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

Final Audit Report

Subject:

AUDIT ON GLOBAL CLAIMS-TO-ENROLLMENT MATCH FOR BLUECROSS AND BLUESHIELD PLANS

Report No. 1A-99-00-08-065

Date: June 23, 2009

--CAUTION--

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

EXECUTIVE SUMMARY

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

Global Claims-to-Enrollment Match
BlueCross and BlueShield Plans

REPORT NO. 1A-99-00-08-065 DATE: June 23, 2009

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations for all BlueCross and BlueShield (BCBS) plans questions $2,961,748 in health benefit charges. The BlueCross BlueShield Association and/or BCBS plans agreed with $2,046,647 and disagreed with $915,101 of the questioned charges.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered health benefit payments from 2005 through June 30, 2008 as reported in the Annual Accounting Statements. Specifically, we reviewed claims paid from January 1, 2005 through June 30, 2008 that were potentially incurred when no patient enrollment records existed, during gaps in patient coverage, or after termination of patient coverage with the BCBS Service Benefit Plan. We determined that the BCBS plans paid 19,363 claim lines that were incurred when no patient enrollment records existed, during gaps in patient coverage, or after termination of patient coverage, resulting in overcharges of $2,961,748 to the FEHBP. These claims were paid for ineligible patients.

CONTENTS

I. INTRODUCTION AND BACKGROUND

INTRODUCTION

This final audit report details the findings, conclusions, and recommendations resulting from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at all BlueCross and BlueShield (BCBS) plans.

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

BACKGROUND

The FEHBP was established by the Federal Employees Health Benefits (FEHB) Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for federal employees, annuitants, and dependents. OPM's Center for Retirement and Insurance Services has overall responsibility for administration of the FEHBP. The provisions of the FEHB Act are implemented by OPM through regulations, which are codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations (CFR). Health insurance coverage is made available through contracts with various health insurance carriers.

The BlueCross BlueShield Association (Association), on behalf of participating 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 approximately 63 local BCBS plans participating in the FEHBP.

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

The Association has also established an FEP Operations Center. The activities of the FEP Operations Center are performed by CareFirst BCBS, 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.

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

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

This is our first global claims-to-enrollment match audit on the BCBS plans. Our preliminary results of the potential health benefit overcharges were presented in a detailed draft report, dated September 5, 2008. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as the Appendix to this report. Also, additional documentation provided by the Association and BCBS plans on various dates through March 25, 2009, was considered in preparing our final report.

II. OBJECTIVE, SCOPE, AND METHODOLOGY

OBJECTIVE

The objective of this audit was to determine whether the BCBS plans complied with contract provisions relative to patient enrollment eligibility.

SCOPE

Our limited scope performance audit was conducted 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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

The audit covered health benefit payments from 2005 through June 30, 2008 as reported in the Annual Accounting Statements. Specifically, we reviewed claims paid from January 1, 2005 through June 30, 2008 that were potentially incurred when no patient enrollment records existed, during gaps in patient coverage, or after termination of patient coverage with the BCBS Service Benefit Plan. Based on our claim error report, we identified 122,496 claim lines, totaling $12,896,198 in payments, for 8,357 patients that were potentially incurred when no patient enrollment records existed, during gaps in patient coverage, or after termination of patient coverage. From this universe of 8,357 patients, we selected and reviewed all patients with cumulative claim line payments of $2,000 or more. Our sample included 73,273 claim lines, totaling $10,529,075 in payments, for 1,106 patients.

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 patient enrollment eligibility. 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 patient enrollment eligibility. Exceptions noted in the areas reviewed are set forth in detail in the "Audit Finding 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 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 Director's Office, FEP Operations Center, and the BCBS plans. Due to time constraints, we did not verify the reliability of the data generated by the various information systems involved. However, while utilizing the computer-generated data during our audit testing, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objective.

The audit was performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida from January 2009 through May 2009.

METHODOLOGY

To test each BCBS plan's compliance with the FEHBP health benefit provisions related to patient enrollment eligibility, we selected all potential ineligible patients with cumulative claim line payments of $2,000 or more that were identified in a computer search. Specifically, we selected for review 73,273 claim lines, totaling $10,529,075 in payments, for 1,106 patients (from a universe of 122,496 claim lines, totaling $12,896,198 in payments, for 8,357 patients) that were potentially incurred when no patient enrollment records existed, during gaps in patient coverage, or after termination of patient coverage with the BCBS Service Benefit Plan.

The claim line payments selected for review were submitted to each applicable BCBS plan for their review and response. For each plan, we then conducted a limited review of the agreed responses and an expanded review of the disagreed responses to determine the appropriate questioned amount. We did not project the sample results to the universe.

The determination of the questioned amount is based on the FEHBP contract, the Service Benefit Plan brochure, and the Association's FEP administrative manual.

III. AUDIT FINDING AND RECOMMENDATIONS

Claims Paid for Ineligible Patients **$2,961,748**

The BCBS plans paid 19,363 claim lines that were incurred when no patient enrollment records existed, during gaps in patient coverage, or after termination of patient coverage with the BCBS Service Benefit Plan, resulting in overcharges of $2,961,748 to the FEHBP. These claims were paid for ineligible patients.

Contract CS 1039, Part III, section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable." Part II, section 2.3(g) states, "If the Carrier or OPM determines that a Member's claim has been paid in error for any reason, the Carrier shall make a diligent effort to recover an overpayment . . . ."

For the period January 1, 2005 through June 30, 2008, we performed a computer search to identify claims paid that were potentially incurred when no patient enrollment records existed, during gaps in patient coverage, or after termination of patient coverage with the BCBS Service Benefit Plan. We identified 122,496 claim lines, totaling $12,896,198 in payments, for 8,357 patients that met this search criteria. Our search criteria took into consideration the 31-day grace period of temporary continuing coverage following termination of eligibility.

From this universe of 8,357 patients, we selected all patients with cumulative claim line payments of $2,000 or more to review. Our sample included 73,273 claim lines, totaling $10,529,075 in payments, for 1,106 patients. Based on our review, we determined that 19,363 claim lines, totaling $2,961,748 in payments, were paid for ineligible patients.[2]

Our audit disclosed the following for these questioned claim line payments:

- For 4,374 of the claim lines questioned, the BCBS plans received the termination of member coverage notices from the federal payroll offices after the claims were already paid. However, the BCBS plans did not review and/or adjust these claims that were paid after the patients' termination dates. As a result, the FEHBP was overcharged $905,610 in claim payments for patients that were not eligible for benefits.

- For 2,949 of the claim lines questioned, data input errors occurred that resulted in incorrect member rosters (e.g., enrollment of a non-covered grandchild or other dependent). As a result, the FEHBP was overcharged $540,154 in claim payments for patients that were not eligible for benefits.

[2] In addition, there were 6,836 claim lines, totaling $1,516,180 in payments, with eligibility errors that were identified by the BCBS plans before the start of our audit (i.e., September 5, 2008) and adjusted or voided by the Association's response due date (i.e., December 5, 2008) to the draft report. Since these eligibility errors were identified by the BCBS plans before the start of our audit and adjusted or voided by the Association's response due date to the draft report, we did not question these claim line payments in the final report.

- For 758 of the claim lines questioned, dependents were added incorrectly to the enrollment files based on the claims information. As a result, the FEHBP was overcharged $98,445 in claim payments for patients that were not eligible for benefits.

- For 11,282 of the claim lines questioned, the BCBS plans did not provide specific reasons why these claim lines were paid for ineligible patients. The FEHBP was overcharged $1,417,539 for these claim payments. Most of these claim payment errors were already identified by the BCBS plans before the start of our audit, but were not adjusted or voided by the Association's response due date to the draft report.

Of the $2,961,748 in questioned charges, $967,722 (33 percent) were identified by the BCBS plans before the start of our audit (i.e., September 5, 2008). However, since the BCBS plans had not completed the recovery process and/or adjusted or voided these claims by the Association's response due date (i.e., December 5, 2008) to the draft report, we are continuing to question these overcharges. The remaining questioned charges of $1,994,026 (67 percent) were identified as a result of our audit.

In addition, we identified the following procedural issues requiring corrective action by the Association and/or FEP Operations Center:

- For 237 patients (15,828 claim lines, totaling $2,519,460 in payments) in our sample, the Association and/or BCBS plans identified that the contract holder (member) or patient had coverage under another contract "R" number and/or patient code (e.g., due to marital status change), but the claim history files were not combined.

  During our review, we identified that each BCBS plan or the FEP Operations Center can combine a member's claims paid under one contract "R" number or patient code with the claims history of a different contract "R" number or patient code. However, when the FEP Operations Center performs this change to the member's claims history, the only field changed within the FEP Direct System, other than the contract "R" number or patient code, is the "File Correction Indicator" located in the "Accumulator Screen". All dates and other claim data fields within the FEP Direct System remain the same. As a result, we did not receive the adjusted claim records for the contract "R" number and/or patient code changes performed by the FEP Operations Center. This adversely affected the preliminary results of our claim error report. Consequently, 15,828 claim lines in our sample, totaling $2,519,460 in payments, were initially identified as being paid for these 237 potentially ineligible patients; however, these claim lines were actually paid for eligible patients.

- Numerous claim lines in our sample, totaling $1,101,246 in payments, were identified as being paid for ineligible patients because the members' effective or termination dates of coverage were entered incorrectly into the FEP Enrollment System. For these sample items, we noted that the FEP Operations Center corrected the applicable patients' effective or termination dates of coverage in the FEP Enrollment System on or after July 1, 2008.

As a result of these enrollment date corrections, the patients' claims were actually incurred during effective dates of coverage.[3]

Association's Response:

In response to the draft audit report, the Association states, "BCBSA identified a total of $2,076,022 of the total questioned amount . . . in claim payments that were incurred when no patient enrollment records existed, during gaps in patient coverage, and/or after termination of patient coverage.

We noted the following reasons for $1,457,488 of the $2,076,022 in overpayments identified:

- $986,793 in overpayments resulted from Member Termination notices that were not received from the OPM Payroll Office until after the claims were already paid.

- $412,446 in overpayments were caused by input errors which resulted in the enrollment of a non-covered grandchild, or other dependents.

- $58,249 in overpayments were the result of dependents added incorrectly to the enrollment file based upon claims information.

We also determined that retroactive enrollment reports were not generated for some of the overpayments listed above because prior to August 18, 2008, the FEP Enrollment System did not generate retroactive enrollment notices for enrollment changes that occurred at the Member level. As of August 18, 2008, the FEP Enrollment system now generates Member level retroactive enrollment reports so that Plans can initiate recovery and recover overpayments in a timely manner. Also, beginning with the FEP Director's Office March 2008 System-Wide Claims Review process, terminated member claims are now included to assist the Plans in identifying terminated member claims that were paid in error so that overpayment recovery activity can be initiated timely.

With respect to . . . the BCBSA contested amount . . . our review indicated the following . . .

- $1,595,848 in questioned claims were contested because recovery was initiated before the audit started and the claim was adjusted either before the audit started or before our response to the Draft Report Response was submitted.

- $883,509 in questioned claims were contested because the claim payment errors were identified and recovery was initiated before the audit; however, the claim has not yet been adjusted.

[3] As part of our testing, we reviewed a sample of the patients' health benefits election forms (Standard Form 2809) to verify the patients' effective enrollment periods. Also, we reviewed the FEP Direct System to verify if the enrollment date corrections were properly updated in the FEP Enrollment System and if the patients' claims were incurred during the "corrected" dates of coverage.

Documentation to support the contested amounts and to support initiation of overpayment recovery before the audit has also been provided. . . . The Plans will continue to pursue the remaining amounts as required by CS 1039, Section 2.3 . . . 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 does not apply to the overpayments identified in the finding."

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 $2,961,748. Based on the Association's response and the BCBS plans' additional documentation, we determined that the Association and/or plans agree with $2,046,647 and disagree with $915,101 of the questioned charges. Although the Association agrees with $2,076,022 in the written response, the BCBS plans' documentation only supports concurrence with $2,046,647.

Based on the Association's response and/or the BCBS plans' documentation, the contested amount of $915,101 represents the following items:

- $885,190 of the contested amount represents claims paid for ineligible patients that were identified by the BCBS plans before the audit started. However, the plans had not recovered these overpayments and adjusted or voided the claims by the Association's response due date to the draft report. Since these overpayments had not been recovered and returned to the FEHBP by the Association's response due date, we are continuing to question this amount in the final report.

- $23,041 of the contested amount represents claim lines that BCBS plans state were paid for eligible patients. However, the plans did not provide sufficient documentation to support that these claim lines were paid for eligible patients.

- $6,870 of the contested amount represents claims paid for ineligible patients where recovery efforts were initiated by the BCBS plans after the audit started, and the payments were recovered and the claims were adjusted or voided by the Association's response due date to the draft report. However, since the plans initiated recovery efforts after the audit started, we are continuing to question this amount in the final report.

Recommendation 1

We recommend that the contracting officer disallow $2,961,748 in claim payments for ineligible patients, and verify that the BCBS plans return all amounts recovered to the FEHBP.

Recommendation 2

We recommend that the contracting officer instruct the Association to develop a corrective action plan for identifying claims that were paid for ineligible patients so that the BCBS plans can initiate recovery efforts and recover overpayments in a timely manner.

Recommendation 3

We recommend that the contracting officer instruct the Association to verify if the FEP Operations Center has effective procedures to ensure that members' enrollment data, such as effective and/or termination dates of coverage, is entered correctly into the FEP Enrollment System.

Recommendation 4

We recommend that the contracting officer instruct the Association to have the FEP Operations Center either discontinue combining a member's claims paid under one "R" number or patient code with the claims history of a different "R" number or patient code, or provide the necessary claim adjustment records to the OIG to account for these changes.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

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V. SCHEDULE A

GLOBAL CLAIMS-TO-ENROLLMENT
BLUECROSS AND BLUESHIELD PLANS

SUMMARY OF QUESTIONED CHARGES BY PLAN SITE

						Reasons for the Errors				Questioned Charges by Year			
Plan Site Number	Plan	Questioned Claim Lines	Questioned Charges	Plan Agrees	Plan Disagrees	Reason 1	Reason 2	Reason 3	Reason 4	2005	2006	2007	2008
3	BCBS of New Mexico	45	$ 9,929	$ 9,929	$ -	$ -	$ -	$ -	$ 9,929	$ 6,386	$ 3,373	$ 170	$ -
5	WellPoint BCBS of Georgia	253	$ 49,867	$ 15,078	$ 34,789	$ 15,078			$ 34,789	$ 37,372	$ 6,838	$ 5,657	$ -
6	CareFirst BCBS (Maryland Service Area)	891	$ 153,210	$ 57,795	$ 95,415	$ 38,570	$ 19,225	$ -	$ 95,415	$ 107,294	$ 32,664	$ 10,049	$ 3,203
7	BCBS of Louisiana	513	$ 110,414	$ 110,414	$ -	$ 80,628	$ -	$ 29,786	$ -	$ 82,591	$ 11,108	$ 16,547	$ 168
9	BCBS of Alabama	160	$ 29,854	$ 29,854	$ -	$ 14,334	$ 15,520	$ -	$ -	$ 14,134	$ 9,781	$ 5,939	$ -
10	BC of Idaho Health Service	17	$ 2,479	$ 2,479	$ -	$ 2,479	$ -	$ -	$ -	$ -	$ 2,479	$ -	$ -
11	BCBS of Massachusetts	164	$ 42,171	$ 42,171	$ -	$ 39,592	$ 2,579	$ -	$ -	$ 297	$ 535	$ 40,715	$ 624
13	Highmark BCBS	201	$ 21,411	$ 20,490	$ 921	$ 7,937	$ 7,937	$ 2,958	$ 2,579	$ 1,115	$ 4,861	$ 15,355	$ 80
15	BCBS of Tennessee	551	$ 50,514	$ 50,514	$ -	$ 28,676	$ 21,838	$ -	$ -	$ 20,346	$ 17,680	$ 8,567	$ 3,921
16	BCBS of Wyoming	40	$ 6,847	$ 6,847	$ -	$ 6,847	$ -	$ -	$ -	$ 761	$ -	$ 3,079	$ 3,007
17	BCBS of Illinois	504	$ 34,624	$ 9,428	$ 25,196	$ 9,238	$ 190	$ -	$ 25,196	$ 12,256	$ 7,170	$ 12,344	$ 2,854
21	WellPoint BCBS - Ohio	989	$ 89,995	$ 89,995	$ -	$ 40,041	$ 2,237	$ -	$ 47,717	$ 48,264	$ 29,927	$ 11,300	$ 504
27	WellPoint BCBS - New Hampshire	5	$ 517	$ 517	$ -	$ -	$ 517	$ -	$ -	$ -	$ 517	$ -	$ -
28	BCBS of Vermont	3	$ 204	$ 204	$ -	$ -	$ 204	$ -	$ -	$ -	$ 204	$ -	$ -
29	BCBS of Texas	2,055	$ 289,570	$ 108,147	$ 181,423	$ 1,520	$ 106,627	$ -	$ 181,423	$ 52,480	$ 136,754	$ 87,038	$ 13,298
30	WellPoint BCBS - Colorado	547	$ 101,079	$ 100,975	$ 104	$ -	$ -	$ -	$ 101,079	$ 42,731	$ 57,289	$ 913	$ 146
31	Wellmark BCBS of Iowa	3	$ 8,911	$ 8,911	$ -	$ 8,911	$ -	$ -	$ -	$ -	$ -	$ -	$ 8,911
32	BCBS of Michigan	140	$ 24,593	$ 24,593	$ -	$ -	$ -	$ 3,178	$ 21,415	$ -	$ 21,312	$ 103	$ 3,178
33	BCBS of North Carolina	1,242	$ 120,961	$ 117,397	$ 3,564	$ -	$ -	$ -	$ 120,961	$ 30,815	$ 52,090	$ 32,770	$ 5,286
36	Capital BC	19	$ 5,035	$ 5,035	$ -	$ 4,530	$ 505	$ -	$ -	$ 2,391	$ 21	$ 2,623	$ -
37	BCBS of Montana	54	$ 6,408	$ 6,408	$ -	$ 6,408	$ -	$ -	$ -	$ 5,973	$ 435	$ -	$ -
39	WellPoint BCBS - Indiana	177	$ 45,998	$ 45,998	$ -	$ 9,519	$ 32,639	$ -	$ 3,840	$ 24,132	$ 2,827	$ 19,039	$ -
40	BCBS of Mississippi	224	$ 23,039	$ 23,039	$ -	$ -	$ 23,039	$ -	$ -	$ 7,475	$ 680	$ 10,879	$ 4,005
41	BCBS of Florida	2,157	$ 305,231	$ 130,884	$ 174,347	$ 1,912	$ 102,877	$ 26,095	$ 174,347	$ 96,054	$ 74,972	$ 108,300	$ 25,905
42	BCBS of Kansas City (Missouri)	159	$ 60,150	$ 60,150	$ -	$ 60,150	$ -	$ -	$ -	$ 59,149	$ 101	$ 900	$ -
44	Arkansas BCBS	93	$ 14,289	$ 14,289		$ 14,289	$ -	$ -	$ -	$ 11,021	$ 312	$ 2,680	$ 276
45	WellPoint BCBS - Kentucky	160	$ 32,890	$ 32,820	$ 70	$ 9,755	$ -	$ 15,405	$ 7,730	$ 4,165	$ 17,063	$ 10,979	$ 683
47	WellPoint BCBS United of Wisconsin	484	$ 60,124	$ 60,047	$ 77	$ 16,423	$ 4,374	$ 16,491	$ 22,836	$ 21,957	$ 16,220	$ 16,397	$ 5,550
48	Empire BCBS (WellPoint)	161	$ 30,782	$ 20,324	$ 10,458	$ 156	$ -	$ -	$ 30,626	$ 3,323	$ -	$ 24,136	$ 3,323
49	Horizon BCBS of New Jersey	140	$ 27,202	$ 27,202	$ -	$ 27,202	$ -	$ -	$ -	$ 14,463	$ 7,236	$ 1,565	$ 3,938
52	WellPoint BC of California	184	$ 126,078	$ 50,150	$ 75,928	$ 50,150	$ -	$ -	$ 75,928	$ 26,999	$ 46,744	$ 44,153	$ 8,182
53	BCBS of Nebraska	109	$ 37,325	$ 35,514	$ 1,811	$ 26,525	$ -	$ -	$ 10,800	$ 24,623	$ 6,660	$ 2,074	$ 3,968
54	Mountain State BCBS	448	$ 105,393	$ 105,393	$ -	$ 8,603	$ 96,790	$ -	$ -	$ 73,241	$ 25,603	$ 2,333	$ 4,216
55	Independence BC	3	$ 13,697	$ 13,697	$ -	$ 13,697	$ -	$ -	$ -	$ -	$ -	$ 440	$ 13,257
56	BCBS of Arizona	276	$ 66,887	$ 66,887	$ -	$ 59,007	$ 7,880	$ -	$ -	$ 8,319	$ 9,100	$ 42,481	$ 6,987
58	Regence BCBS of Oregon	321	$ 34,050	$ 34,050	$ -	$ 34,050	$ -	$ -	$ -	$ 16,186	$ 15,210	$ 464	$ 2,190
59	WellPoint BCBS - Maine	34	$ 3,562	$ 3,236	$ 326	$ 3,236	$ -	$ -	$ 326	$ 110	$ 2,343	$ 1,109	$ -
60	BCBS of Rhode Island	299	$ 15,482	$ -	$ 15,482	$ -	$ -	$ -	$ 15,482	$ 11,118	$ 4,085	$ 279	$ -
61	WellPoint BCBS - Nevada	35	$ 967	$ 847	$ 120	$ 58	$ -	$ 16	$ 893	$ 109	$ 396	$ 376	$ 86
62	WellPoint BCBS - Virginia	706	$ 90,163	$ 90,163	$ -	$ 11,064	$ 79,099	$ -	$ -	$ 15,907	$ 31,629	$ 28,210	$ 14,417
66	Regence BCBS of Utah	264	$ 56,237	$ 36,744	$ 19,493	$ 36,744	$ -	$ -	$ 19,493	$ 12,222	$ 10,137	$ 4,979	$ 28,899
67	BS of California	535	$ 34,694	$ 19,317	$ 15,377	$ -	$ 200	$ -	$ 34,494	$ 4,989	$ 11,506	$ 14,965	$ 3,234
69	Regence BS (Washington)	81	$ 5,950	$ 5,950	$ -	$ 1,618	$ -	$ 2,327	$ 2,005	$ 3,348	$ 543	$ 1,895	$ 164
70	BCBS of Alaska	266	$ 27,212	$ 25,296	$ 1,916	$ 25,296	$ -	$ -	$ 1,916	$ 5,527	$ 17,926	$ 3,718	$ 41
75	Premera BC (Washington)	78	$ 5,214	$ 5,214	$ -	$ 4,168	$ 1,046	$ -	$ -	$ 2,139	$ 1,709	$ 594	$ 772
76	WellPoint BCBS of Missouri	302	$ 72,111	$ 46,478	$ 25,633	$ 235	$ -	$ 2,047	$ 69,829	$ 29,939	$ 34,574	$ 2,377	$ 5,221
78	BCBS of Minnesota	812	$ 204,085	$ 204,085	$ -	$ 142,878	$ 2,332	$ -	$ 58,875	$ 173,602	$ 21,341	$ 6,809	$ 2,333
82	BCBS of Kansas	90	$ 11,711	$ 11,711	$ -	$ 11,711	$ -	$ -	$ -	$ 2,517	$ -	$ 9,194	$ -

V. SCHEDULE A

GLOBAL CLAIMS-TO-ENROLLMENT
BLUECROSS AND BLUESHIELD PLANS

SUMMARY OF QUESTIONED CHARGES BY PLAN SITE

						Reasons for the Errors				Questioned Charges by Year			
Plan Site Number	Plan	Questioned Claim Lines	Questioned Charges	Plan Agrees	Plan Disagrees	Reason 1	Reason 2	Reason 3	Reason 4	2005	2006	2007	2008
83	BCBS of Oklahoma	721	$ 88,643	$ 25,294	$ 63,349	$ 25,152	$ -	$ 142	$ 63,349	$ 19,464	$ 24,096	$ 17,535	$ 27,548
84	Excellus BCBS of Utica-Watertown	45	$ 2,405	$ 2,405	$ -	$ 2,405	$ -	$ -	$ -	$ 361	$ 2,044	$ -	$ -
85	CareFirst BCBS (DC Service Area)	1,572	$ 194,159	$ 27,617	$ 166,542	$ 153	$ 12,499	$ -	$ 181,507	$ 121,213	$ 54,074	$ 15,098	$ 3,774
88	BC of Northeastern Pennsylvania	10	$ 2,939	$ 2,527	$ 412	$ 2,527	$ -	$ -	$ 412	$ -	$ 217	$ 2,722	$ -
89	BCBS of Delaware	10	$ 2,138	$ 2,138	$ -	$ 2,138	$ -	$ -	$ -	$ 2,138	$ -	$ -	$ -
92	CareFirst BCBS (Overseas)	11	$ 2,348	$ -	$ 2,348	$ -	$ -	$ -	$ 2,348	$ 2,348	$ -	$ -	$ -
	Totals	**19,363**	**$ 2,961,748**	**$ 2,046,647**	**$ 915,101**	**$ 905,610**	**$ 540,154**	**$ 98,445**	**$ 1,417,539**	**$ 1,263,364**	**$ 834,386**	**$ 649,849**	**$ 214,149**

BCBS = BlueCross BlueShield
BC = BlueCross
BS = BlueShield

Reasons for the Errors:

Reason 1 = The BCBS plans received the termination of member coverage notices from the federal payroll offices after the claims were already paid. However, when the member termination notices were subsequently received, the BCBS plans did not review and/or adjust these claims that were incurred and paid after the patients' termination dates.

Reason 2 = Data input errors occurred that resulted in incorrect member rosters (e.g., enrollment of a non-covered grandchild or other dependent).

Reason 3 = Dependents were added incorrectly to the enrollment files based on the claims information.

Reason 4 = The BCBS plans did not provide specific reasons why these claim lines were paid for ineligible patients. Most of these claim payment errors were already identified by the BCBS plans before the start of our audit, but were not adjusted or voided by the BCBS Association's response due date to the draft report.

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

AUDIT REPORT

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

Global Claims-to-Enrollment Match
BlueCross and BlueShield Plans

REPORT NO. 1A-99-00-08-065 DATE: June 23, 2009

Michael R. Esser
Assistant Inspector General
for Audits

APPENDIX

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Federal Employee Program
1310 G Street, N.W.
Washington, D.C. 20005
202.942.1000
Fax 202.942.1125

December 23, 2008

[redacted] Group Chief
Experience-Rated Audits Group
Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, Room 6400
Washington, DC 20415-1100

Reference: **OPM DRAFT AUDIT REPORT**
Global Enrollment Audit
Audit Report #1A-99-00-08-065
(Report dated and received 9/1/2008)

Dear Mr. Hirschman:

This is an update to the response to the OPM Global Enrollment Audit Report Response provided on December 10, 2008.

AI1. Global Enrollment Audit
Questioned Amount - $10,529,075

Blue Cross Blue Shield Association (BCBSA) Updated Response:

For claims paid from June 1, 2005 through June 30, 2008, OPM OIG identified 73,273 claim lines totaling $10,529,075 in potential health benefit overcharges. After reviewing the updated Plan responses to the OIG Draft Audit Report, BCBSA identified a total of $2,076,022 of the total questioned amount of $10,529,075 in claim payments that were incurred when no patient enrollment records existed, during gaps in patient coverage, and/or after termination of patient coverage.

We noted the following reasons for $1,457,488 of the $2,076,022 in overpayments identified:

- $986,793 in overpayments resulted from Member Termination notices that were not received from the OPM Payroll Office until after the claims were already paid.

- $412,446 in overpayments were caused by input errors which resulted in the enrollment of a non-covered grandchild, or other dependents.

- $58,249 in overpayments were the result of dependents added incorrectly to the enrollment file based upon claims information.

We also determined that retroactive enrollment reports were not generated for some of the overpayments listed above because prior to August 18, 2008, the FEP Enrollment System did not generate retroactive enrollment notices for enrollment changes that occurred at the Member level. As of August 18, 2008, the FEP Enrollment system now generates Member level retroactive enrollment reports so that Plans can initiate recovery and recover overpayments in a timely manner. Also, beginning with the FEP Director's Office March 2008 System- Wide Claims Review process, terminated member claims are now included to assist the Plans in identifying terminated member claims that were paid in error so that overpayment recovery activity can be initiated timely.

With respect to $8,373,363 of the BCBSA contested amount of $8,453,053, our review indicated the following:

- $2,511,608 in questioned claims were contested because the contract holder/member had coverage under another contract id/member number (due to marital status change, etc.) and the claims history was not combined.
- $1,101,246 in questioned claims were contested because the members' effective date or termination date was entered incorrectly into the FEP Enrollment System.
- $2,281,152 in questioned claims were contested because the members' claims were incurred within the 30 day grace period for terminated members or members' coverage was changed to family coverage, etc., so the members still had coverage.
- $1,595,848 in questioned claims were contested because recovery was initiated before the audit started and the claim was adjusted either before the audit started or before our response to the Draft Report Response was submitted.
- $883,509 in questioned claims were contested because the claim payment errors were identified and recovery was initiated before the audit; however, the claim has not yet been adjusted.

Documentation to support the contested amounts and to support initiation of overpayment recovery before the audit has been provided. In addition, we have attached a schedule listed as Attachment A that shows the amount questioned, contested and recovered by each Plan location.

The Plans will continue to pursue the remaining amounts 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 does not apply to the overpayments identified in the finding.

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

Sincerely,

[redacted]

Director, Program Assurance

Attachment

cc: [redacted]