



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

Final Audit Report

**Audit of the National Association of Letter Carriers
Health Benefit Plan's Pharmacy Operations
as Administered by CaremarkPCS, L.L.C.
for Contract Years 2012 through 2014**

**Report Number 1H-01-00-16-045
September 29, 2017**

EXECUTIVE SUMMARY

Audit of the National Association of Letter Carriers Health Benefit Plan's Pharmacy Operations as Administered by CaremarkPCS, L.L.C.

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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 terms of U.S. Office of Personnel Management contract number CS 1067 with the National Association of Letter Carriers Health Benefit Plan (Plan), the Plan's agreement with CaremarkPCS Health, L.L.C. (PBM), and the applicable Federal regulations.

What Did We Audit?

The Office of the Inspector General (OIG) has completed a performance audit of the Plan's pharmacy benefits operations as administered by the PBM. Our audit consisted of a review of administrative fees, claim payments, fraud and abuse reporting, performance guarantees, and pharmacy rebates related to the FEHBP for contract years 2012 through 2014.



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What Did We Find?

We determined that the Plan and the PBM need to strengthen their procedures and controls related to administrative fees, claim payments, fraud and abuse reporting, and performance guarantees.

Specifically, our audit identified the following deficiencies that require corrective action:

- The Plan paid claims totaling \$54,766 for drugs that were not covered.
- The Plan paid \$19,852 in claims for dependents that were not eligible for coverage at the date the prescription was filled due to their age.
- The Plan inappropriately included non-FEHBP costs in its drawdowns related to the reimbursement of pharmacy costs. Additionally, the OIG was inadvertently provided with pharmacy claims data containing personal health information and other personally identifiable information related to Plan staff members.
- The PBM was unable to provide supporting documentation for all administrative fees charged to the Plan.
- The Plan did not report all cases of suspected fraud, waste, and abuse to the OIG.
- The PBM did not submit its annual performance reports or pay associated penalties to the Plan in a timely manner.

ABBREVIATIONS

5 CFR 890	Title 5, United States Code of Federal Regulations, Part 890
Agreement	The Prescription Benefit Service Agreement between the Plan and the PBM
Contract	OPM Contract Number CS 1067
CY	Contract Years
FEHB	Federal Employees Health Benefits
FEHBP	Federal Employees Health Benefits Program
FWA	Fraud, Waste, and Abuse
GPI	Generic Product Identifier
HIO	Healthcare and Insurance Office
LOCA	Letter of Credit Account
NALC	National Association of Letter Carriers
NDC	National Drug Code
OI	Office of Investigations
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
PBM	CaremarkPCS Health, L.L.C.
Plan	National Association of Letter Carriers Health Benefit Plan

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I. BACKGROUND

This report details the results of our audit of the National Association of Letter Carriers Health Benefit Plan's (Plan) pharmacy operations as administered by CaremarkPCS L.L.C. (PBM) for contract years (CY) 2012 through 2014. The audit was conducted pursuant to the provisions of Contract CS 1067 (Contract) between the U.S. Office of Personnel Management (OPM) and the Plan; the prescription benefit service 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 (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 (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 FEHB 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 National Association of Letter Carriers (NALC) has entered into a Contract with OPM to provide health benefit plans, including prescription drug coverage, as authorized by the FEHB Act to Federal employees and retirees. The Plan's pharmacy administrative operations and responsibilities under the Contract are carried out by the PBM, which is located in Scottsdale, Arizona.

Section 1.11 of the Contract includes a provision which allows for audits of the Plan's operations. Additionally, section 1.26(a) of the Contract outlines transparency standards related to Pharmacy Benefit Manager arrangements (effective January 2012) that require Pharmacy

Benefit Managers to provide pass-through pricing based on their 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.

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

The last OIG audit of the Plan (Report No. 1H-01-00-07-014) was issued on March 17, 2009. The previous audit report did not identify any findings.

The results of our audit were discussed with officials of the Plan and the PBM at an exit conference on April 27, 2017. In addition, a draft report, dated May 24, 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 in this report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

Objective

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

Specifically, our audit objectives were to determine if:

Administrative Fees Review

- The administrative expenses charged to the FEHBP were in support of pharmacy programs, in compliance with the contract and supported by verifiable documentation, and
- The Plan's letter of credit account (LOCA) withdrawals related to pharmacy benefits are in accordance with the terms of the Contract.

Claim Payments Review

- Overage dependents were eligible for coverage at the time of service and that their claims were paid in accordance with the Contract;
- Claims were paid for deceased members;
- Claims were paid for non-FEHBP members or members enrolled in an alternate plan code under the Plan;
- Mail order prescriptions are being filled within the allowable day supply as stated in the benefits brochure;
- Claims were paid to pharmacies debarred by OPM's OIG;
- Claims were paid for any excluded drugs; and
- The retail pharmacy, mail order pharmacy, and specialty pharmacy claim pricing elements were transparent and if the claims reviewed were priced accurately and in accordance with the Agreement.

Fraud and Abuse Review

- The Plan complied with all standards for fraud and abuse listed in Carrier Letter 2003-23, and
- The Plan reported all suspected cases of fraud and abuse to the OPM OIG that were reported by the PBM.

Performance Guarantees Review

- The reported performance guarantees and any associated penalty were reported accurately and that any penalties due were paid to the Plan.

Pharmacy Rebates Review

- The pharmacy rebates were properly supported, accurately calculated, and remitted to the Plan.

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 findings and conclusions based on the audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on the audit objectives.

This performance audit included reviews of administrative fees, claim payments, fraud and abuse reporting, performance guarantees, and rebates related to the FEHBP for CYs 2012 through 2014. A site visit was conducted from August 8 through 11, 2016, at the PBM's office in Scottsdale, Arizona. Additional audit work was completed at our Cranberry Township, Pennsylvania and Washington, D.C. offices.

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 \$3.8 billion in CYs 2012 through 2014, of which approximately two-thirds was paid by the government on behalf of Federal employees. In addition to the premium payments, program income was also generated from the investment of program funds. From the premiums collected and investment income earned during this time period, the following claims were paid related to prescription drug benefits:

Paid Drug Claims		
Contract Year	Total Claims	Amount Paid
2012	██████████	██████████
2013	██████████	██████████
2014	██████████	██████████
Total	██████████	██████████

In planning and conducting the audit, we obtained an understanding of the PBM’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 the applicable 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 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 the costs charged to the FEHBP and services provided to FEHBP subscribers were in accordance with the terms of the Contract, the Agreement, and applicable Federal regulations, we performed the following audit steps:

Administrative Fees Review

- From each CY, we selected the administrative fee invoice with the largest amount due from the Plan. Specifically, we selected 3 invoices, totaling \$30,305,079, from a universe of ██████ invoices, totaling ██████████, to determine if the fees were properly calculated and supported in accordance with the terms of the Agreement.

- From each CY, we selected LOCA drawdown information from the month with the largest pharmacy expenditures for review. Specifically, we selected 3 months of pharmacy expenditures, totaling \$110,537,393, from a universe of 36 months of expenditures, totaling [REDACTED], to determine if the Plan's LOCA withdrawals related to pharmacy benefits were in accordance with the terms of the Contract.

Claim Payments Reviews

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 non-disabled dependents 26 years of age or older ([REDACTED] dependents, with claims totaling [REDACTED]) to determine if the dependents were eligible for coverage at the time of service in accordance with the Contract.
- We identified and reviewed all claims paid for patients aged 100 or older in CY 2014 ([REDACTED] subscribers with claims totaling [REDACTED]), to determine if any claims were paid for deceased members.
- We reviewed all claims to determine if any claims were paid for non-FEHBP members or members enrolled in an alternate plan code.
- We identified and reviewed all non-aspirin mail order claims with a day's supply less than 21 days or greater than 90 days, ([REDACTED] claims, totaling [REDACTED]), to determine if mail order prescriptions were filled in accordance with the days' supply allowed per the Plan's benefits brochures.
- We reviewed all claims to determine if any payments were made to a pharmacy debarred by the OIG's Administrative Sanctions Office.
- We reviewed all pharmacy claims for drugs identified by the PBM as non-covered to determine if any claims were paid for drugs excluded by the Plan.
- We separately identified the universe of brand and generic claims paid to the top five retail pharmacy chains (as identified by the PBM). Specifically, we identified [REDACTED] brand claims, totaling [REDACTED], and [REDACTED] 6 generic claims, totaling [REDACTED]. From those universes, we randomly selected 5 brand and 5 generic claims from each of the pharmacies for each CY (75 brand claims, totaling \$8,202, and 75 generic claims, totaling \$2,209) to determine if the pricing elements were transparent and that the claims were paid correctly.

- We separately identified the universe of mail order brand and generic claims paid. Specifically, we identified [REDACTED] brand claims, totaling [REDACTED], and [REDACTED] generic claims, totaling [REDACTED]. From those universes, we randomly selected 15 brand and 15 generic claims from each CY (45 brand claims, totaling \$18,260, and 45 generic claims, totaling \$1,641) to determine if the pricing elements were transparent and that the claims were paid correctly.
- We separately identified a universe of [REDACTED] specialty pharmacy claims, totaling [REDACTED]. From that universe, we randomly selected 25 claims from each CY (75 claims, totaling \$375,100) to determine if the pricing elements were transparent and that the claims were paid correctly.

Fraud and Abuse Review

- We reviewed the completed fraud and abuse questionnaires provided by both the Plan and the PBM to determine if they complied with all standards for fraud and abuse listed in Carrier Letter 2003-23.
- We compared the listing of fraud, waste, and abuse (FWA) cases that was provided to OPM's OIG by the Plan to the information received by OPM's OIG on the FWA Annual Reports to determine if the Plan reported all suspected cases of FWA, as required by Carrier Letter 2011-13.

Performance Guarantees Review

- We judgmentally selected 5 performance guarantees (out of a universe of 18) based on prior audit experience or the performance guarantee having an associated penalty to determine if the reported performance guarantees were accurate and that any associated penalties were paid to the Plan.

Pharmacy Rebates Review

- We judgmentally selected CY 2012, with rebates received totaling [REDACTED], for review because that CY reported over 99 percent of anticipated rebates received. The total universe of rebates received (as of the date of our audit) was [REDACTED].
 - From CY 2012, we selected and reviewed the pharmacy rebate report related to the fourth quarter, which had the highest amount of rebates received ([REDACTED]). From that quarter, we then judgmentally selected the top 5 manufacturers with the largest rebate invoice amount (\$4,147,298), from a universe of 78 manufacturers with rebate invoice amounts of \$8,161,908. We then judgmentally selected the top two drugs with the largest rebate amount from each of the sampled manufacturers (10 drugs with rebates of \$3,502,933, out of a

universe of 54 drugs with total rebates of \$4,147,298), to determine if the rebates were properly supported, accurately calculated, and remitted to the Plan.

The samples mentioned above, 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

1. Unsupported Administrative Fees

Procedural

The PBM was unable to support all administrative fees, totaling [REDACTED], billed to the Plan for CYs 2012 through 2014.

The PBM did not provide sufficient documentation to support the administrative fees charged to the Plan.

The Agreement states that the Plan will pay the PBM for administrative products and services provided in accordance with the administrative fee provisions set forth in Schedule A of the Agreement.

To determine if the administrative fees paid by the Plan were in accordance with the terms of the Agreement, we reviewed a sample of 120 administrative fee line items (quantities, rates/unit prices, and total charged) from three administrative fee invoices (one each from CY's 2012 through 2014). During our review, the PBM was unable to provide accurate support (quantities, unit prices, and/or total amount charged) for 105 of the 120 administrative fee line items reviewed. Those unsupported administrative fee line items represent [REDACTED] in costs charged to the FEHBP. A listing of these items was provided to the PBM; however, it was unable to provide sufficient supporting documentation for the line items in question.

Due to the lack of documentation, we were unable to determine if the administrative fees billed to the FEHBP were accurate and in accordance with the Agreement.

Recommendation 1

We recommend that the Plan review recent invoices (new claims system) from the PBM to ensure that all line items are supported by sufficient and verifiable documentation. Additionally, the Plan should ensure that all invoice line item rates are traceable to the Agreement or other documentation.

Plan Response:

The Plan agrees that not all supporting documentation requested was provided and stated that the claims adjudication system in place during the scope of the audit did not include the archiving of source documentation for ancillary and administrative fees. However,

beginning in 2015, a new claims system began to be utilized for the Plan's claims that does provide for the archiving of all source documentation for administrative fees.

OIG's Response:

The OIG understands that the information provided does not match the totals reported on the invoices because of the passage of time and normal changes within the claims data itself, and therefore will not question the unverified amount. However, going forward we expect the PBM to maintain archived supporting documentation for all fees charged to the FEHBP at the time of invoicing, regardless of the carrier. Any fees that are not supported in the future will be questioned as unallowable costs to the Program.

2. Inappropriate LOCA Drawdowns and Release of Information

Procedural

The Plan inappropriately included non-FEHBP costs in its drawdowns related to reimbursement of pharmacy costs. Additionally, the OIG was inadvertently provided claims data containing personal health information and other personally identifiable information related to pharmacy claims for Plan staff members.

According to FEHBAR 1632.170 (b) (2), withdrawals from the LOCA will be made on a checks-presented basis for FEHBP disbursements.

Additionally, section 1.31 (a) (2) of the Contract states that the Plan will preserve access and disclosure of information to protect personal privacy.

Our review of the PBM's invoices found costs related to both FEHBP and Plan staff members. The PBM issues invoices four times a month (on the 7th, 15th, 23rd and last day of the month). Additionally, we found that for all invoices issued, claim charges were segregated by group (FEHBP and non-FEHBP). However, a portion of the administrative fees charged on the last invoice of the month are not segregated by group, and according to discussion with the PBM, include administration fees for both groups.

The Plan included non-FEHBP claims and administrative fees in its LOCA drawdowns, and personal health information and personally identifiable information from claims for Plan staff was provided to the OIG.

The commingling of FEHBP and non-FEHBP cost on the PBM's invoices led us to review the Plan's drawdowns related to pharmacy expenses. We determined that non-FEHBP claim expenses were withdrawn from the Plan's LOCA. Discussions with the Plan determined that it permitted this to occur because the pharmacy expenses of the Plan's staff members are ultimately administrative expenses chargeable to the FEHBP and would eventually be drawn

down from the LOCA as such. Because only a small portion of the staff plan costs (the actual administration of the staff plan's claims) are non-FEHBP administrative expenses, the Plan performs a monthly process to remove non-FEHBP costs from its service charge. We determined that the process appears to properly remove the non-FEHBP costs. However, we were unable to determine if the unsegregated administrative fees were accounted for in the process.

Additionally, when claim files were provided to the OIG by the PBM, those files included claims for both FEHBP and Plan staff members. These claim files included personal health information and other personally identifiable information. This occurred because the PBM provided the claim files for all groups billed on its invoices including both FEHBP and the Plan's staff members.

As a result, the FEHBP was initially overcharged for amounts not related to the FEHBP and the OIG was inadvertently provided private and confidential health information of Plan staff members.

Recommendation 2

We recommend that the Plan determine the actual FEHBP cost of its staff members prior to drawing down that amount as an administrative expense cost to the Contract.

Plan Response:

The Plan disagrees with the finding and states that it exercised due diligence to ensure the appropriateness of its daily drawdowns.

The Plan stated that during the scope of the audit non-pharmacy claims were adjudicated on three separate claim platforms (one for each of its health plans; FEHBP, Conversion (former FEHB enrollees) and its NALC staff plan) and each claim payment was made/disbursed against each plan's specific bank account.

Pharmaceutical costs are not paid in the same manner, but are paid in aggregate to the PBM four times monthly. The Pharmacy costs are paid out of the Plan's only administrative expense checking account that is funded by the LOCA. However, the Plan states that all costs that run through this account are allocated to individual plans at disbursement and that once a month it performs a reconciliation to make each plan whole.

The Plan stated that it works methodically to ensure allocations to the plans are correct and it has been conservative when allocating costs to the FEHBP. During the audit scope employee indirect costs were allocated to the FEHB at 98.95 percent (on average). It also states that an OIG audit conducted in 2013 did not include findings related to its management of FEHBP funds.

Lastly, the Plan states that it would agree with the recommendation if it were not for the fact that the drawdowns represent funds remitted to the staff plan in significant amounts.

OIG's Response:

As was stated in the finding, we do not feel that the Plan's actions in regards to its LOCA drawdowns related to pharmacy costs ultimately have a negative effect on the FEHBP. However, its actions violate the LOCA regulations which state that the LOCA withdrawals are only to be made for FEHBP disbursements. Therefore, non-FEHBP costs should not be included in any drawdowns from the LOCA, even if a true-up is later performed.

We see two options in regards to this recommendation for the Plan.

- First, that it draw down all allocated administrative cost (staff plan and other allocated expenses) based on an estimated allocation percentage and not in full at the time of bank clearance. Following that, either monthly or quarterly, the Plan may perform a true-up to determine what the actual allocation percentage should have been and make the parties whole at that point.
- Second, that it work with the OPM contracting office to obtain a waiver of the LOCA requirement in regards to allocated administrative costs only.

Recommendation 3

We recommend that the Plan direct the PBM to establish safeguards to ensure that only FEHBP member claims are released to the OIG for future audits.

Plan Response:

The Plan agrees with the recommendation and states that it will have the PBM begin transmitting only the FEHBP claims data to the OIG in the future.

B. CLAIM PAYMENTS REVIEW

1. Claims Paid for Non-Covered Drugs

\$54,766

The Plan erroneously paid 1,651 pharmacy claims, totaling \$54,766, for drugs that were not a covered benefit.

**The PBM
paid claims
for non-
covered
drugs.**

The Agreement defines covered drugs as “a drug which, under applicable law, requires a prescription and which is covered under the formulary adopted by the Plan.”

Additionally, Section 5 (f) of the Plan’s benefit brochure provides a general listing of the types of drugs that are not covered.

Utilizing the listing of non-covered drugs provided by the PBM, we performed a query of the Plan’s claims universe to identify all claims for non-covered drugs paid during the scope of the audit. We then reviewed the documentation provided by the PBM to determine if there were legitimate reasons for the claims to be paid (for example, members receiving prior authorizations for their prescriptions). Our review determined that 1,651 claims, totaling \$54,766, were erroneously paid for non-covered drugs.

The PBM stated that the errors were due to the fact that the prior claims system, used during the scope of our audit, rejected non-covered drugs based on the National Drug Code (NDC). As new NDCs entered the market, the system did not identify the new codes as non-covered and unallowable. The current claims system that was implemented after the scope of our audit rejects non-covered drugs based on the Generic Product Identifier (GPI). The GPI encompasses multiple NDCs related to the same drug (based on dosage and drug strength). If and when different dosages and/or drug strengths are added to the market, the current claims system will reject those claims because the NDC is automatically associated with the GPI of the non-covered drug.

As a result of the PBM’s prior claims system not properly identifying new non-covered drugs as they entered the market, the FEHBP was overcharged \$54,766.

Recommendation 4

We recommend that the Plan return \$54,766 to the FEHBP for erroneous payments of non-covered drugs.

Plan Response:

The Plan agrees with our recommendation and will work with the PBM to return the funds to the FEHBP.

Recommendation 5

We recommend that the Plan review the PBM's current claims system to ensure that non-covered drugs are properly denied.

Plan Response:

The Plan agrees with our recommendation and states that non-covered drugs fall into two categories. Those that are never covered and those that are covered under special circumstances following prior authorization. The Plan will conduct a review of claims from 01/01/15 to the present to ensure payment for non-covered drugs has not occurred. Should the Plan's review find claim payments for non-covered drugs, it will work with the PBM to return any overpayments identified to the FEHBP and initiate any coding corrections.

The Plan is taking steps to implement oversight controls to include using the PBM's list of non-covered drugs to develop periodic subset lists of non-covered drug categories; periodically testing the PBM's claims system using simulated claims to ensure these claims are denied at the point of sale; and conducting an analysis to determine the frequency of these reviews.

2. Over-Age Dependents

\$19,852

The Plan paid 88 claims, totaling \$19,852, for 16 dependents that were ineligible for coverage on the date the prescription was filled.

Public Law 111-148, section 2714, extended health insurance coverage for unmarried dependent children until age 26.

Additionally, section 2.3 (g) of the Contract states that "It is the Carrier's responsibility to proactively identify overpayments through comprehensive, statistically valid reviews and a robust internal control program."

**The Plan
paid claims
for ineligible
over-age
dependents.**

Finally, section 2.3 (g) (12) of the Contract states, "In compliance with the provisions of the Contracts Dispute Act, the Carrier shall return to the Program an amount equal to the

uncollected erroneous payment where the Contracting Officer determines that (a) the Carrier's failure to appropriately apply its operating procedure caused the erroneous payment”

To determine if claims were paid for dependent children age 26 and older, we queried the Plan's pharmacy claims database and identified claims paid for ■ dependent children age 26 or older. Our review determined that 16 dependents were ineligible for coverage at the time of service.

Specifically, we found that 15 dependents were correctly terminated upon turning age 26 in the Plan's eligibility system. However, the PBM was not provided with this information and continued to pay claims for those individuals. In addition, one dependent had been granted temporary disabled dependent status by the Plan in 2003, allowing for payment of claims (not to exceed one year). The PBM continued to pay claims for this dependent but there was no supporting documentation to show an extension of that status beyond one year.

The Plan stated that its system reflects the correct termination dates and believes that it sent timely eligibility updates to the PBM, but the Plan can no longer document that the eligibility files were sent to the PBM. According to the Plan and the PBM, eligibility update files (changes only) are sent to the PBM daily. However, the Plan does not provide a full eligibility file to the PBM for it to determine any potential enrollment discrepancies.

By not ensuring that the PBM had proper eligibility information for all individuals, the FEHBP was overcharged \$19,852.

Recommendation 6

We recommend that the Plan return \$19,852 to the FEHBP for claim payments on ineligible over-age dependents.

Plan Response:

The Plan disagrees with the amount due to the FEHBP and believes its liability is \$4,393. The Plan believes two of the questioned members are eligible for service based on documentation provided during the audit. The Plan stated that some of the claims were written off as not cost effective to pursue, some of the claims the Plan was able to offset from other benefit payments, and some had been refunded.

OIG's Response:

Upon further review, the OIG agrees that one of the questioned members is eligible because it fell within the grace period after termination. The finding has been adjusted to reflect this.

As for the remaining questioned costs the Plan has not provided any documentation to support its assertions that claims were offset and/or monies were received and returned. Furthermore, amounts being written off as not cost effective to pursue is not an acceptable method of handling claim overpayments. The Plan is required to make documented attempts at recovering overpayments as outlined in section 2.3 of the Contract.

Recommendation 7

We recommend that the Plan provide the PBM periodically with a full eligibility file in addition to the daily update file.

Plan Response:

The Plan agrees with our recommendation and has taken initial steps to create this process.

Recommendation 8

We recommend that the Plan identify all claims paid to ineligible members and initiate recoveries.

Plan Response:

The Plan agrees with our recommendation and believes the implementation of the prior recommendation will improve the process.

OIG's Response:

While we are encouraged that the Plan is implementing the changes from the recommendation above, once the process is fully implemented we believe an eligibility reconciliation should be performed to not only identify ineligible over-aged dependents, but to identify all members who may no longer be eligible. Recoveries must be initiated on all claims for members that are found to be ineligible on the date of service.

C. FRAUD AND ABUSE REVIEW

1. Fraud and Abuse Cases Not Reported by the Plan

Procedural

The Plan did not report all of the suspected FWA cases to OPM OIG for CYs 2012 through 2014.

All suspected fraud, waste, and abuse cases were not reported to the OPM OIG.

According to Carrier Letter 2011-13, the “FEHBP Carrier Special Investigative Units (“Carrier”) are required to submit a written notification to the OPM OIG (“OIG”) within 30 working days of becoming aware of a fraud, waste or abuse issue where there is a reasonable suspicion that a fraud has occurred or is occurring against the [FEHBP]. Reportable fraud, waste or abuse issues include the identification of emerging fraud schemes; suspected internal fraud or abuse by Carrier employees, contractors, or subcontractors; suspected fraud by providers who supply goods or services to FEHBP members; suspected fraud by individual FEHBP members; issues of patient harm, and Carrier participation in class action lawsuits. There is no financial threshold for these initial case notifications.”

We reconciled the number of FWA cases opened to those reported to the OIG in the annual FWA Recovery and Savings Data Reports and found a large variance of opened cases that were not reported to the OIG. Additionally, we reviewed the Plan’s detailed spreadsheet of cases that it reported to the OIG. (See table below.)

	2012	2013	2014
FWA Annual Report – Cases Opened	46	316	1,322
FWA Annual Report – Cases Reported to OIG	8	11	3
Cases Reported to OIG per the Plan	8	11	3

The Plan stated that guidance previously received from the OPM OIG indicated that cases with nominal dollar amounts and low risk allegations were not required to be reported. The Plan is currently participating in the FEHBP FWA Task Force, which is working with the OPM OIG to address this area. The OIG Office of Investigations (OI) confirmed that there are ongoing discussions with FEHBP Carriers and that new guidance is forthcoming.

Nevertheless, the FWA guidance in effect during the majority of the audit scope was Carrier Letter 2011-13. Carrier Letter 2014-29 was issued on December 19, 2014, and updated the standards for FWA reporting and are the current standards in place as of the date of this report.

By not reporting all potential FWA cases to the OPM OIG, the Plan adversely affected the OPM OIG's ability to investigate these potential cases and increased the risks of overcharges to the FEHBP.

Recommendation 9

We recommend that the Plan comply with all official guidance for FWA in place at the time of reporting and continue to follow that guidance until such time an official update or replacement is issued.

Plan Response:

The Plan agrees that it did not report all open cases during the scope of the audit, but believes they are in compliance with all current guidance. The Plan states that complying with Carrier Letter 2011-13's 30 day reporting requirement had challenges; as case notifications require a lengthy list of detailed information which was hard to compile in that time frame. The Plan had also not implemented software and methods of investigating and tracking cases of FWA.

The Plan also indicates that with the issuing of new guidance in Carrier Letter 2014-29 they have made a good faith effort to report cases that meet the "affirmative step" requirement that triggers a case notification. However, it wasn't until November 2016 that the OIG OI defined "affirmative step". Since the clarification, the Plan has been submitting quality case notifications after a preliminary review and an affirmative action has been taken to investigate the complaint. The Plan will continue to follow these directives until such time an update or replacement is issued.

D. PERFORMANCE GUARANTEES REVIEW

1. Performance Guarantees

Procedural

The PBM did not submit the required annual performance reports to the Plan by the due date in the Agreement. Furthermore, the PBM did not timely credit the Plan for penalties related to a performance standard that it failed to meet in CY 2013 and 2014 by the due date in the Agreement.

Exhibit D of the Agreement states that the PBM shall provide the performance guarantee report card no later than 90 days after the end of the CY (by March 31st of each CY). Any penalty amounts must be paid by the end of the month following issuance of the report card (no later than April 30th of each CY).

We reviewed a sample of the reported performance guarantees for CY's 2012 through 2014 to determine if the results of the performance guarantees were calculated accurately, if the standards were met, and whether any associated penalties were paid timely. Our review determined that the results of the performance guarantees were accurately calculated and reported. However, the performance guarantee report cards and associated penalties were not reported or paid timely.

The PBM did not submit performance reports or credit penalty payments in a timely manner.

The performance guarantee report cards, which were due by the end of March, were submitted at the beginning of June for each CY. The performance guarantee penalties, which are due no later than the end of April, were credited at the end of June and beginning of July, respectively, for CYs 2013 and 2014.

The PBM stated that for the CYs 2012 through 2014, the system was set-up to report and measure the performance guarantees at the same time, which caused delays in payment to the Plan for any performance guarantee penalties. In order to align the Plan with the contractual agreement and prevent delays in penalty payments, beginning with CY 2016 quarterly performance guarantee reporting was changed to report 60 days following the quarter end.

Due to the untimely reporting of performance guarantees by the PBM, there was a delay in the Plan being made aware of any unmet performance standards. As a result of these delays, the performance penalties were not paid to the FEHBP in a timely manner.

Recommendation 10

We recommend that the Plan review the PBM's performance guarantee reporting changes implemented in CY 2016 to ensure that the results and any potential penalties are reported and remitted timely.

Plan Response:

The Plan agrees with our recommendation and confirms that for contract year 2016 all quarterly performance guarantee reports were received within 60 days of the quarter's end. The Plan states that this change will allow for any penalties due to be paid within the 90 day requirement.

E. PHARMACY REBATES REVIEW

The results of our review showed that rebates were properly supported, accurately calculated, and remitted to the Plan by the PBM in accordance with the Agreement.

APPENDIX

June 23, 2017

[REDACTED]
Group Chief
Special Audits Group

[REDACTED]
Senior Team Leader
Office of Inspector General
U.S. Office of Personnel Management

**Re: OPM Draft Audit Report Response
National Association of Letter Carriers Health Benefit Plan's Pharmacy
Operations as Administered by CaremarkPCS Health, L.L.C. for Contract
Years 2012 through 2014
Audit Report Number 1H-01-00-16-045 (Dated and Received May 24, 2017)**

Dear [REDACTED] and [REDACTED]:

We appreciate the opportunity to comment on the findings, conclusions and recommendations in the above-referenced Draft Report of the audit of the National Association of Letter Carriers Health Benefit Plan's (Plan) pharmacy operations as administered by CaremarkPCS Health, L.L.C. (PBM) for contract years 2012 through 2014. In the interest of clarity, we have made our comments in response to the findings, conclusions and recommendations within the body of the draft report, which follows.

We look forward to working with the OPM OIG and our Contract Specialist to address these areas, and to receiving additional guidance on F&A as OIG has indicated is forthcoming.

Sincerely,

[REDACTED]

[REDACTED]

Administrator
NALC Health Benefit Plan

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Not Relevant to the Audit Report**

Report No. 1H-01-00-16-045

Unsupported Administrative Fees

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Not Relevant to the Audit Report**

Recommendation 1

We recommend that the Plan direct the PBM to provide all source documentation to support the quantities, unit prices, and/or total amount charged so that our review of administrative fees can be completed.

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Not Relevant to the Audit Report**

The migration from [REDACTED] to [REDACTED] adjudication system is the reason why some source documentation is no longer available to support the administrative fee samples selected by the OIG as part of the audit review process. The [REDACTED] platform, the adjudication system in effect for 2012-2014, did not include the archival of source documentation for ancillary and administrative fees. Administrative invoices were generated from the [REDACTED] platform during this time. In contrast, all source documentation for administrative fees is archived under the Plan's current adjudication system ([REDACTED]) since administrative invoicing is generated from the PBM's [REDACTED] financial system.

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Not Relevant to the Audit Report**

Inappropriate LOCA Drawdowns and Release of Information

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Not Relevant to the Audit Report**

Recommendation 2

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Not Relevant to the Audit Report**

In response to the OIG draft audit finding, that the Plan inappropriately included non-FEHBP costs in its drawdowns related to reimbursement of pharmacy costs, the Plan respectfully disagrees and asserts that it exercised due diligence to ensure the appropriateness of the daily LOCA drawdown during the audit scope period, which we discuss below in greater detail.

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Not Relevant to the Audit Report**

The National Association of Letter Carriers Health Benefit Plan's existence is based on participation as a Federal Employees Health Benefit Plan carrier. During the audit scope timeframe of 2012 through 2014, NALC's operations at the Ashburn, VA facility consisted of three health plans: FEHB, Conversion (former FEHB enrollees) and a Staff Plan (NALC Health Benefit Plan for Employees and Staff).

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Not Relevant to the Audit Report**

Pharmaceutical Rx costs are not paid at the individual claim level, but are paid in the aggregate to CVS Caremark on four billings during a monthly cycle; the billing does segregate the differing plans' Rx costs. CVS Caremark invoices are paid by the Plan's accounting department using the Plan's sole administrative checking account. The administrative checking account is a FEHB account funded by the LOCA drawdowns and all administrative expenses are paid using this account. However, all expenses are allocated to the individual plans at disbursement; and once a month a reconciliation is performed that makes each plan whole during a cash transfer process called "interplan" (due to/from).

Administrative costs are both direct (related to a specific plan) and indirect (shared and allocated between the differing plans). NALC HBP has always methodically allocated expenditures between the differing plans, and expenses defined by OPM as unallowable are charged to the non-FEHB plans. Our methodology has always erred on the side of conservative when allocating to FEHB. In 2013, OIG conducted an audit of the Plan for years 2007 through 2011 which included a review of the Plan's cash management practices related to FEHB Program funds. During that period, the same system for allocating expenses described above was used. The audit disclosed no findings pertaining to cash management and overall concluded that the Plan handled FEHBP funds in accordance with Contract CS 1067 and applicable laws and regulations.

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Not Relevant to the Audit Report**

In regard to the OIG recommendation that the Plan ensure that the costs (claims and administrative fees) related to its staff members are invoiced separately from the costs associated with FEHBP members, as we have indicated above, this was the practice followed during the audit period, and remains the practice followed by the Plan today. Furthermore, the issue

identified by OIG regarding the segregated administrative fees, which are included in the invoice on the last day of the month, has been corrected and currently these charges, which still appear on the final invoice of the month are broken down into FEHBP and non-FEHBP charges.

Recommendation 3

We recommend that the Plan determine the actual FEHBP cost of its staff members prior to drawing down that amount as an administrative expense cost to the FEHBP contract.

NALC Health Benefit Plan Response:

In regard to the OIG recommendation that the Plan determine the actual FEHBP cost of its staff members prior to drawing down the amount as an administrative expense cost to the FEHBP contract, we would agree with the OIG recommendation were it not for the fact that these draws represent funds remitted to the Staff Plan in significant arrears.

See Recommendation 2 for additional detail.

Recommendation 4

We recommend that the Plan direct the PBM to establish safeguards to ensure that only FEHBP member claims are released to the OIG for future audits.

NALC Health Benefit Plan Response:

In order to ensure only FEHBP member claims are released to the OIG for future audits, CVS Health will begin transmitting claim files to the OIG based on Group Level versus Carrier level claims activity. The current process, based on Carrier level claim activity, includes all claims processed for both FEHBP members as well as NALC Staff and Non-group members. All NALC Staff and Non-group members are assigned to a unique Group number as part of NALC's Carrier/Account/Group (CAG) structure. By excluding non-FEHBP member claims from the monthly claim file sent to the OIG, the OIG will only receive a claim file of FEHBP member claim activity.

The Plan will work with CVS Health to implement this change in compliance with Recommendation 4 and will provide an effective date for the new claim file format once all system updates have been completed.

See Recommendation 2 for additional detail.

Claims Paid for Non-Covered Drugs

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Not Relevant to the Audit Report**

Recommendation 5

We recommend that the Plan return \$66,316 to the FEHBP for erroneous payments of non-covered drugs.

NALC Health Benefit Plan Response:

While the Plan and CVS Caremark both agree that erroneous payments for non-covered drugs occurred,

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Not Relevant to the Audit Report**

The Plan will work with CVS Health to initiate a Service Warranty in the amount of \$54,748.03, the amount calculated to be the financial impact for this error. Once the Service Warranty has been completed by the PBM, the erroneous payment for non-covered drugs will be returned to the FEHBP.

Recommendation 6

We recommend that the Plan review the PBM's current claims system to ensure that non-covered drugs are properly denied.

NALC Health Benefit Plan Response:

In support of Recommendation 6, the Plan has requested a list of non-covered drugs with their corresponding GPI numbers from CVS Caremark. Rx labeled non-covered by the Plan fall into two (2) categories, those that are never covered by the Plan (e.g. weight loss) and those that are only covered for specific conditions, such as drugs that could be used for cosmetic purposes. The latter require prior authorization to support a coverage exception. Using this information, the Plan will review claims data to determine if FEHBP members have obtained the appropriate Prior Authorization for claims filled for non-covered drugs effective 1/1/2015 to the present.

Should it be determined that claims were not properly denied in accordance with Plan coverage guidelines for non-covered drugs, the Plan will work with the PBM to initiate coding corrections

to correct the error and ensure full compliance with Plan guidelines. Any applicable overpayment for additional non-covered drug claim activity without proper documentation will be returned to the FEHBP upon completion of a Service Warranty.

Going forward, the Plan is taking the following steps to implement proper oversight and controls:

- the Plan will use the above referenced list requested from CVS Caremark (regularly updated for changes) to develop periodic subset lists of non-covered drug categories to include:
 - Drugs used for cosmetic purposes
 - Nutrients and food supplements
 - Drugs for infertility
 - Weight loss drugs
- the Plan will periodically test the CVS Caremark claims system using simulated prescription claims to ensure drugs falling within these categories are correctly denied at point of sale unless they have a prior authorization, and work with CVS Caremark (1) to correct any errors; and (2) identify instances where actual claims have been paid for non-covered drugs without appropriate documentation to support a coverage exception, and commence recovery steps.
- the Plan will conduct an analysis to determine an appropriate frequency to perform this review based upon criteria to include the current number of non-covered drug GPIs and the volume of claims processed in these categories.

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Not Relevant to the Audit Report**

Over-Age Dependents

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Not Relevant to the Audit Report**

Recommendation 7

We recommend that the Plan return \$19,999 to the FEHBP for claim payments on ineligible over-age dependents.

NALC Health Benefit Plan Response:

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Not Relevant to the Audit Report**

Due to the age and/or amount of the overpayment, some were written off over time or at the time of set-up as not cost effective to pursue.

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Not Relevant to the Audit Report**

The total amount billed to the Plan before credits is \$10,857.53. The actual overpaid amount was \$6,506.47. Benefits totaling \$1,607.60 (Samples 22 and 33) were recouped by offsetting benefits due from other services. We received an additional \$506.01 in refunds (Samples 5 and 17). The Plan believes our liability to the FEHB to be \$4,392.86.

Recommendation 8

We recommend that the Plan provide the PBM periodically with a full eligibility file in addition to the daily update file.

NALC Health Benefit Plan Response:

The Plan is in agreement with the OIG's recommendation that it periodically provide CVS Caremark with a full eligibility file in addition to the daily (aka/ add/change/delete) update file. As an initial step to address the finding that was made during the OIG's field work, in January 2017, the Plan created a process that is initiated on a request basis utilizing the same connectivity channel as is used for the daily file.

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Not Relevant to the Audit Report**

Recommendation 9

We recommend that the Plan identify all claims paid to ineligible members and initiate recoveries.

NALC Health Benefit Plan Response:

The Plan agrees with the OIG recommendation that it identify all claims paid to ineligible members and initiate recoveries.

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Not Relevant to the Audit Report**

Fraud and Abuse Cases Not Reported by the Plan

**Deleted by the OPM-OIG
Not Relevant to the Audit Report**

Recommendation 10

We recommend that the Plan comply with all official guidance for FWA in place at the time of reporting and continue to follow that guidance until such time an official update or replacement is issued.

NALC Health Benefit Plan Response:

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Not Relevant to the Audit Report**

The Plan agrees insofar as it did not report all cases that were opened.

While the Plan agrees on this point, the guidance in Carrier Letter 2011-13 indicates that to meet the 30-day notification requirement, Carriers may provide notification on cases where their investigation is still in the early stages without sufficient evidence to substantiate the allegation. Notwithstanding CL 2011-13's acknowledgement of the practical limits to developing a case within such a compressed timeframe, notifications were expected to include a lengthy list of detailed information, including some information which likely would have been difficult to assemble within the 30-day reporting timeframe applicable during the majority of the audit scope, insofar as the Plan had not yet implemented General Dynamic Health Solutions (GDHS) software and methods of investigating and tracking FWA.

Regarding the required reporting following the issuance of Carrier Letter 2014-29 on December 19, 2014, the Plan made a good faith effort to report cases that met the as yet to be defined "affirmative step" triggering notification to OIG. The Plan's efforts to comply with CL 2014-29's reporting requirements must be placed within the context of the on-going dialog between carriers participating in the FEHBP FWA Task Force and the OIG Office of Investigation. The product of that dialog is evidenced in the November 2016 draft FEHB Fraud and Abuse Definitions, distributed by the OIG Office of Investigations by email (see attachment Exhibit E), which includes a new definition of "affirmative step".

After receiving clarification at the Task Force Meetings in September and November of 2016, the Plan has a clearer understanding of the case notification requirements. In 2017, the Plan's SIU began triaging FWA allegations to submit quality case notifications after a preliminary

review of the complaint is completed and an affirmative action has been taken to investigate the complaint.

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Not Relevant to the Audit Report**

We believe that these measures sufficiently demonstrate the Plan's compliance with all official current guidance. In accordance with Recommendation 10, we will continue to follow these measures until such time as an official update or replacement is issued.

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Not Relevant to the Audit Report**

Performance Guarantees

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Not Relevant to the Audit Report**

Recommendation 12

We recommend that the Plan review the PBM's performance guarantee reporting changes implemented in CY 2016 to ensure that the results and any potential penalties are reported and remitted timely.

NALC Health Benefit Plan Response:

The Plan has reviewed the PBM performance guarantee reporting changes effective 01/01/2016 and can confirm reports are processed 60 days following the end of each quarter.

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Not Relevant to the Audit Report**



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