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

Final Audit Report

Audit of the
American Postal Workers Union Health Plan
Elkridge, Maryland

Report Number 2025-ERAG-005
February 5, 2026

EXECUTIVE SUMMARY

Audit of the American Postal Workers Union Health Plan

Report No. 2025-ERAG-005 **February 5, 2026**

Why did we conduct the audit?

We conducted this limited scope audit to obtain reasonable assurance that the American Postal Workers Union Health Plan (Plan) is complying with the provisions of the Federal Employees Health Benefits Act and regulations that are included, by reference, in the Federal Employees Health Benefits Program (FEHBP) contract. The objectives of our audit were to determine if the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of contract CS 1370.

What did we audit?

Our audit covered miscellaneous health benefit payments and credits, such as cash receipt and provider offset refunds, for contract year 2021 through June 30, 2024, and administrative expense charges for contract years 2021 through 2023, as reported in the Annual Accounting Statements. We also reviewed the Plan's cash management activities and practices related to FEHBP funds for contract year 2021 through June 30, 2024, and the Plan's Fraud and Abuse Program activities for contract year 2023 through June 30, 2024. In addition, we expanded our audit scope for the administrative expense charges to include employee health benefit costs that were related to employee contributions for contract years 2019 through 2023 and accounts payable transactions that were related to non-FEHBP dental flyer printing costs for contract years 2019 through 2024.

Eric W. Keehan
Acting Deputy Assistant Inspector General for Audits

What did we find?

We questioned $37,623,312 in health benefit charges, administrative expense overcharges, cash management activities, and lost investment income (LII), and we identified a procedural finding for the Plan's Fraud and Abuse Program. The Plan agreed with $33,042,331 and disagreed with $4,580,981 of these questioned amounts and agreed with the procedural finding. As part of our review, we verified that the Plan subsequently returned $24,219,653 of these questioned amounts to the FEHBP because of our audit.

Throughout the audit process, we encountered several instances where the Plan responded untimely and/or initially provided incomplete responses to various requests for explanations and supporting documentation. As a result, completion of our audit and issuance of our draft and final reports were delayed by about two months.

Our audit results are summarized as follows:

- Miscellaneous Health Benefit Payments and Credits – We questioned $13,138,195 for uncollected claim overpayments and claim overpayment write-offs; $201,766 for provider offsets; and $9,431 for applicable LII calculated on cash receipt refunds and pharmacy drug rebates that were returned untimely to the FEHBP during the audit scope and prior to our audit notification date.
- Administrative Expenses – We questioned $3,667,879 for employee health benefit cost overcharges; $2,227,295 for pension cost overcharges; $96,086 for unallowable and/or unallocable charges; $59,229 in excess printing and mailing charges for the Plan's benefit plan brochures; $11,168 for an unallowable gift; and $214,957 for applicable LII on these questioned charges.
- Cash Management – We questioned $12,947,394 for excess funds that were held in the Plan's dedicated FEHBP interest bearing account as of June 30, 2024, and $5,049,912 for letter of credit account drawdown errors. We also noted that the Plan inaccurately reported the working capital deposits in the 2021 through 2023 Annual Accounting Statements and incorrectly calculated the working capital deposit benchmark amounts during the audit scope.
- Fraud and Abuse Program – We found that the Plan is not in compliance with the communication and reporting requirements for fraud and abuse cases set forth in contract CS 1370 and FEHBP Carrier Letter 2017-13.

ABBREVIATIONS

AAS	**Annual Accounting Statement**
APWU	**American Postal Workers Union**
APWUHP	**American Postal Workers Union Health Plan**
CFR	**Code of Federal Regulations**
FAR	**Federal Acquisition Regulations**
FEHB	**Federal Employees Health Benefits**
FEHBAR	**Federal Employees Health Benefits Acquisition Regulations**
FEHBP	**Federal Employees Health Benefits Program**
FWA	**Fraud, Waste, and Abuse**
LII	**Lost Investment Income**
LOCA	**Letter of Credit Account**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
PBM	**Pharmacy Benefit Manager**
Plan	**American Postal Workers Union Health Plan**
PSHBP	**Postal Service Health Benefits Program**
WC	**Working Capital**

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I. BACKGROUND

This final report details the findings, conclusions, and recommendations from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at the American Postal Workers Union (APWU) Health Plan. The APWU Health Plan is located in Elkridge, Maryland.

The audit was performed by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established 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 eligible 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 APWU Health Plan (Plan) is a fee-for-service plan with preferred provider organizations. The Plan enrollment is open to all postal service employees who are members of APWU and all other federal employees and annuitants that elect to become associate members of APWU. APWU is the sponsor and administrator of the Plan, operating under contract CS 1370 (contract) to provide a health benefits plan authorized by the FEHB Act. Members have a choice of enrollment in a High Option or a Consumer Driven Health Plan.

APWU's contract with OPM is experience-rated. Thus, the costs of providing benefits in the prior year, including underwritten gains and losses that have been carried forward, are reflected in current and future years' premium rates. In addition, the contract provides that in the event of termination, unexpended program funds revert to the FEHBP Trust Fund. In recognition of these provisions, the contract requires that an accounting of program funds be submitted at the end of each contract year. The accounting is made on a statement of operations known as the Annual Accounting Statement.

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

Our prior audit of the Plan (Report No. 1B-47-00-17-003, dated July 27, 2017), covering the Plan's cash management activities and practices related to FEHBP funds for contract year 2014 through June 30, 2016, disclosed no significant audit findings.

The results of this audit were provided to the Plan in written notifications of findings and recommendations and discussed with Plan officials throughout the audit and at an exit conference on August 14, 2025. The results were also presented in detail in a draft report, dated September 22, 2025. The Plan's comments offered in response to the draft report were considered in preparing our final report and are included as an Appendix to this final report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The objectives of our audit were to determine whether the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of contract CS 1370 with OPM. Specifically, our objectives were as follows:

Miscellaneous Health Benefit Payments and Credits

- To determine whether miscellaneous payments charged to the FEHBP were in compliance with the terms of the contract.
- To determine whether credits and miscellaneous income relating to FEHBP benefit payments (such as health benefit refunds, subrogation recoveries, and pharmacy drug rebates) were returned timely to the FEHBP.
- To determine whether the Plan made diligent efforts to recover uncollected claim overpayments in accordance with the overpayment recovery requirements in the contract.

Administrative Expenses

- To determine whether administrative expenses charged to the contract were actual, allowable, necessary, and reasonable expenses incurred in accordance with the terms of the contract and applicable laws and regulations.

Cash Management

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

Fraud and Abuse Program

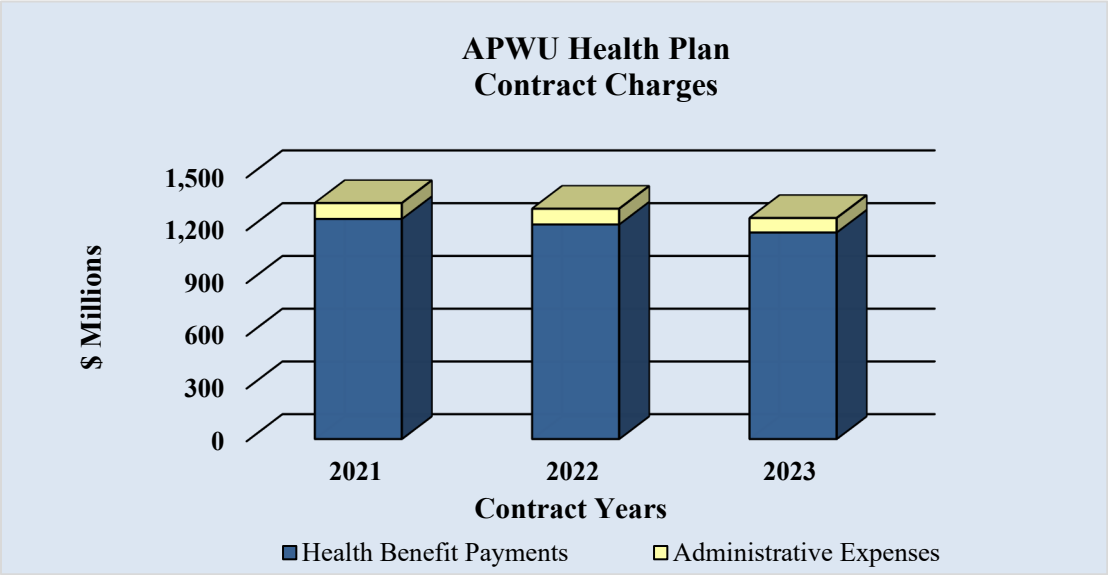
- To determine whether the Plan's communication and reporting of fraud and abuse cases to OPM and the OPM Office of the Inspector General complied with the terms of contract CS 1370 and FEHBP Carrier Letter (Carrier Letter) 2017-13.

SCOPE

We conducted our limited scope performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient and appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We reviewed the Plan's FEHBP Annual Accounting Statements for contract years 2021 through 2023. During this 3-year period, the Plan paid approximately $3.6 billion in FEHBP health

benefit payments and charged the FEHBP approximately $262 million in administrative expenses (see chart below).



Specifically, we reviewed miscellaneous health benefit payments and credits (such as cash receipt and provider offset refunds, subrogation recoveries, pharmacy drug rebates, and uncollected claim overpayments) for contract year 2021 through June 30, 2024, and administrative expense charges for contract years 2021 through 2023, as reported in the Annual Accounting Statements. We also reviewed the Plan's cash management activities and practices related to FEHBP funds for contract year 2021 through June 30, 2024, and the Plan's Fraud and Abuse Program activities for contract year 2023 through June 30, 2024. In addition, we expanded our audit scope for the administrative expense charges to include employee health benefit costs that were related to employee contributions for contract years 2019 through 2023 and accounts payable transactions that were related to non-FEHBP dental flyer printing costs for contract years 2019 through 2024.

In planning and conducting our audit, we obtained an understanding of the Plan's internal control structure to help determine the nature, timing, and extent of our auditing procedures. This was determined to be the most effective approach to select areas of audit. For those areas selected, we primarily relied on substantive tests of transactions and not tests of controls. Based on our testing, we did not identify significant matters involving the Plan's internal control structure and operations. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the Plan had complied with the contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations (FAR) and Federal Employees Health Benefits Acquisition Regulations (FEHBAR), as appropriate), and the laws and regulations governing the FEHBP. The results of our tests indicate that, with respect to the items tested, the Plan did not comply with all provisions of the contract and federal regulations.

Exceptions noted in the areas reviewed are set forth in detail in the Audit Findings and Recommendations section of this audit report. With respect to the items not tested, nothing came to our attention that caused us to believe that the Plan had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the 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.

The audit fieldwork was performed by staff in our Cranberry Township, Pennsylvania; Jacksonville, Florida; and Washington, D.C., offices from March 3, 2025, through August 14, 2025, and also at the Plan's office in Elkridge, Maryland, during two site visits from March 17 through March 21, 2025, and May 12 through May 16, 2025. Throughout the audit process, we encountered several instances where the Plan responded untimely and/or initially provided incomplete responses to various requests for explanations and supporting documentation. As a result, completion of our audit fieldwork and issuance of our draft and final reports were delayed by about two months.

METHODOLOGY

We obtained an understanding of the internal controls over the Plan's financial, cost accounting, and cash management systems by inquiry of Plan officials.

We interviewed Plan personnel and reviewed the Plan's policies, procedures, and accounting records during our audit of miscellaneous health benefit payments and credits. For contract year 2021 through June 30, 2024, we judgmentally selected and reviewed the following FEHBP items:

Health Benefit Refunds – Cash Receipts and Provider Offsets[1]

- A judgmental sample of 100 cash receipt health benefit refunds, totaling $6,956,383 (from a universe of 20,530 cash receipt refunds, totaling $17,422,238 for the audit scope). Our sample consisted of the 25 highest dollar cash receipt refunds from each year of the audit scope, which included refunds ranging from $13,032 to $405,107.

- A judgmental sample of 100 health benefit refunds that were set up and/or potentially returned via provider offsets, totaling $1,224,024 (from a universe of 1,627 refunds that were set up and/or potentially returned via provider offsets, totaling $1,630,077 for the audit scope). Our sample consisted of the 100 highest dollar provider offsets from the audit scope, which included all offsets from $2,594 to $164,500. Provider offsets occur

[1] The Plan's FEHBP universes of cash receipt and provider offset refunds included items such as solicited and/or unsolicited refunds (claim overpayment recoveries).

when the Plan reduces payments to participating providers for the purpose of recovering refunds related to previous claim overpayments.

Other Health Benefit Payments, Credits, and Recoveries

- All 48 pharmacy drug rebate amounts, totaling $403,927,838, for the audit scope.

- A judgmental sample of 20 monthly subrogation recovery amounts, totaling $5,903,463 (from a universe of 42 monthly subrogation recovery amounts, totaling $8,317,522 for the audit scope). Our sample consisted of the five highest dollar monthly subrogation recovery amounts from each year of the audit scope, which included monthly recovery amounts ranging from $79,228 to $1,392,054.

- A judgmental sample of 40 uncollected claim overpayments, totaling $3,683,911 (from a universe of 21,879 uncollected claim overpayments, totaling $15,841,470 as of June 30, 2024). Our sample consisted of the 40 highest dollar uncollected claim overpayments as of June 30, 2024, which included all uncollected claim overpayments from $56,326 to $205,646. We reviewed these uncollected claim overpayments to determine if the Plan made diligent efforts to recover the applicable funds.

- A judgmental sample of 20 hospital bill audit recovery amounts, totaling $1,602,213 (from a universe of 11,557 hospital bill audit recovery amounts, totaling $20,273,773 for the audit scope). Our sample consisted of the five highest dollar hospital bill audit recovery amounts from each year of the audit scope, which included recovery amounts ranging from $47,481 to $199,998.

- A judgmental sample of 10 collection agency recovery amounts, totaling $659,655 (from a universe of 151 collection agency recovery amounts, totaling $1,819,092 for the audit scope). Our sample consisted of the 10 highest dollar collection agency recovery amounts from the audit scope, excluding recoveries that were already selected as part of our sample of cash receipt refunds. Our sample included all collection agency recovery amounts from $36,109 to $127,896.

- A judgmental sample of 10 workers' compensation recovery amounts, totaling $287,747 (from a universe of 61 workers' compensation recovery amounts, totaling $430,693 for the audit scope). Our sample consisted of the 10 highest dollar workers' compensation recovery amounts from the audit scope, which included all recovery amounts from $13,534 to $60,418.

- A judgmental sample of 10 claim overpayment write-offs, totaling $99,195 (from a universe of 4,713 claim overpayment write-offs, totaling $446,111 for the audit scope). Our sample consisted of the 10 highest dollar claim overpayment write-offs from the audit scope, which included all write-offs from $4,334 to $28,857. We reviewed these

claim overpayment write-offs to determine if the Plan made diligent efforts to recover the applicable funds before writing these overpayments off.

- A judgmental sample of 10 fraud recovery amounts, totaling $93,622 (from a universe of 121 fraud recovery amounts, totaling $256,485 for the audit scope). Our sample consisted of the 10 highest dollar fraud recovery amounts for the audit scope, excluding recoveries that were already selected as part of our sample of cash receipt refunds. Our sample included all fraud recovery amounts from $1,841 to $24,046.

- A judgmental sample of 10 provider audit recovery and/or payment amounts, totaling $5,269 in net payment amounts (from a universe of 926 provider audit recovery and/or payment amounts, totaling $23,740 in net payment amounts for the audit scope). Our sample included the five highest dollar recovery amounts and the five highest dollar payment amounts for the audit scope, which included all recovery amounts from $2,256 to $5,686 and all payment amounts from $1,383 to $17,165.

- All 19 other miscellaneous health benefit payment amounts, totaling $135,170,491, for the audit scope. These other miscellaneous payment amounts were for items such as the Medicare Advantage Program and pharmacy claims processing fees.

We reviewed these samples to determine if health benefit refunds and recoveries, pharmacy drug rebates, and miscellaneous credits were timely returned to the FEHBP and if miscellaneous payments were properly charged to the FEHBP. The results of these samples were not projected to the applicable universes of miscellaneous health benefit payments and credits, since we did not use statistical sampling.

We judgmentally reviewed administrative expenses charged to the FEHBP for contract years 2021 through 2023. Specifically, we reviewed administrative expenses relating to cost centers, natural accounts, accounts payable transactions, pensions, post-retirement benefits, employee health benefits, employee compensation limits, prior period adjustments, subcontracts, gains and losses, benefit plan brochures, lobbying, and Patient Protection and Affordable Care Act fees.[2]

[2] In general, the Plan records administrative expense transactions to natural accounts and cost centers. For contract years 2021 through 2023, the Plan charged administrative expenses of $263,503,101 (before adjustments) to the FEHBP, from 37 cost centers that contained 137 natural accounts. From this universe, we selected a judgmental sample of 15 cost centers to review, which totaled $220,585,806 in expenses charged to the FEHBP. We also selected a judgmental sample of 30 natural accounts to review, which totaled $140,713,244 in expenses charged to the FEHBP through the cost centers. For contract year 2023, we additionally reviewed a sample of 100 accounts payable transactions that were judgmentally selected from cost centers and natural accounts that were charged to the FEHBP. Because of the way we select and review each of these samples, there is a duplication of some of the administrative expenses tested. We selected these cost centers, natural accounts, and accounts payable transactions based on high dollar amounts, our nomenclature review, and/or our trend analysis. We reviewed the charges from these cost centers, natural accounts, and accounts payable transactions for allowability, allocability, and reasonableness. The results of these samples were not projected to the universe of administrative expenses, since we did not use statistical sampling.

We used the FEHBP contract, the FAR, the FEHBAR, and/or the Affordable Care Act (Public Law 111-148) to determine the allowability, allocability, and reasonableness of charges.

We reviewed the Plan's cash management activities and practices to determine whether the Plan handled FEHBP funds in accordance with contract CS 1370 and applicable laws and regulations. Specifically, we reviewed letter of credit account (LOCA) drawdowns, working capital calculations, adjustments and/or balances, U.S. Department of Treasury offsets, and interest income transactions for contract year 2021 through June 30, 2024, as well as the Plan's dedicated FEHBP investment account activity during the scope and the balance as of June 30, 2024. As part of our testing, we selected and reviewed a judgmental sample of 84 LOCA drawdowns, totaling $1,067,248,245 (from a universe of 863 LOCA drawdowns, totaling $4,568,831,590 for contract year 2021 through June 30, 2024), for the purpose of determining if the Plan's drawdowns were appropriate and adequately supported. Our sample included the two highest dollar LOCA drawdowns from each month of the audit scope. The sample results were not projected to the universe of LOCA drawdowns, since we did not use statistical sampling.

We also interviewed the Plan's Special Investigations Unit staff regarding the effectiveness of the Fraud and Abuse Program, as well as reviewed the Plan's communication and reporting of fraud and abuse cases to OPM and the OIG for contract year 2023 through June 30, 2024, to test compliance with contract CS 1370 and Carrier Letter 2017-13.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

1. Claim Overpayments – Uncollected and Write-Offs $13,138,195

The Plan had not recovered and/or returned funds to the FEHBP for 2,899 claim overpayments, totaling $13,138,195, that were paid to health care providers. First, because of the Plan's lack of due diligence with recovery efforts, the Plan had not recovered and/or returned funds to the FEHBP for 919 claim overpayments, totaling $4,315,517. These claim overpayments were outstanding from 42 days to over 3½ years as of June 30, 2024. Although the Plan complied with most of the steps required to recover these claim payments, the Plan had not attempted to recover these overpayments through third-party collections. Therefore, we determined overall that the Plan was not prompt and diligent with the recovery efforts for these 919 claim overpayments. Second, and not because of the Plan's lack of due diligence, we are also questioning 1,980 claim overpayments, totaling $8,822,678. The Plan had previously suspended offsetting future provider benefit payments to recover these funds, due to contractual arrangements and other system issues, but currently is still doing business with these providers and has the ability to recover these 1,980 claim overpayments through provider offsets. Based on contract CS 1370, the Plan must make prompt and diligent efforts to recover erroneous benefit payments until the debts are paid in full or determined to be uncollectible. Accordingly, the Plan should continue to pursue and recover these 2,899 claim overpayments, totaling $13,138,195, from the applicable health care providers.

Contract CS 1370, 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 prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider." Section 2.3(g) also states, "Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall –

(1) Send a written notice of erroneous payment to the member or provider . . .

(2) After confirming that the debt does exist . . . send follow-up notices . . . at 30, 60 and 90 day intervals, if the debt remains unpaid and undisputed;

(3) (i) The Carrier may offset future Benefits payable . . . to a provider on behalf of the Member to satisfy a debt due under the FEHBP if the debt remains unpaid and undisputed for 120 days after the first notice. . . .

(4) After applying the first three steps, refer cases when it is cost effective to do so to a collection attorney or a collection agency if the debt is not recovered; . . .

(5) Make prompt and diligent effort to recover erroneous payments until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost

effective to pursue further collection efforts or it would be against equity and good conscience to continue collection efforts;

(6) Additional prompt and diligent efforts are required for significant claim overpayments that exceed $10,000 per each claim. Examples of such efforts include copies of dated notices, offset attempt(s) made, certified letter communication(s), and third-party collection efforts to the extent required under (g)(4) above. The Carrier should maintain and provide to OPM upon request, documentation of those efforts."

Regarding reportable monetary findings, contract CS 1370, Part III, Section 3.16 (a) states, "Audit findings . . . in the scope of an OIG audit are reportable as questioned charges unless the Carrier provides documentation supporting that the findings were already identified and corrected . . . prior to audit notification."

Uncollected Claim Overpayments

As of June 30, 2024, there were 21,879 uncollected FEHBP claim overpayments, totaling $15,841,470. From this universe, we selected and reviewed a high dollar sample of 40 uncollected claim overpayments, totaling $3,683,911, to determine if the Plan made diligent efforts to recover the applicable funds. For our sample, we judgmentally selected the 40 highest dollar uncollected claim overpayments as of June 30, 2024, which included all uncollected claim overpayments from $56,326 to $205,646.

Based on our review, we identified the following exceptions:

- The Plan had not made all reasonable and diligent efforts to recover 11 claim overpayments, totaling $846,476. Specifically, the Plan had not attempted to recover these overpayments through the Plan's third-party collection agency. According to the Plan, the primary reason these 11 claim overpayments were not pursued through third-party collections was due to the absence of a specified reason for each of these claim overpayments within the recovery system. The files related to these claim overpayments that were provided to collections contained a "No Reason" message in the claim overpayment reason field. Apparently, the collection agency will not accept or pursue overpayments unless the Plan provides a specific reason for the overpayment. Since this issue impacted other uncollected claim overpayments, we expanded our review of this exception type and identified an additional 906 uncollected claim overpayments, totaling $3,429,569, where the overpayments were not pursued through third-party collections. Our expanded review consisted of all uncollected claim overpayments of $500 or more that were categorized in the Plan's system as "No Reason" and were not part of our original sample. As a result, we are questioning $4,276,045 ($846,476 plus $3,429,569) for these 917 (11 plus 906) claim overpayments that had not been recovered and/or returned to the FEHBP.

- We noted that the Plan had not recovered claim overpayments in our sample through provider offsets. According to the Plan, there were difficulties with setting up provider offsets for these claim overpayments due to contract restrictions with the Plan's previous vendor's network of providers and issues with the Plan's claims system core program function. Since the Plan currently has a new provider network vendor with provider offset capabilities and the Plan is still doing business with most of these network providers that have uncollected claim overpayments, we believe that the Plan can now recover these overpayments through provider offsets. Accordingly, we analyzed the universe of all uncollected claim overpayments and identified at least 1,978 additional claim overpayments, totaling $8,813,245, where the Plan can now attempt recovery efforts using provider offsets. Our analysis included all uncollected claim overpayments as of June 30, 2024, with overpayments of $500 or more, except for the uncollected claim overpayments that were already questioned above as not being pursued through third-party collections and the uncollected claim overpayments that were paid to U.S. Department of Veterans Affairs providers.

As a result, we are questioning $13,089,290 ($4,276,045 plus $8,813,245) for 2,895 (917 plus 1,978) claim overpayments that had not been recovered and/or returned to the FEHBP.

Claim Overpayment Write-Offs

For contract year 2021 through June 30, 2024, the Plan wrote off 4,713 FEHBP claim overpayments, totaling $446,111. From this universe, we selected and reviewed a judgmental sample of 10 claim overpayment write-offs, totaling $99,195, to determine if the Plan made prompt and diligent efforts to recover the applicable funds before writing these overpayments off. Our sample included the 10 highest dollar claim overpayment write-offs from the audit scope, which included all write-offs from $4,334 to $28,857.

Based on our review of these claim overpayments write-offs, we identified the following exceptions:

- The Plan did not make reasonable and diligent efforts to recover two provider claim overpayments, totaling $39,472. Specifically, we determined that the Plan did not mail all four standard refund request letters to the applicable providers due to a system issue that prevented the letters from being mailed. The Plan stated that corrective actions have since been implemented to address this system issue.

- In addition, for two claim overpayment write-offs, totaling $9,433, we determined that the Plan mailed the four standard refund request letters to the applicable providers and referred these overpayments to third-party collections but were still unsuccessful with recovery efforts. However, after additional research, we noted that the Plan did not use provider offsets to recover these claim overpayments due to the

same issues discussed above (i.e., contract restrictions with the previous vendor's network of providers and issues with the Plan's claims system core program function). Since the Plan currently has a new provider network vendor with provider offset capabilities and the Plan is still doing business with these providers, we believe that the Plan can now recover these claim overpayments through provider offsets. Therefore, we are also questioning these claim overpayment write-offs since the Plan should take all reasonable steps to increase the chances of recovering FEHBP claim overpayments.

As a result, we are questioning $48,905 ($39,472 plus $9,433) for four (two plus two) claim overpayments that had not been recovered and/or returned to the FEHBP.

Summary of Exceptions

The Plan had not recovered and/or returned funds to the FEHBP for 2,899 claim overpayments, totaling $13,138,195.

In total, we are questioning $13,138,195 ($13,089,290 plus $48,905) for 2,899 (2,895 plus 4) claim overpayments that had not been recovered and/or returned to the FEHBP. For 919 (917 plus 2) of these claim overpayments, totaling $4,315,517 ($4,276,045 plus $39,472), we concluded that the Plan had not taken all required prompt and diligent efforts to recover these claim overpayments, such as pursuing the recovery through third-party collections. For the remaining 1,980 (1,978 plus 2) claim overpayments, totaling $8,822,678 ($8,813,245 plus $9,433), where the Plan had previously not used provider offsets to recover these claim overpayments, we believe that the Plan currently has the ability to recover these claim overpayments through provider offsets. Based on contract CS 1370, the Plan must make prompt and diligent efforts to recover erroneous benefit payments until the debts are paid in full or determined to be uncollectible. The contract also requires additional prompt and diligent efforts for claim overpayments exceeding $10,000. Of the 2,899 questioned claim overpayments, 290 of these overpayments, totaling $11,568,331, exceed $10,000. Accordingly, the Plan should continue to pursue and recover these 2,899 claim overpayments from the applicable health care providers.

Recommendation 1

Because of the Plan's lack of due diligence with recovery efforts, we recommend that the contracting officer require the Plan to return $4,315,517 to the FEHBP for the 919 questioned uncollected claim overpayments that were not previously pursued through third-party collections, whether recovered or not, as all prompt and diligent efforts to recover these overpayments were not made timely.

Plan Response:

The Plan disagrees with the recommendation. The Plan states, "We disagree with the language in this recommendation that APWU Health Plan did not exercise due diligence regarding these uncollected overpayments. These overpayments have not been deemed uncollectable and we are still pursuing reimbursement from the providers. APWU Health Plan has already implemented updated procedures to enhance the overall effectiveness of this process such as offsets from future payments and referring these overpayments to our third-party collection agency. These actions reflect our continued commitment to exercising our due diligence in the recovery of these funds.

As of 10/31/2025:

- **Out of 919 claims, 772 of these overpayments are still in an active status.**
- **The overall balance of $4,315,517 has been reduced to $3,510,787. Details of activity are as follows:**

    1. **Closed cases: $508,850, recovered through hard-copy checks and Auto Recovery (AR) actions, which began in October 2025. Of this amount, AR accounts for $336,759.**
    2. **Written-off cases: Two cases totaling $39,472 were discussed during discovery; no further action will be taken.**
    3. **Voided case: One overpayment of $62,572 was voided and is no longer valid.**
    4. **Auto Recovery on open cases: Since offsets began in October 2025, an additional $193,835 has been recovered.**
    5. **VA claims: Of the 919 claims, 84 are VA related. One claim has been closed for $2,432. The remaining 83, totaling $291,779, cannot be processed through Auto Recovery due to VA regulations and will be referred to our third-party collection vendor for further recovery efforts."**

OIG Comments:

We disagree with the Plan's response. We continue to conclude that because of the Plan's lack of due diligence with recovery efforts for the 919 questioned uncollected claim overpayments, totaling $4,315,517, the Plan had not recovered and/or returned these funds to the FEHBP. Specifically, although the option was available, the Plan did not pursue recovery efforts through third-party collections as required by contract CS 1370. Again, contract CS 1370 states that the Carrier should make all prompt and diligent efforts to recover erroneous payments from providers. When recovery efforts are not undertaken promptly, the chance of recovery diminishes. The description of prompt and diligent efforts includes using provider offsets and third-party collections if available. As a result of our audit finding, we also noted that the Plan immediately implemented corrective

actions and is currently making progress with recovering these 919 questioned claim overpayments (based on the Plan's response/status for this recommendation). Therefore, we will continue to question these 919 uncollected claim overpayments that were not previously pursued through third-party collections.

Recommendation 2

We recommend that the contracting officer require the Plan to recover and return $8,822,678 to the FEHBP for the 1,980 questioned uncollected claim overpayments where the Plan had not previously used provider offsets to recover these claim overpayments, but now has the ability to recover these overpayments through provider offsets. If these overpayments are determined to be uncollectible, then the contracting officer should require the Plan to provide adequate documentation demonstrating that all prompt and diligent efforts were made, including use of provider offsets, future FEHBP member benefit payment offsets, and/or third-party collections, to recover these funds before writing them off, as required by the FEHBP contract.

Plan Response:

The Plan agrees with the recommendation and states, "The Plan has already introduced updated procedures to enhance the overall efficiency of this process. Any claims related to these amounts that are still outstanding, will be set to offset from future payments and/or will be sent to our third-party collection vendor. These actions reflect our continued commitment to exercising our due diligence in the recovery of these funds.

- **Out of 1,980 claims, 1,690 of these overpayments are still in an active status.**

- **The overall balance of $8,822,678 has been reduced to $7,779,296. Details of activity are as follows:**
  1. **Closed cases: $904,261 recovered through hard-copy checks and Auto Recovery (AR) actions, which began in October of 2025. AR accounts for $309,461 of this amount.**
  2. **Voided payments: Four overpayments totaling $11,709 were voided. Two were reprocessed after funds were returned and plan liability changed; the two other were invalid.**
  3. **Auto Recovery on open cases: Since offsets began in October of 2025, an additional $127,412 has been recovered.**
  4. **VA Claims: Six VA-related claims totaling $5,000 cannot be processed through Auto Recovery due to VA regulations and will be referred to our third-party collection vendor for further recovery efforts."**

OIG Comments:

As a result of our audit finding, we noted that the Plan immediately implemented corrective actions and is currently making progress with recovering these 1,980 questioned claim overpayments (based on the Plan's response/status for this recommendation).

Recommendation 3

We recommend that the contracting officer require the Plan to implement the necessary corrective actions to ensure that claim overpayments are adequately pursued, monitored, recovered, and returned to the FEHBP, as required by Section 2.3(g) of contract CS 1370. If the options are available and cost effective, the Plan should use provider offsets, future FEHBP member benefit payment offsets, and/or third-party collections to recover claim overpayments. The Plan should also be more mindful when entering vendor contracts that restrict or limit the Plan's ability to recover FEHBP claim overpayments, since contracts between the Plan and vendors do not supersede the FEHBP contract.

Plan Response:

The Plan agrees with the recommendation and states, "The Plan has already implemented updated procedures to improve the overall efficiency and effectiveness of our overpayment process. These updates include the reinstatement of the Offset/Auto Recovery language in our overpayment letters and the active use of Offset/Auto Recovery process, which applies future claim payments towards outstanding balances.

This review will be conducted at 120 days to ensure the issuance of the 30-, 60-, and 90-day letters are not impacted. If a provider responds and agrees to the recovery prior to letter generation that will be considered valid provider contact, and no further letters will be issued by the Plan. Any unrecovered balances at the 120-day mark will be transitioned to our third-party collection vendor for further action."

2. Health Benefit Refunds and Pharmacy Drug Rebates $211,197

Because of the Plan's lack of due diligence with recovery efforts, the Plan had not recovered and/or returned funds (provider offsets) to the FEHBP for nine claim overpayments, totaling $201,766, that were paid to health care providers. Although the Plan set up these claim overpayments as provider offsets, the Plan had not pursued all recovery efforts required by the contract, such as mailing all applicable refund request letters to the providers and/or referring provider claim overpayments to third-party collections. These claim overpayments were outstanding from 438 to 1,265 days as of June 30, 2024. Based on contract CS 1370, the Plan must make prompt and diligent efforts to recover erroneous benefit payments until the debt is paid in full or determined

to be uncollectible. Accordingly, the Plan should continue to pursue and recover these nine claim overpayments from the applicable health care providers.

The Plan also untimely returned 19 cash receipt refunds, totaling $1,664,746, and one pharmacy drug rebate amount, totaling, $5,331,153 to the FEHBP during the audit scope. Since the Plan returned these 19 cash receipt refunds and the one pharmacy drug rebate amount to the FEHBP during the audit scope and prior to our audit notification date, we did not question these total principal amounts as a monetary finding. However, we are questioning $9,431 for applicable lost investment income (LII) calculated on these cash receipt refunds and the pharmacy drug rebate amount that were returned untimely to the FEHBP.

Contract CS 1370, 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 prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider." Section 2.3(g) also states, "Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall –

(1) Send a written notice of erroneous payment to the member or provider . . .

(2) After confirming that the debt does exist . . . send follow-up notices . . . at 30, 60 and 90 day intervals, if the debt remains unpaid and undisputed;

(3) (i) The Carrier may offset future Benefits payable . . . to a provider on behalf of the Member to satisfy a debt due under the FEHBP if the debt remains unpaid and undisputed for 120 days after the first notice. . . .

(4) After applying the first three steps, refer cases when it is cost effective to do so to a collection attorney or a collection agency if the debt is not recovered; . . .

(5) Make prompt and diligent effort to recover erroneous payments until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to pursue further collection efforts or it would be against equity and good conscience to continue collection efforts;

(6) Additional prompt and diligent efforts are required for significant claim overpayments that exceed $10,000 per each claim. Examples of such efforts include copies of dated notices, offset attempt(s) made, certified letter communication(s), and third-party collection efforts to the extent required under (g)(4) above. The Carrier should maintain and provide to OPM upon request, documentation of those efforts."

Contract CS 1370, Part II, Section 2.3 (i) states, "All health benefit refunds and recoveries, including erroneous payment recoveries, must be deposited into the working

capital or investment account within 30 days and returned to or accounted for in the FEHBP letter of credit account within 60 days after receipt by the Carrier."

48 CFR 52.232-17(a) states, "all amounts that become payable by the Contractor . . . shall bear simple interest from the date due . . . The interest rate shall be the interest rate established by the Secretary of the Treasury . . . which is applicable to the period in which the amount becomes due, . . . and then at the rate applicable for each six-month period as fixed by the Secretary until the amount is paid."

Health Benefit Refunds – Provider Offsets

For contract year 2021 through June 30, 2024, there were 1,627 health benefit refunds, totaling $1,630,077, that were set up and/or potentially returned to the FEHBP via the Plan's provider offset process (based on the Plan's universe file of provider offset refunds). From this universe, we selected and reviewed a judgmental sample of 100 provider offset refunds, totaling $1,224,024, to determine if the Plan timely returned these refunds to the FEHBP. Our sample included the 100 highest dollar provider offset refunds from the audit scope, which included all offset refunds from $2,594 to $164,500. Provider offsets occur when the Plan reduces payments to participating providers for the purpose of recovering refunds related to previous claim overpayments.

Based on our review of the sample, we determined that the Plan had not performed adequate due diligence to recover and return nine claim overpayments, totaling $201,766, to the FEHBP. Although the Plan set up these claim overpayments as provider offsets, the Plan had not pursued all recovery efforts required by contract CS 1370. Specifically, the Plan did not send all the follow-up refund request letters to the providers at 30-, 60-, and 90-day intervals as required by the contract. In addition, the Plan did not attempt to recover these nine overpayments through the Plan's third-party collection agency. The contract also requires additional prompt and diligent efforts for claim overpayments exceeding $10,000. For the questioned provider offsets, there were two claim overpayments, totaling $174,662, that exceeded $10,000. Our understanding is that the Plan should take all reasonable steps (e.g., mailing refund request letters, calling the providers, offsetting future benefit payments, and/or sending the providers to third-party collections) to increase the chances of recovering the FEHBP claim overpayments, especially significant overpayments exceeding $10,000. As a result, since all prompt and diligent recovery efforts were not previously made by the Plan, we are questioning $201,766 for provider offsets where the Plan had not recovered and/or returned the applicable funds to the FEHBP for nine claim overpayments.

Health Benefit Refunds – Cash Receipts

The Plan provided a universe of FEHBP cash receipt health benefit refunds that included items such as solicited and unsolicited refunds (claim overpayment recoveries). For contract year 2021 through June 30, 2024, there were 20,530 cash receipt refunds,

totaling $17,422,238, that were received by the Plan during the audit scope. From this universe, we selected and reviewed a judgmental sample of 100 cash receipt refunds, totaling $6,956,383, to determine if the Plan timely returned these refunds to the FEHBP. Our sample consisted of the 25 highest dollar cash receipt refunds from each year of the audit scope, which included refunds ranging from $13,032 to $405,107.

Based on our review of the sample, we determined that the Plan returned 19 of these cash receipt refunds (19 percent of the sample), totaling $1,664,746, untimely to the FEHBP during the audit scope. Specifically, we noted that the Plan deposited these 19 refunds into the dedicated FEHBP investment account from 1 to 17 days late. Since the Plan returned these 19 cash receipt refunds to the FEHBP during the audit scope and prior to our audit notification date, we did not question the total principal amounts of $1,664,746 as a monetary finding. However, since we noted that the Plan did not calculate and return applicable LII to the FEHBP, we are questioning LII of $1,325 on these 19 cash receipt refunds that were returned untimely to the FEHBP during the audit scope (as calculated by the OIG).

Pharmacy Drug Rebates

The Plan's pharmacy benefit managers negotiate drug rebates with various drug manufacturers. The Plan receives these pharmacy drug rebates multiple times a year (usually on a quarterly basis) as offsets to the biweekly pharmacy drug claim invoices and/or via electronic wire transfers/checks. For contract year 2021 through June 30, 2024, the Plan received 48 pharmacy drug rebate amounts, totaling $403,927,838. We selected and reviewed all of these pharmacy drug rebate amounts for the purpose of determining if the Plan timely returned the applicable funds to the FEHBP.

In one instance, we determined that the Plan returned a pharmacy drug rebate amount of $5,331,153 untimely to the FEHBP during the audit scope. Specifically, we noted that the Plan deposited this pharmacy drug rebate amount 12 days late to the dedicated FEHBP investment account. Since the Plan returned these funds to the FEHBP during the audit scope and prior to our audit notification date, we did not question the total principal amount of $5,331,153 as a monetary finding. However, since we noted that the Plan did not calculate and return applicable LII to the FEHBP, we are questioning LII of $8,106 on these funds that were returned untimely to the FEHBP (as calculated by the OIG).

Summary of Exceptions

In total, we are questioning $211,197 for this audit finding, consisting of $201,766 for the nine questioned claim overpayments where the Plan had not pursued all recovery efforts required by the contract and $9,431 ($1,325 plus $8,106) for applicable LII calculated on 19 cash receipt refunds and 1 pharmacy drug rebate amount that were returned untimely to the FEHBP during the audit scope. As part of our review, we verified that the Plan

subsequently returned the questioned LII of $9,431 to the FEHBP in September 2025 for this audit finding.

Recommendation 4

Due to the Plan's lack of due diligence with recovery efforts, we recommend that the contracting officer require the Plan to return $201,766 to the FEHBP for the questioned provider offsets where the Plan had not recovered and/or returned funds to the FEHBP for nine FEHBP claim overpayments.

Plan Response:

The Plan disagrees with the recommendation. The Plan states, "We disagree with the language that APWU Health Plan did not exercise due diligence for these uncollected overpayments. These overpayments have not been deemed uncollectable and we are still pursuing reimbursement from the providers. APWU Health Plan has already implemented updated procedures to enhance the overall effectiveness of this process such as offsets from future payments and referring these overpayments to our third-party collection agency.

There are 9 claims that make up the balance of $201,766. These claims were previously set up as Offset/Auto Recovery (AR). The Plan has recovered $12,505 from the original advance balance $214,271, reducing it to the current $201,766 that was reported. The last partial payment recovery was on 02/21/25 for $20. All AR actions were initiated prior to reparations being made. This subset of overpayments will now be referred to our third-party collections vendor for further recovery efforts."

OIG Comments:

We disagree with the Plan's response. We continue to conclude that because of the Plan's lack of due diligence with recovery efforts for the nine claim uncollected claim overpayments, totaling $201,766, the Plan had not recovered and/or returned these funds to the FEHBP. Although the Plan set up these claim overpayments as provider offsets, the Plan had not pursued all recovery efforts required by the contract. Specifically, the Plan did not send all the follow-up refund request letters to the applicable providers at 30-, 60-, and 90-day intervals as required by the contract. Also, the Plan did not previously attempt to recover these nine claim overpayments through the Plan's third-party collection agency. Again, contract CS 1370 states that the Carrier should make all prompt and diligent efforts to recover erroneous payments from providers. As a result of our audit, we noted that the Plan has implemented corrective actions and will now refer these questioned uncollected claim overpayments to third-party collections for additional recovery efforts (based on the Plan's response to this recommendation). Therefore, we will continue to question these nine uncollected claim overpayments.

Recommendation 5

We recommend that the contracting officer require the Plan to return $9,431 to the FEHBP for the questioned LII calculated on the cash receipt refunds and pharmacy drug rebate amount that were returned untimely to the FEHBP during the audit scope. However, since we verified that the Plan subsequently returned $9,431 to the FEHBP for the questioned LII, no further action is required for this LII amount.

Plan Response:

The Plan agrees with the recommendation.

Recommendation 6

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that all health benefit refunds and pharmacy drug rebates are returned timely to the FEHBP (i.e., deposited into the FEHBP investment account within 30 days after receipt and returned to the letter of credit account via drawdown adjustments within 60 days after receipt).

Plan Response:

The Plan agrees with the recommendation and states, "The Plan has established procedures to ensure that all deposits are made within the required 30-day timeframe. As a result of these measures, the Plan has not experienced any late deposits since January 2024."

B. ADMINISTRATIVE EXPENSES

1. Employee Health Benefit Costs $3,667,879

The Plan overcharged the FEHBP $3,667,879 for employee health benefit costs in contract years 2019 through 2023. Specifically, the Plan did not offset employee health benefit costs with the employee contributions prior to charging these costs to the FEHBP. In addition, the Plan inappropriately withdrew funds from the LOCA for the employee contributions and then transferred these funds out of the FEHBP investment account. All FEHBP funds received by the Plan related to employee health benefit costs were subsequently deposited into the Plan's Health and Welfare Trust. As a result of this audit finding, we are questioning $3,667,879 for employee health benefit costs that were inappropriately overcharged to the FEHBP and transferred into the Plan's Health and Welfare Trust. Since these questioned overcharges are held in the Plan's interest-bearing Health and Welfare Trust, LII is not applicable for this audit finding.

Contract CS 1370, Part III, Section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable."

48 CFR 31.201-5 states, "The applicable portion of any income, rebate, allowance, or other credit relating to any allowable cost and received by or accruing to the contractor shall be credited to the Government either as a cost reduction or by cash refund."

For contract years 2021 through 2023, the Plan charged the FEHBP $19,562,460 ($6,378,201 for contract year 2021, $6,492,801 for contract year 2022, and $6,691,458 for contract year 2023) for employee health benefit costs. We reviewed these charges to determine if the Plan properly charged these employee health benefit costs to the FEHBP. During our review, we identified that the Plan did not offset employee health benefit costs with the employee contributions (withholdings) prior to charging employee health benefit costs to the FEHBP. In addition, the Plan inappropriately withdrew funds from the LOCA for the employee contributions and then transferred these funds out of the FEHBP investment account and into the Plan's Health and Welfare Trust, resulting in overcharges to the FEHBP. These LOCA drawdowns and investment account transfers were not necessary since the employee contributions should have reduced the employee health benefit charges, and not increased the charges to the FEHBP.

The Plan overcharged the FEHBP $3,667,879 for employee health benefit costs in contract years 2019 through 2023.

As a result of these errors, the Plan overcharged the FEHBP $2,247,934 ($725,663 for contract year 2021, $763,238 for contract year 2022, and $759,033 for contract year 2023) for employee health benefit costs in contract years 2021 through 2023. Based on the significance of these exceptions, we expanded our review to include the employee health benefit contributions for contract years 2019 and 2020. Based on our expanded review, we determined that the Plan inappropriately overcharged an additional $1,419,945 ($616,126 for contract year 2019 and $803,819 for contract year 2020) to the FEHBP for employee health benefit costs in contract years 2019 and 2020 that were related to the employee contribution exceptions.

In total, we are questioning $3,667,879 ($2,247,934 plus $1,419,945) for employee health benefit costs that were overcharged to the FEHBP for contract years 2019 through 2023. Since these questioned overcharges are held in the Plan's interest-bearing Health and Welfare Trust, where interest earned on the Trust funds will be returned to the FEHBP when reducing surplus amounts, LII is not applicable for this audit finding.

Recommendation 7

We recommend that the contracting officer require the Plan to return $3,667,879 to the FEHBP for the questioned employee health benefit costs that were overcharged to the FEHBP for contract years 2019 through 2023. However, since we verified that the Plan

subsequently returned $3,667,879 to the FEHBP for these questioned overcharges by confirming that the Plan did not charge the FEHBP for allowable employee health benefit costs of $4,223,856 in contract year 2024, because of a significant surplus in the Plan's Health and Welfare Trust, no further action is required for the questioned amount of $3,667,879.

Note: Although no additional corrective actions are necessary regarding the questioned employee health benefit overcharges of $3,667,879, we noted that the Plan is still maintaining a large surplus in the Plan's Health and Welfare Trust. After receiving our notification of findings and recommendations, the Plan informed us that the Health and Welfare Trust had a surplus of $29,241,825 as of December 31, 2024. Therefore, the Plan should continue to not charge the FEHBP for employee health benefit costs until the Plan reduces the surplus amount to a reasonable reserve level, as determined by the Plan and agreed to by the contracting officer (see Recommendation 9).[3]

Recommendation 8

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that employee health benefit costs are properly charged to the FEHBP in accordance with the terms of the FEHBP contract and applicable federal regulations.

Recommendation 9

We recommend that the contracting officer require the Plan to implement corrective actions to reduce the remaining surplus (i.e., $29,241,825 as December 31, 2024) to a reasonable reserve level, as determined by the Plan and agreed to by the contracting officer.

Plan Response:

The Plan agrees with the finding and recommendations. For the procedural recommendations, the Plan states, "The Plan has revised its procedures for handling of the employee contributions related to health insurance. Beginning July 2025, these contributions are no longer included in the LOCA draw. The 15% portion representing employee withholdings continues to remain with FEHB. . . . The Plan is actively working with its actuary . . . to monitor the funding levels of the . . . Trust. Based on current projections, the Plan will not be making contributions to the Trust as long as funding levels remain above 100%."

[3] The Plan stated, "The Funding Policy of the Fund [Health and Welfare Trust] is to have contributions to the Fund being no less than the amount necessary to provide the anticipated costs of the current benefits for the next year and to provide for a reasonable level of reserves, excluding all plan assets and liabilities for retiree benefits, if applicable."

2. Pension Cost Overcharges $2,428,118

The Plan overcharged the FEHBP $2,227,295 for pension costs in contract years 2022 and 2023. Specifically, the Plan incorrectly charged the FEHBP $984,803 in contract year 2022 and $1,242,492 in contract year 2023 for management pension plan termination costs that had not been incurred. As a result of this audit finding, the Plan subsequently returned $2,428,118 to the FEHBP, consisting of $2,227,295 for pension costs that were overcharged to the FEHBP and $200,823 for applicable LII on these questioned overcharges.

As previously cited from contract CS 1370, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. Also, as previously cited from FAR 52.232-17(a), all amounts that become payable by the Contractor should include simple interest from the date due.

48 CFR 31.205-6(j)(1) states, "Pension plans are normally segregated into two types of plans: defined-benefit and defined-contribution pension plans. The contractor shall measure, assign, and allocate the costs of all defined-benefit pension plans and the costs of all defined-contribution pension plans in compliance with 48 CFR 9904.412 - Cost Accounting Standard for Composition and Measurement of Pension Cost and 48 CFR 9904.413 - Adjustment and Allocation of Pension Cost. Pension costs are allowable subject to the referenced standards and the cost limitations and exclusions set forth in paragraph (j)(1)(i) and in paragraphs (j)(2) through (j)(6) of this subsection."

Regarding pension plan terminations, 48 CFR 9904.413-50(c)(12)(iii) states, "The calculation of the difference between the market value of the assets and the actuarial accrued liability shall be made as of the date of the event . . . that caused the . . . pension plan termination . . . ." Additionally, 48 CFR 9904.413-50(c)(12)(vii) states, "The full amount of the Government's share of an adjustment is allocable, without limit, as a credit or charge during the cost accounting period in which the event occurred . . . ."

In total, the Plan charged the FEHBP $5,728,783 ($3,457,783 in contract year 2021, $1,021,000 in contract year 2022, and $1,250,000 in contract year 2023) for pension costs in contract years 2021 through 2023. Specifically, the Plan charged the FEHBP $5,107,435 ($2,857,435 in contract year 2021, $1,000,000 in contract year 2022, and $1,250,000 in contract year 2023) for the Plan's management pension plan and $621,348 ($600,348 in contract year 2021 and $21,000 in contract year 2022) for the Plan's employee pension plan. We reviewed the Plan's calculations of pension costs charged to the FEHBP to determine if these costs were calculated in accordance with the contract and applicable regulations. Specifically, we recalculated the pension costs using documentation provided by the Plan and compared our calculated amounts to what the Plan charged the FEHBP for pension costs.

The Plan overcharged the FEHBP $2,227,295 for pension costs in contract years 2022 and 2023.

Based on our review of pension costs charged to the FEHBP, we noted an exception related to management pension plan termination costs. For contract years 2022 and 2023, the Plan charged the FEHBP $1 million and $1.25 million, respectively, for management pension plan termination costs. However, the Plan only incurred and paid costs of $15,197 in contract year 2022 and $7,508 in contract year 2023 from the account for actuary services that were related to the expected termination of the Plan's management pension plan. We noted that no additional termination-related fees were paid out of this account during the audit scope.

During our audit fieldwork, the Plan informed us that management pension plan termination activities started in contract year 2025 with an estimated completion timeframe in contract year 2026. As stated in the criteria section of this audit finding, pension plan termination costs should only be charged to the FEHBP during the year when the activities were incurred. According to the Plan, "Expenses were drawn to prepare for termination expenses whenever the market environment dictates it would be time to do so." We noted that these funds were transferred to the Plan's management pension plan account where the Plan earned monthly interest. However, only $22,705 ($15,197 plus $7,508) in termination-related costs were actually incurred and paid out. Since the Plan held $2,250,000 in LOCA drawdown reimbursements for pension plan termination costs but only incurred $22,705 of these costs, we determined that the Plan charged the FEHBP $2,227,295 ($2,250,000 less $22,705) in excess of what was allowed for contract years 2022 and 2023.

As part of our review, we verified that the Plan subsequently returned $2,428,118 to the FEHBP from June 2025 through August 2025 because of this audit finding, consisting of $2,227,295 for the questioned pension cost overcharges in contract years 2022 and 2023 and $200,823 for applicable LII on these questioned overcharges (as calculated by the OIG).

Recommendation 10

We recommend that the contracting officer require the Plan to return $2,227,295 to the FEHBP for the pension costs that were overcharged to the FEHBP. However, since we verified that the Plan subsequently returned $2,227,295 to the FEHBP for these questioned overcharges, no further action is required for this amount.

Recommendation 11

We recommend that the contracting officer require the Plan to return $200,823 to the FEHBP for the questioned LII calculated on the pension cost overcharges. However, since we verified that the Plan subsequently returned $200,823 to the FEHBP for the questioned LII, no further action is required for this LII amount.

Recommendation 12

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that pension costs are properly charged to the FEHBP in accordance with the terms of the FEHBP contract and applicable federal regulations.

Plan Response:

The Plan agrees with the finding and recommendations. Regarding the procedural recommendation, the Plan states, "The Plan has not, and will not, fund the Management Pension Plan until the termination process is finalized. Accordingly, the Plan is not requesting any funds from FEHB for pension-related expenses prior to termination."

3. Unallowable and/or Unallocable Charges $105,096

The Plan charged unallowable and/or unallocable costs of $96,086 to the FEHBP for contract years 2019 through 2024. Specifically, the Plan charged the FEHBP for accounts payable transactions related to non-FEHBP dental flyer printing costs and a computer where the Plan could not support the existence of the asset. As a result of this audit finding, the Plan subsequently returned $105,096 to the FEHBP, consisting of $96,086 for these questioned unallowable and/or unallocable charges and $9,010 for applicable LII on these questioned charges.

As previously cited from contract CS 1370, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. Also, as previously cited from FAR 52.232-17(a), all amounts that become payable by the Contractor should include simple interest from the date due.

48 CFR 31.201-4 states, "A cost is allocable if it is assignable or chargeable to one or more cost objectives on the basis of relative benefits received or other equitable relationship. Subject to the foregoing, a cost is allocable to a Government contract if it –

(a) Is incurred specifically for the contract;

(b) Benefits both the contract and other work, and can be distributed to them in reasonable proportion to the benefits received; or

(c) Is necessary to the overall operation of the business, although a direct relationship to any particular cost objective cannot be shown."

In the APWU Health Plan benefit brochures for contract years 2019 through 2024, the supplemental dental plans are noted as "Non-FEHBP Benefits Available to Plan

Members." Each of these brochures states, "The benefits on this page [including dental plans] are not part of the FEHB contract or premium . . . These programs and materials are the responsibility of the Plan . . . ."

The Plan provided a universe of 17,339 accounts payable transactions, totaling $82,826,358, for contract year 2023. From this universe, we selected and reviewed a judgmental sample of 100 accounts payable transactions, totaling $19,035,248, to determine if the costs were actual, allowable, allocable, and/or reasonable. We selected these 100 accounts payable transactions based on high dollar cost amounts and/or our nomenclature review of the universe. Based on our review of these accounts payable transactions, we identified the following exceptions:

- We determined that the Plan charged costs to the FEHBP for an accounts payable transaction of $26,000 related to unallocable printing costs for APWU's dental benefit flyers. The supplemental dental plan advertised in the flyers is a non-FEHBP benefit. As cited above from the Plan's benefit brochure, non-FEHBP benefits, such as a supplemental dental plan, are not part of the FEHBP contract; therefore, these costs are not allocable and chargeable to the FEHBP. Due to concerns with the Plan charging the FEHBP for non-FEHBP dental flyer printing costs, we expanded our scope to identify all related costs that were charged to the FEHBP for contract years 2019 through 2024. Based on our expanded review, we identified nine accounts payable transactions, including the transaction identified in our original sample, totaling $90,937 ($11,420 in 2019, $14,467 in 2021, $3,512 in 2022, $54,732 in 2023, and $6,806 in 2024), for unallocable printing costs related to flyers that advertised APWU's non-FEHBP dental plan.

- We also determined that the Plan charged $5,149 to the FEHBP for a computer and several computer accessories that the Plan purchased for the Chief Operating Manager in May 2023, who subsequently retired five months later in October 2023. The Plan could not locate this computer, which the Plan believes could be in the possession of the former Chief Operating Manager. Since we could not verify the existence of the computer and/or if the computer is being used to benefit the FEHBP, we determined that these charges were unallowable and/or unallocable to the FEHBP.

In total, we are questioning $96,086 ($90,937 plus $5,149) for these unallowable and/or unallocable costs that were inappropriately charged to the FEHBP. As part of our review, we verified that the Plan subsequently returned $105,096 to the FEHBP from June 2025 through September 2025 because of this audit finding, consisting of $96,086 for the questioned unallowable and/or unallocable charges in contract years 2019 through 2024 and $9,010 for applicable LII on these questioned charges (as calculated by the OIG).

Recommendation 13

We recommend that the contracting officer require the Plan to return $96,086 to the FEHBP for the questioned unallowable and/or unallocable costs that were charged to the FEHBP. However, since we verified that the Plan subsequently returned $96,086 to the FEHBP for these questioned charges, no further action is required for this amount.

Recommendation 14

We recommend that the contracting officer require the Plan to return $9,010 to the FEHBP for the questioned LII calculated on the unallowable and/or unallocable charges. However, since we verified that the Plan subsequently returned $9,010 to the FEHBP for the questioned LII, no further action is required for this LII amount.

Recommendation 15

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that unallowable and/or unallocable costs are not charged to the FEHBP.

Plan Response:

The Plan agrees with the finding and recommendations. Regarding the procedural recommendation, the Plan states, "In response to the audit findings concerning unallocable dental flyer costs, the Plan has instituted a corrective billing procedure whereby all invoices related to non-FEHBP dental flyer printing will be issued directly by the supplier to, and paid by, the American Postal Workers Union. To reinforce financial oversight, the Plan has implemented multiple layers of expense review and continues to monitor all expenditures closely to ensure accuracy, transparency, and accountability."

4. Benefit Plan Brochures $63,698

The Plan printed an excessive amount of benefit plan brochures for contract years 2021 through 2023. As a result, we are questioning $63,698 for this audit finding, consisting of $59,229 for the excess printing and mailing costs related to benefit plan brochures and $4,469 for LII calculated through December 31, 2025, on these questioned charges.

OPM's Healthcare and Insurance Office provides guidance (i.e., "Brochure Quantity Form for Fee-for-Service Plans") to the carriers as to how many brochures are allowed to be printed. OPM determines the quantity of the brochures that the Plan may charge to the FEHBP for each contract year. According to this guidance, all brochures that are printed over this approved quantity are not chargeable to the contract unless approved by OPM.

As previously cited from contract CS 1370, costs charged to the FEHBP must be allowable. Also, as previously cited from FAR 52.232-17(a), all amounts that become payable by the Contractor should include simple interest from the date due.

For the 2021 through 2023 benefit plan brochures, the Plan charged the FEHBP $809,581 for the cost of printing and mailing the brochures. Based on our review of these charges, we determined that the Plan printed an excessive amount of benefit plan brochures in each contract year. Although the contracting officer only approved the total printing of 467,957 benefit plan brochures (176,237 benefit plan brochures in 2021, 152,920 in 2022, and 138,800 in 2023) for contract years 2021 through 2023, the Plan printed 502,300 brochures (183,000 in 2021, 159,650 in 2022, and 159,650 in 2023), resulting in the Plan printing a total excess amount of 34,343 (502,300 less 467,957) benefit plan brochures. As stated above, the cost to print benefit plan brochures over the amount approved by the contracting officer is not chargeable to the contract. We also noted that the Plan did not request OPM approval for the printing of these additional benefit plan brochures. Therefore, we determined that the Plan overcharged the FEHBP $59,229 for printing and mailing these additional benefit plan brochures.

In total, we are questioning $63,698 for this audit finding, consisting of $59,229 for the excess printing and mailing costs related to benefit plan brochures for contract years 2021 through 2023 and $4,469 for applicable LII calculated through December 31, 2025, on these questioned overcharges (as calculated by the OIG).

Recommendation 16

We recommend that the contracting officer disallow $59,229 that was overcharged to the FEHBP for excessive printing and mailing costs related to benefit plan brochures for contract years 2021 through 2023.

Recommendation 17

We recommend that the contracting officer require the Plan to return $4,469 to the FEHBP for applicable LII calculated through December 31, 2025, on the questioned excessive printing and mailing charges, as well as LII accruing after December 31, 2025.

Recommendation 18

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that excessive printing and mailing costs related to benefit plan brochures are not charged to the FEHBP.

Plan Response:

The Plan disagrees with the finding and monetary recommendations. The Plan states, "As stated in 48 CFR [48 CFR 31.201-3 (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.' We believe the brochure-related costs meet this standard of reasonableness. Extra brochures are ordered to support outreach efforts at health fairs, where they are distributed to prospective members. Additionally, brochures are used internally for training purposes, and surplus quantities are necessary to replace any brochures that may have been damaged or lost in transit."

However, the Plan agrees with the procedural recommendation. The Plan states, "As part of our adherence to the . . . (OPM) requirements . . . our Plan will only order the quantity of brochures that has been explicitly approved by our Contracting Officer."

OIG Comments:

We disagree with the Plan's response. This is not a question of reasonableness. As noted in the audit finding, this is a question of complying with OPM's guidelines for the allowed (approved) quantity of benefit plan brochures, which the Plan did not follow for contract years 2021 through 2023. The OPM contracting office provided clear guidance to the Plan as to how many brochures were allowed to be printed for contract years 2021 through 2023. Again, according to this yearly guidance, all brochures that are printed over the approved quantity are not chargeable to the contract unless approved by OPM. Therefore, we continue to question the excess printing and mailing costs related to benefit plan brochures as well as applicable LII.

5. Unallowable Gift $11,823

The Plan charged an unallowable gift of $11,168 to the FEHBP for contract year 2023. Specifically, the gift was for a company vehicle that the Plan gave to a retiring employee. As a result of this audit finding, the Plan subsequently returned $11,823 to the FEHBP, consisting of $11,168 for the unallowable gift and $655 for applicable LII on this questioned charge.

As previously cited from contract CS 1370, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. Also, as previously cited from FAR 52.232-17(a), all amounts that become payable by the Contractor should include simple interest from the date due.

48 CFR 31.205-13(b) states, "Costs of gifts are unallowable."

During our review of gains and losses that were credited and/or charged to the FEHBP for contract years 2021 through 2023, we identified that the Plan charged an unallowable gift of $11,168 to the FEHBP in December 2023. Specifically, the gift was for a company vehicle that the Plan gave to the retiring Chief Operating Manager. The Plan charged this gift to the FEHBP in the form of a loss, which was the remaining value of the vehicle that was given to the retiring employee. We determined that since this transaction is for a gift, the loss is unallowable in accordance with 48 CFR 31.205-13(b), which states that a gift is an unallowable charge to the FEHBP.

As part of our review, we verified that the Plan subsequently returned $11,823 to the FEHBP from March 2025 through May 2025 for this audit finding, consisting of $11,168 for the questioned unallowable gift that was charged to the FEHBP in contract year 2023 and $655 for applicable LII on this questioned charge (as calculated by the OIG).

Recommendation 19

We recommend that the contracting officer disallow $11,168 for the questioned unallowable gift that was charged to the FEHBP in contract year 2023. However, since we verified that the Plan subsequently returned $11,168 to the FEHBP for this questioned charge, no further action is required for this amount.

Recommendation 20

We recommend that the contracting officer require the Plan to return $655 to the FEHBP for the questioned LII calculated on the unallowable gift that was charged to the FEHBP. However, since we verified that the Plan subsequently returned $655 to the FEHBP for the questioned LII, no further action is required for this LII amount.

Plan Response:

The Plan agrees with the finding and recommendations.

C. CASH MANAGEMENT

1. Excess Funds and Working Capital Deposit Exceptions $12,947,394

The Plan used excess funds that accumulated in the Plan's dedicated FEHBP interest bearing account as working capital (WC) funds and did not accurately report on the Annual Accounting Statements (AAS) for contract years 2021 through 2023 the actual WC deposit balances held by the Plan. Also, we determined that the Plan calculated a WC deposit benchmark amount over the amount needed to meet the Plan's daily cash needs for FEHBP claim payments. As a result, we are questioning $12,947,394 of the excess funds maintained in the Plan's dedicated FEHBP interest bearing account as of June 30, 2024, the Plan's inaccurate reporting on the AASs of the WC deposit balances

actually held by the Plan, and the Plan's incorrect methodology used to determine the WC deposit benchmark amount. The Plan subsequently returned these questioned excess funds of $12,947,394 to the FEHBP in July 2025, after receiving our audit notification letter, and because of our audit. Since these questioned excess WC funds were maintained in the Plan's dedicated FEHBP interest bearing account, LII is not applicable for this audit finding.

OPM's "Letter of Credit System Guidelines" (Guidelines), dated April 2018, state: "Carriers should maintain a working capital balance equivalent to an average of two (2) days of paid claims. The working capital fund [deposit] should be established using federal funds. Carriers are required to monitor their working capital fund on a monthly basis and adjust, if necessary, on a quarterly basis. The interest earned on the working capital funds must be credited to the FEHB Program at least on a monthly basis. The working capital is not required but strongly recommended." The Guidelines include specific instructions for calculating the WC deposit. These Guidelines also state, "OPM will monitor drawdowns to ensure Carriers are maintaining minimal balances of Federal funds. If OPM determines Carrier-held funds exceed the minimal level, all future requests for funds must be preapproved by OPM." In the calculation instructions, the Carrier's WC calculation must also exclude administrative expenses and service charges.

According to OPM's Annual Reporting Instructions for Experience-Rated Carriers, for a Carrier's end of year WC balance, "The total of the ending working capital [reported on the AAS] should agree with the amount held by Carrier."

The Plan held excess FEHBP funds of $17,997,306 as of June 30, 2024.

We reviewed the Plan's WC deposit amounts reported on the AASs for contract years 2021 through 2023. Specifically, the Plan reported ending WC deposit balances of $27,000,000 for contract year 2021, $22,870,223 for contract year 2022, and $24,565,533 for contract year 2023. Based on our review of the Plan's supporting documentation for these reported WC deposit balances, we determined the following:

- First, the Plan could not support that LOCA drawdowns were made to establish and fund a WC deposit. The Plan calculated a WC benchmark amount but did not specifically withdraw funds from the LOCA to officially establish a WC deposit. To fund the Plan's WC deposit, the Plan basically used excess funds accumulated over the years as the source to cover the WC deposit. The Plan's theory was as long as the FEHBP interest bearing account balance was less than the WC deposit benchmark calculation, all was good. In some instances, the Plan even refrained from withdrawing funds from the LOCA when the bank balances were too high, again since the Plan's objective was not to hold more cash than the calculated WC deposit benchmark amount.

As of June 30, 2024, the Plan held $17,997,306 in excess funds in the Plan's dedicated FEHBP interest bearing account. The Plan could not specifically support how these funds accumulated over time, but we believe that these excess funds are related to unreturned health benefit refunds and/or recoveries as well as LOCA drawdown errors. As examples, we identified several instances where the Plan did not completely return LOCA drawdown worksheet credit adjustments of $3,799,912 to the FEHBP, which included FEHBP health benefit refunds and/or recoveries, and in one instance where the Plan did not return a duplicate LOCA drawdown amount of $1,250,000 to the FEHBP (see the "Letter of Credit Account Drawdown Errors" audit finding (C2) on pages 34 through 36 of this report for specific details). Without proper accounting of what funds are included in the Plan's FEHBP interest bearing account balance, there is an increased risk of mishandling FEHBP funds as well as not identifying and correcting LOCA drawdown errors that may result in the accumulation of excess funds. As a result, we are questioning $12,947,394 ($17,997,306 less $3,799,912 less $1,250,000) in excess funds maintained in the Plan's dedicated FEHBP interest bearing account, which excludes the amounts that are questioned in the "Letter of Credit Account Drawdown Errors" audit finding.

- Second, the WC deposit amounts reported on the AASs were not the actual WC deposit amounts held by the Plan in the dedicated FEHBP interest bearing account. The amounts reported on the AASs were the Plan's WC benchmark calculations. According to the AAS instructions provided to the Plan by OPM, this amount should be the actual WC deposit held by the Plan at the end of each year and not a WC benchmark.

- Third, when reviewing the Plan's WC benchmark calculations, we determined that the Plan should not include the following items in the calculations, because these items significantly overstate the Plan's WC deposit benchmark amounts (based on the Plan's daily cash needs): biweekly electronic payments to the Pharmacy Benefit Manager (PBM) for pharmacy drug claims and/or administrative expenses; vendor high option fees; Administrative Services Only fees; and bank fees. As of June 30, 2024, the Plan calculated a WC deposit benchmark amount of $28,413,785 ($16,628,397 for the High Option and $11,785,388 for the Consumer Driven Health Plan Option).

  To determine if the Plan calculated an appropriate WC deposit benchmark amount, we recalculated what the Plan's WC deposit benchmark amount should have been and determined that, as of June 30, 2024, the WC deposit benchmark amount should have been $18,552,457 ($9,578,491 for the High Option and $8,973,966 for the Consumer Driven Health Plan Option) instead of $28,413,785. For our calculation of the allowable WC deposit benchmark amount, we followed the methodology in the Guidelines by selecting the single highest day of checks-presented dollars for the quarter and then calculating the checks-presented dollars for the week that included this

date. We also excluded from our calculation all non-health benefit charges, such as vendor high option, Administrative Services Only, and bank fees as well as the biweekly PBM electronic payments for pharmacy drug claims and/or administrative expenses where the Plan knows the PBM payment amounts a couple of days before making the electronic payments to the PBM and withdrawing the funds from the LOCA.[4] As a result, we determined that the Plan calculated a WC deposit benchmark amount $9,861,328 ($28,413,785 minus $18,552,457) over the amount needed to meet the Plan's daily cash needs for FEHBP claim payments.

Conclusion and Summary of Exceptions

For this audit finding, we are questioning $12,947,394 of the excess funds maintained in the Plan's dedicated FEHBP interest bearing account as of June 30, 2024, the Plan's inaccurate reporting on the AASs of the WC deposit balances that were actually held by the Plan, and the Plan's incorrect methodology used to determine the WC deposit benchmark amount as of June 30, 2024. The Plan subsequently returned these questioned excess funds to the FEHBP in July 2025, after receiving our audit notification letter (dated July 1, 2024), and because of our audit. Since these questioned excess WC funds were held in the Plan's dedicated FEHBP interest bearing account, LII is not applicable for this audit finding.

We recognize that the excess funds held by the Plan fluctuated daily and therefore the amount of excess funds subsequently returned to the FEHBP would not equal the questioned amount of $12,947,394. In 2025, the Plan also implemented the Postal Service Health Benefits Program (PSHBP) option. As a result, when returning the excess funds related to contract years 2024 and prior, the Plan had to split and return these excess funds to the FEHBP and PSHBP options. We noted that on multiple dates in July 2025, the Plan returned all excess funds of $19,449,719 to the FEHBP and PSHBP options via OPM wire transfers and/or applicable LOCA drawdown adjustments. As part of our review, we verified that $12,426,932 of these excess funds were returned to the FEHBP and $7,022,787 of these excess funds were returned to the PSHBP.

Recommendation 21

We recommend that the contracting officer require the Plan to return $12,947,394 to the FEHBP for the questioned excess funds (e.g., accumulation of unreturned health benefit refunds and/or recoveries and LOCA drawdown errors) that were held in the Plan's dedicated FEHBP interest bearing account as of June 30, 2024. Since we understand that excess funds held by the Plan may have fluctuated daily, and therefore increased and/or

[4] In our opinion, as a cash management best practice and because of the significance of these biweekly PBM payments (e.g., biweekly payments of $700,000–$11 million from January–June 2024), the Plan should consider excluding these biweekly payments from the WC deposit calculations and just request these LOCA drawdown reimbursements one or two days (if necessary) before making these electronic payments to the PBM.

decreased since June 30, 2024, the contracting officer should require the Plan to return all remaining excess funds to the FEHBP that the Plan held as of July 2025, when the Plan officially established the WC deposits for the FEHB plan options. However, since we verified that the Plan subsequently returned $12,426,932 to the FEHBP in July 2025 (via wire transfer to OPM) for all remaining excess funds that the Plan held for the Plan's FEHB plan options as of July 2025, no further action is required for our questioned excess funds of $12,947,394.

Recommendation 22

We recommend that the contracting officer require the Plan to perform a separate LOCA drawdown request to properly establish a WC deposit (based on the Plan's WC deposit calculation). However, since we verified that the Plan subsequently performed a separate LOCA drawdown in July 2025 to properly establish the WC deposit, no further action is required for this procedural recommendation.

Recommendation 23

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that the WC deposit held by the Plan throughout the year and at calendar year-end is accurately reported on the Plan's 2025 AAS (and going forward).

Recommendation 24

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that the WC deposit benchmark amount is correctly calculated and the WC deposit is timely adjusted (if necessary) at least on a quarterly basis.

Recommendation 25

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that unreturned health benefit refunds and/or recoveries and LOCA drawdown errors are timely identified and corrected (i.e., returned to the FEHBP via LOCA drawdown adjustments).

Plan Response:

The Plan agrees with the finding and recommendations. For the procedural recommendations, the Plan states, "In July 2025, the Plan initiated a separate LOCA drawdown to establish the working capital, based on the calculation completed on July 1, 2025. . . . Beginning with the 2025 AAS and going forward, the

Plan will report working capital as of year-end. . . . The Plan's Contracting Officer reviewed and approved the revised working capital calculation completed in July 2025. Additionally, the calculation was reviewed by OIG auditors to ensure its accuracy. Both the calculation and the LOCA requests and returned LOCA funds received their approval. . . . In accordance with the guidelines provided by OIG in July 2025, the Plan has calculated and established a working capital amount for each LOCA. Any funds exceeding this amount will be returned to the LOCA, while additional funds needed will be drawn down from the LOCA. This process has been reviewed and approved by both OIG and the Plan's Contracting Officer."

OIG Comments:

We provided the Plan with a copy of OPM's "Letter of Credit System Guidelines" that includes specific instructions for calculating the WC deposit. We also provided the Plan with a copy of OPM's "Annual Reporting Instructions for Experience-Rated Carriers" that includes specific instructions for reporting a Carrier's WC deposit adjustments and balances.

When reviewing the Plan's July 2025 WC deposit calculation, we identified a minor exception with the calculation and immediately notified the Plan. The Plan subsequently reported this exception to the contracting officer, which then reviewed the calculation and allowed the exception.

2. Letter of Credit Account Drawdown Errors $5,049,912

The Plan had not returned $3,799,912 to the FEHBP for seven credit adjustments that were reported on the Plan's LOCA drawdown worksheets. These LOCA drawdown credit adjustment errors occurred due to the Plan not carrying forward credit adjustment balances to subsequent LOCA drawdowns. Also, the Plan inadvertently overdrew $1,250,000 from the LOCA on December 28, 2023, because of a duplicate LOCA drawdown error. As a result, we are questioning $5,049,912 for these eight LOCA drawdown errors. Since the questioned funds for these eight LOCA drawdown errors were maintained in the Plan's dedicated FEHBP interest bearing account, LII is not applicable for this audit finding.

As previously cited from Contract CS 1370, all health benefit refunds and recoveries must be deposited into the dedicated FEP investment account within 30 days and returned to the LOCA within 60 days after receipt by the Carrier. Also, as previously cited from contract CS 1370, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable.

48 CFR 31.201-5 states, "The applicable portion of any income, rebate, allowance, or other credit relating to any allowable cost and received by or accruing to the contractor shall be credited to the Government either as a cost reduction or by cash refund."

LOCA Drawdown Credit Adjustments

During our initial review of LOCA drawdowns for contract year 2021 through June 30, 2024, we identified one instance where the Plan had not fully returned a LOCA credit adjustment that was reported on the Plan's April 2022 monthly LOCA drawdown worksheet. Specifically, the Plan had not returned $47,078 to the FEHBP for this LOCA credit adjustment. As a result, we expanded our review and identified six additional instances where the Plan had not fully returned LOCA credit adjustments to the FEHBP. We noted that these seven LOCA credit adjustments consisted of items such as pharmacy drug rebates, health benefit refund deposits, miscellaneous health benefit credits, workers' compensation settlements, and interest income. We also noted that these seven LOCA credit adjustment errors occurred due to the Plan not carrying forward the credit adjustment balances to subsequent LOCA drawdowns until the remaining credit balances were fully exhausted. As a result, the Plan had not returned $3,799,912 to the FEHBP for these seven LOCA credit adjustments that were reported on the Plan's LOCA drawdown worksheets on various dates from April 2022 through May 2024.

LOCA Overdraw for Pension Plan Termination Costs

While reviewing the Plan's 2023 pension plan termination costs, we identified a LOCA overdraw of $1,250,000 that occurred on December 28, 2023. We determined that the overdraw occurred because of human error, as follows. On December 26, 2023, a Plan employee manually entered $1,250,000 on the LOCA drawdown worksheet to increase the LOCA drawdown for pension plan termination costs. On December 27, 2023, another Plan employee entered the same costs of $1,250,000 as a miscellaneous debit on the Plan's LOCA drawdown worksheet, which then increased the LOCA drawdown amount by $1,250,000 on December 28, 2023. Because of this inadvertent error, the Plan overdrew $1,250,000 from the LOCA on December 28, 2023, resulting in a duplicate LOCA drawdown for the pension plan termination costs.

Summary of Exceptions

The Plan made eight LOCA drawdown errors totaling $5,049,912.

In total, the Plan subsequently returned $5,049,912 to the FEHBP in June and July of 2025 for this audit finding, consisting of $3,799,912 for seven LOCA drawdown credit adjustments that were not previously returned to the FEHBP and $1,250,000 for one inadvertent LOCA overdraw (a duplicate LOCA drawdown error). Since these questioned amounts were held in the Plan's dedicated FEHBP interest bearing account, LII is not applicable for this audit finding. As part of our review, we also verified that the Plan implemented a procedure change starting in June 2024 that ensured LOCA credit adjustment balances are carried forward to subsequent LOCA drawdowns until the remaining credit balances are fully exhausted. We reviewed the Plan's monthly LOCA

drawdown worksheets for July 2024 through December 2024 and noted that there were no additional LOCA credit adjustment balance errors.

Recommendation 26

We recommend that the contracting officer require the Plan to return $5,049,912 to the FEHBP for the questioned LOCA drawdown errors. However, since we verified that the Plan subsequently returned $5,049,912 to the FEHBP for these questioned LOCA drawdown errors, no further action is required for this amount.

Plan Response:

The Plan agrees with the finding and recommendation.

D. FRAUD AND ABUSE PROGRAM

1. Special Investigations Unit — Procedural

The Plan is not in compliance with the communication and reporting requirements for fraud and abuse cases that are set forth in Carrier Letter 2017-13. Specifically, we identified an issue with the Plan's untimely reporting of a fraud and abuse case to the OIG and an error on the Plan's 2023 Fraud, Waste, and Abuse (FWA) Annual Report. Without awareness of these existing potential fraud and abuse issues, the OIG cannot investigate the broader impact of these potential issues on the FEHBP as a whole. Additionally, the accuracy of fraud and abuse case activities that are reported on the Plan's FWA Annual Report is essential to avoid presenting a false narrative of the Plan's progress with identifying and preventing fraud, waste, and abuse in the FEHBP.

Carrier Letter 2017-13 (OPM Federal Employees Health Benefits Fraud, Waste, and Abuse), dated November 20, 2017, states that all Carriers "are required to submit a written notification to OPM-OIG within 30 working days when there is a reportable FWA that has occurred against the FEHB Program. Potential FWA issues become reportable to the OIG if, after a preliminary review of the allegation and/or complaint, the Carrier takes an affirmative step to expand, further investigate, develop and/or close an allegation/complaint."

In one instance, the Plan untimely reported a fraud and abuse case 76 days late to the OIG.

For contract year 2023 through June 30, 2024, the Plan opened 594 fraud and abuse cases with potential FEHBP exposure. From this universe, we selected and reviewed a judgmental sample of 30 cases and determined if the Plan timely reported these cases to the OIG. Based on our review, we determined that the Plan untimely reported a case 76 days late to the OIG. Additionally, we reviewed the Plan's 2023 FWA Annual Report for accuracy and completeness and identified a

reporting error in the "Allegations/Complaints/Cases where there is FEHB Program Exposure" category, which was understated by one case.

Ultimately, the Plan's untimely and/or inaccurate reporting of potential FEHBP cases to the OIG has resulted in non-compliance with the communication and reporting requirements that are set forth in Carrier Letter 2017-13. Timely case notifications allow the OIG to investigate if other FEHBP Carriers are exposed to the identified fraudulent activity. As a result, an untimely OIG notification by the Plan may result in additional improper payments being made by other FEHBP health insurance Carriers. This also does not allow the OIG's Administrative Sanctions Group to be notified in a timely manner.

Recommendation 27

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to meet the communication and reporting requirements of fraud and abuse cases that are contained in Carrier Letter 2017-13.

Plan Response:

The Plan agrees with the finding and recommendation. The Plan states, "To ensure compliance with FEHBP Carrier Letter 2017-13, the Plan's Fraud, Waste, and Abuse (FWA) team has implemented enhanced staff training and upgraded the FWA case tracking system. These improvements introduce additional safeguards to support accurate documentation and timely reporting of cases to the Office of Inspector General (OIG)."

IV. SCHEDULE A – QUESTIONED CHARGES

AMERICAN POSTAL WORKERS UNION HEALTH PLAN
ELKRIDGE, MARYLAND

QUESTIONED CHARGES

AUDIT FINDINGS	2019	2020	2021	2022	2023	2024	2025	TOTAL
A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS								
1. Claim Overpayments - Uncollected and Write-Offs	$0	$0	$0	$0	$0	$13,138,195	$0	$13,138,195
2. Health Benefit Refunds and Pharmacy Drug Rebates*	0	0	194,699	306	16,192	0	0	211,197
TOTAL MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS	$0	$0	$194,699	$306	$16,192	$13,138,195	$0	$13,349,392
B. ADMINISTRATIVE EXPENSES								
1. Employee Health Benefit Costs	$616,126	$803,819	$725,663	$763,238	$759,033	$0	$0	$3,667,879
2. Pension Cost Overcharges*	0	0	0	984,803	1,289,280	108,879	45,156	2,428,118
3. Unallowable and/or Unallocable Charges*	11,420	186	14,582	4,243	61,279	11,171	2,215	105,096
4. Benefit Plan Brochures*	0	0	8,610	12,109	39,242	997	2,740	63,698
5. Unallowable Gift*	0	0	0	0	11,168	545	110	11,823
TOTAL ADMINISTRATIVE EXPENSES	$627,546	$804,005	$748,855	$1,764,393	$2,160,002	$121,592	$50,221	$6,276,614
C. CASH MANAGEMENT								
1. Excess Funds and Working Capital Deposit Exceptions	$0	$0	$0	$0	$0	$12,947,394	$0	$12,947,394
2. Letter of Credit Account Drawdown Errors	0	0	0	157,776	1,250,000	3,642,136	0	5,049,912
TOTAL CASH MANAGEMENT	$0	$0	$0	$157,776	$1,250,000	$16,589,530	$0	$17,997,306
D. FRAUD AND ABUSE PROGRAM								
1. Special Investigations Unit (Procedural)	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL FRAUD AND ABUSE PROGRAM	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL QUESTIONED CHARGES	$627,546	$804,005	$943,554	$1,922,475	$3,426,194	$29,849,317	$50,221	$37,623,312

* We included lost investment income (LII) within audit findings A2 ($9,431), B2 ($200,823), B3 ($9,010), B4 ($4,469), and B5 ($655). Therefore, no additional LII is applicable through December 31, 2025. However, additional LII may be applicable after December 31, 2025, for audit finding B4.

American Postal Workers Union Health Plan 2025 OIG Audit Response *[Revised Draft Report Response, dated November 7, 2025]*

Section: Draft Report Response

In response to the OIG issued draft report 2025-ERAG-005 APWUHP Draft Report.pdf, American Postal Workers Union Health Plan (APWUHP) is issuing the following responses to address recommendations made within the report. APWUHP takes any audits conducted by OIG very seriously and strives to cooperate with the OIG personnel involved during all steps of an audit.

For purposes of organization, APWUHP has crafted responses based on draft report area, section, and recommendation number. Below are the responses to the recommendations, categorized by the areas within the draft report.

OIG Recommendation 1

We recommend that the contracting officer require the Plan to return $4,315,517 to the FEHBP for the 919 questioned uncollected claim overpayments that were not previously pursued through third-party collections, whether recovered or not, as all prompt and diligent efforts to recover these overpayments were not made timely.

APWUHP Response:

We disagree with the language in this recommendation that APWU Health Plan did not exercise due diligence regarding these uncollected overpayments. These overpayments have not been deemed uncollectable and we are still pursuing reimbursement from the providers. APWU Health Plan has already implemented updated procedures to enhance the overall effectiveness of this process such as offsets from future payments and referring these overpayments to our third-party collection agency. These actions reflect our continued commitment to exercising our due diligence in the recovery of these funds.

As of 10/31/2025:

- Out of 919 claims, 772 of these overpayments are still in an active status.
- The overall balance of $4,315,517 has been reduced to $3,510,787. Details of activity are as follows:

    1. **Closed cases:** $508,850, recovered through hard-copy checks and Auto Recovery (AR) actions, which began in October 2025. Of this amount, AR accounts for $336,759.

2. **Written-off cases:** Two cases totaling $39,472 were discussed during discovery; no further action will be taken.
3. **Voided case:** One overpayment of $62,572 was voided and is no longer valid.
4. **Auto Recovery on open cases:** Since offsets began in October 2025, an additional $193,835 has been recovered.
5. **VA claims:** Of the 919 claims, 84 are VA related. One claim has been closed for $2,432. The remaining 83, totaling $291,779, cannot be processed through Auto Recovery due to VA regulations and will be referred to our third-party collection vendor for further recovery efforts.

OIG Recommendation 2

We recommend that the contracting officer require the Plan to recover and return $8,822,678 to the FEHBP for the 1,980 questioned uncollected claim overpayments where the Plan had not previously used provider offsets to recover these claim overpayments, but now has the ability to recover these overpayments through provider offsets. If these overpayments are determined to be uncollectible, then the contracting officer should require the Plan to provide adequate documentation demonstrating that all prompt and diligent efforts were made, including use of provider offsets, future FEHBP member benefit payment offsets, and/or third-party collections, to recover these funds before writing them off, as required by the FEHBP contract.

APWUHP Response:

The Plan agrees with the procedural recommendation. The Plan has already introduced updated procedures to enhance the overall efficiency of this process. Any claims related to these amounts that are still outstanding, will be set to offset from future payments and/or will be sent to our third-party collection vendor. These actions reflect our continued commitment to exercising our due diligence in the recovery of these funds.

- Out of 1,980 claims, 1,690 of these overpayments are still in an active status.

- The overall balance of $8,822,678 has been reduced to $7,779,296. Details of activity are as follows:

    1. **Closed cases:** $904,261 recovered through hard-copy checks and Auto Recovery (AR) actions, which began in October of 2025. AR accounts for $309,461 of this amount.
    2. **Voided payments:** Four overpayments totaling $11,709 were voided. Two were reprocessed after funds were returned and plan liability changed; the two other were invalid.
    3. **Auto Recovery on open cases**: Since offsets began in October of 2025, an additional $127,412 has been recovered.
    4. **VA Claims:** Six VA-related claims totaling $5,000 cannot be processed through Auto Recovery due to VA regulations and will be referred to our third-party collection vendor for further recovery efforts.

OIG Recommendation 3

We recommend that the contracting officer require the Plan to implement the necessary corrective actions to ensure that claim overpayments are adequately pursued, monitored, recovered, and returned to the FEHBP, as required by Section 2.3(g) of contract CS 1370. If the options are available and cost effective, the Plan should use provider offsets, future FEHBP member benefit payment offsets, and/or third-party collections to recover claim overpayments. The Plan should also be more mindful when entering vendor contracts that restrict or limit the Plan's ability to recover FEHBP claim overpayments, since contracts between the Plan and vendors do not supersede the FEHBP contract.

APWUHP Response:

The Plan agrees with this recommendation. The Plan has already implemented updated procedures to improve the overall efficiency and effectiveness of our overpayment process. These updates include the reinstatement of the Offset/Auto Recovery language in our overpayment letters and the active use of Offset/Auto Recovery process, which applies future claim payments towards outstanding balances.

This review will be conducted at 120 days to ensure the issuance of the 30-, 60-, and 90-day letters are not impacted. If a provider responds and agrees to the recovery prior to letter generation that will be considered valid provider contact, and no further letters will be issued by the Plan.

Any unrecovered balances at the 120-day mark will be transitioned to our third-party collection vendor for further action.

OIG Recommendation 4

Due to the Plan's lack of due diligence with recovery efforts, we recommend that the contracting officer require the Plan to return $201,766 to the FEHBP for the questioned provider offsets where the Plan had not recovered and/or returned funds to the FEHBP for nine FEHBP claim overpayments.

APWUHP Response:

We disagree with the language that APWU Health Plan did not exercise due diligence for these uncollected overpayments. These overpayments have not been deemed uncollectable and we are still pursuing reimbursement from the providers. APWU Health Plan has already implemented updated procedures to enhance the overall effectiveness of this process such as offsets from future payments and referring these overpayments to our third-party collection agency.

There are 9 claims that make up the balance of $201,766. These claims were previously set up as Offset/Auto Recovery (AR). The Plan has recovered $12,505 from the original advance balance $214,271, reducing it to the current $201,766 that was reported. The last partial payment recovery was on 02/21/25 for $20. All AR actions were initiated prior to

reparations being made. This subset of overpayments will now be referred to our third-party collections vendor for further recovery efforts.

OIG Recommendation 5

We recommend that the contracting officer require the Plan to return $9,431 to the FEHBP for the questioned LII calculated on the cash receipt health benefit refunds and pharmacy drug rebate amount that were returned untimely to the FEHBP. However, since we verified that the Plan subsequently returned $9,431 to the FEHBP for the questioned LII, no further action is required for this LII amount.

APWUHP Response:

The Plan agrees with this recommendation and that no further action is required.

OIG Recommendation 6

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that all health benefit refunds and pharmacy drug rebates are returned timely to the FEHBP (i.e., deposited into the FEHBP investment account within 30 days after receipt and returned to the letter of credit account via drawdown adjustments within 60 days after receipt).

APWUHP Response:

The Plan agrees with this recommendation. The Plan has established procedures to ensure that all deposits are made within the required 30-day timeframe. As a result of these measures, the Plan has not experienced any late deposits since January 2024.

OIG Recommendation 7

We recommend that the contracting officer require the Plan to return $3,667,879 to the FEHBP for the questioned employee health benefit costs that were overcharged to the FEHBP for contract years 2019 through 2023. However, since we verified that the Plan subsequently returned $3,667,879 to the FEHBP for these questioned charges by confirming that the Plan did not charge the FEHBP for allowable employee health benefit costs of $4,223,856 in contract year 2024, because of a significant surplus in the Plan's Health and Welfare Trust, no further action is required for the questioned amount of $3,667,879.

APWUHP Response:

The Plan agrees with this recommendation and that no further action is required.

OIG Recommendation 8

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that employee health benefit costs are properly charged to the FEHBP.

APWUHP Response:

The Plan agrees with this recommendation. The Plan has revised its procedures for handling of the employee contributions related to health insurance. Beginning July 2025, these contributions are no longer included in the LOCA draw. The 15% portion representing employee withholdings continues to remain with FEHB.

OIG Recommendation 9

We recommend that the contracting officer require the Plan to implement corrective actions to reduce the remaining surplus (i.e., $29,241,825 as December 31, 2024) to a reasonable reserve level, as determined by the contracting officer.

APWUHP Response:

The Plan agrees with this recommendation. The Plan is actively working with its actuary, *[deleted by the OIG]*, to monitor the funding levels of the Health & Welfare Trust. Based on current projections, the Plan will not be making contributions to the Trust as long as funding levels remain above 100%.

OIG Recommendation 10

We recommend that the contracting officer require the Plan to return $2,227,295 to the FEHBP for the pension costs that were overcharged to the FEHBP. However, since we verified that the Plan subsequently returned $2,227,295 to the FEHBP for these questioned overcharges, no further action is required for this amount.

APWUHP Response:

The Plan agrees with this recommendation and that no further action is required.

OIG Recommendation 11

We recommend that the contracting officer require the Plan to return $200,823 to the FEHBP for the questioned LII calculated on the pension cost overcharges. However, since we verified that the Plan subsequently returned $200,823 to the FEHBP for the questioned LII, no further action is required for this LII amount.

APWUHP Response:

The Plan agrees with this recommendation and that no further action is required.

OIG Recommendation 12

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that pension costs are properly charged to the FEHBP in accordance with the terms of the FEHBP contract and applicable federal regulations.

APWUHP Response:

The Plan agrees with this recommendation. The Plan has not, and will not, fund the Management Pension Plan until the termination process is finalized. Accordingly, the Plan is not requesting any funds from FEHB for pension-related expenses prior to termination.

OIG Recommendation 13

We recommend that the contracting officer require the Plan to return $96,086 to the FEHBP for the questioned unallowable and/or unallocable costs that were charged to the FEHBP. However, since we verified that Plan subsequently returned $96,086 to the FEHBP for these questioned charges, no further action is required for this amount.

APWUHP Response:

The Plan agrees with this recommendation and that no further action is required.

OIG Recommendation 14

We recommend that the contracting officer require the Plan to return $9,010 to the FEHBP for the questioned LII calculated on the unallowable and/or unallocable charges. However, since we verified that the Plan subsequently returned $9,010 to the FEHBP for the questioned LII, no further action is required for this LII amount.

APWUHP Response:

The Plan agrees with this recommendation and that no further action is required.

OIG Recommendation 15

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that unallowable and/or unallocable costs are not charged to the FEHBP.

APWUHP Response:

The Plan agrees with this recommendation. In response to the audit findings concerning unallocable dental flyer costs, the Plan has instituted a corrective billing procedure whereby all invoices related to non-FEHBP dental flyer printing will be issued directly by the supplier to, and paid by, the American Postal Workers Union. To reinforce financial oversight, the Plan has implemented multiple layers of expense review and continues to monitor all expenditures closely to ensure accuracy, transparency, and accountability.

OIG Recommendation 16

We recommend that the contracting officer disallow $59,229 that were charged to the FEHBP for excessive printing and mailing costs related to benefit plan brochures for contract years 2021 through 2023.

APWUHP Response:

We respectfully disagree with this audit finding. As stated in 48 CFR that is mentioned above "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". We believe the brochure-related costs meet this standard of reasonableness. Extra brochures are ordered to support outreach efforts at health fairs, where they are distributed to prospective members. Additionally, brochures are used internally for training purposes, and surplus quantities are necessary to replace any brochures that may have been damaged or lost in transit.

OIG Recommendation 17

We recommend that the contracting officer require the Plan to return $3,088 to the FEHBP for applicable LII calculated through June 30, 2025, on the questioned excessive printing and mailing charges, as well as LII accruing after June 30, 2025.

APWUHP Response:

We respectfully disagree with this audit finding. As stated in 48 CFR that is mentioned above "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". We believe the brochure-related costs meet this standard of reasonableness. Extra brochures are ordered to support outreach efforts at health fairs, where they are distributed to prospective members. Additionally, brochures are used internally for training purposes, and surplus quantities are necessary to replace any brochures that may have been damaged or lost in transit.

OIG Recommendation 18

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that excessive printing and mailing costs related to benefit plan brochures are not charged to the FEHBP.

APWUHP Response:

The Plan agrees with this recommendation. As part of our adherence to the U.S. Office of Personnel Management (OPM) requirements for the FEHB Program, our Plan will only order the quantity of brochures that has been explicitly approved by our Contracting Officer.

OIG Recommendation 19

We recommend that the contracting officer disallow $11,168 for the questioned unallowable gift that was charged to the FEHBP in contract 2023. However, since we verified that the Plan subsequently returned $11,168 to the FEHBP for this questioned charge, no further action is required for this amount.

APWUHP Response:

The Plan agrees with this recommendation and that no further action is required.

OIG Recommendation 20

We recommend that the contracting officer require the Plan to return $655 to the FEHBP for the questioned LII calculated on the unallowable gift that was charged to the FEHBP in contract year 2023. However, since we verified that the Plan subsequently returned $655 to the FEHBP for the questioned LII, no further action is required for this LII amount.

APWUHP Response:

The Plan agrees with this recommendation and that no further action is required.

OIG Recommendation 21

We recommend that the contracting officer require the Plan to return $12,947,394 to the FEHBP for the questioned excess funds (i.e., accumulation of unreturned health benefit refunds and/or recoveries and LOCA drawdown errors) that were held in the Plan's dedicated FEHBP interest bearing account as of June 30, 2024. Since we understand that excess funds held by the Plan may have fluctuated daily, and therefore increased and/or decreased since June 30, 2024, the contracting officer should require the Plan to return all remaining excess funds to the FEHBP that the Plan held as of July 2025, when the Plan officially established the WC deposits for the FEHB plan options. However, since we verified that the Plan subsequently returned $12,426,932 to the FEHBP in July 2025 (via wire transfer to OPM) for all remaining excess funds that the Plan held for the Plan's FEHB plan options as of July 2025, no further action is required for our questioned excess funds of $12,947,394.

APWUHP Response:

The Plan agrees with this recommendation and that no further action is required.

OIG Recommendation 22

We recommend that the Plan perform a separate LOCA drawdown request to properly establish a working capital deposit.

APWUHP Response:

The Plan agrees with this recommendation. In July 2025, the Plan initiated a separate LOCA drawdown to establish the working capital, based on the calculation completed on July 1, 2025.

OIG Recommendation 23

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that the working capital deposit held by the Plan throughout the year and at calendar year-end is accurately reported on the Plan's Annual Accounting Statement.

APWUHP Response:

The Plan agrees with this recommendation. The Plan has followed the guidance provided by OPM Accounting in 2017 regarding the reporting of working capital on the Annual Accounting Statement (AAS). We have consistently recorded working capital in accordance with those instructions. Beginning with the 2025 AAS and going forward, the Plan will report working capital as of year-end.

OIG Recommendation 24

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that the working capital deposit benchmark amount is correctly calculated and the WC deposit is timely adjusted (if necessary) on at least a quarterly basis.

APWUHP Response:

The Plan agrees with this recommendation. The Plan's Contracting Officer reviewed and approved the revised working capital calculation completed in July 2025. Additionally, the calculation was reviewed by OIG auditors to ensure its accuracy. Both the calculation and the LOCA requests and returned LOCA funds received their approval.

OIG Recommendation 25

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that unreturned health benefit refunds and/or recoveries and LOCA drawdown errors are timely identified and corrected (i.e., returned to the FEHBP via LOCA drawdown adjustments).

APWUHP Response:

The Plan agrees with this recommendation. In accordance with the guidelines provided by OIG in July 2025, the Plan has calculated and established a working capital amount for each LOCA. Any funds exceeding this amount will be returned to the LOCA, while additional funds needed will be drawn down from the LOCA. This process has been reviewed and approved by both OIG and the Plan's Contracting Officer.

OIG Recommendation 26

We recommend that the contracting officer require the Plan to return $5,049,912 to the FEHBP for the questioned LOCA drawdown errors. However, since we verified the Plan subsequently returned $5,049,912 to the FEHBP for these questioned LOCA drawdown errors, no further action is required for this amount.

APWUHP Response:

The Plan agrees with this recommendation and that no further action is required.

OIG Recommendation 27

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to meet the communication and reporting requirements of fraud and abuse cases that are contained in FEHBP Carrier Letter 2017-13.

APWUHP Response:

The Plan agrees with this recommendation. To ensure compliance with FEHBP Carrier Letter 2017-13, the Plan's Fraud, Waste, and Abuse (FWA) team has implemented enhanced staff training and upgraded the FWA case tracking system. These improvements introduce additional safeguards to support accurate documentation and timely reporting of cases to the Office of Inspector General (OIG).

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