



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

Final Audit Report

**AUDIT OF CLAIM AMOUNTS PAID THAT
EQUALED OR EXCEEDED COVERED CHARGES
AT ALL BLUE CROSS AND BLUE SHIELD PLANS**

**Report Number 1A-99-00-18-005
March 13, 2020**

EXECUTIVE SUMMARY

Audit of Claim Amounts Paid That Equaled or Exceeded Covered Charges at all Blue Cross and Blue Shield Plans

Report No. 1A-99-00-18-005

March 13, 2020

Why Did We Conduct The Audit?

The objective of our audit was to determine whether the Blue Cross and Blue Shield (BCBS) plans charged costs to the Federal Employees Health Benefits Program (FEHBP) and provided services to FEHBP members in accordance with the terms of the BCBS Association's contract with the U.S. Office of Personnel Management. Specifically, our objective was to determine whether the BCBS plans complied with contract provisions relative to claims where the amounts paid were equal to or exceeded covered charges.

What Did We Audit?

The Office of the Inspector General (OIG) has completed a limited scope audit of the FEHBP operations at all BCBS plans. The audit covered claim payments from January 1, 2015, through September 30, 2017. Specifically, we identified claims that were reimbursed during this period where amounts paid equaled or exceeded covered charges.

What Did We Find?

Our audit identified 396 improperly paid claims totaling \$7,015,173 in net overcharges to the FEHBP. Specifically, we identified the following:

- \$6,004,911 in net overcharges due to manual processor errors;
- \$630,681 in net overcharges due to various system errors;
- \$217,823 in net overcharges due to provider billing errors;
- \$106,104 in net overcharges due to untimely contract loading errors;
- \$49,885 in overcharges due to improper coordination of benefits; and
- \$5,769 in net overcharges due to improper member liability calculations.



Michael R. Esser
Assistant Inspector General for Audits

ABBREVIATIONS

| | |
|--------------------|---|
| Association | Blue Cross Blue Shield Association |
| BCBS | Blue Cross and Blue Shield |
| Contract | Contract CS 1039 between OPM and the Association |
| FEHB Act | Federal Employees Health Benefits Act |
| FEHBP | Federal Employees Health Benefits Program |
| FEP | Federal Employee Program |
| FEPDirect | Association's nation-wide claims processing system |
| HIO | Healthcare and Insurance Office |
| Non-par | Not Participating in Plan's local provider network |
| OIG | Office of the Inspector General |
| OPM | U.S. Office of Personnel Management |
| Plan(s) | Blue Cross and Blue Shield Plan(s) |
| SBP | Service Benefit Plan |

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I. BACKGROUND

This final audit report details the findings, conclusions, and recommendations resulting from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations, as it relates to claims where amounts paid equaled or exceeded covered charges, at all Blue Cross and Blue Shield (BCBS) plans. The audit was performed by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as authorized by the Inspector General Act of 1978, as amended.

The FEHBP was established by the Federal Employees Health Benefits Act (FEHB Act), Public Law 86-382, enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for Federal employees, annuitants, and dependents. OPM's Healthcare and Insurance Office (HIO) has overall responsibility for administration of the FEHBP. As part of its administrative responsibilities, the HIO contracts with various health insurance carriers that provide service benefits, indemnity benefits, and/or comprehensive medical services. The provisions of the FEHB Act are implemented by OPM through regulations, codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations.

The BCBS Association (Association), on behalf of participating BCBS plans (Plans), has entered into contract CS 1039 (Contract), a Government-wide Service Benefit Plan (SBP) contract, with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its Federal subscribers. There are 36 BCBS companies participating in the FEHBP. The 36 companies are comprised of 64 local Plans.

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

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

¹ Throughout this report, when we refer to "FEP," we are referring to the SBP lines of business at the BCBS plan(s). When we refer to the "FEHBP," we are referring to the program that provides health benefits to Federal employees.

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

All recommendations from our previous audit focusing on claims where amounts paid equaled or exceeded covered charges (Report No. 1A-99-00-13-003, dated November 22, 2013) for claims reimbursed from February 1, 2010, through July 31, 2012, have been closed.

Our sample selections, instructions, and preliminary audit results of the potential claim payment errors were presented to the Association in a draft report, dated September 10, 2019. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as an Appendix to this report. We also considered additional documentation provided by the Association and Plans on various dates through October 11, 2019.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVE

The objectives of our audit were to determine whether the Plans charged costs to the FEHBP and provided services to the FEHBP members in accordance with the terms of the Contract.

Specifically, our objective was to determine whether the Plans complied with the Contract's provisions relative to claims where the amounts paid were equal to or exceeded covered charges.

SCOPE AND METHODOLOGY

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.

This performance audit covered claim payments from January 1, 2015, through September 30, 2017. Using SAS software, we queried the claims data to identify inpatient facility, outpatient facility, and professional claims during this period where the amounts paid equaled or exceeded covered charges. Our queries identified 7,131,218 claim lines, totaling \$3,740,234,025 in payments meeting this criteria. Audit fieldwork was conducted from July 2018 through May 2019, and was performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida.

In planning and conducting our audit, we obtained an understanding of the Plans' internal control structures to help determine the nature, timing, and extent of our auditing procedures. Our audit approach consisted mainly of substantive tests of transactions and not tests of controls. Based on our testing, we did not identify any significant matters involving the Plans' internal control structures or their 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 Plans' systems of internal controls taken as a whole.

We also conducted tests to determine whether the Plans had complied with the contract, the applicable procurement regulations (i.e., the Federal Acquisition Regulation and the Federal Employees Health Benefits Acquisition Regulation, as appropriate), and the laws and regulations governing the FEHBP as they relate to claim payments. The results of our tests indicate that, with respect to the items tested, the Plans did not fully comply with the provisions of the contract relative to claim payments. Any exceptions noted in the areas reviewed are set forth 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 Plans had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP Director's Office, the FEP Operations Center, and the BCBS plans. Through the performance of audits and an OIG in-house claims data reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify areas to test and to select our samples. The BCBS claims data is provided to us on a monthly basis by the FEP Operations Center, and after a series of internal steps, uploaded into our data warehouse. However, due to time constraints, we did not verify the reliability of the data generated by the BCBS plans' local claims systems. While utilizing the computer-generated data during our audit, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

To determine whether the health benefit costs charged to the FEHBP and the services provided to its members during the audit scopes described were in accordance with the Contract, applicable Federal regulations, the SBP brochure, and the Association's FEP Procedures Administrative Manual, we selected the following judgmental samples for review:

- Professional and Inpatient Facility Claims:
 - a. All claims with amounts paid equal to or greater than \$50,000, resulting in 1,505 professional claims, totaling \$108,024,006, and 3,973 inpatient claims, totaling \$352,696,220; and
 - b. Random samples of 7,500 of both professional and inpatient facility claims with amounts paid less than \$50,000, resulting in professional claims totaling \$1,606,887, and inpatient claims totaling \$83,861,421.

In total, we selected 9,005 professional claims, totaling \$109,630,893, and 11,473 inpatient facility claims, totaling \$436,557,641, for review.

- Outpatient Facility Claims:
 - a. All claims with amounts paid equal to or greater than \$25,000, resulting in 1,934 claims totaling \$76,679,166; and
 - b. A random sample of 7,500 claims, totaling \$6,066,952, with amounts paid less than \$25,000.

In total, we selected 9,434 outpatient facility claims, totaling \$82,746,118, for review.

We utilized SAS software to select all judgmental and random samples for review. The samples that were selected and reviewed in performing the audit were not statistically based.

Consequently, the results were not projected to the universe since it is unlikely that the results are representative of the universe taken as a whole.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. Claims Where Amounts Paid Equaled or Exceeded Covered Charges

\$7,015,173

We identified 396 improperly paid claims totaling \$7,015,173 in FEHBP health benefit overcharges.

We used the following criteria to support our questioning of these claim payments:

- Part III, section 3.2 (b) (1) of the Contract states that the costs charged by the carrier must be actual, allowable, reasonable, and verifiable by accounting support.
- Additionally, part II, section 2.3 (g) of the Contract states that when a claim payment error is identified the carrier must make a prompt and diligent effort to recover the monies completely or until the debit is deemed uncollectable.

Various processing and/or payment errors by the local BCBS Plans resulted in improper payments totaling \$7,015,173.

The claims selected for review were submitted to each Plan for its analysis and response. We then conducted a limited review of the responses by selecting a small sample of claims that the plans determined were correctly paid, and a larger sample of claims the plans determined were incorrectly paid to determine the reliability of each Plan's responses.

As part of this limited review, we also verified the adequacy of the supporting documentation and the accuracy and completeness of the Plans' responses. For those claims that were incorrectly paid, we calculated the amount of the claim payment errors. Finally, we tested the claim payment errors to determine whether the Plans had initiated recovery efforts, adjusted or voided the claims, and/or completed the recovery process by the audit request due date (April 6, 2018).

The overcharges identified stemmed from various claim payment errors, which were comprised of the following:

- We questioned 290 claims, totaling \$6,004,911 in net overcharges, because of various manual claim processors errors. Examples of the processor errors that caused the overpayments include manual overrides of claims that deferred for review within either the Plans' local system or the Association's nation-wide claims processing system (FEPDirect) and manually adjusting the pricing of claims for incorrect allowance amounts.

- We questioned 58 claims, totaling \$630,681 in net overcharges, due to system errors such as the system not properly deferring claims when billed charges were less than contractual rates, or the system's incorrect application of pricing allowances.
- We questioned 20 claims, totaling \$217,823 in net overcharges, due to provider billing errors.
- We questioned 16 claims, totaling \$106,104 in net overcharges, due to untimely contract rate loading. Specifically, the proper rates for the providers were not updated or loaded into the system at the time the claims were processed, resulting in improper payments to the providers.
- We questioned two claims that were not properly coordinated with members' other insurance coverage. These claim payment errors resulted in overcharges of \$49,885.
- Finally, we questioned 10 claims where the claim was priced with an incorrect patient liability amount², resulting in \$5,769 in net overcharges.

While the errors identified were limited to a small number of claims, the overcharges related to these errors are substantial. Therefore, it is important to address the root causes of these errors.

Recommendation 1

We recommend that the contracting officer disallow \$7,015,173 for claim overpayments and verify that the BCBS plans return all amounts recovered to the FEHBP.

Association Response;

The Association agrees with \$7,006,346, of which \$3,933,282 has been returned to the FEHBP and \$3,073,064 is still in the recovery stage or has been deemed uncollectible. Additionally, the Association stated that \$9,058 of potential overcharges are still under review by the Plans.

OIG Comments;

After reviewing the Association's response and additional documentation provided by the Plans,

² Patient liability is the amount the member is responsible to pay (i.e., coinsurance, deductible, non-par allowance, etc.)

we determined that the Association and Plans actually acknowledge and agree with \$7,006,116 in claim net overpayments, instead of the stated \$7,006,346. The variance between the two amounts is due to immaterial overcharges totaling \$230.

The \$7,006,116 agreed to by the Association and the Plans is comprised of the following:

- 310 claims, totaling \$5,711,573 in net overpayments, were found as a result of this audit.
- 32 claims, totaling \$714,733 in overpayments, were deemed uncollectible by the Plans after four attempts were made to recoup the monies from the providers. As part of the Association's response to the draft report, they state that documentation to support uncollectible claim overpayments would be provided only after the final report was issued. As such, we continue to question these claim overpayments.
- 46 claims, totaling \$579,810 in net overpayments, were deemed uncollectible by the Plans according to the FEP Overpayment Recovery Protocol, which limits the time period a plan may pursue the recoupment of an overpayment made to certain providers. However, contract CS 1039 Part II, section 2.3(g) states, "*The recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment under 48 C.F.R. §1631.201-70(h) regardless of any time period limitations in the written agreement with the provider.*" As such, we continue to question these claim overpayments.

Additionally, the Association and/or Plans are still reviewing eight claims questioned, totaling \$9,057. In total, this report questions \$7,015,173 in claim overpayments.

Recommendation 2

We recommend that the Association work with its local Plans to ensure that claims processors are properly trained on how to review and process claims that defer for manual review from both the local systems and FEPDirect to minimize manual processor errors.

Association Response;

The Association stated that an analysis will be performed to determine which plans require additional training and will provide an update upon issuance of the final report.

Recommendation 3

We recommend that the Association work with its local Plans to review system issues that have caused improper claim payments to occur. Specifically, why the system does not always defer claims when necessary, and also why the system does not apply accurate pricing allowances.

Association Response;

The Association stated that it will analyze which Plans need systematic evaluation to determine the cause for claim payment issues and will provide an update on this recommendation upon issuance of the final report.

Recommendation 4

We recommend that the Association work with its local Plans to ensure that contract rates are updated accurately and timely when there is a contractual change with any provider, and that retroactive adjustments to affected claims are performed to reflect rate changes.

Association Response;

The Association stated that it will work with identified Plans to ensure contractual rate loading and retroactive adjustment issues are acknowledged and rectified. An update on this recommendation will be provided upon issuance of the final report.

Recommendation 5

We recommend that the Association ensure that other insurance benefits are accurate within FEPDirect so that claim payments are properly coordinated.

Association Response;

The Association stated that it issues annual coordination of benefit questionnaires to members to help ensure benefits are properly updated within FEPDirect. Additionally, it provided support that shows other party liability edits within FEPDirect that should make eligible claims defer for proper coordination.

OIG Comment;

While the Association's response appears to address the recommendation, we will not be able to verify the effectiveness of the corrective actions until they are tested on a future audit.

B. Non-Participating Provider - Program Concern

This audit identified 1,001 non-participating (non-par) outpatient claims, totaling \$20,379,837 in payments between 2015 and 2017, that were priced using billed charges as the allowance rather than a more reasonable rate such as a local Plan allowance, a usual and customary rate or a Medicare limiting charge.

While we recognize that these non-par outpatient claims were paid in accordance with the 2015 through 2017 benefit structures, we estimated that the FEHBP could have saved \$17,800,534 had lower cost allowances been utilized during this time period. Specifically, in deriving this amount, we compared what was paid for each claim to the local plan allowances, based on type of service.

In 2019, OPM updated the FEHBP benefit structure for outpatient non-par non-emergency services that limited payment to the local Plan allowance rather than billed charges. While this change mitigates a large portion of this program concern, it does not address the non-par emergency claims, which are still being paid at billed charges. The biggest hurdle OPM faces in correcting this issue is the impact to the member.

We understand that OPM has a legitimate concern about the financial impact on FEHBP members who may unintentionally use a non-par provider in an emergency. However, allowing these types of providers to be paid at billed charges does not incentivize them to join a provider network, as their reimbursement is higher in a non-par role. Until this issue is addressed, amounts paid for these types of services will continue to incur a significant cost to the FEHBP.

Recommendation 6

We recommend that OPM work with its health plan partners to structure a way to limit payment to non-par emergency providers that will not impose a financial impact on FEHBP members.

Association Response;

The Association stated that no response was required.

APPENDIX

October 11, 2019



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Deleted by the OIG - Not Relevant to the Final Report

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U.S. Office of Personnel Management
1900 E Street, Room 6400
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**Reference: OPM DRAFT AUDIT REPORT
Audit of Claim Amounts Paid that Equaled or Exceeded Covered Charges
Audit Report Number 1A-99-00-18-005
Issued September 10, 2019**

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Below is the Blue Cross and Blue Shield Association (BCBSA) response to the recommendations included in the above referenced U.S. Office of Personnel Management ("OPM") Draft Audit Report.

Recommendation 1

We recommend that the contracting officer disallow \$8,738,988 for claim overpayments and verify that the BCBS plans return all amounts recovered to the FEHBP.

BCBSA Response

BCBS Plans reviewed the reported claim payment errors and agree to \$7,006,346 in claim payment errors, contest claim payment errors totaling \$1,723,584. Questioned claims totaling \$9,058 are still under evaluation by the Plans.

Plans contested overpayments because the OIG erroneously questioned:

- Non-par claims where the member did not pay coinsurance because the member either met the Catastrophic Maximum on the questioned claim or on a prior claim
- Non-par claims where the services qualified for the non-par benefit relief process in accordance with the FEP Benefit Brochure for the applicable year
- Ambulance claims for accidental injury or emergency services that are paid in full in accordance with the FEP Benefit Policy Manual
- Coinsurance and deductible for the hearing aid benefit/services as stated in the benefit brochure

Of the identified payment errors, Plans reported that \$3,933,282 in overpayments have been returned to the FEP Program and \$3,073,064 in overpayments that are either still in the recovery stage or uncollectible. Documentation to support recovered and uncollectible claims will be provided once the Final Report is issued. Documentation to support contested claims have been provided to support the Plans' position.

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Recommendation 2

We recommend that the Blue Cross Blue Shield Association (BCBSA) work with its local plans to ensure that claims processors are properly trained on how to review and process claims that defer for manual review from both the local systems and FEP Express to try to minimize manual processor errors.

BCBSA Response

BCBSA will perform an analysis of the reported claim errors and determine which Plans require additional training. An update of the results of our analysis, as well as, evidence that the training has been performed will be provided once the Final Report is issued.

Recommendation 3

We recommend that BCBSA work with its local plans to review system issues that have caused improper claim payments to occur. Specifically, why the system does not always defer claims when necessary, and also why the system does not apply accurate pricing allowances.

BCBSA Response

BCBSA will perform an analysis of the reported claim errors and determine which Plans should evaluate why the system did not defer claims or apply accurate pricing allowance. An update on this recommendation will be provided once the Final Report is issued.

Recommendation 4

We recommend that BCBSA work with its local plans to ensure that contract rates are updated accurately and timely when there is a contractual change with any provider, and that retroactive adjustments to affected claims are performed to reflect rate changes.

BCBSA Response

BCBSA will work with the identified Plans to evaluate internal controls over processes to accurately and timely update contract changes in its local system, as well as, the processes to ensure that retroactive changes are applied to claims adjudicated at the incorrect rate. An update on this recommendation will be provided once the Final Report is issued.

Recommendation 5

We recommend that BCBSA ensure that members other insurance benefits are accurate within FEP Express so that claim payments are properly coordinated.

BCBSA Response

FEP Operations Center issues annual Coordination of Benefits (COB) questionnaires to members to ensure that other insurance benefits are appropriately recorded in FEPDirect. Also, FEPDirect currently has an edit in place to defer for other insurance payment as appropriate, which also helps to ensure that member other insurance benefits are accurate in FEPDirect.

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Recommendation 6

We recommend that OPM work with its health plan partners to structure a way to limit payment to non-par emergency providers that will not impose a financial impact on FEHBP members.

BCBSA Response

No response required from BCBSA.

Thank you for this opportunity to respond to the recommendations included in this Draft Report. If you have any questions, please contact me at [REDACTED] or [REDACTED] at [REDACTED].

Sincerely,



FEP Program Assurance

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Report Fraud, Waste, and Mismanagement

Fraud, waste, and mismanagement in Government concerns everyone: Office of the Inspector General staff, agency employees, and the general public. We actively solicit allegations of any inefficient and wasteful practices, fraud, and mismanagement related to OPM programs and operations. You can report allegations to us in several ways:

By Internet: <http://www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse>

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