Management
Office of the Inspector General
1900 E Street NW, Room 6400
Washington, DC 20415

Re: Audit of Aetna Open Access – Northern New Jersey
Contract Number CS 2867 – Plan Code JR
Report No. 1C-JR-00-15-046

Dear [REDACTED]:

Thank you for the opportunity to respond to the draft audit report dated January 28, 2016. After careful review of the draft report, we agree with the draft report's findings on the medical and pharmacy claims not allowed by the FEHBP under the MLR Claims Data section of the report. However, we respectfully disagree with the OIG's findings that the Aetna Open Access's method to determine the portion of federal income taxes attributed to the FEHBP was not fair and equitable for purposes of calculating the 2012 and 2013 Minimum Loss Ratio. We believe that Aetna Open Access's calculation of federal income taxes was consistent with the standard required in the MLR regulations.

We also respectfully disagree with the Draft Report's recommendation to use "Direct Premiums Earned" when calculating the premium ration used to determine non-income related taxes, regulatory fees, quality health improvement expenses, and fraud reduction expenses allocations.

DELETED BY OIG – NOT RELEVANT FOR FINAL REPORT

Please see the attached analysis in support of Aetna Open Access's position. If you have any questions as you review our response, please contact me.

Sincerely,

[REDACTED]

[REDACTED]

Executive Director

cc: Alan Spielman
Assistant Director for Federal Employees Insurance Operations, OPM

Lloyd Williams
Deputy Assistant Director for Federal Employees Insurance Operations, OPM

Janet L. Barnes
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Chief, Audit Resolution, OPM

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President, Federal Plans, Aetna

Response to Draft Report dated January 28, 2016

**Audit of Aetna Open Access – Northern New Jersey
Blue Bell, Pennsylvania**

Report No. 1C-JR-00-15-046

I. Introduction/Executive Summary

Aetna submits the following comments to the above mentioned draft report (“Draft Report”) issued by the Office of Personnel Management (“OPM”) Office of Inspector General (“OIG”) under the Federal Employees Health Benefits Program (“FEHBP”). The audit covered the FEHBP contract for the Aetna Open Access – Northern New Jersey Plan Code JR, (hereinafter, the “Plan”) for the contract years 2012 and 2013 Medical Loss Ratio (“MLR”) program.

The Draft Report cites three specific findings in the MLR calculation that were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM. The Plan agrees with the Draft Report’s findings on the medical and pharmacy claims not allowed by the FEHBP.

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The Plan respectfully disagrees with the Draft Report’s recommendation to calculate the premium ratio used to allocate non-income related taxes, regulatory fees, quality health improvement expenses, and fraud reduction expenses with Direct Premiums Earned. The Plan’s usage of the Direct Premiums Written produces the most accurate results, which is explained in detail in this response.

The Plan also respectfully disagrees with the finding pertaining to the tax allocation methodology. Specifically, the Plan disagrees with the OIG’s use of the premium ratio allocation method to determine the FEHBP’s portion of federal income tax. The federal MLR regulations at 45 C.F.R. §158.170 require that the tax allocation method be based upon a generally accepted accounting method (“GAAM”) that is expected to yield the most accurate results. The Plan believes its calculation is correct and meets the standards set under a GAAM and therefore satisfies the requirements of 45 C.F.R. § 158.170. In this response, the Plan demonstrates through a detailed explanation that the method the Plan used to allocate Federal income tax provides the most accurate results, and is consistent with the method used to calculate the Department of Health and Human Services (“HHS”) MLR filings.

II. Medical Loss Ratio Background

The Affordable Care Act (“ACA”) passed in 2010 included a requirement that a minimum amount of premiums collected by health insurance carriers must be spent on medical benefits. This requirement became known as the MLR and requires health insurance carriers to meet a predetermined threshold for the percentage of premium that is spent on medical benefits. Failure to meet the threshold requires a rebate of premium to policyholders.

The MLR is calculated as total claims paid divided by premiums. However, the ACA allows for certain adjustments to both the claim and premium numbers in the ratio. Claims include medical benefits paid on behalf of members and are adjusted by the cost of health care quality improvement activities (“QIA”). Premiums include premium revenue from members and plan sponsors and are adjusted by federal and state taxes, and licensing and regulatory fees.

In 2012, OPM adopted an MLR requirement for the FEHBP on a pilot basis and the Plan elected to participate in the pilot. *See* 77 Fed. Reg. 19522 (April 2, 2012). OPM published MLR regulations and other guidance that generally adopts the HHS MLR guidelines in addition to a few requirements specific to the FEHBP MLR program.

III. Tax Allocations and Generally Accepted Accounting Method

a. Background

The amount of federal taxes to be used as an adjustment to premiums is the amount allocated to health insurance coverage reported on the MLR form. A health insurer pays federal taxes on all of its business net income on a combined basis. Consequently, the amount of federal income tax related to health insurance coverage reported on the MLR form must be allocated. The ACA did not include specific rules for calculating MLR. Rather, HHS was directed to establish detailed rules by regulation. HHS promulgated regulations in 2010 and 2011 that contain detailed rules, including the method to allocate expenses in the MLR calculation. 75 Fed. Reg. 74864 (Dec. 1, 2010) as amended by 76 Fed. Reg. 76574 (Dec. 7, 2011).

The applicable regulation states in part, “[a]llocation to each category should be based on a generally accepted accounting method that is expected to yield the most accurate results.” and “[a]ny basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios or similar analyses.” (see 45 C.F.R. §§ 158.170(b)(1) and (3)).

b. Aetna Open Access-Northern New Jersey Non-Income related taxes, regulatory fees, quality health improvement expenses, and fraud reduction Expense Allocations

The Plan allocated non-income related taxes, regulatory fees, quality health improvement expenses, and fraud reduction expenses applicable to the FEHBP filing using a premium ratio allocation method. The premium ratio is calculated by taking OPM premium for the plan divided by the HHS large group Direct Premiums Written (HHS Part 2 line 1.1 on a date of service basis). The Draft Report contends, “The Plan’s use of “Direct Premiums Written” in determining the large group premium ratio does not produce the most accurate results. Instead, “Direct Premiums Earned” should be the basis for the allocation since it more accurately represents the premiums earned by the Plan.” The Plan disagrees with the draft audit report.

The FEHBP MLR Rules instruct plans to refer back to the HHS rules when they do not provide specific instructions for components of the MLR filing, as is the case with expense allocation. The Plan allocates expenses on the HHS filing using a direct written premium ratio and applied a consistent approach to the FEHBP MLR filing. The use of the direct written premium allocation is explicit in the HHS filing expense narrative. Allocating the FEHBP expenses on a direct premium earned basis would result in allocating the expenses on a different basis than the expenses that are derived in the large group on the HHS filing. Calculating the premium ratio allocation using direct premiums earned for the FEHBP would be in direct contrast to the HHS expense allocation method and in contrast with the FEHBP instructions that refer us back to using the HHS filing.

In 2013, Aetna began to report date of service (DOS) premium on the HHS filing as direct written premium (HHS Part 2 line 1.1). As 2013 is a transition year, the HHS form will include the prior year (2012)'s unearned premium reported. However, beginning in 2014, the use of DOS premium will eliminate the need to report unearned premium adjustments. In addition, the Plan uses OPM's subscription premium in their FEHBP-specific MLR calculation. The subscription premium represents what is truly due for the proper calendar year (e.g. 2014). When calculating the subscription premium, any amounts paid in 2014 for calendar year 2013 is removed and any amounts that will be paid in 2015 for 2014 are included. This calculation provided by OPM is consistent with the Plan's DOS direct written premium reflected on the HHS filings beginning in 2013. Therefore, the use of the HHS DOS direct written premium will already be on an earned basis consistent with the OPM premium and will not need any further adjustments. Thus, the Plan asserts that the appropriate basis for the expense allocation is direct premiums written.

Also, direct earned premium requires a calculation to capture unearned premium adjustments in the total, whereas direct written premium is tied directly to the HHS filing (part 2, line 1.1) and is less prone to error.

In order to remain consistent with the HHS filing and the OPM subscription premium in the FEHBP MLR calculation, the Plan asserts that the appropriate method for calculating the expense allocation is to apply direct premiums written to the premium ratio.

c. Aetna Open Access-Northern New Jersey Income Tax Allocations

The Plan adopted a method to allocate federal income tax that is based upon the net income or loss generated by the "reporting unit." With respect to the HHS MLR filing, the "reporting unit" is the MLR segment and contract situs or location ("MLR Pool") as outlined in the HHS filing form. For the FEHBP MLR filing, the "reporting unit" is the Plan Code that is included in the FEHBP MLR filing form. With respect to federal income tax returns, the "reporting unit" is the legal entity.

Allocated income tax can be either an expense or a refund depending on whether a reporting unit experiences net income or loss. For the HHS and FEHBP MLR tax allocations, Aetna allocates income tax expense to reporting units with net income and an income tax refund to reporting units with a net loss. This allocation is consistent with Generally Accepted Accounting Principles (“GAAP”) as promulgated by the Financial Accounting Standards Board and with Statutory Accounting Principles (“SAP”) as promulgated by the National Association of Insurance Commissioners. In fact, the MLR calculation for income taxes instructs the use of SAP as the accounting standard for such taxes.

The income tax allocation method that the Plan uses for the FEHBP MLR reporting and HHS MLR reporting is consistent with the United States (“US”) accounting principles explained above. The only difference between the Plan’s HHS MLR reporting and FEHBP MLR reporting is that the HHS form includes all the MLR Pools in a legal entity. The FEHBP MLR form includes only the reported Plan Code activity and that Plan Code may include more than one legal entity. Therefore, the Plan allocates general and administrative expenses along with the Plan Code’s premiums and incurred claims in order to determine the net income or loss from the Plan Code. The final step is the allocation of income tax expense or refund to the Plan Code using the tax rate applicable to the net income or loss in the Plan’s income tax returns.

Unlike income taxes, non-income taxes, such as employment taxes and QIA expenses, are not based on income. Therefore, these specific items are allocated based on the premium ratio allocation method used by the Plan, with which the Draft Report agrees.

IV. OIG Tax Allocation Audit Findings

The Draft Report contains a preliminary finding that the Plan did not use a fair and equitable allocation method to determine the portion of Federal income taxes attributed to the FEHBP. According to the Draft Report, the premium ratio allocation method that the Plan used for non-income tax expenses and QIA is also the appropriate method for income tax expense.

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The Plan respectfully disagrees that the premium ratio allocation method is an appropriate method to allocate income taxes as there is no conceptual basis in applicable US accounting standards for income taxes to be determined based solely on premium. It is net income or loss that generates income tax expense and refunds under US tax laws and regulations, as well as US accounting principles. Relying solely on premiums produces inaccurate results as this method ignores a fundamental accounting principle that income taxes are determined on net income or loss.

a. Aetna Open Access FEHBP Tax Allocation not proportionate, appropriate or a GAAM

The Draft Report states, “the Plan’s above described method used to allocate the Federal income taxes to the FEHBP is not applied proportionately, appropriately, and is not based on a generally accepted accounting method.”

As discussed previously in this response, the Plan asserts that with respect to allocating income taxes, a GAAM must account for income net of expenses (i.e., net income or loss) in order to be appropriate and yield an accurate result. The Plan’s tax allocation method is appropriate as Plan Codes reporting net loss are allocated a proportionate income tax refund and Plan Codes reporting net income are allocated a proportionate income tax expense.

This allocation method is consistent with the HHS MLR tax allocations that allocate a proportionate income tax refund to MLR Pools reporting net losses and income tax expense to MLR Pools reporting net income.

The Plan’s income tax allocation method is a GAAM and conforms with GAAP and SAP accounting principles that produce income tax expense for reporting units with net income and income tax refund for reporting units with net losses.

b. Aetna Open Access FEHBP Tax Allocation treats FEHBP Plan Code as a legal entity

The Draft Report states, “it is not suitable to treat the FEHBP as if it were its own entity since expenses are not tracked at the group level and the method is not related to actual expenses incurred. A more appropriate method, which the Plan used for several other expenses in its MLR calculation as stated above, is the premium ratio allocation method.”

The Plan did not treat the Plan Code as if it were its own legal entity. Rather, the Plan simply computed the net income or loss attributable to the Plan Code, as that is the reporting unit required to file the FEHBP MLR form. This computation included the actual premiums and claims associated with the Plan Code and associated expenses allocated to the Plan Code.

1. Allocation of expenses to determine Plan’s net income or loss.

The Plan applied the following premium ratio to allocate non-income tax expenses and other non-tax expenses to determine the Plan’s net income or loss:

$$\frac{\text{Aetna Open Access Plan Code Premium}}{\text{Legal Entity Premium for all HHS Large Group Pools}}$$

Since the Plan Code was included in the HHS Large Group pools, this ratio is a GAAM that yields the most accurate allocation of non-income tax expenses and other non-tax expenses such as QIA.

With respect to the FEHBP, this allocation was used only for those expenses that are applicable to the FEHBP business. For instance, the Plan's expense allocation specifically excluded state premium tax expense and broker commissions since FEHBP premiums are exempt from state premium tax and the FEHBP does not use brokers.

2. Income tax expense or refund allocated based on net income

As discussed above, income tax expense or refunds are fundamentally different from non-income tax or other non-tax expenses because they are based upon the net income or loss of the reporting unit. Therefore, it is necessary to determine net income or loss in order to appropriately allocate income taxes to the Plan Code.

The Plan's method to allocate income tax expense or refund applies the non-income tax and non-tax expense allocation method discussed in the section above to determine the net income or loss from the Plan Code and then uses this result to allocate income tax expense or refund to the Plan Code. This is not an attempt to treat the Plan Code as if it were its own legal entity, but necessary to determine the appropriate income tax expense or refund to allocate to the Plan Code.

The Plan does not allocate income tax expense or refund on the HHS MLR filings using a premium ratio used for non-income taxes because a premium ratio would not be a GAAM that yields the most accurate result. The same method is necessary for the FEHBP MLR filing; the income tax allocation method must be different from the allocation method for non-income tax and other non-tax expenses in order to be a GAAM. If a premium ratio is used to allocate income tax, the same amount of income tax would be allocated to two Plan Codes with the same premium income even though one incurred significantly higher claims. Please reference the examples in the Plan's response to the Draft Report of Aetna HealthFund, Report No. 1C-22-00-14-071. Example 1 in this report illustrates how two hypothetical plan codes (Ohio and Texas) are allocated the same income tax expense under this method even though they incurred higher claims. That result is inconsistent with US accounting principles and is not the most accurate allocation method as required by the HHS MLR regulations.

V. Aetna Open Access Income Tax Allocation Method

The Plan's method to allocate income tax expense or refund is based upon the net income or loss associated with the Plan Code for the year. The Plan Code's income tax allocation is the final allocation performed after calculating the Plan Code's net income. All applicable expenses other than income taxes are allocated to the Plan Code using a gross premium percentage ratio that is calculated by dividing the Plan Code's premium by the premium for all large group pools. The Plan Code's claims and these allocated expenses are deducted from the Plan Code's gross premium to generate the net income or loss per Plan Code. Then the income tax is allocated by multiplying the Plan Code net income or loss by the applicable tax rate. This produces an income tax

expense for Plan Codes that generate net income or an income tax refund for Plan Codes that generate net losses.

The Draft Report method differs from the Plan's method in that it utilizes the gross premium ratio, used to allocate expenses other than income tax, to allocate the total income tax expense or refund for all large group pools. This method does not account for the fact that some Plan Codes generate net income and others generate a net loss.

Please reference the examples in the Plan's response to the Draft Report of Aetna HealthFund, Report No. 1C-22-00-14-071, which demonstrate why the Plan's method is proportionate, consistent and accurate. These standards establish that the Plan's method is a GAAM that yields the most accurate results.

VI. Aetna's Response to Other OIG Findings

Medical and Pharmacy Claims Paid on Ineligible Members – The Plan agrees with the Draft Report's finding of \$ [REDACTED] and has applied this adjustment to the updated MLR calculation at the end of this response. The Plan is currently working with OIG and OPM to implement an appropriate action plan to address this finding going forward.

Inappropriate Eyeglasses Allowance Applied – The Plan agrees with the Draft Report's findings of \$200 and has applied this adjustment to the updated MLR calculation at the end of this response. The Plan intends to provide refresher training instructions via a memorandum for claims processors to address this mistake going forward.

Gender Specific Claims Paid on Ineligible Members – The plan agrees with the Draft Report's findings of \$ [REDACTED] and has applied this adjustment to the updated MLR calculation at the end of this response. The Plan intends to provide refresher training instructions via a memorandum for claims processors to address this mistake going forward.

Non-Covered Benefits – The plan agrees with the Draft Report's findings of \$ [REDACTED] and has applied this adjustment to the updated MLR calculation at the end of this response. The Plan intends to provide refresher training instructions via a memorandum for claims processors to address this mistake going forward.

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VII. Conclusion

As explained above and demonstrated in the examples referenced, the Plan's income tax allocation method is a GAAM that yields the most accurate result. That is, the Plan's method produces consistent results when the Plan Code results are the same, and is not impacted by changes resulting from other activity occurring within the legal entity. An

allocation method that produces a different result when the activity of other business or Plan Codes change cannot be considered a GAAM that yields the most accurate result.

The Plan has updated the MLR calculation to account for all adjustments made during the onsite portion of the audit and to remove the \$ [REDACTED] in ineligible medical and pharmacy claims. The updated MLR calculation results in the Plan meeting the 85.0% MLR threshold, and therefore no penalty is owed to the FEHBP for 2012 or 2013.



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