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

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# Final Audit Report

**AUDIT OF  
GLOBAL CLAIMS-TO-ENROLLMENT MATCH FOR  
BLUE CROSS AND BLUE SHIELD PLANS**

**Report Number 1A-99-00-15-008  
January 21, 2016**

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# EXECUTIVE SUMMARY

## *Audit of Global Claims-to-Enrollment Match*

Report No. 1A-99-00-15-008

January 21, 2016

### **Why Did We Conduct the Audit?**

The objectives of our audit were to determine whether the Blue Cross and Blue Shield (BCBS) plans charged costs to the Federal Employee Health Benefits Program (FEHBP) and provided services to the FEHBP members in accordance with the terms of its contract with the U.S. Office of Personnel Management. Specifically, our objective was to determine whether the BCBS plans complied with contract provisions relative to claims paid for ineligible patients.

### **What Did We Audit?**

The Office of the Inspector General has completed a limited scope audit of the FEHBP operations at all BCBS plans. The audit covered claim payments from January 1, 2012, through September 30, 2014, as reported in the Blue Cross and Blue Shield Association's Government-wide Service Benefit Plan Annual Accounting Statements. Specifically, we identified claims from this period that were paid when the patient's enrollment status was identified as ineligible.



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for Audits*

### **What Did We Find?**

Our limited scope audit was conducted in accordance with Government Auditing Standards. This report questions \$13,258,298 in health benefit charges. These questioned health benefit charges are summarized as follows:

#### **A. Member Enrollment Issues – Dollar Threshold Review**

- Our review determined that the FEHBP was overcharged \$10,051,009 in health benefit charges for claims that were paid for ineligible patients.

#### **B. Member Enrollment Issues – Statistical Sample Review**

- Our review of a statistical sample of claims where there was a conflict with enrollment coverage for patients with cumulative claim line payments less than \$2,500 projected that the FEHBP was overcharged \$3,207,289 in health benefit charges for claims that were paid for ineligible patients.

# ABBREVIATIONS

<b>ACA</b>	<b>Affordable Care Act</b>
<b>Association</b>	<b>Blue Cross Blue Shield Association</b>
<b>APM</b>	<b>Administrative Procedures Manual</b>
<b>BCBS</b>	<b>Blue Cross Blue Shield</b>
<b>CFR</b>	<b>Code of Federal Regulations</b>
<b>DO</b>	<b>Director's Office</b>
<b>FEHB</b>	<b>Federal Employees Health Benefits</b>
<b>FEHBP</b>	<b>Federal Employees Health Benefits Program</b>
<b>FEP</b>	<b>Federal Employee Program</b>
<b>FEP OC</b>	<b>Federal Employee Program Operations Center</b>
<b>FOIA</b>	<b>Freedom of Information Act</b>
<b>OPM</b>	<b>U.S. Office of Personnel Management</b>
<b>Plan(s)</b>	<b>Blue Cross and Blue Shield Plan(s)</b>

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# I. BACKGROUND

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 all Blue Cross and Blue Shield (BCBS) plans. The audit was performed by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as authorized by the Inspector General Act of 1978, as amended.

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 Healthcare and Insurance 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 Blue Cross Blue Shield Association (Association), on behalf of participating BCBS 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 BCBS plans throughout the United States to process the health benefit claims of its federal subscribers. There are 64 local BCBS plans participating in the FEHBP.

The Association has established a Federal Employee Program (FEP<sup>1</sup>) Director's Office (DO) in Washington, D.C. to provide centralized management for the Service Benefit Plan. The FEP DO coordinates the administration of the contract with the Association, member BCBS plans, and OPM.

The Association has also established an FEP Operations Center (OC). The activities of the FEP OC 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.

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<sup>1</sup> Throughout this report, when we refer to "FEP", we are referring to the Service Benefit Plan lines of business at the Plan(s). 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 each BCBS plan is responsible for establishing and maintaining a system of internal controls.

Findings from our previous global claims-to-enrollment match audit of all BCBS plans (Report No. 1A-99-00-10-061, dated September 8, 2011) for claims reimbursed from July 1, 2008 through September 30, 2010, have been resolved.

Our sample selections, instructions, and preliminary audit results of the potential enrollment errors were presented to the Association in a draft report, dated December 12, 2014. 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. Also, additional documentation provided by the Association and BCBS plans on various dates through December 8, 2015, was considered in preparing our final report.

## II. OBJECTIVES, SCOPE, AND METHODOLOGY

### Objectives

The objectives of our audit were to determine whether the BCBS plans charged costs to the FEHBP and provided services to the FEHBP members in accordance with the terms of the contract. Specifically, our objective was to determine whether the plans complied with contract provisions relative to claims paid for ineligible patients.

### Scope

The audit covered health benefit payments from January 1, 2012 through September 30, 2014, as reported in the Blue Cross and Blue Shield Association's Government-wide Service Benefit Plan Annual Accounting Statements. To test each BCBS plan's compliance with the FEHBP health benefit provisions related to enrollment eligibility, we performed a computer search on our claims data warehouse to identify all BCBS claims that were reimbursed for potentially ineligible patients from January 1, 2012 through September 30, 2014. This universe is comprised of claims for two distinct potential member enrollment issues. The first category, "Conflict with Enrollment Coverage," consists of claims incurred during gaps in patient coverage or after termination of patient coverage. The second category, "No Enrollment Record on File," consists of claims incurred when no patient enrollment records existed. Exhibit I contains a summary of the total claims universe for this audit.

**Exhibit I – Universe of Potentially Ineligible Patients**

Category	Patients	Claim Lines	Amounts Paid
Conflict with Enrollment Coverage	34,747	248,591	\$34,406,164
No Enrollment Record on File	1,097	23,969	\$2,789,145
<b>Total</b>	<b>35,844</b>	<b>272,560</b>	<b>\$37,195,309</b>

From this universe we selected two separate samples of claims to review as part of this audit. The first sample included a review of *all* claim lines in *both* categories for patients with cumulative claim payments *over* \$2,500. The second was a *statistical sample* of claim lines from *only* the "Conflict with Enrollment Coverage" category for patients with cumulative claim payments *under* \$2,500. Exhibit II contains a summary of the sample selections.

**Exhibit II – Summary of Sample Selections**

Category	Sample Selection Criteria	Claim Lines	Amounts Paid
Conflict with Enrollment Coverage <u>AND</u> No Enrollment Record on File	All claims for patients with cumulative claim payments <b>over</b> \$2,500.	108,718	\$27,950,803
Conflict with Enrollment Coverage	Statistical sample of claims for patients with cumulative claim payments <b>under</b> \$2,500.	7,650	\$1,812,595

**Methodology**

The claims selected for review were submitted to each BCBS plan for their review and response. We then conducted a limited review of the plans’ “paid correctly” responses and an expanded review of the plans’ “paid incorrectly” responses. Specifically, we verified supporting documentation and the accuracy and completeness of the plans’ responses, determined if the claims were paid correctly, and/or calculated the appropriate questioned amounts for the claim payment errors. Additionally, we verified on a limited test basis if the BCBS plans had initiated recovery efforts, adjusted or voided the claims, and/or completed the recovery process by the audit request due date (i.e., February 23, 2015) for the claim payment errors in our sample.

The determination of the questioned amount is based on the FEHBP contract, the 2012 through 2014 Service Benefit Plan brochures, and the Association’s FEP Administrative Procedures Manual (APM).

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 did not consider each BCBS plan’s internal control structure in planning and conducting our auditing procedures. Our audit approach consisted mainly of substantive tests of transactions and not tests of controls. Therefore, we do not express an opinion on each BCBS plan’s system of internal controls taken as a whole.

We also conducted tests to determine whether the BCBS plans had complied with the contract and the laws and regulations governing the FEHBP as they relate to claims paid for ineligible patients. The results of our tests indicate that, with respect to the items tested, the BCBS plans did not fully comply with the provisions of the contract relative to claims paid for ineligible patients. Exceptions noted are explained 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 BCBS plans 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 DO, the FEP OC, and the BCBS plans. Through audits and a reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify the universe of potential enrollment claim payment errors. The BCBS claims data is provided to us on a monthly basis by the FEP OC, and after a series of internal steps, uploaded into our data warehouse. However, due to time constraints, we did not verify the reliability of the data generated by the BCBS plans' local claims systems. 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.

Audit fieldwork was performed at our offices in Washington, D.C., Cranberry Township, Pennsylvania and Jacksonville, Florida through July 2015.

# III. AUDIT FINDINGS AND RECOMMENDATIONS

The sections below detail the results of our review of claims that were potentially paid for members that did not have active FEP coverage on the date the service was incurred. This review was done in two parts – a review of all claims over a dollar threshold and a review of a statistical sample of claims.

## A. Member Enrollment Issues – Dollar Threshold Review \$10,051,009

As mentioned in the Scope section above, our first sample of claims selected for review included *all* claim lines in *both* categories of enrollment issues for patients with cumulative claim payments *over* the dollar threshold of \$2,500. Exhibit III provides a breakdown of this sample selection by category.

**Exhibit III – Summary of Dollar Threshold Review**

Category	Claim Lines Reviewed	Amount Paid for Claim Lines Reviewed	Claim Lines Paid in Error	Amount Paid in Error
Conflict with Enrollment Coverage	92,032	\$25,522,864	39,869	\$9,035,056
No Enrollment Record on File	16,686	\$2,427,939	5,604	\$1,015,953
<b>Total</b>	108,718	\$27,950,803	45,473	<b>\$10,051,009</b>

These claims were reviewed to determine whether the BCBS plans complied with contract provisions relative to claims paid for ineligible patients. Our review determined that the BCBS plans incorrectly paid 45,473 claim lines, totaling \$10,051,009 in payments, for ineligible patients.

These 45,473 claim payment errors are comprised of the following:

- 40,077 claim lines were questioned due to retroactive enrollment adjustments, resulting in overcharges of \$8,820,513 to the FEHBP. Retroactive adjustments occur when the patient’s enrollment status has changed, but the enrollment system is not timely updated to reflect the change. Our review determined these claim payment errors were due to either:
  - 1) The Federal payroll offices or FEP OC did not receive accurate member information for several months or years after the subscriber was due to be terminated, so the ineligible patients remained active in the Association’s FEP Express nation-wide claims processing system; or

2) The BCBS plans did not initiate recovery after the retroactive enrollment adjustment was identified because of the Association’s “60-day recovery limit” policy or because of provider contract recovery limitations.

However, contract CS 1039 does not support the Association’s position on delaying recovery on all retroactive enrollment claims errors, and also states that the BCBS plans should make a prompt and diligent effort to recover erroneous claim payment errors, regardless of the provider contract limitations. See the *Procedural Issues* section below for a discussion of our concerns regarding the “60-day recovery limit” policy.

- 4,742 claim lines were questioned due to FEP Express system processing errors, resulting in overcharges of \$920,291 to the FEHBP.
- 463 claim lines were questioned due to local system processing errors, resulting in overcharges of \$219,928 to the FEHBP.
- 176 claim lines were questioned due to manual processor errors, resulting in overcharges of \$88,875 to the FEHBP.
- 15 claim lines were questioned due to provider billing errors, resulting in overcharges of \$1,402 to the FEHBP.

### *Procedural Issues*

We have serious concerns with the Association’s efforts to implement corrective actions to prevent claim payments for ineligible patients. Year-after-year, retroactive enrollment adjustments are the primary reason for enrollment-related claim payment errors. Due to the nature of the enrollment process, we recognize that some retroactive enrollment errors will occur.

**We have serious concerns regarding the Association’s lack of corrective action to prevent claim payments for ineligible payments.**

Although the Association has taken steps to identify these errors after the payment has already been made, this has proven insufficient, and the Association should take additional measures to reduce the frequency of these errors from occurring in the first place. The procedural controls that the Association could implement to reduce these improper payments include, but are not limited to:

- The Association could evaluate the benefit of implementing an automated process to reconcile enrollment discrepancies between the FEP OC and employing agencies. An automated reconciliation could leverage all of the electronic data available from the bi-weekly enrollment premium reports. The current manual process is not efficient because

FEP OC claims processors are unable to resolve the large volume (approximately 38,000) of contract holder discrepancies that are identified each quarter.

- The Association could modify the FEP Express system to automatically defer claims where a member’s enrollment data is incomplete or the member has coverage under another FEP number. Claims simply should not be automatically paid without manual review when the enrollee’s file is incomplete and/or the enrollee’s file has not been updated.
- The Association could also implement a process to identify members whose enrollment was terminated due to fraud, intentional misrepresentation of information, or non-payment of premiums, and then modify the “60-day recovery limit” policy to allow immediate recovery of claim payments for these members. The 60-day recovery limit policy was developed by the Association because the Affordable Care Act (ACA) prohibits the recovery of claim payment errors that were the result of retroactive enrollment changes where the member termination is not related to fraud, intentional misrepresentation of information, or non-payment of premiums. However, the Association’s policy recommends the BCBS plans delay recovery on *all* claims where the retroactive enrollment error is related to a member termination or cancellation. This policy was implemented without addressing the fact that many members are not covered by this ACA rule (i.e., those whose termination was related to fraud, misrepresentation, or not paying premiums). This policy causes unnecessary delays in the recovery process and often results in overpayments not being returned to the FEHBP.
- We also detected issues with the Association’s process of notifying members that their coverage has been terminated. We identified 6,966 ineligible members and determined that approximately 9 percent of these individuals were not formally notified of their coverage termination. Failure to promptly notify a member that their enrollment has been terminated increases the risk that these members will continue to submit claims for services for which they were not covered.

Based on our experience in resolving global claims audits with the Association, we expect that the Association will determine that a substantial portion of the \$10,051,009 in questioned costs are “unrecoverable” due to a variety of reasons such as provider contract limitations or that all recovery efforts have been exhausted. OPM’s contract office has historically accepted the Association’s argument that these unrecoverable claim payments were made in good faith, and has not required the Association to return this money to the FEHBP.

**\$10 million in enrollment-related claim overpayments were not made in good faith.**

Contract CS 1039, Part III, section 2.3 (8)(i) states, “The Carrier may charge the contract for benefit payments made erroneously but in good faith . . . .” However, we do not agree that these

claim payment errors were made in good faith, and therefore we recommend that the entire \$10,051,009 be returned to the FEHBP regardless of the Plan's ability to recover the funds from the providers. As discussed on page 14 (*Basis for questioning projected costs*), we have reported that the BCBS Plans' have made significant enrollment-related claim payment errors for at least 10 years, and no prudent business would continue to take only minimal, and unsuccessful, procedural measures to prevent such a magnitude of improper payments.

**Association's Response:**

In response to the draft report which questioned \$27,950,803 in potential overpayments, the Association agrees with \$3,364,278 in overpayments and states, ***"These overpayments were the result of retroactive enrollment changes where the claim was processed before a termination notice was received either from the Payroll Office or from the member (in the case of a divorce, etc.). Where possible, recovery efforts have been initiated for the identified errors. The Plans will continue to pursue these overpayments as required by CS 1039, Section 2.3 (g)(I). "Any benefit payments the Plans are unable to recover are allowable charges to the Program. In addition, as good faith erroneous payments, lost investment income is not applicable to these confirmed overpayments."***

The Association also states, ***"Due to the nature of the enrollment process, we will continue to receive retroactive enrollment updates after the claim has been processed. However, the daily Claims Audit Monitoring Tool (CAMT) Retroactive Enrollment Report updated daily with retroactive enrollment activity is designed to identify retroactive terminations so that Plans can timely initiate recoveries on applicable erroneous payments. Additional tools to identify retroactive terminations include the CAMT Terminated Member roster, which identifies retroactive terminations that may not have been captured on the daily CAMT Retroactive enrollment report. We continue to monitor both processes to promote timely identification and recovery of terminated member claims."***

Regarding the remaining questioned charges in the draft report, the Association contested \$24,586,526 due to the following reasons:

- Members had coverage at the time the claims were incurred; therefore, the claims were paid correctly;
- Potential overpayments were identified before the audit started and were recovered before the draft report response was submitted;
- Overpayments were identified before the audit and recovery was initiated but not yet collected or were uncollectible because the retroactive termination notice was received after the Plan's provider contract limit for recovering overpayments had passed.

- The overpayments were below the Plan’s recovery threshold, and further attempts to recover these overpayments exceed the cost to recover the overpayments.

Regarding corrective actions, the Association states, ***“BCBSA [the Association] will work with the Plans to identify root causes where Plans did not identify and initiate recovery of claims . . . before the audit started. BCBSA [the Association] will also work with the FEP Operations Center [FEP OC] to identify root causes where the retroactive termination notices were not issued to Plans so that appropriate overpayment recovery activity could be initiated before the audit started. Once the root cause analysis is completed, BCBSA [the Association] will work with Plans and the FEPOC to implement the necessary corrective actions so that terminated member activity is timely detected and recovery is timely initiated to recovery related overpayments.”***

Note – the procedural recommendations were not included in the draft audit report and the Association has not had the opportunity to respond to them.

**OIG Comments:**

After reviewing the Association’s response and additional documentation provided by the BCBS plans, we revised the questioned charges from our draft report to \$10,051,009. If claim overpayments were identified by the BCBS plans before our audit notification date (i.e., October 1, 2014) and adjusted or voided by the draft report due date (i.e., February 23, 2015), we did not consider these as claim payment errors in this final audit report.

Based on the Association’s response and documentation provided by the BCBS plans, we determined that the Association and/or plans acknowledge that \$9,979,536 in claim overpayments were made for ineligible patients, and contests that the remaining \$71,473 in claim payments were appropriately paid for actively enrolled members.

Acknowledged claim payment overpayments

The Association acknowledges that \$9,979,536 in claim overpayments were made. This amount is comprised of the following:

- \$131,873 represents claim overpayments for which the BCBS plans did not initiate recovery because the individual *claim lines* questioned were under \$100, and the Association does not consider this material. However, the total overpayment for each of these claims (the sum of all claim lines) is greater than \$100, and therefore we continue to question these costs.
- \$2,715,123 represents claim overpayments for which the BCBS plans did not initiate recovery because they believe they were restricted by contract limitations, or that recovery efforts had been exhausted. However, we continue to question these costs because the BCBS Plans are required by contract CS 1039 to attempt recovery regardless of provider contract limitations,

or because they have not provided us with documentation supporting that all recovery efforts have been exhausted.

- \$7,132,540 represents claim overpayments for which the BCBS plans have committed to pursue recovery<sup>2</sup>.

#### Contested claim overpayments

The Association contests that \$71,473 in claim payments were made for individuals that the Association believes did have coverage at the time the service was provided. However, the BCBS plans did not provide sufficient documentation to demonstrate that the member was, in fact, eligible to receive these benefits, and we therefore continue to question these costs.

#### Recommendation 1

We recommend that the contracting officer disallow \$10,051,009 for claim overpayments and verify that the BCBS plans return all amounts recovered to the FEHBP, regardless of the Plans' ability to recover the claim payments from providers.

#### Recommendation 2

Due to the number of errors related to retroactive enrollment adjustments, we recommend that the contracting officer verify the Association is timely resolving enrollment discrepancies identified during the quarterly reconciliation process between the employing agencies and FEP OC. This includes contacting the appropriate employing agency to obtain the necessary documentation, issuing the enrollee's termination notices and terminating the enrollee in the FEP Express system. The contracting officer should also require the Association to utilize the enrollee premium files that are made available from the employee agencies every pay period. This action includes timely identifying enrollment changes and discrepancies, and taking the necessary actions to resolve the discrepancies with employee agencies.

#### Recommendation 3

We recommend that the contracting officer require the Association to perform a cost analysis to determine the benefit of automating the process of updating the FEP Express system when enrollment discrepancies are identified between the FEP OC and employing agencies. If determined cost effective, we recommend that the contracting officer require the Association to implement these automated procedures.

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<sup>2</sup> Although the Association acknowledges that there were \$7,132,540 in claim payment errors, it contends that \$3,136,596 of this amount should not be labeled as "questioned" because the BCBS Plans initiated recovery efforts before they received our claims sample. However, Contract CS 1039 states that claims should be reported as questioned charges unless the Plans initiated recovery prior to receiving notification of the audit. Recovery efforts for all of these claim overpayments began after the notification letter was issued, therefore we continue to label the entire \$7,132,540 as questioned costs.

#### **Recommendation 4**

We recommend that the contracting officer require the Association to implement a process to identify ineligible members who were terminated due to fraud or intentional misrepresentation of information yet continued to improperly file claims (e.g., medical or pharmacy). This process should be performed on a monthly basis, and the members identified should be reported to the OPM OIG Office of Investigations.

#### **Recommendation 5**

We recommend that the contracting officer require the Association to immediately update its “60-day recovery limit” policy that limits the BCBS plans from initiating recovery for at least 60-days on *all* retroactive enrollment terminations or cancelations. The policy should only restrict recovery efforts for members who are eligible to contest their enrollment termination, and should allow for immediate recovery efforts for members whose coverage termination was due to fraud, intentional misrepresentation of information, or non-payment of premiums. The Claims Audit Monitoring Tool should be modified to reflect this new policy.

#### **Recommendation 6**

We recommend that the contracting officer require the Association to enhance the FEP Express system by adding an edit that defers claims where a patient’s enrollment is incomplete or who has coverage under another FEP member number. In addition, the FEP Express system should defer all claims for members whose enrollment file contains inconsistencies, and not allow payment on these claims until the member’s enrollment file is properly updated. This edit should contain a unique deferral code that cannot be overridden by claims processors.

#### **Recommendation 7**

We recommend that the contracting officer require the Association to evaluate its procedures for notifying members that their coverage has been terminated. The Association should attempt to identify the cause(s) that led to nine percent of the members we reviewed not receiving notification of coverage termination. Once a cause is identified, appropriate corrective action should be implemented.



**B. Member Enrollment Issues – Statistical Sample Review****\$3,207,289**

As mentioned in the Scope section, above, our second sample of claims selected for review was a statistical sample of claim lines from only the “Conflict with Enrollment Coverage” category for patients with cumulative claim payments under \$2,500. Exhibit IV shows this universe of claim lines.

**Exhibit IV – Universe for Statistical Sample**

Category	Criteria	Claim Lines	Amount Paid
Conflict with Enrollment Coverage	Patients with cumulative payments <b>under</b> \$2,500	156,559	\$8,883,300

From this universe, we reviewed a statistical sample of 7,650 claim lines, totaling \$1,812,595 in payments, with the intention of projecting the results to the entire population.

For our statistical review prediction module, we used a ratio estimator to determine the sample size and total overpayment amount. This module used a stratified dollar-unit sample design, where each dollar in a stratum’s value had the same probability of selection.

We used automated software to generate the random-stratified dollar-unit sample, which targeted a 4 percent margin of error and a 95 percent confidence level, with a presumed universe error rate of 40 percent.<sup>3</sup> Each sample unit was identified as a single FEHBP paid claim line. See Exhibit V for a summary of our statistical review prediction module.

**Exhibit V**

Prediction Module	
Estimator Approach	Ratio Method
Margin of Error	4 percent
Confidence Interval	95 percent
Presumed Error Rate	40 percent

Our review determined that from the statistical sample of 7,650 claim lines the BCBS plans paid 2,955 claim lines for ineligible patients, resulting in overcharges of \$556,851 to the FEHBP.

These overcharges were the result of the following:

<sup>3</sup> The presumed universe error rate of 40 percent was calculated using the results from our prior audit (Report No. 1A-99-00-10-061). Of the 59,364 claim lines reviewed from our prior audit, the BCBS plans incorrectly paid 23,244 claim lines for ineligible patients.

- Retroactive enrollment changes for 2,273 claim lines resulted in \$424,617 in overcharges;
- Recovery was not initiated when a retroactive enrollment change was previously identified for 509 claim lines, resulting in \$96,436 in overcharges;
- Manual processing errors for 135 claim lines resulted in \$26,789 in overcharges;
- FEP Express system processing errors for 35 claim lines resulted in \$5,734 in overcharges; and
- Provider billing errors for three claim lines resulted in \$3,275 in overcharges.

Based on our projection of the sample results, we are 95 percent confident that the true value of claims paid for ineligible patients from the universe described above is between \$3,114,869 and \$3,299,709. Our best estimate of the true value, the point estimate, is \$3,207,289, and this is the amount we are questioning in this report. Exhibit VI shows a summary of this statistical review.

**Exhibit VI – Summary of Statistical Review**

Universe of Claim Lines	Claim Lines Sampled	Claim Lines Paid in Error from Sample	Overcharges from Sample	Projection of Overcharges
156,559	7,650	2,955	\$566,851	\$3,207,289

Basis for questioning projected costs

The FEPDO’s guidance to the BCBS plans regarding the enrollment process appears inadequate and lacks sufficient oversight. Our prior global claims-to-enrollment match audits determined that \$7.92 million in claims were paid for ineligible patients during the period between 2005 and September 30, 2010. This represents approximately \$1.38 million in enrollment claim payment errors per year. In this current audit our *Member Enrollment Issues – Dollar Threshold Review* questions over \$10 million in claims that were paid for ineligible patients for the period of 2012 through September 30, 2014. This represents approximately \$3.64 million in enrollment claim payment errors per year – a 164 percent increase (\$2.26 million) in enrollment claim payment errors per year since our last audit was performed.

CS 1039 states that costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. In the conduct of competitive business, no prudent person would continue to take only minimal, and unsuccessful, measures to prevent such a magnitude of improper payments - knowing the nature of the enrollment process and the high risk associated with making improper payments. Therefore, we conclude that the FEP DO unreasonably charged the FEHBP for claims that were not paid in good faith in accordance with CS 1039. The full amount of the

estimated improper payments should be returned to the FEHBP trust fund, regardless of the FEP DO's ability to recover the improper payments from the specific providers to whom they were made.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments.

48 CFR 31.201-3 states, "(a) A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person in the conduct of competitive business."

**Association's Response:**

*"BCBSA [the Association] contests the OIG's additional questioned amount of \$3,207,289 because it does not allow BCBSA [the Association] to successfully resolve questioned claims in accordance with requirements as stated in CS 1039 related to Audit Resolution and Reportable findings. Further, BCBSA [the Association] does not agree to the validity or understand the statistical calculations performed to derive the additional questioned amounts. . . .*

*When OIG issues a Draft Report of findings to the Carrier, the Carrier must respond with all available, accurate and relevant documentation to validate or invalidate the findings. This must be done within the timeframe specified in the OIG Draft Report transmittal letter.*

*To enable this, Carriers must expeditiously tender all documentation necessary for resolution of the audit. This includes overpayment recoveries via check or certification, full documentation of the Carriers position for findings being contested, evidence supporting due diligence assertions, and support for all other pertinent issues which OPM must consider, as appropriate . . . .*

*Because Plans do not have the exact claims that are being questioned, there is no way that they can determine which claims to provide support for uncollectible, contested or recovered claims, thus Plans are unable to resolve the audit finding. . . ."*

The Association also states, *"The distribution of the Universe appears to be skewed towards the lower dollar end of the scale. This does not appear to correlate to the OIG point estimate of \$3,207,289.*

*If the approach is to be from a statistical perspective, we should have a clear and an agreed upon understanding of the Methodology used to determine the;*

- *Population to be sampled (how/why was a cumulative amount of \$2,500 derived)*

- *Sample Size determination*
- *Error Rate Calculation*
- *Factor(s) used to determine Point estimation*
- *Point estimation used (i.e., Average, Median)*

...

*In summary, because detail claims questioned as errors is not provided with the OIG questioned amount and due to insufficient documentation was provided to replicate/validate the point value estimate of \$3,207,289 used in the report, BCBSA [the Association] disagrees to the proposed total questioned amount of \$3,207,289 for Enrollment claim errors paid by the Program as non-covered charges.”*

**OIG Comments:**

We acknowledge that the statistical sampling methodology used in this review does not present the Association with the specific claim lines questioned, and that it is therefore unable to research and resolve these claims in accordance with CS 1039.

**Claim overpayments were not “reasonable”, and therefore funds should be returned to the FEHBP regardless of the Association’s ability to tie the questioned dollars to a specific claim line.**

However, the elements of CS 1039 cited by the Association are only applicable to claim overpayments made in good faith. As mentioned above, the Association has continued to make repeated overpayments without taking effective measures to prevent them. In other words, the payments were not “reasonable” as defined by the CFR, and therefore we do not consider the Association’s inability to associate the questioned dollars to a specific claim line applicable to this audit finding.

With regards to the details of the sampling methodology, we believe that all of the relevant statistical information is contained in the explanation above, but will directly address the specific elements questioned by the Association.

- The population sampled for this review was “Conflict with Enrollment Coverage” claims with cumulative payments under \$2,500. The \$2,500 threshold was judgmentally selected as the point below which it is not feasible to review every individual claim, and where statistical sampling would be more appropriate to determine the overpayments from this universe. In our opinion, it is not financially practical to initiate individual recovery for these claims, but the total volume of claims, and error rate, in this universe warrants that we estimate the overpayments.

- The sample size was determined using statistical analysis software that applied a random stratified dollar-unit sample targeting a 4 percent margin of error and a 95 percent confidence level, with a presumed universe error rate of 40 percent.
- The error rate was calculated using the error rate identified in our prior Global Claims-to-Enrollment Match audit (Report No. 1A-99-00-10-061).
- The point estimate was derived using the ratio estimator method, which is an appropriate estimator to use in the context of stratified dollar-unit sample designs, where each dollar in a stratum's value has the same probability of selection.

The sampling approach we used during this audit represents a valid statistical sampling methodology, and all of the relevant details and variables have been outlined in this report.

**Recommendation 8**

We recommend that the contracting officer disallow \$3,207,289 for claims that were not paid in good faith and unreasonably charged to the FEHBP.

## IV. MAJOR CONTRIBUTORS TO THIS REPORT

### Information Systems Audits Group

██████████, Auditor

██████████, Auditor-in-Charge

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██████████, Senior Team Leader

██████████, Group Chief

**APPENDIX A**



**BlueCross BlueShield  
Association**

An Association of Independent  
Blue Cross and Blue Shield Plans

Federal Employee Program  
1310 G. Street, NW  
Washington, DC 20005  
202.942.1000  
Fax 202.942.1125

March 10, 2015

██████████, Group Chief  
Claims & IT Audits Group  
U.S. Office of Personnel Management  
1900 E Street, Room 6400  
Washington, D.C. 20415-1100

Reference: **OPM DRAFT AUDIT REPORT  
Global Enrollment Audit  
Audit Report #1A-99-00-15-008  
(Report dated and received 12/12/2014)**

Dear ██████████:

This is in response to the above referenced U.S. Office of Personnel Management (OPM) Draft Report concerning the Global Enrollment Audit for claims paid during the period of January 1, 2012 through September 30, 2014, which questioned \$27,950,804 in potential payment errors. Our comments concerning the findings in the report are as follows:

**Recommendation 1**

We recommend that the contracting officer disallow \$27,950,804 for claims paid on behalf of ineligible patients, and have the BCBS plans return all amounts recovered to the FEHBP.

**BCBSA Response**

**IR1A. Enrollees Coverage Conflicts with Dates of Service \$25,522,865**

Our review of the IR1A that questioned claims paid for members that may have had gaps in coverage identified \$3,132,137 and in overpayments. These overpayments were the result of retroactive enrollment changes where the claim was processed before a termination notice was received either from the Payroll Office or from the member (in the case of a divorce, etc.). Where possible, recovery efforts have been initiated for the identified errors. The Plans will

continue to pursue these overpayments as required by CS 1039, Section 2.3 (g)(I). “Any benefit payments the Plans are unable to recover are allowable charges to the Program. In addition, as good faith erroneous payments, lost investment income is not applicable to these confirmed overpayments”.

Due to the nature of the enrollment process, we will continue to receive retroactive enrollment updates after the claim has been processed. However, the daily Claims Audit Monitoring Tool (CAMT) Retroactive Enrollment Report updated daily with retroactive enrollment activity is designed to identify retroactive terminations so that Plans can timely initiate recoveries on applicable erroneous payments. Additional tools to identify retroactive terminations include the CAMT Terminated Member roster, which identifies retroactive terminations that may not have been captured on the daily CAMT Retroactive enrollment report. We continue to monitor both processes to promote timely identification and recovery of terminated member claims.

We disagree that the remaining payments totaling \$22,390,728 were paid due to the following reasons:

- \$15,435,283 was paid correctly because the Members had coverage at the time the claims were incurred.
- \$2,638,198 in potential overpayments was identified before the audit started and was recovered before the draft report response was submitted.
- \$4,148,544 in overpayments was identified before the audit and recovery was initiated but not yet collected, was uncollectible because the retro termination notice was received after the Plan’s provider contract limit for recovering overpayments had passed.
- \$168,703 in overpayments is below the Plan’s recovery threshold, and further attempts to recover these overpayments exceed the cost to recover the overpayments.

See Attachment A, for a schedule to support the amount questioned and contested by each Plan.

**IR1b. Patients with No Enrollment Record**

**\$2,427,939**

Our review of IR1b that questioned claims paid for members that did not have an enrollment record on file identified \$232,141 in overpayments. These overpayments were the result of retroactive enrollment changes where the claim was processed before a notification from the either the Payroll Office or from the member (in the case of a divorce, etc.) updated the member enrollment coverage. Where possible, recovery efforts have been initiated for the identified errors. The Plans will continue to pursue these overpayments as required by CS 1039, Section 2.3 (g)(I). “Any benefit payments the Plans are unable to recover are allowable charges to the Program. In addition, as good faith erroneous payments, lost investment income is not applicable to these confirmed overpayments”.



We disagree that the remaining payments totaling \$2,195,798 were paid in error based upon the following reasons:

- \$1,251,692 was paid correctly because the Members had coverage at the time the claims were incurred.
- \$348,348 in potential overpayments was identified before the audit started and was recovered before the draft report response was submitted.
- \$579,614 in overpayments was identified before the audit and recovery was initiated but not yet collected, was uncollectible because the retro termination notice was received after the Plan's provider contract limit for recovering overpayments had passed.
- \$16,143 in overpayments is below the Plan's recovery threshold, and further attempts to recover these overpayments exceed the cost to recover the overpayments.

See Attachment B, for a schedule to support the amount questioned and contested by each Plan.

### **Recommendation 2**

We recommend that documentation be provided for each claim payment error that was identified in this preliminary finding.

#### **BCBSA Response**

Documentation to support claims audited was provided to the OIG.

### **Recommendation 3**

We recommend that the contracting officer instruct the Association to have the BCBS plans identify the root cause(s) of the claim payment errors and implement corrective actions/procedures to prevent these types of errors in the future.

#### **BCBSA Response**

BCBSA will work with the Plans to identify root causes where Plans did not identify and initiate recovery of claims totaling \$3,027,101 for IR1A and \$230,067 for IR1B before the audit started. BCBSA will also work with the FEP Operations Center to identify root causes where the retroactive termination notices were not issued to Plans so that appropriate overpayment recovery activity could be initiated before the audit started. Once the root cause analysis is completed, BCBSA work with Plans and the FEPOC to implement the necessary corrective actions so that terminated member activity is timely detected and recovery is timely initiated to recovery related overpayments.

Thank you for the opportunity to provide a response to the Draft Report. If you have any questions in the interim, please contact [REDACTED] at [REDACTED] [@bcbsa.com](mailto:[REDACTED]@bcbsa.com) or at [REDACTED].

Sincerely,

[REDACTED]  
Managing Director, FEP Program Assurance

cc: [REDACTED], OPM  
[REDACTED], FEP

## APPENDIX B

Response to **Audit Inquiry Global Enrollment**  
Friday, August 14, 2015

### **Audit Inquiry 1 Response**

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BCBSA contests the OIG's additional questioned amount of \$3,207,289 because it does not allow BCBSA to successfully resolve questioned claims in accordance with requirements as stated in CS 1039 related to Audit Resolution and Reportable findings. Further, BCBSA does not agree to the validity or understand the statistical calculations performed to derive the additional questioned amounts.

#### **CS1039 Requirements**

##### SECTION 3.15 AUDIT RESOLUTIONS (JAN 2011)

When OIG issues a Draft Report of findings to the Carrier, the Carrier must respond with all available, accurate and relevant documentation to validate or invalidate the findings. This must be done within the timeframe specified in the OIG Draft Report transmittal letter.

To enable this, Carriers must expeditiously tender all documentation necessary for resolution of the audit. This includes overpayment recoveries via check or certification, full documentation of the Carriers position for findings being contested, evidence supporting due diligence assertions, and support for all other pertinent issues which OPM must consider, as appropriate

##### SECTION 3.16 REPORTABLE FINDINGS (JAN 2013)

(b) Claim payment findings (i.e., claim overpayments) in the scope of an OIG audit are reportable as questioned charges unless the Carrier provides documentation supporting that these findings were already identified (i.e., documentation that the plan initiated recovery efforts) prior to audit notification letter.

Because Plans do not have the exact claims that are being questioned, there is no way that they can determine which claims to provide support for uncollectible, contested or recovered claims, thus Plans are unable to resolve the audit finding.

## Evaluation of Statistical Validity of OIG's Conclusion

The distribution of the Universe appears to be skewed towards the lower dollar end of the scale. This does not appear to correlate to the OIG point estimate of \$3,207,289.

If the approach is to be from a statistical perspective, we should have a clear and an agreed upon understanding of the Methodology used to determine the;

- Population to be sampled (how/why was a cumulative amount of \$2,500 derived)
- Sample Size determination
- Error Rate Calculation
- Factor(s) used to determine Point estimation
- Point estimation used (i.e., Average, Median)

Measure	Claim Line Universe (156,559)
Sum	\$ 8,883,300.00
Mean	\$ 57.00
Standard Deviation	\$ 118.00
Median	\$ 25.00
Minimum	\$ 0.01
Maximum	\$ 2,463.00

In summary, because detail claims questioned as errors is not provided with the OIG questioned amount and due to insufficient documentation was provided to replicate/validate the point value estimate of \$3,207,289 used in the report, BCBSA disagrees to the proposed total questioned amount of \$3,207,289 for Enrollment claim errors paid by the Program as non-covered charges.



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Washington Metro Area: (202) 606-2423

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

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