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

Final Audit Report

Audit of the Mail Handlers Benefit Plan's Pharmacy Operations as Administered by CaremarkPCS Health, L.L.C. for Contract Years 2012 through 2014

Report Number 1H-01-00-16-044
October 2, 2017

EXECUTIVE SUMMARY

Audit of the Mail Handlers Benefit Plan's Pharmacy Operations As Administered by CaremarkPCS Health, L.L.C.

Report No. 1H 01-00-16-044 **October 2, 2017**

Why Did We Conduct the Audit?

The objective of the audit was to determine whether costs charged to the Federal Employees Health Benefits Program (FEHBP) and services provided to its members were in accordance with the U.S. Office of Personnel Management Contract Number CS 1146 and applicable Federal regulations.

What Did We Audit?

The Office of the Inspector General has completed a performance audit of the Mail Handlers Benefit Plan's (Plan) Pharmacy Operations as Administered by CaremarkPCS Health, L.L.C. (PBM). Our audit consisted of a review of the administrative fees, fraud and abuse program, performance guarantees, pharmacy claims eligibility and pricing, and manufacturer rebates as they relate to the FEHBP for contract years 2012 through 2014. Our site visit was conducted from August 8 through August 12, 2016, at the PBM's office in Scottsdale, Arizona. Additional audit work was completed at our office in Cranberry Township, Pennsylvania.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

We did not find any deficiencies during our review of the administrative fees, fraud and abuse program, performance guarantees and manufacturer rebates. However, we determined that the Plan needs to strengthen its procedures and controls related to dependent eligibility during our review of claim payments.

Specifically, our audit identified the following deficiency that requires corrective action:

1. The Plan paid $1,562,397 in pharmacy claims for 302 dependents age 26 or older whose eligibility to participate in the FEHBP could not be supported.

ABBREVIATIONS

5 CFR 890	**Title 5, Code of Federal Regulations, Chapter 1, Part 890**
Act	**Federal Employees Health Benefits Act**
Agreement	**The Managed Prescription Drug Program Agreement between the Mail Handlers Benefit Plan and CaremarkPCS Health, L.L.C**
Contract	**OPM Contract Number CS 1146**
CY	**Contract Year**
FEHBP	**Federal Employees Health Benefits Program**
FOIA	**Freedom of Information Act**
HIO	**Healthcare and Insurance Office**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
PBM	**CaremarkPCS Health, L.L.C.**
Plan	**Mail Handlers Benefit Plan**

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I. BACKGROUND

This report details the results of our audit of the Mail Handlers Benefit Plan's (Plan) pharmacy operations as administered by CaremarkPCS Health, L.L.C (PBM) for contract years (CY) 2012 through 2014. The audit was conducted pursuant to the provisions of Contract CS 1146 (Contract) between the U.S. Office of Personnel Management (OPM) and the Plan; the Managed Prescription Drug Program Agreement between the Plan and the PBM (Agreement); Title 5, United States Code, Chapter 89; and Title 5, Code of Federal Regulations, Chapter 1, Part 890 (5 CFR 890). The audit was performed by OPM's Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

The Federal Employees Health Benefits Program (FEHBP) was established by the Federal Employees Health Benefits Act (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. OPM's Healthcare and Insurance Office (HIO) has overall responsibility for administration of the FEHBP, including the publication of program regulations and agency guidance. As part of its administrative responsibilities, the HIO contracts with various health insurance carriers that provide service benefits, indemnity benefits, and/or comprehensive medical services. The provisions of the Act are implemented by OPM through regulations codified in 5 CFR 890.

Pharmacy Benefit Managers are primarily responsible for processing and paying prescription drug claims. The services provided typically include retail pharmacy, mail order, and specialty drug benefits. For drugs acquired through retail, the PBM contracts directly with the approximately 50,000 retail pharmacies located throughout the United States. For maintenance prescriptions that typically do not need to be filled immediately, the PBM offers the option of mail order pharmacies. The PBM also provides specialty pharmacy services for members with rare and/or chronic medical conditions. Pharmacy Benefit Managers are used to develop, allocate, and control costs related to the pharmacy claims program.

The Plan contracted with the PBM, located in Scottsdale, Arizona, to provide pharmacy benefits and services to its members for CYs 2012 through 2014. Section 1.11 of the Contract includes a provision which allows for audits of the program's operations. Additionally, section 1.26(a) of the Contract outlines transparency standards that require the PBM to provide pass-through pricing based on its cost. Our responsibility is to review the performance of the PBM to determine if the Plan charged costs to the FEHBP and provided services to its members in accordance with the Contract, the Agreement, and the Federal regulations.

Our previous audit of the Plan (Report No. 1B-45-00-12-017), dated December 13, 2012, identified one procedural finding related to fraud and abuse reporting. Specifically, the Plan's 2009 annual fraud and abuse report was missing a cost and benefit analysis of the Plan's fraud and abuse program, and it did not include the number of cases referred to OPM/OIG. The finding was closed by OPM on January 9, 2013, after the contracting office reaffirmed the Plan's commitment to adhering to all requirements found in section 1.9 of the Contract. No other leads were identified from the previous audit.

The results of our audit were discussed with officials of the Plan and the PBM at an exit conference on February 21, 2017. In addition, a draft report, dated May 18, 2017, was provided to the Plan and PBM for review and comment. The Plan's response to the draft report was considered in preparing the final report and is included as an Appendix.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The main objective of the audit was to determine whether the costs charged to the FEHBP and services provided to its members were in accordance with the terms of the Contract, the Agreement, and applicable Federal regulations.

Our specific audit objectives were to determine if:

Administrative Fees Review

- The Plan paid the PBM administrative fees in accordance with their Agreement and if the fees were properly documented.

Fraud and Abuse Program Review

- The Plan and the PBM complied with the requirements of the fraud, waste, and abuse Carrier Letter 2014-29 and if potential fraud cases were being reported to OPM.

Performance Guarantees Review

- The PBM's performance reports and any associated penalties were properly calculated and submitted timely.

Claim Payment Review

- Claims were paid for ineligible dependents age 26 and older.
- Claims were paid for excluded drugs.
- Claims were paid for deceased members.
- Claims were paid for non-FEHBP members or members enrolled in an alternate plan code.
- Mail order claims were paid for supplies beyond the allowable maximum days.
- Claims were paid to debarred pharmacies.
- Claims were paid with a zero quantity filled.
- Claims were paid with an unusually high quantity.

- High dollar claims were paid incorrectly.

- The pricing elements for the retail, mail order, and specialty drug claims were transparent and paid correctly in accordance with the Agreement.

Manufacturer Rebates Review

- The FEHBP was credited the appropriate amount of drug manufacturer rebates in a timely manner.

SCOPE AND METHODOLOGY

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 and appropriate evidence to provide a reasonable basis for our finding and conclusion based on the audit objectives. We believe that the evidence obtained provides a reasonable basis for our finding and conclusion based on the audit objectives.

This performance audit included reviews of administrative fees, the fraud and abuse program, performance guarantees, claims payments, and manufacturer rebates related to the FEHBP for CYs 2012 through 2014. The audit fieldwork was conducted from November 16, 2016, through February 21, 2017, and was completed at our Cranberry Township, Pennsylvania office.

The Plan is responsible for providing FEHBP members with medical and prescription drug benefits. To meet this responsibility, the Plan collected premium payments of approximately $4.5 billion in CYs 2012 through 2014, of which approximately two-thirds was paid by the government on behalf of Federal employees. Total pharmacy claims paid were approximately $1 billion in CYs 2012 through 2014 (See below).

Contract Year	Earned Premiums	Total Claims	Claims Paid
2012	$1,585,861,974	[redacted]	[redacted]
2013	$1,500,908,108	[redacted]	[redacted]
2014	$1,441,866,826	[redacted]	[redacted]
Total	**$4,528,636,908**	[redacted]	[redacted]

In planning and conducting the audit, we obtained an understanding of the Plan's internal control structure to help determine the nature, timing, and extent of our auditing procedures. This was determined to be the most effective approach to select areas of audit. For those areas selected,

we primarily relied on substantive tests of transactions and not tests of controls. Additionally, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Plan's system of internal controls taken as a whole.

We also conducted tests of accounting records and other auditing procedures as we considered necessary to determine compliance with the Contract, the Agreement and Federal regulations. Exceptions noted in the areas reviewed are set forth in the "Audit Findings and Recommendations" section of this report. With respect to the items not tested, nothing came to our attention that caused us to believe that the Plan had not complied, in all material respects, with those provisions.

In conducting the audit, we relied to varying degrees on computer-generated data provided by the Plan. Due to the time constraints, we did not verify the reliability of the data generated by the various information systems involved. However, while utilizing the computer-generated data during our audit, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

To determine whether costs charged to the FEHBP and services provided to its members for contract years 2012 through 2014 were in accordance with the terms of the Contract and applicable Federal regulations, we performed the following audit steps:

Administrative Fees Review

- For each CY, we reviewed the monthly administrative fee invoices and line items, to determine if the fees were properly calculated and supported in accordance with the terms of the Agreement between the Plan and the PBM.

Fraud and Abuse Program Review

- We reviewed all [redacted] potential fraud and abuse cases reported by the PBM to the Plan to determine if those cases were reported to OPM.

- We reviewed the Plan's policies and procedures for fraud and abuse to ensure that they comply with OPM's standards.

Performance Guarantees Review

- For each CY, we reviewed all performance guarantees to determine if the guarantees were met, reported accurately, and that any associated penalties were paid to the Plan timely.

Claim Payment Review

Unless stated otherwise, the claim samples below were selected from the complete claims universe of [redacted] claims, totaling $[redacted], for CYs 2012 through 2014.

- We identified and reviewed all [redacted] dependents, 26 years of age or older, to determine if the members were eligible for coverage due to a disability and incapable of self-support.

- We identified and reviewed all [redacted] National Drug Codes that the Plan had for non-covered drugs to determine if any claims were paid for excluded drugs.

- We judgmentally selected the 50 oldest members with paid claims from the most recent CY (2014) to determine if any of those members were deceased and if they had a claim paid after their date of death.

- We reviewed all claims to determine if any were paid for non-FEHBP members or members enrolled in another FEHBP plan code.

- We reviewed all [redacted] claims with a day supply greater than 90 days to determine if the claims were allowable and properly paid.

- Using National Provider Identifiers, we reviewed all claims to determine if any payments were made to pharmacies debarred by the OIG's Administrative Sanctions Office.

- We reviewed all claims to ensure that none were paid with a zero quantity dispensed.

- We judgmentally selected and reviewed the top 150 claims (totaling $477,128) with the highest quantity filled to determine if the claims were allowable and properly paid.

- We judgmentally selected and reviewed 60 claims (totaling approximately $3.1 million) with the highest dollar amounts paid to determine if the claims were allowable and properly paid.

- We identified a universe of [redacted] retail pharmacy claims totaling approximately $[redacted] for the top 5 retail pharmacies. From this universe, we randomly selected 25 brand and 25 generic claims for each CY (150 claims totaling $13,236) to determine if the pricing elements were transparent and if the claims were paid correctly.

- We identified a universe of [redacted] specialty pharmacy claims, totaling approximately $[redacted]. From this universe, we randomly selected 25 claims from each CY (75 claims totaling $[redacted]) to determine if the pricing elements were transparent and if the claims were paid correctly.

- We identified a universe of [redacted] mail order pharmacy claims totaling approximately $[redacted]. From this universe, we randomly selected 15 brand and 15 generic claims from each CY (90 claims totaling $[redacted]) to determine if the pricing elements were transparent and if the claims were paid correctly.

Manufacturer Rebates Review

- We identified a universe of approximately $[redacted] in drug manufacturer rebates. From this universe, we judgmentally selected one manufacturer from 2013 (the middle of our audit scope) that had the largest variance in drug rebates from one quarter to the next. We then reviewed all rebates from this drug manufacturer for all of 2013 (totaling $[redacted]) to determine if the rebates were properly supported, accurately calculated, and remitted to the Plan.

The samples that were selected and reviewed in performing the audit were not statistically based. Consequently, the results could not be projected to the universe since it is unlikely that the results are representative of the universe taken as a whole.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. Administrative Fees Review

The results of our review showed that the Plan paid the correct administrative fees to the PBM in accordance with their agreement.

B. Fraud and Abuse Program Review

The results of our review showed that the Plan and the PBM had sufficient policies and procedures in place to help prevent fraud, waste, and abuse.

C. Performance Guarantees Review

The results of our review showed that the PBM complied with the performance guarantees and penalties outlined in its agreement with the Plan.

D. Claims Payment Review

The results of our pricing review showed that the PBM complied with the pricing transparency standards and had sufficient policies and procedures in place to accurately price the retail, mail order, and specialty claims.

The results of our eligibility review showed that the Plan and the PBM had sufficient policies and procedures in place to accurately determine eligibility in its pharmacy operations, with the exception of the following:

1. Overage Dependents $1,562,397

The Plan paid $1,562,397 in pharmacy claims for 302 dependents age 26 or older whose eligibility to participate in the FEHBP could not be supported.

Title 5, Code of Federal Regulations, Section 890.302 allows dependent children under the age of 26 and dependents age 26 or older who are incapable of self-support due to a disability which existed before age 26, to be covered by the enrollment of a Federal employee or annuitant in the FEHBP. The regulation also requires certification from a physician and a decision by the Federal employment office showing that the dependent is incapable of self-

support due to a disability in order for the Plan to continue providing coverage to that member beyond their 26th birthday.

We found 302 dependents age 26 or older whose eligibility to participate in the FEHBP was unsupported.

Section 3.8 of the Contract, Contractor Records Retention, requires the Plan to maintain documentation that supports costs for a period of six years after the end of the contract term for which the records relate.

We reviewed the pharmacy claims paid for 2012 through 2014 to determine if any dependents remained enrolled in the FEHBP beyond their 26th birthday. Our review showed that the Plan paid claims for [redacted] dependents age 26 and older. Sufficient support was provided for [redacted] of the [redacted] dependents that showed the members were eligible for coverage in the FEHBP. However, the Plan was unable to provide evidence to support that the remaining 302 dependents were eligible for FEHBP coverage beyond their 26th birthday because the disability certification was not maintained or the member was not removed from the FEHBP timely.

Without adequate controls in place to terminate ineligible dependents at age 26, or to maintain the necessary documentation to show dependent eligibility beyond age 26, there is a significant risk of overcharges to the FEHBP.

Recommendation 1

We recommend that the Plan provide evidence to support that the 302 dependents were eligible to remain enrolled in the FEHBP due to a disability and incapable of self-support, or return $1,562,397 to the program.

Recommendation 2

We recommend that the Plan review its system controls for terminating dependents upon turning age 26 to ensure that ineligible members are not enrolled in the FEHBP.

Recommendation 3

We recommend that the Plan maintain proof of dependent eligibility for a period of six years after claims are paid in accordance with its records retention clause. This means it should maintain evidence to support the eligibility for disabled dependents for up to six years after they are no longer enrolled in the FEHBP.

Plan Response:

*The Plan agrees that we need to verify the eligibility of these members, but it disagreed with our assessment that inadequate internal controls resulted in a significant risk of FEHBP overcharges. The following information was provided (**See Appendix for full response**):*

- [redacted] *of the members in question were properly terminated 31 days after their 26th birthday.*

- *Aetna's predecessor, Coventry, accidently disposed of the eligibility documentation, but Aetna is maintaining the documentation going forward.*

- *Aetna has been working with the OIG, OPM, and the payroll offices to verify eligibility.*

- *More than 60 percent of the members in question had a disabled status in Aetna's system prior to the year 2000 and two thirds of that group had a disability status in Aetna's system prior to 1990, meaning these members have been enrolled for a significantly long time and likely would have found work where they can obtain insurance instead of defrauding the Federal government. The Plan also finds it highly unlikely that the dependent's parents would collaborate with their child this long while committing fraud, so the Plan's logical explanation is that these members are incapable of self-support due to a disability.*

- *Aetna's own investigation into this matter showed that most of the members in question had a past medical code showing a behavioral health condition, such as* [redacted] *had cerebral palsy,* [redacted] *had epilepsy or seizure disorders,* [redacted] *had schizophrenia/paranoia/manic or neurotic depression,* [redacted] *had paraplegia/quadriplegia or other paralysis,* [redacted] *had Down's syndrome,* [redacted] *had severe intellectual or mental defect, and* [redacted] *had infantile autism.*

OIG Comment:

We respect the fact the Plan is working diligently to verify the eligibility of the remaining 302 members in question, but we are unable to verify that the Plan's internal controls are properly terminating dependents at age 26 for the following reasons:

- The [redacted] dependents that the Plan reported as never being disabled, but were terminated timely, is inaccurate. Our evidence shows that these [redacted] dependents had claims paid beyond 31 days after their 26th birthday. While we agree that the Plan has some type of control in place to terminate dependents 31 days after their 26th birthday, our evidence shows that these non-disabled members had claims paid after

they should have been terminated. Therefore, the controls the Plan has in place are not sufficient in properly terminating all dependents at age 26 (+31 day grace period).

- The Plan admitted that its predecessor, Coventry, failed to properly maintain documentation when it inadvertently disposed of the eligibility information. Even if the Plan is maintaining documentation going forward, we still have 302 dependents over the age of 26 whose eligibility to participate in the FEHBP cannot be supported. We would like to see Aetna's policies and procedures for maintaining documentation for disabled dependents in order to resolve recommendation three.

- We agree that the Plan has been diligently working with the OIG, OPM, and the payroll offices to verify eligibility for the members in question and we hope that all remaining unsupported dependents can be verified, especially since the number of dependents over age 26 is significantly higher than any other similarly sized group that we have audited.

- The Plan's statement that a large number of these unsupported members were labeled as disabled dependents in its system prior to 2000 and 1990, clearly shows the risk that the OIG has identified of potential significant overcharges to the FEHBP. The amount of time that these individuals have remained enrolled in the Plan beyond age 26 without supporting documentation, in no way means that they are disabled or eligible for coverage. Instead, our audit has shown that the large number of unsupported dependents over the age of 26 is likely due to insufficient controls where the member wasn't terminated timely after reaching the maximum age for FEHBP coverage or after being granted an extension of coverage for a short-term disability.

- In response to the Plan providing the past medical history for the members in question, we agree that over [redacted] members had an existing condition that qualifies them for FEHBP coverage beyond their 26th birthday (cerebral palsy). Unfortunately, the majority of the other members did not have a disease or condition that OPM allows for continued FEHBP coverage. We already removed the [redacted] members with cerebral palsy from the finding, and we also removed all members that OPM's Retirement Services verified as being disabled and incapable of self-support. OPM's Retirement Services worked quickly to verify the eligibility of over [redacted] members in question and found that only a small portion of these members actual qualify for FEHBP coverage. The majority of the [redacted] members had no supporting documentation showing that they were allowed FEHBP coverage beyond their 26th birthday. Again, we have already reduced the number of dependents in question to reflect those whose eligibility was supported by either a covered disease, documentation properly

maintained by the Plan, or OPM's certification of a disability and being incapable of self-support. Our finding has been revised to reflect the 302 dependents who still need documentation to prove that they are eligible for FEHBP coverage. The questioned costs of $1,562,397 should be returned to the FEHBP unless documentation can be obtained to show that the members are eligible for coverage.

E. Manufacturer Rebates Review

The results of our review showed that the PBM invoiced, collected, and returned all rebates due to the carrier under the manufacturer drug rebates agreements and in accordance with the contract and regulations.

APPENDIX

aetna®
15400 Calhoun Drive, Suite 300
Rockville, MD 20855
Attn.: [redacted]

June 23, 2017

[redacted], Group Chief
Special Audit Group
U.S. Office of Personnel Management
Office of Inspector General
1900 E Street, NW, Room 6400
Washington, DC 20415-1100

RE: OPM OIG DRAFT AUDIT REPORT NO. 1H-01-00-16-044
Audit of the Mail Handlers Benefit Plan's Pharmacy Operations as **ADMINISTERED BY CAREMARK PCS HEALTH, LLC**
FOR CONTRACT YEARS 2012-2014

Dear [redacted]:

Attached please find the response of Aetna management to U.S. Office of Personnel Management Office of Inspector General Draft Audit Report No. 1H-01-00-16-0144, Audit of the Mail Handlers Benefit Plan's Pharmacy Operations as Administered by CaremarkPCS Health, LLC, for Contract Years 2012-2014. Aetna looks forward to discussing the contents of this response at your convenience, and to this audit's prompt and mutually satisfactory resolution. Please contact me if you have any questions or require additional information regarding this response before its issuance in final form.

Sincerely,

[redacted], Federal Government Relations
Aetna Federal Plans

Enclosures

cc: [redacted], Executive Director, MHBP
[redacted], OPM Contracting Officer

Aetna Management Response to
OPM OIG Draft Audit Report No. 16-044

June 23, 2017

D. Pharmacy Claims Eligibility and Pricing Review

1. Overage Dependents ***$2,636,859***

The Plan paid $2,636,859 **(after receiving additional support from OPM, the OIG reduced the questioned costs to $1,562,397 for the final report)** *in pharmacy claims for* [redacted] **(after receiving additional support from OPM, the OIG reduced the number of ineligible dependents to 302 for the final report)** *dependents age 26 or older whose eligibility to participate in the Federal Employees Health Benefit Program (FEHBP) could not be supported.*

Title 5, Code of Federal Regulations, Section 890.302 allows dependent children under the age of 26 and dependents age 26 or older who are incapable of self-support due to a disability to be covered by the enrollment of a Federal employee or annuitant in the FEHBP. The regulation also requires certification from a physician and a decision by the Federal employment office showing that the dependent is incapable of self-support due to a disability in order for the Plan to continue providing coverage to that member beyond their 26th birthday.

Section 3.8 of the Contract, Contractor Records Retention, requires the Plan to maintain documentation that supports costs for a period of six years after the end of the contract term for which the records relate.

We reviewed the pharmacy claims for 2012 through 2014 to determine if any dependents remain enrolled in the FEHBP beyond their 26th birthday. Our review showed that the Plan paid claims for [redacted] *dependents ago 26 and older. The Plan provided sufficient support for* [redacted] *of the* [redacted] *dependents that showed the members were eligible for coverage in the FEHBP. However, the Plan was unable to provide evidence to support that the remaining* [redacted] *dependents were eligible for FEHBP coverage beyond their 26th birthday because the disability certification was not maintained or the member was not removed from the FEHBP timely.*

Without adequate controls in place to terminate ineligible dependents at age 26, or to maintain the necessary documentation to show dependent eligibility beyond age 26, there is a significant risk of overcharges to the FEHBP.

Recommendation 1

We recommend that the Plan provide evidence to support that the [redacted] dependents were eligible to remain enrolled in the FEHBP due to a disability and incapable of self-support, or return $2,636,859 to the program.

Aetna Response: In Section I.D.1 of the above-referenced Draft Audit Report ("Draft Report"), the OIG asserts that the MHBP paid $2,636,859 in benefits on 2012-2014 pharmacy claims "for [redacted] dependents age 26 or older whose eligibility [for coverage] could not be supported" because Aetna, as MHBP administrator, was unable to provide documentation showing that those individuals either (1) qualified for FEHBP coverage beyond age 26 as an unmarried dependent child incapable of self-support due to a previously-existing mental or physical disability, *see* 5 U.S.C. § 8901(5), 5 C.F.R. §890.30(c)-(e) (hereinafter referred to as "disabled dependents"); or (2) "w[ere] removed from the FEHBP timely." The OIG further asserts that "without adequate controls in place" for the MHBP to demonstrate these things, there is "a significant risk of [benefit] overcharges to the FEHBP."

As explained below, the OIG's characterization of this issue is incomplete in several material respects and inaccurate in others, and the conclusion it draws from that characterization – namely, that "[in]adequate controls" resulted in "a significant risk of [benefit] overcharges" to the FEHBP during the period audited – unwarranted. For example, Section I.D.1 of the Draft Report states that the OIG "reviewed pharmacy claims paid for 2012 through 2014 … [and determined] … that the Plan paid claims for [redacted] dependents age 26 or older." Included among these [redacted] individuals that Recommendation 1 refers to, however, are some [redacted] who turned age 26 *during* the 2012-2014 audit period and never had MHBP coverage as disabled dependents; the materials Aetna furnished the OIG auditors indicates that Aetna systematically terminated each one of those persons' coverage on the 31st day following their 26th birthday as 5 C.F.R. §§ 890.304(c)(1), 890.401, requires. Accordingly, any pharmacy benefits the MHBP issued for those individuals during the audit period necessarily were for charges incurred either prior to their 26th birthday or during the 31-day temporary extension of coverage period immediately thereafter, *i.e.*, while they properly were enrolled in the MHBP. On its face, then, and as further illustrated in the MHBP's response to Recommendation 2 below, the MHBP had (and continues to have) adequate controls in place to ensure the timely removal of dependent children who straightforwardly "age out" of eligibility for MHBP coverage.

Exclusive of that group of individuals, the MHBP's eligibility files reflect that every other one of the remaining [redacted] "overage dependents" to which the Draft Report refers is enrolled in the MHBP

as a disabled dependent.[1] To the extent the MHBP cannot produce a copy of the underlying agency payroll office documentation substantiating disabled dependent status for these individuals, that inability is not attributable to inadequate internal controls. Rather, as Aetna advised the OIG auditors during the course of their field work, that inability stems from the fact that Aetna's predecessor as MHBP administrator, Coventry Health Care ("Coventry"), inadvertently disposed of much of that payroll office documentation in 2008, during the process of converting the MHBP onto the Coventry legacy claims payment and eligibility systems (known as "IDX") on which the MHBP continues to be administered today. At the same time that it advised the OIG of this, Aetna expressed its reservations about unduly alarming the individuals for whom it no longer possessed that documentation by contacting them (or their parent(s) or guardian) and asking them to "re-establish" that they satisfy the statutory and regulatory requirements for FEHBP disabled dependent coverage by submitting a treating physician's statement to that effect, except as a last resort. Instead, Aetna proposed the more conservative approach of seeking replacement copies of the original determinations of disabled dependent status from the agency payroll offices that had issued them. The OIG acquiesced in this suggested approach, and furnished Aetna with a letter on OIG letterhead to attach to those requests which it hoped would facilitate those efforts.

Regrettably, to date those efforts have garnered few payroll office responses, so more recently Aetna – again, with the OIG's help – has coordinated with OPM's Retirement Operations Division for its assistance in procuring replacement copies for approximately [redacted] of those disabled dependents. That effort remains ongoing, as does Aetna's continuing efforts to elicit replacement documentation from other agency payroll offices, and the MHBP greatly appreciates the OIG's cooperation and assistance in these endeavors. Admittedly, after these efforts are exhausted Aetna likely will have no alternative but to contact some of these disabled dependents and seek treating physicians' statements from them as described above; the goal of Aetna's approach, however, is to reduce that number as much as possible in order to minimize possible MHBP member disruption.

The fact that Aetna is unable to produce agency payroll office documentation corroborating that these members qualify for FEHBP coverage as disabled dependents, however, in no way dictates a conclusion that their classification as such in the MHBP's eligibility files is unwarranted or incorrect, much less a conclusion that significant FEHBP overcharges may have occurred or were at risk of occurring. To begin with, for more than sixty percent (60%) of that group, the effective date of their MHBP enrollment status as a disabled dependent occurred before January 1, 2000, and for more than two-thirds of that group, before January 1, 1990, even. In other words, some [redacted] MHBP disabled dependents for whom payroll office documentation is unavailable have a pre-

[1] Or was so enrolled for a portion of the 2012-2014 audit period. The information Aetna furnished the OIG auditors shows during that period several disabled dependents terminated their MHBP enrollment for reasons unrelated to age or disability, and one of them died. That information also shows a handful of instances where an individual classified as a disabled dependent was actually the MHBP enrollee's spouse.

1970s birthdate. Stated simply, it defies credulity that hundreds of middle-aged adults – many of whom, were they in fact not disabled and thus capable of gainful, self-supporting employment, presumably would be eligible for their own employer-sponsored health coverage – knowingly would choose instead to remain covered fraudulently, for decades, as dependents under their now-elderly parents' FEHBP coverage. It is exponentially even more unlikely that their now-elderly parents would have collaborated with them for decades in perpetrating that elaborate fraud.[2] Rather, the only logical explanation for these individuals' continuing FEHBP enrollment is the obvious one reflected in the MHBP's eligibility files: that they qualify for that coverage as dependents incapable of self-support due to a physical or mental disability already in existence on the date they otherwise would have lost their FEHBP eligibility due to age.

Aetna's own investigation of the claims histories for these individuals substantiates this common-sense conclusion. In that investigation, Aetna reviewed the recent claims histories of this population to ascertain the ICD-9 diagnosis codes that appeared with the greatest frequency on claims for payment submitted on their behalf. The results of that review, which Aetna shared with the OIG auditors, revealed that nearly every one of these individuals has a primary diagnosis of some type of severe congenital, accidental, or behavioral health condition that on its face alone plausibly might have justified a payroll office determination of disabled dependent status. By way of example, the ICD-9 codes that appear most frequently as the primary diagnosis for this population are, respectively: cerebral palsy (instances);[3] epilepsy/seizure disorder (instances); schizophrenia/paranoia/manic or neurotic depression (instances); paraplegia/quadriplegia/other paralysis (instances); Down's syndrome (instances); severe intellectual/mental defect (instances); and infantile autism (instances). Simply stated, Aetna's investigation affirms the above conclusion.

As MHBP administrator, Aetna understands and acknowledges its obligation to persist in its efforts to reconstruct (and thereafter to maintain) the enrollment documentation establishing these individuals' eligibility for FEHBP coverage beyond age 26, and thus agrees with this element of the OIG's Recommendation 1. For the reasons stated above, however, the MHBP disagrees with Recommendation 1 to the extent it suggests that inadequate internal controls resulted in a significant risk of FEHBP overcharges for these individuals.

Recommendation 2

We recommend that the Plan review its system controls for terminating dependents upon age 26 to ensure that ineligible members are not enrolled in the FEHBP.

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[2] Or, for that matter, that such a massive case of enrollment fraud would have escaped detection until this late date instead of being uncovered in a prior OIG (or internal) audit.

[3] The OIG since has accepted a diagnosis code of cerebral palsy as sufficient indicia of disabled dependent status for those individuals for whom the underlying payroll office documentation has not yet been obtained.

Aetna Response: As evidenced by Aetna's response to Recommendation 1 above, during the period audited (and continuing to this day), the IDX eligibility and claims adjudication system utilized to administer the MHBP systematically terminates dependents who otherwise do not qualify for FEHBP coverage on the 31st day following the day they turn age 26 as 5 C.F.R. §§ 890.304(c)(1), 890.401, requires. We have attached to this response a copy of the systems control document titled "[MHBP] Overage Dependent Termination Process" dating from Coventry's 2008 systems conversion to IDX evidencing that fact, as well as its 2010 "System Change Document" modifying that process to implement the Affordable Care Act requirement that dependent children coverage be extended from age 22 to age 26.

For these reasons, the OIG should withdraw this Recommendation 2.

Recommendation 3

We recommend that the Plan maintain proof of dependent eligibility for a period of six years after claims are paid in accordance with its records retention clause. This means it should maintain evidence to support the eligibility for disabled dependents for up to six years after they are no longer enrolled in the FEHBP.

Aetna Response: As evidenced by Aetna's response to Recommendation 1 above, the absence of payroll office documentation evidencing the MHBP eligibility as disabled dependents of the individuals over age 26 that the OIG identified is not attributable to any failure to have adequate controls in place to maintain that documentation, but rather to Coventry's inadvertent disposal of some of it during the course of its 2008 conversion of the MHBP onto the IDX eligibility and claims adjudication systems. At all times following the IDX system conversion's 2008 completion, Coventry, and now Aetna, have maintained (and continue to maintain) that documentation.

For this reason, the OIG should withdraw this Recommendation 3.

Deleted by the OIG
Not relevant to the final report

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