



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

Final Audit Report

Subject:

**BLUECROSS BLUESHIELD OF MINNESOTA
EAGAN, MINNESOTA**

Report No. 1A-10-78-10-002

Date: March 30, 2010

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Office of the
Inspector General

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

AUDIT REPORT

Federal Employees Health Benefits Program
Service Benefit Plan Contract CS 1039
BlueCross BlueShield Association
Plan Code 10

BlueCross BlueShield of Minnesota
Plan Codes 220/720
Eagan, Minnesota

REPORT NO. 1A-10-78-10-002

DATE: March 30, 2010

A handwritten signature in black ink, appearing to read "Michael R. Esser".

Michael R. Esser
Assistant Inspector General
for Audits



UNITED STATES OFFICE OF PERSONNEL MANAGEMENT

Washington, DC 20415

Office of the
Inspector General

EXECUTIVE SUMMARY

Federal Employees Health Benefits Program
Service Benefit Plan Contract CS 1039
BlueCross BlueShield Association
Plan Code 10

BlueCross BlueShield of Minnesota
Plan Codes 220/720
Eagan, Minnesota

REPORT NO. 1A-10-78-10-002 DATE: March 30, 2010

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at BlueCross BlueShield of Minnesota (Plan), in Eagan, Minnesota, questions \$33,482 in health benefit charges and lost investment income (LII). The BlueCross BlueShield Association agreed (A) with this questioned amount.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered claim payments from January 1, 2006 through June 30, 2009, as well as miscellaneous payments and credits from 2004 through 2008 as reported in the Annual Accounting Statements.¹ In addition, we reviewed the Plan's cash management practices related to FEHBP funds for contract years 2004 through 2008. Due to errors identified during our review of fraud recoveries, we expanded our audit scope to also include fraud recoveries in 2009.

Questioned items are summarized as follows:

¹ For claim payments, we only performed a system review of claims paid from January 1, 2008 through June 30, 2009, and reviewed a listing of debarred providers to determine if any claims were inappropriately paid to these providers from January 1, 2006 through June 30, 2009.

HEALTH BENEFIT CHARGES

Claim Payments

The audit disclosed no findings pertaining to claim payments. Overall, we concluded that the claims in our system review and debarred provider samples were paid in accordance with the FEHBP contract, the Service Benefit Plan brochure, the Plan's provider agreements, and/or the Association's Federal Employee Program administrative manual.

Miscellaneous Payments and Credits

- **Provider Settlements (A)** **\$24,734**

The Plan overcharged the FEHBP for two provider settlements paid in 2007. As a result, the FEHBP is due \$24,734, consisting of \$21,932 for provider settlement overcharges and \$2,802 for LII.

- **Fraud Recoveries and Health Benefit Refunds (A)** **\$8,748**

The Plan did not return six fraud recoveries and three health benefit refunds to the FEHBP. As a result, the FEHBP is due \$8,748, consisting of \$8,153 for recoveries and refunds not returned and \$595 for LII.

CASH MANAGEMENT

Overall, we concluded that the Plan handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations, except for the audit findings pertaining to cash management noted in the "Miscellaneous Payments and Credits" section.

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I. INTRODUCTION AND BACKGROUND

INTRODUCTION

This final audit report details the findings, conclusions, and recommendations resulting from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at BlueCross BlueShield of Minnesota (Plan). The Plan is located in Eagan, Minnesota.

The audit was performed by the Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

BACKGROUND

The FEHBP was established by the Federal Employees Health Benefits (FEHB) 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 Retirement and Benefits Office has overall responsibility for administration of the FEHBP. The provisions of the FEHB Act are implemented by OPM through regulations, which are codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations (CFR). Health insurance coverage is made available through contracts with various health insurance carriers.

The BlueCross BlueShield Association (Association), on behalf of participating BlueCross and BlueShield plans, has entered into a Government-wide Service Benefit Plan contract (CS 1039) with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BlueCross and BlueShield plans throughout the United States to process the health benefit claims of its federal subscribers. The Plan is one of approximately 63 local BlueCross and BlueShield plans participating in the FEHBP.

The Association has established a Federal Employee Program (FEP¹) Director's Office in Washington, D.C. to provide centralized management for the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the Association, member BlueCross and BlueShield plans, and OPM.

The Association has also established an FEP Operations Center. The activities of the FEP Operations Center are performed by CareFirst BlueCross BlueShield, located in Washington, D.C. These activities include acting as fiscal intermediary between the Association and member plans, verifying subscriber eligibility, approving or disapproving the reimbursement of local plan payments of FEHBP claims (using computerized system edits), maintaining a history file of all FEHBP claims, and maintaining an accounting of all program funds.

¹ Throughout this report, when we refer to "FEP" we are referring to the Service Benefit Plan lines of business at the Plan. When we refer to the "FEHBP" we are referring to the program that provides health benefits to federal employees.

Compliance with laws and regulations applicable to the FEHBP is the responsibility of the Association and Plan management. Also, management of the Plan is responsible for establishing and maintaining a system of internal controls.

All findings from our prior audit of the Plan (Report No. 1A-10-78-05-005, dated September 15, 2006) for contract years 1999 through 2003 were satisfactorily resolved, except for a finding related to claim payment errors, which is in the process of being resolved.

The results of this audit were provided to the Plan in written audit inquiries; were discussed with Plan and/or Association officials throughout the audit and at an exit conference; and were presented in detail in a draft report, dated January 22, 2010. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as an Appendix to this report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The objectives of our audit were to determine whether the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract. Specifically, our objectives were as follows:

Health Benefit Charges

- To determine whether the Plan complied with contract provisions relative to benefit payments.
- To determine whether miscellaneous payments charged to the FEHBP were in compliance with the terms of the contract.
- To determine whether credits and miscellaneous income relating to FEHBP benefit payments were returned promptly to the FEHBP.

Cash Management

- To determine whether the Plan handled FEHBP funds in accordance with applicable laws and regulations concerning cash management in the FEHBP.

SCOPE

We conducted our limited scope 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 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.

We reviewed the BlueCross and BlueShield FEHBP Annual Accounting Statements as they pertain to Plan codes 220 and 720 for contract years 2004 through 2008. During the period, the Plan paid approximately \$1.1 billion in health benefit charges (See Schedule A).

Specifically, we reviewed approximately \$9 million in claim payments made from January 1, 2006 through June 30, 2009.² In addition, we reviewed miscellaneous payments and credits, such as refunds and subrogation recoveries, and cash management for 2004 through 2008. Due to errors identified during our review of fraud recoveries, we expanded our audit scope to also include all fraud recoveries in 2009.

² For claim payments, we only performed a system review of claims paid from January 1, 2008 through June 30, 2009, and reviewed a listing of debarred providers to determine if any claims were inappropriately paid to these providers from January 1, 2006 through June 30, 2009.

In planning and conducting our 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. Based on our testing, we did not identify any significant matters involving the Plan's internal control structure and its operation. However, 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 to determine whether the Plan had complied with the contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations (FAR) and Federal Employees Health Benefits Acquisition Regulations (FEHBAR), as appropriate), and the laws and regulations governing the FEHBP. The results of our tests indicate that, with respect to the items tested, the Plan did not comply with all provisions of the contract and federal procurement regulations. Exceptions noted in the areas reviewed are set forth in detail in the "Audit Findings and Recommendations" section of this audit 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 our audit, we relied to varying degrees on computer-generated data provided by the FEP Director's Office, the FEP Operations Center and the Plan. Due to 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 testing, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

The audit was performed at the Plan's office in Eagan, Minnesota from October 12 through October 23, 2009. Audit fieldwork was also performed at our office in Cranberry Township, Pennsylvania.

METHODOLOGY

We obtained an understanding of the internal controls over the Plan's claims processing and financial systems by inquiry of Plan officials.

To test the Plan's compliance with the FEHBP health benefit provisions, we selected and reviewed a judgmental sample of 85 claims (referred to as our system review) that were paid during the period January 1, 2008 through June 30, 2009.³ In addition, we reviewed all debarred providers in Minnesota for the purpose of determining if any claims were inappropriately paid to

³ For this period, we identified 2,622,517 claim lines, totaling \$388,210,529 in payments, using a standard criteria based on our experience. From this universe, we selected and reviewed a judgmental sample of 85 claims (representing 1,308 claim lines) totaling \$9,185,382 in payments. We selected our sample from an OIG-generated "Place of Service Report" (SAS application) that stratified the claims by place of service (POS), such as provider's office and payment category, such as \$50 to \$99.99. We judgmentally determined the number of sample items to select from each POS stratum based on the stratum's total claim dollars paid.

these providers. We used the FEHBP contract, the Service Benefit Plan brochure, the Plan's provider agreements, and the Association's FEP administrative manual to determine the allowability of benefit payments. The results of these samples were not projected to the universe of claims.

We interviewed Plan personnel and reviewed the Plan's policies, procedures, and accounting records during our audit of miscellaneous payments and credits. For contract years 2004 through 2008, we also judgmentally selected and reviewed 56 high dollar health benefit refunds, totaling \$3,867,317 (from a universe of 8,531 refunds, totaling \$10,337,994); 10 high dollar special plan invoices, totaling \$4,350,884 in net payments (from a universe of 110 special plan invoices, totaling \$7,700,165 in net payments); 19 provider settlements, totaling \$1,321,823 in net payments (from a universe of 4,034 provider settlements, totaling \$5,214,826 in net payments); and 8 fraud cases, totaling \$8,087 in recoveries (from a universe of 12 fraud cases, totaling \$17,333 in recoveries), to determine if refunds and recoveries were promptly returned to the FEHBP and if miscellaneous payments were properly charged to the FEHBP.⁴ In addition, we expanded our testing of fraud recoveries to also include two recoveries, totaling \$5,341, from 2009. The results of these samples were not projected to the universe of miscellaneous payments and credits.

We also reviewed the Plan's cash management to determine whether the Plan handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations.

⁴ See the audit findings for "Provider Settlements" (A2.a) and "Fraud Recoveries and Health Benefit Refunds" (A2.b) on pages 6 through 9 for specific details of our sample selection methodologies.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. HEALTH BENEFIT CHARGES

1. Claim Payments

The audit disclosed no findings pertaining to claim payments. Overall, we concluded that the claims in our system review and debarred provider samples were paid in accordance with the FEHBP contract, the Service Benefit Plan brochure, the Plan's provider agreements, and/or the Association's Federal Employee Program administrative manual.

2. Miscellaneous Payments and Credits

a. Provider Settlements

\$24,734

The Plan overcharged the FEHBP for two provider settlements paid in 2007. As a result, the FEHBP is due \$24,734, consisting of \$21,932 for provider settlement overcharges and \$2,802 for lost investment income (LII).

Contract CS 1039, Part III, section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable."

48 CFR 52.232-17(a) states, "all amounts that become payable by the Contractor ... shall bear simple interest from the date due ... The interest rate shall be the interest rate established by the Secretary of the Treasury as provided in Section 611 of the Contract Disputes Act of 1978 (Public Law 95-563); which is applicable to the period in which the amount becomes due, as provided in paragraph (e) of this clause, and then at the rate applicable for each six-month period as fixed by the Secretary until the amount is paid."

For the period 2004 through 2007, there were 4,034 provider settlements totaling \$5,214,826 in net charges to the FEHBP. From this universe, we selected and reviewed a judgmental sample of 18 provider settlements, totaling \$666,772 in net charges, for the purpose of determining whether the Plan properly charged or timely returned these settlements to the FEHBP. From each year, we selected settlements based on the following methodology: highest dollar corporate settlement credit, highest dollar corporate settlement charge, highest dollar FEP settlement credit, highest dollar FEP settlement charge, and highest FEP allocation rate. If the same provider settlement was selected under more than one of these methodologies, then we only counted that settlement as one sample item. Also, there were no provider settlement payments and/or recoveries in 2008.

In one instance, we determined that the Plan did not correctly allocate a provider settlement charge to FEP. Due to a clerical error made on the Plan's settlement allocation spreadsheet, the Plan incorrectly allocated 19.44 percent to FEP instead of 4.4 percent, resulting in an overcharge of \$11,249 to the FEHBP. As a result, we reviewed additional provider settlement allocations to determine whether there were similar errors. We found one additional settlement error, again due to a clerical error, where the Plan incorrectly allocated 22.98 percent to FEP instead of 3.74 percent, resulting in an overcharge of \$10,683 to the FEHBP.

In total, the FEHBP is due \$24,734, consisting of \$21,932 for two provider settlement overcharges and \$2,802 for LII on these overcharges. We calculated LII on the questioned provider settlement overcharges through the dates (October 21, 2009 and November 5, 2009) when the Plan deposited the funds into the FEP investment account.

Association's Response:

The Association agrees with this finding. The Association states that the Plan returned the questioned amount of \$24,734 to the FEHBP on January 14, 2010. In addition, the Association states, "The error was due to a clerical error and to reduce the risk of this occurring again, the Plan now uses MS Access instead of an Excel Spreadsheet to allocate and track provider settlements."

Recommendation 1

We verified that the Plan deposited a total of \$21,932 into the FEP investment account on October 21, 2009 and November 5, 2009 for these provider settlement overcharges. Therefore, we recommend that the contracting officer verify that the Plan returned these funds to the FEHBP letter of credit account (LOCA).

Recommendation 2

We recommend that the contracting officer verify that the Plan credited the FEHBP \$2,802 for LII on the provider settlement overcharges.

b. Fraud Recoveries and Health Benefit Refunds \$8,748

The Plan did not return six fraud recoveries and three health benefit refunds to the FEHBP. As a result, the FEHBP is due \$8,748, consisting of \$8,153 for recoveries and refunds not returned and \$595 for LII.

Contract CS 1039, Part II, Section 2.3 (i) states, "All health benefit refunds and recoveries, including erroneous payment recoveries, must be deposited into the working capital or investment account within 30 days and returned to or accounted for in the FEHBP letter of credit account within 60 days after receipt by the Carrier."

48 CFR 52.232-17(a) states, "all amounts that become payable by the Contractor ... shall bear simple interest from the date due ... The interest rate shall be the interest rate established by the Secretary of the Treasury as provided in Section 611 of the Contract Disputes Act of 1978 (Public Law 95-563), which is applicable to the period in which the amount becomes due, as provided in paragraph (e) of this clause, and then at the rate applicable for each six-month period as fixed by the Secretary until the amount is paid."

Fraud Recoveries

For the period 2004 through 2008, there were 12 fraud recoveries totaling \$17,333. From this universe, we selected and reviewed a judgmental sample of eight fraud recoveries, totaling \$8,087, for the purpose of determining if the Plan returned these recoveries to the FEHBP in a timely manner. Our sample included four recoveries that were judgmentally selected and four recoveries that, according to the Plan, were not returned to the FEHBP.

Based on our review, we determined that the Plan did not return four fraud recoveries, totaling \$2,001, to the FEHBP. The Plan stated that these recoveries were not returned to the FEHBP due to a lack of communication between the Plan's departments after implementing the Association's "Fraud Information Management System" in 2005.

As a follow-up step, we requested the Plan to review all 2009 FEP fraud recoveries to determine if there were similar problems. The Plan reported two fraud recoveries, totaling \$5,341, during this period. Based on our review of the Plan's documentation, we determined that the Plan did not return these two recoveries to the FEHBP.

In total, the Plan did not return six fraud recoveries, totaling \$7,342, to the FEHBP. We determined that the FEHBP is also due \$497 for LII on these recoveries. We calculated LII on these questioned recoveries through the date (December 29, 2009) when the Plan deposited the funds into the FEP investment account.

Health Benefit Refunds

For the period 2004 through 2008, there were 8,531 health benefit refunds (including subrogation recoveries) totaling \$10,337,994. From this universe, we selected and reviewed a judgmental sample of 56 refunds, totaling \$3,867,317, for the purpose of determining if the Plan returned refunds to the FEHBP in a timely manner. From each year in the audit scope, we selected all refunds greater than \$20,000.

Based on our review, we determined that the Plan did not return three health benefit refunds, totaling \$811, to the FEHBP. Specifically, two refunds were not deposited into the FEP investment account and adjusted through the LOCA, and one refund was not adjusted through the LOCA. For the two refunds that were not deposited into the FEP investment account, we determined that the FEHBP is also due \$98 for LII on

these refunds. We calculated LII on these refunds through the date (December 4, 2009) when the Plan deposited the funds into the FEP investment account.

Association's Response:

The Association agrees with this finding. The Association states that the Plan returned the questioned amount of \$8,748 to the FEHBP on January 14, 2010. In addition, the Association states, "The Plan's process has been revised to ensure timely return of FEHBP's portion of collected fraud recoveries and health benefit refunds to the Program."

Recommendation 3

We verified that the Plan deposited a total of \$8,153 into the FEP investment account on various dates in December 2009 for the questioned fraud recoveries and health benefit refunds. Therefore, we recommend that the contracting officer verify that the Plan returned these funds to the LOCA.

Recommendation 4

We recommend that the contracting officer verify that the Plan credited the FEHBP \$595 for LII on the questioned fraud recoveries and health benefit refunds.

B. CASH MANAGEMENT

Overall, we concluded that the Plan handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations, except for the audit findings pertaining to cash management noted in the "Miscellaneous Payments and Credits" section.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

[REDACTED] Auditor-In-Charge

[REDACTED] Auditor

[REDACTED] Auditor

[REDACTED] Auditor

[REDACTED] Chief [REDACTED]

[REDACTED] Senior Team Leader

V. SCHEDULE A

BLUECROSS BLUESHIELD OF MINNESOTA
EAGAN, MINNESOTA

HEALTH BENEFIT CHARGES AND AMOUNTS QUESTIONED

HEALTH BENEFIT CHARGES	2004	2005	2006	2007	2008		Total
A. HEALTH BENEFIT CHARGES							
PLAN CODE 220/720*	\$172,945,156	\$190,497,897	\$212,906,910	\$239,670,991	\$268,831,675		\$1,084,852,629
MISCELLANEOUS PAYMENTS AND CREDITS	120,013	765,079	38,642	4,002,861	2,774,044		7,700,639
TOTAL HEALTH BENEFIT CHARGES	\$173,065,169	\$191,262,976	\$212,945,552	\$243,673,852	\$271,605,719		\$1,092,553,268
AMOUNTS QUESTIONED	2004	2005	2006	2007	2008	2009	Total
A. HEALTH BENEFIT CHARGES							
1. CLAIM PAYMENTS	\$0	\$0	\$0	\$0	\$0	\$0	\$0
2. MISCELLANEOUS PAYMENTS AND CREDITS							
a. PROVIDER SETTLEMENTS**	0	0	0	22,681	1,083	970	24,734
b. FRAUD RECOVERIES AND HEALTH BENEFIT REFUNDS**	0	282	2,281	479	126	5,580	8,748
B. CASH MANAGEMENT	0	0	0	0	0	0	0
TOTAL AMOUNTS QUESTIONED	\$0	\$282	\$2,281	\$23,160	\$1,209	\$6,550	\$33,482

* We only reviewed claim payments from January 1, 2006 through June 30, 2009.

** This audit finding also includes lost investment income.



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

February 22, 2010

[REDACTED] Group Chief
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**Reference: OPM DRAFT AUDIT REPORT
MINNESOTA BLUE CROSS BLUE SHIELD
Audit Report Number 1A-10-54-07-02
(Dated and received January 22, 2010)**

Dear [REDACTED]

This is our response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Federal Employees' Health Benefits Program (FEHBP) operations for Minnesota BlueCross BlueShield. Our comments concerning the findings in the report are as follows:

AI 2a. Provider Settlements

\$24,734

We do not contest this finding. The error was due to a clerical error and to reduce the risk of this occurring again, the Plan now uses MS Access instead of an Excel Spreadsheet to allocate and track provider settlements.

The Plan returned \$24,734 to the Program, consisting of \$21,932 for two provider settlement overcharges and \$2,802 for Lost Investment Income (LII) via wire transfer on January 14, 2010.

AI 2b. Fraud Recoveries and Health Benefit Refunds

\$8,748

We do not contest this finding. The error was due to a process gap between Plan departments. The Plan's process has been revised to ensure timely return of FEHBP's portion of collected fraud recoveries and health benefit refunds to the Program.

The Plan returned \$8,748 to the Program, consisting of \$8,153 for recoveries and refunds not previously returned and \$595 for Lost Investment Income (LII) via wire transfer on January 14, 2010.

[REDACTED]
OPM Draft Audit Response
February 22, 2010
Page 2 of 2

We appreciate the opportunity to provide our response to each of the findings and request that our comments be included in their entirety as part of the Final Audit Report.

[REDACTED]
Executive Director
Program Integrity

[REDACTED]
cc: [REDACTED]