U.S. Office of Personnel Management

Office of the Inspector General

Office of Audits

Final Audit Report

Audit of Claims Processing and Payment Operations at Premera Blue Cross for Contract Years 2018 through 2020

Report Number 2022-CAAG-009
February 8, 2023

– Caution–

This report has been distributed to Federal officials who are responsible for the administration of the subject program. This non-public version may contain confidential and/or proprietary information, and should not be further released unless authorized by the OIG.

Executive Summary

Audit of Claims Processing and Payment Operations at
Premera Blue Cross for Contract Years 2018 through 2020

Report No. 2022-CAAG-009 **February 8, 2023**

Why Did We Conduct the Audit?

The objective of our audit was to determine whether the health benefit costs charged to the Federal Employees Health Benefits Program (FEHBP) and services provided to its members by Premera Blue Cross (Plan) (plan codes 10, 11, and 13) were in accordance with the terms of the Blue Cross and Blue Shield Association's contract with the U.S. Office of Personnel Management.

What Did We Audit?

The Office of the Inspector General has completed a performance audit of the FEHBP claim operations at the Plan. Specifically, we performed various claim reviews to determine if the internal controls over the claims processing system were sufficient to ensure that claims were properly processed and paid by the Plan. Our audit work was remotely conducted by staff in the Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida areas.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

Overall, we found that the Plan's internal controls over its claims processing system were generally effective in ensuring that health care claims were properly processed and paid.

However, for the areas reviewed, our audit identified 2,250 incorrectly paid claims resulting in FEHBP overpayments of $2,009,414. Specifically, the claim payment errors identified indicate a need to strengthen procedures and controls related to the following areas:

- Incorrect bundling of ambulatory payment classification claims; and
- Duplicate claim payments.

Additionally, we identified claims for 10 members who overpaid their cost share (copayments, coinsurances, and/or deductibles) by $2,874 due to participating providers having the wrong provider network status assigned to the claims. These members were not reimbursed for the overpayments.

Abbreviations

5 CFR 980	**Title 5, Code of Federal Regulations, Chapter 1, Part 890**
Act	**Federal Employees Health Benefits Act**
APC	**Ambulatory Payment Classification**
Association	**Blue Cross and Blue Shield Association**
BCBS	**Blue Cross and Blue Shield**
CFR	**Code of Federal Regulations**
Contract	**Contract CS 1039 – The contract between the Blue Cross and Blue Shield Association and the U.S. Office of Personnel Management**
EOB	**Explanation of Benefits**
FEHBP	**Federal Employees Health Benefits Program**
FEP	**Federal Employee Program**
FEP Direct	**The Association's Nation-wide Claims Processing System**
HIO	**OPM's Healthcare and Insurance Office**
Med A	**Medicare Part A**
Med B	**Medicare Part B**
Non-PAR	**Non-Participating Provider**
OIG	**The Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
PAR	**Participating Provider**
Plan	**Premera Blue Cross**
POS	**Place of Service**
SBP	**Service Benefit Plan**

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I. Background

This final report details the results of our performance audit of the Federal Employees Health Benefits Program (FEHBP) claims processing and payment operations at Premera Blue Cross (Plan) (plan codes 10, 11, and 13) for contract years 2018 through 2020. The audit was remotely conducted in the Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida areas.

The audit was conducted pursuant to the provisions of contract CS 1039 (Contract) between the Office of Personnel Management (OPM) and the Blue Cross and Blue Shield Association (Association); Title 5, United States Code, Chapter 89; and Title 5, Code of Federal Regulations (CFR), Chapter 1, Part 890 (5 CFR 890). The audit was performed by OPM's 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 (Act), Public Law 86-382, enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for Federal employees, annuitants, and dependents. OPM's Healthcare and Insurance Office (HIO) has overall responsibility for administration of the FEHBP, including the publication of program regulations and agency guidance. As part of its administrative responsibilities, the HIO contracts with various health insurance carriers that provide service benefits, indemnity benefits, and/or comprehensive medical services. The provisions of the Act are implemented by OPM through regulations codified in 5 CFR 890.

The Association, on behalf of participating Blue Cross Blue and Shield (BCBS) plans, has entered into a Government-wide Service Benefit Plan (SBP) contract with OPM to provide a health benefit plan authorized by the Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its Federal subscribers.

The Association has established a Federal Employee Program (FEP) 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 BCBS plans, and OPM.

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

Compliance with laws and regulations applicable to the FEHBP, as well as the terms and conditions of the Contract, is the responsibility of the Association and management at the Plan. In addition, the Plan is responsible for establishing and maintaining a system of internal controls.

The most recent audit report issued that covered claim payments for the Plan was report number 1A-10-70-17-019, dated October 2, 2017, which covered claim payments for contract years 2014 through 2016. There were no findings in the previous audit.

The results of our audit were discussed with Association and Plan officials throughout the audit, including the issuance of four Notices of Findings and Recommendations, and at an exit conference on July 19, 2022. We issued a draft report, dated July 28, 2022, to solicit the Association's comments to the findings and recommendations. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as appendices to this report.

II. Objective, Scope, and Methodology

Objective

The objective of our audit was to determine whether the health benefit costs charged to the FEHBP and services provided to its members by the Plan were in accordance with the terms of the Contract.

Scope and Methodology

We conducted our 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 included the following reviews for contract years 2018 through 2020:

- ambulatory payment classification (APC) claim line bundling;
- potential duplicate claim payments;
- claims potentially charged with an incorrect provider network status;
- place of service (POS) claims review;
- claims paid with unlisted procedure codes; and
- claims potentially uncoordinated with Medicare.

Due to the COVID-19 pandemic, we were unable to conduct site visits during the audit. Consequently, all audit fieldwork was remotely conducted by staff in the Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida areas from March 2022 through July 2022.

We reviewed the Association's annual accounting statements for contract years 2018 through 2020 and determined that the Plan paid approximately $2.3 billion in health benefit payments as they pertain to the following plan codes and coverage areas:

- 430, 934, and 936 – Premera Blue Cross of Washington; and
- 439 and 939 – Premera BCBS of Alaska.

In planning and conducting our audit, we obtained an understanding of both the Association's and Plan's 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. While we identified a large dollar finding related to a system error, based on our review we do not feel it is a significant matter involving the Association's and Plan's internal control structures and operations as the system error was both identified and corrected by the Plan prior to the start of this audit. Furthermore, since our audit would not

necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Association's or the Plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the Association and the Plan had complied with the Contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations and Federal Employees Health Benefits Acquisition Regulations, as appropriate), and the laws and regulations governing the FEHBP as they relate to claim payments. With the exception of those areas noted in the "Findings and Recommendations" section of this audit report, we found that the Association and Plan were in compliance with the health benefit provisions of the Contract. With respect to any areas not tested, nothing came to our attention that caused us to believe that the Association and 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 FEP Director's Office, the FEP Operations Center, the Association and the Plan. Through the performance of audits and an 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 the OPM OIG on a monthly basis by the FEP Operations Center, and after a series of internal steps, uploaded into our data warehouse. 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.

We selected various samples of claims or claim lines to determine whether the Plan complied with the Contract's provisions relative to health benefit payments. We utilized SAS software to judgmentally select all samples reviewed.

The following specific reviews were conducted during our audit (unless otherwise stated, the samples covered the full scope of the audit, contract years 2018 through 2020):

1. **Ambulatory Payment Classification Bundling Review** – With the assistance of the Plan, we identified all claim lines in the Plan's local claims system that utilized the APC pricing methodology with allowed amounts of $0 and amounts paid greater than $0 that were paid between February 1, 2019, and December 31, 2020.

   This resulted in a universe of 2,243 claims with potential overpayments totaling $1,944,914. We selected the entire universe for review to determine if the claim lines were bundled properly and paid correctly.

2. **Potential Duplicate Claim Payments Review** – As part of our review, we categorized separate potential duplicate claim payments into three categories – "best matches," "near matches," and "inpatient facility matches." The universe of potential duplicate claim groups was derived from the following search criteria:

- Our "best match" logic identifies and groups unique claim numbers that contain most of the same claim data, including patient code, procedure code, diagnosis code, and sex code.

- Our "near match" logic identifies and groups unique claim numbers that contain most of the same claim data, except for patient code, procedure code, diagnosis code, or sex code.

- Our "inpatient facility match" search criteria identified duplicate or overlapping dates of service.

From the period August 1, 2019, through December 31, 2020, for each of the duplicate claim groups we identified the following universes with potential overpayments of $250 or more:

Universe of Duplicate Claim Payments Identified

Group/ Overpayment	Best Matches	Near Matches	Inpatient Facility Matches	Total
Duplicate Groups	48	92	5	145
Potential Overpayments	$167,655	$239,087	$28,853	$435,595

From the universes, we judgmentally selected all duplicate groups from each group with potential duplicate payments totaling $2,500 or greater. We reviewed the samples to determine if the claims identified were actual duplicate payments and to quantify any potential FEHBP overpayments. (See the table below for a summary of the total sample selected.)

Duplicate Claim Payment Samples Selected

Group/ Overpayment	Best Matches	Near Matches	Inpatient Facility Matches	Total
Duplicate Groups	25	23	4	52
Potential Overpayments	$135,664	$131,532	$27,490	$294,686

3. **Provider Network Status Review** – We identified all claims paid where a provider was paid as both a participating (PAR) and a non-participating (Non-PAR) provider. This

resulted in a universe of 1,715 providers with 735,771 claim lines paid totaling $267,683,447.

From this universe, we judgmentally selected all providers where the total amount paid was greater than $200,000 for providers in Washington and $20,000 for providers in Alaska and the claims amount paid percentage of PAR and Non-PAR claims were 10 percent or more of the total amount paid respectively. In total, we selected 40 providers, with 38,300 claim lines totaling $47,404,381, to determine if the providers were assigned the correct network status.

4. **Place of Service Review** – We identified all claims where the FEHBP paid as the primary insurer and the claim was not subject to the Omnibus Budget Reconciliation Acts of 1990 or 1993, or case management guidelines. This resulted in an overall universe of 5,835,657 claim lines, totaling $2,057,346,785, grouped by the claims' assigned place of service (19 total locations where the service was performed with stratified dollar amount ranges for each location).

   From the universe, we judgmentally selected all POS groups in which the total amount paid represented three percent or more of the total claims paid. From these POS groups, we excluded stratified amount paid ranges where the total amount paid was less than $100 and where there was less than 10 percent of the total amount paid in each POS group. This narrowed our results to five POS groups for Washington and seven POS groups for Alaska. With a target of 120 samples (60 for both states), we judgmentally selected how many claims should be reviewed from each POS group based on a ratio of amount paid in each group compared to the total of all groups remaining. In total, we selected 121 claims whose total claim amount paid (all claim lines association with the claim) was $4,003,387. We reviewed each to determine if the claims were paid accurately according to the provider contract with the Plan and the SBP brochure.

5. **Unlisted Procedure Code Review** – We identified a universe of 5,925 claim lines, totaling $1,537,425 from both plan sites, where the procedure code utilized was either "unlisted," "miscellaneous," or "unclassified."

   We sorted and quantified this universe by the applicable Current Procedural Technology code and Healthcare Common Procedure Coding System code categories and judgmentally selected all codes with a cumulative amount paid of $50,000 or greater. This narrowed our results to six codes.

   We then selected a random sample of 5 claim lines from all codes selected resulting in a sample of 30 claim lines, totaling $45,698, to determine if the claim lines were priced and paid properly.

6. **Claims Requiring Coordination of Benefits with Medicare Review** – As part of our review, we separated the uncoordinated claims into six categories based on the place of

service and whether Medicare Part A (Med A) or Part B (Med B) should have been the primary payer, as follows:

Categories A and B	Categories A and B consist of inpatient claims that should have been coordinated with Med A. If the BCBS plans indicated that Med A benefits were exhausted, we reviewed the claims to determine whether there were any inpatient services that were payable by Med B. For these categories Med A pays all covered costs (except for deductibles and coinsurance) for inpatient care in hospitals, skilled nursing facilities, and hospice care. Consequently, in determining potential overcharges for the claim lines improperly paid in these categories, we reduced the amount paid using the applicable Medicare deductible and/or copayment.
Categories C and D	Categories C and D include inpatient claims with ancillary items that should have been coordinated with Med B. If the BCBS plans indicated that members had Med B only, we reviewed the claims to determine whether there were any inpatient services that were payable by Med B. For these categories, Med B covers a portion of inpatient facility charges for ancillary services such as medical supplies, diagnostic tests, and clinical laboratory services, and pays 80 percent for these services after the calendar year deductible has been met. Based on our experience, ancillary items account for approximately 30 percent of the total inpatient claim payment. Consequently, in determining potential overcharges for the claim lines improperly paid in these categories we estimated a 25 percent overcharge for the inpatient claim lines (0.30 x 0.80 = 0.24 ~ 25 percent).
Categories E and F	Categories E and F include outpatient facility and professional claims where Med B should have been the primary payer. For these categories, Med B pays 80 percent of most outpatient charges and professional claims after the calendar year deductible has been met. Consequently, in determining potential overcharges for the claim lines improperly paid in these categories we used 80 percent of the amount paid as the amount overcharged.

We identified a universe of 863 claims with potential coordination of benefits with Medicare errors totaling $1,180,521.

We identified one member whose claims paid amounted to 58 percent of the overall universe (26 claims, totaling $683,729) and judgmentally selected those claims for review to determine if they were paid correctly or if they should have been coordinated with Medicare.

During our review, we utilized the Contract, the 2018 through 2020 SBP brochures, the Association's FEP Procedures Administrative Manual, and various manuals and other documents provided by the Plan to determine compliance with program requirements, as well as deriving any amounts questioned. The samples selected and reviewed were not statistically based. Consequently, the results were not projected to their respective universes since it is unlikely that the results are representative of the universes taken as a whole.

III. Findings and Recommendations

The objective of our audit was to determine if the internal controls over the Plan's claims processing system were sufficient to ensure that claims were properly processed and paid by the Plan. Although we identified FEHBP overcharges of $2,009,414, the overall results of our audit indicated that the internal controls implemented by the Association and the Plan were generally working as intended.

1. Claim Payment Errors: $2,009,414

Our claim reviews found that the Plan incorrectly paid 2,250 claims, resulting in FEHBP overpayments of $2,009,414. The claim payment errors we found were a result of the following review areas which we cover in more detail below:

- Incorrect bundling of ambulatory payment classification (APC) claims; and
- Duplicate claim payments.

Section 3.2 (b) (1) of the Contract states that carriers may only charge costs to the Contract that are "actual, allowable, allocable, and reasonable."

Additionally, Section 2.3 (g) (i) of the Contract amendment 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 … the recovery of any overpayment must be treated as an erroneous benefit payment, overpayment or duplicate payment … regardless of any time period limitations in the written agreement with the provider."

A. Incorrect Bundling of APC Claims

The Plan's claims system did not identify bundled claims correctly, causing overpayments by the FEHBP.

Our review identified 2,243 claims with overpayments totaling $1,944,914 where a system error allowed individual claim lines to be paid when they were already bundled and paid on another claim line.

Bundling occurs when providers and/or health care facilities are paid a single payment for all (or most) of the services performed to treat a patient. When this occurs, the Plan's claims data records all claim lines billed by a provider or health care facility, but the payment is made on only one line of the claim and others are paid at $0.

When the Plan updated to a new local claims system in February 2019, it was unaware that the system did not include an indicator on claim lines that required bundling. When the claims passed through to the Association's nation-wide claims processing system (FEP Direct), there was nothing in the claims data to indicate that certain lines should be bundled and not be priced and paid individually at the claim line level. This caused FEP Direct to not only pay the bundled line, but also all other individual claim lines that were already bundled, causing claims to be overpaid.

To identify overpayments caused by this error, we focused our review on outpatient ambulatory care providers who utilize the APC pricing methodology per their contract with the Plan. We initially reviewed 32 claims from APC providers and found 20 claims were overpaid by $87,838. Due to the high error rate, we decided to expand our sample to all claims incurred for each provider utilizing the APC pricing methodology from February 1, 2019, through December 31, 2020. In order to do this, the Plan queried its local claims system to find all claim lines where the contract reference field indicated it was an APC priced claim. Based on the results of the query, we found a total of 2,243 claims that were overpaid by $1,944,914 (which included the 20 claims in our initial review).

During our audit, the Plan informed us that it had identified the bundled line indicator error and updated its local system to correct the error. However, it did not attempt to identify, correct, or recover any FEHBP claims that may have been paid incorrectly prior to the error's correction. The Plan stated this was not done because it would not be easy to identify which claims were affected. However, during our audit we were able to easily identify claims meeting this criteria and determine an overpayment for each.

The Plan should have identified claims that were paid incorrectly immediately once the error was detected but did not do so. Due to the Plan not making any effort to identify claims known to be likely affected by the system error until identified by this audit, and thus not demonstrating the due diligence required to recover overpayments under section 2.3 (g) of the Contract, it is our position that the FEHBP should be reimbursed the full $1,944,914 that was overpaid on the 2,243 claims, regardless of the success of the Plan's recovery efforts.

Recommendation 1:

We recommend that the contracting officer disallow $1,944,914 in overcharges to the FEHBP for 2,243 claims that were incorrectly paid due to a system error related to the bundling of ambulatory payment classification claims. The Plan did not attempt to identify FEHBP claim overpayments or make efforts to recover the overpayments.

Association's Response:

The Association stated that the Plan will return any funds recovered to the FEHBP.

OIG Comments:

We would like to re-emphasize that, in our opinion, the Plan is responsible to return the full $1,944,914 regardless of the success of its recovery efforts. The Plan was aware of this error well before our audit, as it involved multiple fixes to its system before it was fully corrected in May 2021. During this time, it was fully aware that claims, including FEHBP claims, were paid incorrectly but did not attempt to identify affected claims until this audit. This lack of effort does not meet the requirement for prompt and diligent efforts to recover

overpayments spelled out in Contract section 2.3 (g) which states, "It is the Carrier's responsibility to proactively identify overpayments …" and "the Carrier shall make a prompt and diligent effort to recover the erroneous payment … ." The Association sets up proactive systems for its local plans to follow to ensure that overpayments are identified and followed up on in a timely manner to ensure that recoveries are initiated promptly. It knows, as we do, that time is of the essence when it comes to recovering overpayments.

Due to the Plan not making a proactive attempt to identify claims affected by the system error and not making a prompt and diligent effort to recover erroneous overpayments that it knew were made, the full amount should be returned to the FEHBP.

B. Duplicate Claim Payments

Our review identified seven duplicate claim payments, totaling $64,500 in overpayments, where FEP Direct appropriately deferred the claims prior to payment as duplicates, but were then overridden incorrectly by the Plan's claims processors.

Improper submission of re-issued claims by providers led to duplicate claim payments.

The seven duplicate claim payments identified were for claims where the provider resubmitted a claim to the Plan improperly (without a reissued claim identifier). Providers often reissue claims when they discover billable procedures were left off the original submission. Therefore, it is important for providers to properly identify reissued claims with the proper identifier so the claims system will know it is not a new claim. If properly identified as a reissued claim, the claim system would have matched the reissued claim to the prior claim number and only the newly billed procedures would have been paid.

However, when these claims were received, without the reissued claim identifier, the Plan's local claim system, not knowing the claims were reissues of a prior paid claim, treated them as new claims (assigning them new claim numbers). Fortunately, when the claims processed in the Association's claim system, they were identified as possible duplicates, deferred, and were flagged for processor review prior to payment.

When the claims were manually reviewed at the Plan, the processors did not identify repeat procedures billed for the same person, for the same date, and the same provider on a prior claim and overrode the claim deferral and allowed the claims to pay. The Plan stated that when processor errors like these are discovered, it works with the processors and regularly updates its internal process based on opportunities and trends discovered.

The Association stated they will work with the Plan to issue semi-annual and annual communication to providers on the proper way to re-submit corrected claims. To be proactive in preventing future improper submissions, the Plan should also send out targeted reminders to all providers (both PAR and Non-PAR) it identifies as improperly submitting a

corrected claim. Although there are no contractual obligations with a Non-PAR provider, that does not prevent the Plan from sending reminders on proper resubmission of claims.

As a result of processor errors, which allowed duplicate claim payments to be made, the FEHBP was overcharged $64,500. A total of $31,019 has been recovered to date, with a total of $33,481 still due to the FEHBP.

Recommendation 2:

We recommend that the contracting officer disallow $64,500 in duplicate claim payment overcharges to the FEHBP. To date, $31,019 has been recovered, leaving a remaining amount of $33,481 due to the FEHBP.

Association's Response:

The Association stated that the Plan will return any funds recovered to the FEHBP.

Recommendation 3:

We recommend that the contracting officer direct the Association to require the Plan to send communication to providers on the proper way to re-submit claims when resubmission errors are identified.

Association's Response:

The Association will work with the Plan to send communication to the providers as appropriate.

2. Member Cost Share Overpayments: Procedural

Our claim reviews identified 22 claims (for 10 members) where claims systems errors caused an incorrect provider network status to be applied to the claim. As a result, the members (**not** the FEHBP) were overcharged $2,874 for their cost share (copayments, coinsurances, and/or deductibles).

Members were overcharged due to provider network status errors.

Cost-share is defined by the SBP as the member's "out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care" that they receive. Copayments are a "fixed amount of money" members "pay to the provider, facility, pharmacy" when they receive certain services. Coinsurance is a ratio of the Plan's allowance that the member is responsible for when their deductible is not yet met. The "fixed" amount of the copayment and "ratio" of the coinsurance is relative to whether the provider is PAR or Non-PAR, with Non-PAR typically resulting in higher out-of-pocket costs to the member.

For the purposes of this finding, we identified two PAR providers where the Plan's claims system inappropriately identified them as Non-PAR, resulting in the 10 members being charged a coinsurance rate of 35 percent. Had the claims system properly identified these providers as PAR providers, the member cost shares would have been either:

- A $25 copay; or
- A coinsurance rate of 15 percent.

The Plan stated these errors occurred when it transitioned to the FEP Bridge Claims system from April through June 2019 and provider rates were loaded incorrectly. The Plan states the issue was corrected by July 2019.

When initially brought to the Plan's attention, it stated it was not its normal practice to go back into closed years for potential member reimbursement issues because the review could affect many claims, potentially many providers, and sometimes have a negative financial impact on the members. For the members in question, we manually reviewed their Explanation of Benefits (EOB) to determine when each met their out-of-pocket maximum for the year, then calculated the total cost share paid by each, and determined the correct cost share amount.

We asked the Association and Plan to provide us with any policies and procedures they have for correcting claims in which the member was overcharged, and as of the date of this report none have been provided. The Plan also stated that the provider would be responsible for reimbursing the members.

We are concerned that fiscal responsibility to FEHBP members is not taken into consideration when claim overpayments are identified and corrected years after the claim was incurred. If a member has overpaid their cost share, there should be a way for them to be alerted of the overpayment, who owes them the overpayment (whether the provider or the Plan) and for them to recoup the overpayment. The Association has no policies in place for plans to follow in these situations.

As a result of provider network status errors, 10 FEHBP members were overcharged $2,874 in member cost share.

Recommendation 4:

We recommend that the contracting officer direct the Association to have the Plan adjust all claims to reflect the appropriate member cost share.

Association's Response:

The Association stated that they will work with the Plan on this recommendation.

Recommendation 5:

We recommend that the contracting officer direct the Association to ensure the Plan notifies the members of the amounts they overpaid and direct the providers to reimburse them.

Association's Response:

The Association stated that they will work with the Plan on this recommendation.

OIG Comments:

We encourage the Association to ensure that the notification to the members, if done via an EOB, clearly identifies the reason for and the amount of the overpayment to them and from whom the reimbursement should come.

Recommendation 6:

We recommend that the contracting officer direct the Association to implement FEP-wide policies for local plans to follow to ensure member cost-share overcharges are properly reimbursed to them.

Association's Response:

The Association stated that they are evaluating "implementing a policy to ensure member's cost share is returned to the member when the Plan does not initiate recovery on claim overpayments that are either below the overpayment recovery threshold or past the Plan's recovery time limits."

OIG Comments:

We would like to reiterate that a policy does need to be implemented for all FEP, as the Association and its member Plans hold not only a medical, but also a financial fiduciary obligation to the FEHBP members. The policy should allow the provider or the Plan an opportunity to reimburse the member directly or indirectly (depending on the outcome of the reprocessing of the claims). Additionally, this policy should include all member cost share overpayments, not just those "that are either below the overpayment recovery threshold or past the Plan's recovery time limits" as addressed in the Association's response.

Additionally, we believe that the contracting officer should consider adding language to its FEHBP carrier contracts or through other carrier guidance to ensure that a situation such as this, where a member overpays their cost share due to an error by the Plan, is properly addressed by the carriers. In this case, neither the local plan nor the contract holder had policies and procedures in place to account for this circumstance.

Appendix A

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September 15, 2022

Ms. Stephanie M. Oliver
Group Chief, Claim Audits and Analytics Group
Office of the Inspector General
U.S. Office of Personnel Management
1900 E. Street, Room 6400
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Reference: **OPM Draft AUDIT REPORT**
Premera BlueCross BlueShield
Report No. 2022-CAAG-009
Dated July 28, 2022

Dear Ms. Oliver:

This is the Premera Blue Cross Blue Shield response to the above referenced OPM Draft Audit Report covering the FEHBP. Our comments concerning the findings in the report are as follows:

1. Claim Payment Errors **Amount Redacted by the OPM-OIG As amount questioned has changed**

Recommendation 1

Redacted by the OPM-OIG
Not relevant to the Final Report

Plan Response

The Plan initiated recovery on all overpayments and will return any funds recovered to the FEHB Program.

Recommendation 2

Redacted by the OPM-OIG
Not relevant to the Final Report

Plan Response

The Plan has initiated recovery on all overpayments and will return funds recovered to the FEHB Program.

Recommendation 3

Redacted by the OPM-OIG
Not relevant to the Final Report

BCBSA Response

BCBSA will work with the Plan to send communication to the providers as appropriate.

Redacted by the OPM-OIG
Not relevant to the Final Report

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

Sincerely,

[redacted]

[redacted]
Managing Director, FEP Program Assurance

Redacted by the OPM-OIG
Not relevant to the Final Report

Appendix B

As part of our review of the Association's response to the draft report, we reviewed its extensive response to the provider network status finding and because of our review we modified the finding to what is now found in the report as "Member Cost Share Overpayments" (see page 12). This revised finding also included new recommendations which were not previously shared with the Association. Therefore, we reissued Notice of Finding and Recommendation number four to obtain the Association's comments for our final report.

The Association's November 18, 2022, responses are included below.

Recommendation 1:

We recommend that the contracting officer direct the Association to have the Plan adjust all claims to reflect the appropriate member cost share.

Association/Plan Response to Recommendation 1:

☒ The Association/Plan concurs with the factual accuracy of this recommendation.

☐ The Association/Plan partially concur with the factual accuracy of this recommendation.

☐ The Association/Plan do not concur with the factual accuracy of this recommendation.

Association Comments:

BCBSA will work with the Plan on this recommendation.

Recommendation 2:

We recommend that the contracting officer direct the Association to ensure the Plan notifies the members of the amounts they overpaid and direct the providers to reimburse them.

Association/Plan Response to Recommendation 2:

☒ The Association/Plan concurs with the factual accuracy of this recommendation.

☐ The Association/Plan partially concur with the factual accuracy of this recommendation.

☐ The Association/Plan do not concur with the factual accuracy of this recommendation.

Association Comments:

BCBSA will work with the Plan on this recommendation.

Recommendation 3:

We recommend that the contracting officer direct the Association to implement policies and procedures for Plans to follow to ensure member overcharges are properly returned.

Association/Plan Response to Recommendation 3:

☒ The Association/Plan concurs with the factual accuracy of this recommendation.

☐ The Association/Plan partially concur with the factual accuracy of this recommendation.

☐ The Association/Plan do not concur with the factual accuracy of this recommendation.

Association Comments:

BCBSA submitted a request to the FEP Policy Workgroup to evaluate implementing a policy to ensure member's cost share is returned to the member when the Plan does not initiate recovery on claim overpayments that are either below the overpayment recovery threshold or past the Plan's recovery time limits.

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