U.S. Office of Personnel Management

Office of the Inspector General

Office of Audits

Final Audit Report

Audit of Premera BlueCross
Mountlake Terrace, Washington

Report Number 2022-ERAG-0011
December 12, 2022

Executive Summary

Audit of Premera BlueCross

Report No. 2022-ERAG-0011 **December 12, 2022**

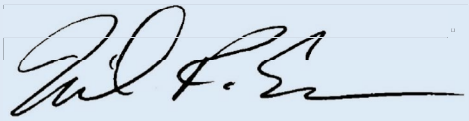
Why did we conduct the audit?

We conducted this audit to obtain reasonable assurance that Premera BlueCross (Plan), which includes Premera BlueCross of Washington (Plan codes 430/934/936) and Premera BlueCross BlueShield of Alaska (Plan codes 439/939), 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 contract.

What did we audit?

Our audit covered miscellaneous health benefit payments and credits, such as claim overpayment refunds and medical drug rebates, for contract year 2017 through June 30, 2021, and administrative expense charges for contract years 2016 through 2020, as reported in the Annual Accounting Statements for Premera BlueCross of Washington and Premera BlueCross BlueShield of Alaska. We also reviewed the Plan's cash management activities and practices related to FEHBP funds for contract year 2017 through June 30, 2021, and the Plan's Fraud and Abuse Program activities for contract year 2020 through June 30, 2021.

Due to concerns with the Plan's uncollected claim overpayments applicable to Indian Health Service (IHS) providers, we expanded our review of these IHS overpayments to include contract yeah 2017 through May 31, 2022.



Michael R. Esser
Assistant Inspector General for Audits

What did we find?

We questioned $3,508,556 in health benefit charges, administrative expense overcharges, and lost investment income (LII). The BlueCross BlueShield Association and/or Plan agreed with $3,506,986 and disagreed with $1,570 of the questioned amounts. As part of our review, we verified that the Plan subsequently returned $1,718,518 of the uncontested questioned amounts to the FEHBP because of the audit. However, the FEHBP is still due a balance of $1,788,468 for the remaining uncontested questioned amounts.

Our audit results are summarized as follows:

- Miscellaneous Health Benefit Payments and Credits – Because of the Plan's lack of due diligence with recovery efforts, we questioned $3,198,939 where the Plan had not recovered and/or returned funds to the FEHBP for IHS claim overpayments. We also questioned $38,701 for LII calculated on health benefit refunds and recoveries and a letter of credit account overdraw that the Plan returned untimely to the FEHBP during the audit scope. We verified that the Plan has returned $1,410,471 of the questioned IHS claim overpayments and $37,131 of the questioned LII to the FEHBP.

- Administrative Expenses – We questioned $270,916 in administrative expense overcharges and LII, consisting of $246,401 in overcharges for unallocable cost center and natural account costs, $8,517 in overcharges for BlueCross BlueShield Association dues, $1,520 in overcharges for Affordable Care Act fees, and $14,478 for applicable LII on these questioned overcharges. We verified that the Plan has returned these questioned amounts to the FEHBP.

- Cash Management – The audit disclosed no significant findings pertaining to the Plan's cash management activities and practices related to FEHBP funds. Overall, we determined that the Plan handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations.

- Fraud and Abuse Program – The Plan is complying with the communication and reporting requirements for fraud and abuse cases that are set forth in Contract CS 1039 and FEHBP Carrier Letter 2017-13.

Abbreviations

Association	**BlueCross BlueShield Association**
BCBS	**BlueCross and/or BlueShield**
BCBSA	**BlueCross BlueShield Association**
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**
FEP	**Federal Employee Program**
FSTS	**FEP Special Investigations Unit Tracking System**
IHS	**Indian Health Service**
LII	**Lost Investment Income**
LOCA	**Letter of Credit Account**
Memorandum	**FEP Memorandum Number 20-019 FYI**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
PCORI	**Patient-Centered Outcomes Research Institute**
Plan	**Premera BlueCross**
SIU	**Special Investigations Unit**
SPI	**Special Plan Invoice**

Table of Contents

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 Premera BlueCross (Plan), pertaining to Premera BlueCross of Washington (Plan codes 430/934/936) and Premera BlueCross BlueShield of Alaska (Plan codes 439/939). The Plan's headquarters are in Mountlake Terrace, Washington.

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 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 BlueCross BlueShield Association (Association or BCBSA), on behalf of participating local BlueCross and/or BlueShield (BCBS) plans, has entered into a Government-wide Service Benefit Plan contract (Contract CS 1039) with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its Federal subscribers. The Plan is one of 34 BCBS companies participating in the FEHBP. These 34 companies include 60 local BCBS plans.

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

The Association has also established an FEP Operations Center. The activities of the FEP Operations Center are performed by the Service Benefit Plan Administrative Services Corporation, an affiliate of CareFirst BCBS, located in Washington, D.C. These activities include acting as intermediary for claims processing between the Association and local BCBS plans, processing and maintaining subscriber eligibility, adjudicating member claims on behalf of BCBS plans, approving or disapproving the reimbursement of local plan payments of FEHBP claims (using computerized system edits), maintaining a history file of FEHBP claims, and maintaining claims payment data.

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

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

Our previous audit of the Plan (Report No. 1A-10-69-11-035, dated October 26, 2011), covering contract years 2006 through 2010, disclosed no audit findings and recommendations. We also included this Plan in each of the following recent focused audits that covered a sample of BCBS plans:

- Final Report No. 1A-99-00-18-045 (dated August 7, 2019) for pension, post-retirement benefit, and Affordable Care Act costs for contract years 2014 through 2017; and

- Final Report No. 1A-99-00-17-001 (dated March 14, 2018) for cash management activities and practices related to FEHBP funds for contract year 2015 through June 30, 2016.

All findings related to the Plan in these recent focused audits have been satisfactorily resolved.

The results of this audit were provided to the Plan in written audit inquiries; were discussed with Plan and/or Association officials throughout the audit and at an exit conference on June 2, 2022; and were presented in detail in a draft report, dated July 21, 2022. 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. Also, additional documentation provided by the Association and/or Plan on various dates through November 1, 2022, was considered in preparing our 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 the contract. 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 were returned timely to the FEHBP.

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.

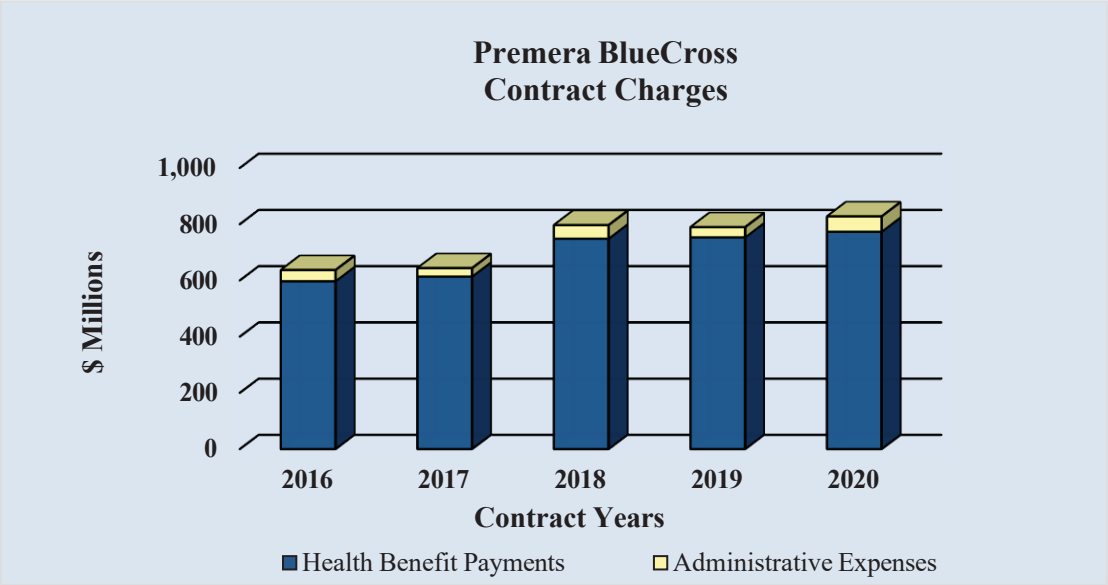
Fraud and Abuse Program

- To determine whether the Plan's communication and reporting of fraud and abuse cases complied with the terms of Contract CS 1039 and FEHBP 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 BlueCross and BlueShield FEHBP Annual Accounting Statements pertaining to the Premera BCBS plans of Washington (Plan codes 430/934/936) and Alaska (Plan codes 439/939) for contract years 2016 through 2020. During this period, the Plan paid approximately $3.5 billion in FEHBP health benefit payments and charged the FEHBP approximately $205 million in administrative expenses for the Premera BCBS plans of Washington and Alaska combined (see chart on the next page).



Specifically, we reviewed miscellaneous health benefit payments and credits (such as cash receipt and provider offset refunds, uncollected claim overpayments, fraud recoveries, medical drug rebates, and special plan invoices) for contract year 2017 through June 30, 2021, and administrative expense charges for contract years 2016 through 2020. We also reviewed the Plan's cash management activities and practices related to FEHBP funds for contract years 2017 through June 30, 2021, and the Plan's Fraud and Abuse Program activities for contract year 2020 through June 30, 2021.

Due to concerns with the Plan's uncollected FEP claim overpayments applicable to Indian Health Service (IHS) health care providers, we expanded our review of these IHS claim overpayments. For this expanded review, we increased our scope to include these uncollected IHS claim overpayments for contract year 2017 through May 31, 2022.

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 and the FEP Director's Office. 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 remotely in the Cranberry Township, Pennsylvania; Jacksonville, Florida; and Washington, D.C. areas from February 1, 2022, through June 2, 2022. Throughout the audit process, the Plan did a great job providing complete and timely responses to our numerous requests for explanations and supporting documentation. We appreciated the Plan's cooperation and responsiveness during the pre-audit and fieldwork phases of this audit.

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 2017 through June 30, 2021, we judgmentally selected and reviewed the following FEP items:

- A high dollar sample of 150 FEP health benefit refunds, totaling $20,454,369 (from a universe of 51,475 FEP health benefit refunds, totaling $77,647,066, for the audit scope).[2] From each year of the audit scope, our sample consisted of the 20 highest dollar cash receipt refunds and the 10 highest dollar provider offset refunds, which included refunds from $27,482 to $2,494,561.

- A high dollar sample of 25 uncollected FEP claim overpayments, totaling $1,795,028 (from a universe of 9,009 uncollected FEP claim overpayments, totaling $6,308,558, for the audit scope). Our sample consisted of the 25 highest dollar uncollected claim overpayments from the audit scope, which included all uncollected overpayments from $32,205 to $271,559. We reviewed these uncollected claim overpayments to determine if the Plan made diligent efforts to recover the applicable funds.

[2] The Plan's FEP universe of health benefit refunds included cash receipt and provider offset refunds for items such as solicited and unsolicited refunds (claim overpayment recoveries), provider audit recoveries, and subrogation recoveries.

- A judgmental sample of 10 FEP fraud recoveries, totaling $809,883 (from a universe of 19 FEP fraud recoveries, totaling $942,165, for the audit scope). Our sample consisted of the 10 highest dollar fraud recoveries from the audit scope, which included all fraud recoveries from $4,775 to $571,445.

- All 21 medical drug rebate amounts, totaling $253,102, for the audit scope.

- A judgmental sample of 20 special plan invoices (SPI) for miscellaneous payments and credits, totaling $2,289,420 in net FEP payments (from a universe of 383 SPIs, totaling $3,624,783 in net FEP payments, for the audit scope). We judgmentally selected these SPIs based on our nomenclature review of high dollar invoice amounts. Specifically, we selected two SPIs with the highest dollar payment amounts and two SPIs with the highest dollar credit amounts (excluding SPIs for medical drug rebates and fraud recoveries) from each year in the audit scope. SPIs are used by the Plan to process items such as miscellaneous health benefit payment and credit transactions that do not include primary claim payments or checks.

We reviewed these samples to determine if health benefit refunds and recoveries, medical 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 universe 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 2016 through 2020. Specifically, we reviewed administrative expenses relating to cost centers; natural accounts; allocations; pensions; post-retirement benefits; non-recurring projects; executive compensation limits; Association dues; subcontracts; lobbying; and Patient Protection and Affordable Care Act fees.[3] 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 1039 and applicable laws and

[3] In general, the Plan records administrative expense transactions to natural accounts that are then allocated through cost centers to the Plan's various lines of business, including the FEP. For contract years 2016 through 2020, the Plan allocated administrative expenses of $155,311,713 (before adjustments) to the FEHBP, from 336 cost centers that contained 75 natural accounts. From this universe, we selected a judgmental sample of 50 cost centers to review, which totaled $59,208,690 in expenses allocated to the FEHBP. We also selected a judgmental sample of 18 natural accounts to review, which totaled $40,978,353 in expenses allocated to the FEHBP through the cost centers. 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 and natural accounts based on high dollar amounts, our nomenclature review, and our trend analysis. We reviewed the expenses from these cost centers and natural accounts 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.

regulations.[4] Specifically, we reviewed letter of credit account (LOCA) drawdowns and United States Treasury offsets for contract year 2017 through June 30, 2021. As part of our testing, we selected and reviewed a judgmental sample of 79 LOCA drawdowns, totaling $347,855,985 (from a universe of 1,083 LOCA drawdowns, totaling $3,294,113,734, for contract year 2017 through June 30, 2021), for the purpose of determining if the Plan's drawdowns were appropriate and adequately supported. Our sample included 20 weeks of LOCA drawdowns that were selected based on the week with highest dollar drawdown day within the highest dollar drawdown month from each quarter in 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 regarding the compliance of the **Fraud and Abuse Program**, as well as reviewed the Plan's communication and reporting of fraud and abuse cases to test compliance with Contract CS 1039 and FEHBP Carrier Letter 2017-13.

[4] During our audit scope, the Plan did not have a working capital deposit. (Note: Based on OPM's "Letter of Credit System Guidelines" (dated April 2018), a working capital deposit is recommended but not required.) Therefore, the Plan also did not have a dedicated FEP investment account.

III. Audit Findings and Recommendations

A. Miscellaneous Health Benefit Payments and Credits

1. Indian Health Service Claim Overpayments: $3,198,939

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 1,103 FEP claim overpayments that were paid to Indian Health Service (IHS) health care providers. Although the Plan mailed refund request letters to these IHS providers, we noted that the Plan was not prompt and diligent with the recovery efforts for these overpayments. As a result, the Plan had not recovered and/or returned $3,198,939 to the FEHBP for these IHS claim overpayments. Based on Contract CS1039, 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. Unless the Plan provides support that these claim overpayments were uncollectible, we can only conclude that the Plan did not make diligent efforts to recover these funds. Accordingly, the Plan should continue to pursue and recover these claim overpayments from the applicable IHS health care providers.

As a result of this finding, we verified that the Plan subsequently recovered and returned $1,410,471 of these questioned claim overpayments to the FEHBP as of October 11, 2022. We noted that the Plan recovered substantially all of these overpayments from the applicable IHS providers via provider offsets (voucher deductions), where the Plan reduced subsequent benefit payments to the providers for the purpose of recovering the refunds related to the overpayments.

Contract CS 1039, 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 to the member or the provider at 30, 60 and 90 day intervals, if the debt remains unpaid and undisputed;

(3) 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 1039, 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."

During contract year 2017 through June 30, 2021, there were 9,009 uncollected FEP claim overpayments, totaling $6,308,558. From this universe, we selected and reviewed a high dollar sample of 25 uncollected FEP claim overpayments, totaling $1,795,028. For our sample, we selected the 25 highest dollar uncollected overpayments from the audit scope, ranging from $32,205 to $271,559, to determine if the Plan made diligent efforts to recover the applicable funds.

The Plan did not make diligent efforts to recover $3,198,939 in FEP claim overpayments.

Based on our review, we determined that the Plan was not diligent with the recovery efforts for 7 of the 13 FEP claim overpayments, totaling $603,996, applicable to IHS health care providers in our sample. Since these claim overpayments were each over $10,000, the contract specifically requires additional prompt and diligent efforts by the Plan. For these seven claim overpayments, we determined that the Plan mailed the standard four refund request letters to the applicable IHS health care providers but did not make additional prompt and diligent efforts (such as sending additional letters/notices, mailing certified letters, calling the IHS providers, and/or documenting reasons for delays and/or disagreements) until after receiving our audit notification. Although the Plan eventually mailed a fifth letter for each of these seven claim overpayments, we noted a significant time-lapse (one to four years) in each instance between when the standard four letters were mailed by the Plan to when the fifth letter was mailed in February 2022, only after receiving our audit notification letter (dated July 1, 2021). According to the Plan, these additional fifth letters were mailed to the applicable IHS providers because of our audit. During the time-lapse between these fourth and fifth refund request letters, no additional efforts were made by the Plan to recover these IHS claim overpayments.

After additional discussions with Plan officials regarding these uncollected IHS claim overpayments, we were informed that these overpayments could be set-up for provider offsets (voucher deductions) based on the Plan's agreements with the IHS providers, but the Plan inadvertently had not set-up provider offsets for these uncollected IHS overpayments. Therefore, we expanded our scope and requested the Plan to provide a detailed universe of all uncollected IHS claim overpayments exceeding $10,000 for contract year 2017 through May 31, 2022. For this period, there were 57 IHS claim overpayments (including the 7 claim overpayments in our sample that were previously questioned above), totaling $1,699,391, that had not been recovered and returned to the FEHBP. Based on Contract CS 1039, the Plan may offset future benefits payable to a provider to satisfy a debt due under the FEHBP if the debt remains unpaid and undisputed for 120 days after the initial notice. In addition, the contract clearly states that the Plan should take all reasonable steps to increase the chances of recovering FEP claim overpayments, especially overpayments exceeding $10,000. These uncollected IHS claim overpayments probably could have been recovered and returned to the FEHBP if the Plan had used all available resources, including provider offsets, to recover them.

We also requested the Plan to identify all uncollected IHS claim overpayments of $10,000 or less for contract year 2017 through May 31, 2022. For this request, the Plan provided a universe of 4,930 claim overpayments, totaling $2,353,886, that had not been recovered and returned to the FEHBP. Since these claim overpayments did not exceed $10,000, the Plan is not required to perform additional prompt and diligent efforts. However, because the Plan could have set-up provider offsets for the IHS providers, these overpayments probably could have also been recovered and returned to the FEHBP after providing the standard refund request letters at 30, 60 and 90-day intervals, based on Contract CS 1039. Due to the significant number of uncollected IHS claim overpayments, we are only questioning the overpayments of $500 or more from this universe, since we consider these overpayments as reasonable and cost effective to recover via provider offsets. Therefore, we are questioning 1,046 of these claim overpayments, totaling $1,499,548, that have not been recovered and returned to the FEHBP. However, for all uncollected IHS claim overpayments less than $500 in this universe, the Plan should also make diligent efforts to recover and return these overpayments to the FEHBP via provider offsets, if reasonable and cost effective to do so.

During our review of the Plan's schedules of the uncollected IHS claim overpayments, we also noted that the most frequently identified reasons for these overpayments were because of the following: patient no longer covered, policy terminated, other carrier liability, incorrect allowed amount, FEP billed in error, and services not medically necessary. Although these are considered "typical" claim overpayment reasons, we find it to be unusual and concerning that there are so many uncollected IHS claim overpayments (i.e., 4,987 overpayments (57 plus 4,930)) applicable to IHS providers for contract year 2017 through May 31, 2022.

In total, we determined that the Plan was not diligent in its efforts to recover and return 1,103 IHS claim overpayments (57 plus 1,046), totaling $3,198,939 ($1,699,391 plus $1,499,548), to the FEHBP. Based on our sample results and the Plan's supporting schedules for the uncollected IHS claim overpayments, we recognize that the Plan generally mailed the standard four refund request letters to the applicable IHS providers for these claim overpayments. However, after receiving no responses from the IHS providers, the Plan should have continued recovery efforts, such as setting up provider offsets, to recover these claim overpayments as well as made additional prompt and diligent efforts for the claim overpayments exceeding $10,000. Based on our sample results and the Plan's schedule of 57 uncollected IHS claim overpayments exceeding $10,000, there appears to be no instances where IHS providers had responded to the Plan's refund request letters prior to this audit. Similarly, based on our nomenclature review of the Plan's schedule of 4,930 uncollected IHS claim overpayments of $10,000 or less, there appears to be no instances where IHS providers had responded to the Plan's standard refund request letters. We find it to be unusual and very concerning that the IHS providers had not responded to these inquiries regarding claim overpayments.

Association/Plan Response:

The Association and/or Plan agree with the finding and recommendations. For the monetary recommendation, the Association states, "The Plan . . . will continue to pursue recovery of all IHS overpayments greater than $500 . . . As of October 28, 2022, $1,442,418 has been recovered and returned to the Program. The Plan will continue to recover the amount due and will provide an update ....."

OIG Comments:

As part of our review, we verified that the Plan has recovered and returned $1,410,471 to the FEHBP as of October 11, 2022, for the questioned IHS claim overpayments. We noted that the Plan has recovered substantially all of these claim overpayments from the applicable providers via provider offsets. However, the FEHBP is still due $1,788,468 ($3,198,939 minus $1,410,471) for the remaining questioned IHS claim overpayments of $500 or more. (Note: We believe that these questioned IHS claim overpayments of $500 or more should be reasonable and cost effective to recover via provider offsets.)

Recommendation 1:

We recommend that the contracting officer require the Plan to return $3,198,939 to the FEHBP for the questioned IHS claim overpayments of $500 or more that were considered uncollectible by the Plan, whether recovered or not, as prompt and diligent efforts to recover, including provider offsets, were not made timely. However, since we verified that the Plan subsequently returned $1,410,471 of these questioned claim overpayments to the FEHBP, the contracting officer only needs to ensure that the Plan returns the remaining questioned overpayments of $1,788,468 to the FEHBP.

Recommendation 2:

We recommend that the contracting officer require the Association to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that IHS claim overpayments are adequately pursued, monitored, recovered, and returned to the FEHBP, as required by Section 2.3(g) of Contract CS 1039. If the option is available and cost effective, the Plan should also use provider offsets to recover uncollected FEP claim overpayments.

Association Response:

"BCBSA will work with the Plan to provide evidence demonstrating that the Plan implemented the necessary corrective actions to ensure that FEP IHS claim overpayments are adequately pursued, monitored, recovered, and returned to the FEHBP. Documentation will be provided once the Final Report is issued."

Recommendation 3:

We recommend that the contracting officer require the Association to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to reduce the outstanding balance of IHS claim overpayments.

Association/Plan Response:

"The Plan agrees to work with BCBSA to implement the necessary corrective actions to reduce the outstanding balance of IHS claim overpayments. The Plan does not agree that any additional action is necessary to minimize IHS overpayments from occurring in the future. The $3.2 million in overpayments represents 1% of the total claim payments made to IHS during the audit timeframe. The 1,103 overpayment claims represent 0.02% of the total claims paid to IHS during the audit timeframe. We will continue to look for efficiencies in our process to avoid overpayments but do not believe it to be an issue at this time, based on the IHS processing and payments."

"BCBSA will work with the Plan to provide evidence and supporting documentation to demonstrate that the Plan has implemented the necessary corrective actions to reduce claim outstanding overpayments to IHS providers. Documentation will be provided once the Final Report is issued."

OIG Comments:

After reviewing the draft report response, we revised this recommendation for the final report. The Association and/or Plan agree with this revised recommendation.

2. Health Benefit Refunds and Recoveries: $38,701

Our audit determined that the Plan untimely returned numerous health benefit refunds and recoveries to the FEHBP during the audit scope, resulting in lost investment income (LII) of $37,131 due to the FEHBP. Additionally, when reviewing heath benefit refunds and recoveries, we identified that the Plan inadvertently overdrew $3,935,005 in funds from the LOCA on July 10, 2018. The Plan returned this LOCA overdraw to the FEHBP via several LOCA drawdown adjustments in July 2018 but did not calculate and return LII of $1,570 to the FEHBP. Since the Plan returned these health benefit refunds and recoveries and this LOCA overdraw to the FEHBP during the audit scope and prior to our audit notification date, we did not question the principal amounts as monetary findings. However, we are questioning LII of $38,701 ($37,131 plus $1,570) for this audit finding, calculated on the health benefit refunds and recoveries and the LOCA overdraw that were returned untimely to the FEHBP during the audit scope.

Contract CS 1039, Part II, Section 2.3 (i) states, "All health benefit refunds and recoveries . . . must be deposited into the working capital or investment account [if applicable] within 30 days and returned to or accounted for in the FEHBP letter of credit account within 60 days after receipt by the Carrier."

Contract CS 1039, Part III, section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable."

FAR 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."

Regarding reportable monetary findings, Contract CS 1039, 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."

Health Benefit Refunds – Questioned LII of $33,689

The Plan provided a consolidated universe of FEP health benefit refunds that included all cash receipt and provider offset refunds for items such as solicited and unsolicited refunds (claim overpayment recoveries), provider audit recoveries, and subrogation recoveries. For contract year 2017 through June 30, 2021, there were 51,475 FEP health benefit refunds, totaling $77,647,066. From this universe, we selected and reviewed a high dollar sample of 150 health benefit refunds, totaling $20,454,369, to determine if the Plan timely returned these refunds to the FEHBP. Our sample included the 20 highest

dollar cash receipt refunds and the 10 highest dollar provider offset refunds from each year of the audit scope.

Based on our review, we determined that the Plan returned 32 cash receipt refunds, totaling $4,070,062, untimely to the FEHBP during the audit scope. Specifically, we noted that the Plan returned these cash receipt refunds to the LOCA from 1 to 548 days late. Since the Plan returned these refunds to the FEHBP during the audit scope and prior to our audit notification date, we did not question this principal amount as a monetary finding. However, since these funds were returned untimely to the LOCA, we calculated LII of $11,597 on these refunds.

The Plan's general procedure is to calculate and return LII to the FEHBP on all FEP health benefit refunds that are knowingly returned late. While preparing for our audit, the Plan also self-disclosed an issue where the Plan had not fully calculated and returned LII to the FEHBP for numerous untimely returned health benefit refunds. According to the Plan, this only occurred in situations where the refunds were processed in parts because the claim adjustments occurred on multiple dates. Basically, the Plan calculated and returned LII on the initial amount of the untimely returned refund but inadvertently did not calculate and return LII on the remaining refund amount(s). Therefore, we requested the Plan to identify and calculate the total LII impact of this issue. Based on our review of the Plan's analysis and supporting documentation for this issue, we are questioning an additional $22,092 for applicable LII on untimely returned refunds to the FEHBP during the audit scope.

As a result of the above exceptions, we are questioning $33,689 ($22,092 plus $11,597) for LII on the health benefit refunds returned untimely to the FEHBP.

Special Plan Invoices (SPI) - Questioned LII of $3,442

We reviewed SPIs to determine if the Plan properly calculated, charged, and/or credited SPI amounts to the FEHBP. For contract year 2017 through June 30, 2021, there were 383 SPIs, totaling $3,624,783 in net FEP payments, for miscellaneous health benefit payments and credits. From this universe, we selected and reviewed a judgmental sample of 20 SPIs, totaling $2,289,420 in net FEP payments. We judgmentally selected these 20 SPIs based on our nomenclature review of high dollar SPI amounts. Specifically, for SPI pay codes related to miscellaneous health benefit payments and credits, we selected two SPIs with the highest dollar payment amounts and two SPIs with the highest dollar credit amounts (excluding SPIs for medical drug rebates and fraud recoveries) from each year in the audit scope.

Based on our review, we determined that the Plan untimely returned six SPI amounts, totaling $550,326, to the FEHBP during the audit scope. These six SPIs were for health benefit refunds and recoveries that could not be processed and/or adjusted in the FEP Direct Claims System. We noted that the Plan returned these health benefit refunds and

recoveries to the LOCA from 45 to 125 days late. 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 principal amount as a monetary finding. However, since these funds were returned untimely to the LOCA, we calculated LII of $3,442 on these six SPI amounts.

LOCA Overdraw – Questioned LII of $1,570

While reviewing health benefit refunds and recoveries, we identified that on July 10, 2018, the Plan inadvertently withdrew $3,935,005 from the LOCA for administrative and quality improvement cost settlement adjustments. These cost settlement adjustments were also previously wired into the Plan's corporate bank account by the Association, and therefore should not have been added to the LOCA drawdown. This duplicate drawdown amount by the Plan resulted in an overdraw of $3,935,005 to the FEHBP. The Plan returned this LOCA overdraw to the FEHBP via several LOCA drawdown adjustments in July 2018 but did not calculate and return applicable LII to the FEHBP for the overdraw. As a result, we are questioning LII of $1,570 calculated on this overdraw.

Summary

In total, the Plan subsequently returned $37,131 ($33,689 plus $3,442) to the FEHBP for LII calculated on health benefit refunds and recoveries that were returned untimely to the FEHBP during the audit scope. However, the FEHBP is still due $1,570 for LII calculated on the LOCA overdraw.

Association/Plan Response:

The Association and/or Plan partially agree with the audit finding and monetary recommendation but agree with the procedural recommendation. For the contested amount, the Association states, "The Plan disagrees with the $1,570 for LII on the LOCA overdraw. FAM Vol III – Chapter 5 – FEP Cash Management – Lost Investment Income outlines:

> **'FEHBAR 1652.215-71 requires Plans to invest excess FEP funds and credit FEP for the interest earned. The FEHBAR specifically lists unreturned refunds as an example of excess FEP funds. Plans may be liable for lost investment income if they fail to deposit funds in the FEP Investment Account while they research and process FEP refunds.**
>
> **FEP policy requires all refunds to be deposited in the FEP Investment Account promptly upon being received by the Plan. The identification and deposit process should be completed within 30 days of the Plan's initial receipt of the funds. Plans are liable for lost investment income on refunds that are not invested in the FEP Investment Account within 30 days of receipt.'**

The Plan withdrew $3,935,005 on July 10, 2018 and returned the funds via LOCA drawdown adjustments [to the FEHBP] from July 11 through 13, 2018. As the Plan returned the funds in accordance with the refund process and within 30 days of receipt, it is the Plan's position that no interest is owed."

OIG Comments:

As part of our review, we verified that the Plan returned $37,131 to the FEHBP as of June 16, 2022, for the questioned LII calculated on the health benefit refunds and recoveries that were returned untimely to the FEHBP during the audit scope. However, the FEHBP is still due $1,570 for the LII calculated on the LOCA overdraw, which the Plan is contesting.

Regarding the contested LII on the LOCA overdraw, we disagree with the Plan's use of FEHBAR 1652.215-71. The excess FEP funds of $3,935,005 resulted from a LOCA drawdown error by the Plan and were not related to a claim overpayment refund. Also, Contract CS 1039 does allow more days for the BCBS plans to return FEP claim overpayment refunds to the FEHBP (e.g., 30 days to determine if the refunds belong to the FEP before depositing the funds into the FEP investment account) but does not provide additional guidance for LOCA drawdown errors. Therefore, we can only take Contract CS 1039 and FEHBAR 1652.215-71 at face value.

FEHBAR 1652.215-71(e) clearly states, "Investment income lost as a result of failure to credit income due the contract or failure to place excess funds in income producing investments and accounts shall be paid from the date the funds should have been invested or appropriate income was not credited....."

Since the Plan does not maintain a dedicated FEP investment account (or an FEP interest bearing account), these excess FEHBP funds were held in the Plan's corporate account earning interest income (probably comparable to the contested LII amount). As a result, the Plan benefitted from maintaining these excess FEHBP funds in the Plan's corporate account, even if for only a couple of days. The Plan should not be unduly enriched by funds that did not actually belong to them. Therefore, we will continue to question this contested LII amount of $1,570 applicable to the LOCA overdraw.

Recommendation 4:

We recommend that the contracting officer require the Plan to return $38,701 to the FEHBP for the questioned LII on health benefit refunds and recoveries returned untimely to the FEHBP and LII on the LOCA overdraw. However, since we verified that the Plan subsequently returned $37,131 of this questioned LII to the FEHBP, the contracting officer only needs to ensure that the Plan returns the remaining questioned LII of $1,570 to the FEHBP (applicable to the LOCA overdraw).

Recommendation 5:

We recommend that the contracting officer require the Association to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that health benefit refunds and recoveries are timely returned to the FEHBP (i.e., returned to the LOCA via drawdown adjustment). The contracting officer should also require the Association to provide a certification that the Plan has implemented these corrective actions.

Association Response:

"BCBSA will work with the Plan to provide evidence demonstrating that the Plan implemented the necessary corrective actions to ensure that health benefit refunds and recoveries are timely returned to the FEHBP . . . Documentation and a certification will also be provided once the Final Report is issued."

B. Administrative Expenses

1. Unallocable Cost Center and Natural Account Costs: $259,950

The Plan charged unallocable cost center and natural account costs of $246,401 to the FEHBP for contract years 2016 through 2020. As a result of this finding, the Plan subsequently returned $259,950 to the FEHBP, consisting of $246,401 for the unallocable charges and $13,549 for applicable LII on these questioned charges.

As previously cited from Contract CS 1039, 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."

The Plan charged unallocable costs of $246,401 to the FEHBP.

For contract years 2016 through 2020, the Plan allocated administrative expenses of $155,311,713 (before adjustments) to the FEHBP from 336 cost centers that contained 75 natural accounts. From this universe, we selected a judgmental sample of 50 cost centers to review, which totaled $59,208,690 in expenses allocated to the FEHBP. We also selected a judgmental sample of 18 natural accounts to review, which totaled $40,978,353 in expenses allocated to the FEHBP through the cost centers. We selected these cost centers and natural accounts based on high dollar amounts, our nomenclature review, and our trend analysis. We reviewed the expenses from these cost centers and natural accounts for allowability, allocability, and reasonableness.

Based on our review, we determined that the Plan inadvertently charged the following unallocable cost center and natural account costs to the FEHBP for contract years 2016 through 2020:

- The Plan charged unallocable costs to the FEHBP related to the Association's BlueCard Program for contract years 2017 through 2020. Specifically, the Plan allocated and charged $202,267 to the FEHBP for these costs through cost centers "96265" (Mainframe Replatform) and "43206" (Claims and Payment Team 1). The Association's BlueCard Program streamlines the administration of benefits for members that receive health care while traveling out of state. While FEHBP members are also afforded these benefits, these related activities are performed by the FEP Operations Center through the FEP Direct System, which is the Association's nation-wide claims adjudication system. Therefore, these BlueCard Program invoice payments only benefited the Plan's other lines of business, making these costs unallocable to the FEP.

- The Plan charged unallocable costs to the FEHBP from cost center "96125" (Identification Card Production) in contract year 2016. Specifically, the Plan allocated and charged vendor costs of $27,276 to the FEHBP for services related to the production of member identification cards. Since local BCBS plans do not create identification cards for the FEP members, costs from this vendor are unallocable to the FEP.

- The Plan charged unallocable bank fees to the FEHBP from natural account "63000" (Bank Service Charges) for contract years 2016 through 2020. Specifically, the Plan allocated and charged bank fees of $16,858 to the FEHBP for claim disbursement accounts that were not applicable to the FEP.

In total, we are questioning $259,950 for this audit finding, consisting of $246,401 ($202,267 plus $27,276 plus $16,858) for unallocable cost center and natural account costs that were charged to the FEHBP and $13,549 for applicable LII on these questioned charges (as calculated by the Plan). We reviewed and accepted the Plan's LII calculation.

Association/Plan Response:

The Plan agrees with the finding and recommendations.

OIG Comments:

As part of our review, we verified that the Plan returned $259,950 to the FEHBP in February 2022 and March 2022, consisting of $246,401 for the questioned unallocable charges and $13,549 for applicable LII on these questioned charges.

Recommendation 6:

We recommend that the contracting officer disallow $246,401 for the questioned unallocable costs that were charged to the FEHBP for contract years 2016 through 2020. However, since we verified that the Plan subsequently returned $246,401 to the FEHBP for these questioned charges, no further action is required for this amount.

Recommendation 7:

We recommend that the contracting officer require the Plan to return $13,549 to the FEHBP for the questioned LII calculated on the unallocable cost center and natural account charges. However, since we verified that the Plan subsequently returned $13,549 to the FEHBP for the questioned LII, no further action is required for this LII amount.

2. BlueCross BlueShield Association Dues: $9,446

The Plan overcharged the FEHBP $8,517 for Association dues in contract years 2016 and 2017. Specifically, the Plan did not use updated membership enrollment data when calculating the Association dues that were charged to the FEHBP. Because of our audit, the Plan subsequently returned $9,446 to the FEHBP, consisting of $8,517 for the Association dues that were overcharged to the FEHBP and $929 for applicable LII on these overcharges.

FEP Memorandum Number 20-019 FYI (Memorandum), titled BCBSA Regular Member Plan Dues and Other Assessments: 2015-2020, dated February 3, 2020, provides guidance to the BCBS plans with respect to charging the FEHBP for Association dues. The Memorandum also includes specific guidance for the allocation of the BCBS plan dues.

As previously cited from Contract CS 1039, 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.

Regarding reportable monetary findings, Contract CS 1039, 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 (i.e., administrative expense overcharges . . . were already processed and returned to the FEHBP) prior to audit notification."

To determine the reasonableness of the amounts charged to the FEHBP, we reviewed each year within the audit scope and recalculated the FEP's share of the Association dues in accordance with the methods in the Memorandum. Based on our review, we determined that the Plan overcharged the FEHBP $8,517 ($7,854 in contract year 2016 and $663 in contract year 2017) for Association dues. In response to our Standard Information Request (during our pre-audit phase), the Plan also disclosed these overcharges and stated that when calculating the FEP's share of Association dues for contract years 2016 and 2017, the Plan inadvertently did not use updated membership enrollment data. The Plan identified these overcharges while preparing for our audit.

In total, we are questioning $9,446 for this audit finding, consisting of $8,517 for the Association dues that were overcharged to the FEHBP and $929 for applicable LII on these overcharges (as calculated by the Plan). We reviewed and accepted the Plan's LII calculation.

Association/Plan Response:

The Plan agrees with the finding and recommendations.

OIG Comments:

As part of our review, we verified that the Plan returned $9,446 to the FEHBP in November 2021 and December 2021, consisting of $8,517 for the questioned overcharges and $929 for applicable LII.

Recommendation 8:

We recommend that the contracting officer disallow $8,517 for the Association dues that were overcharged to the FEHBP in contract years 2016 and 2017. However, since we verified that the Plan subsequently returned $8,517 to the FEHBP for these questioned Association dues, no further action is required for this amount.

Recommendation 9:

We recommend that the contracting officer require the Plan to return $929 to the FEHBP for the questioned LII calculated on the Association dues that were overcharged to the FEHBP. However, since we verified that the Plan subsequently returned $929 to the FEHBP for the questioned LII, no further action is required for this LII amount.

3. Affordable Care Act Fees: $1,520

Our audit determined that the Plan overcharged the FEHBP $1,520 for Affordable Care Act fees in contract year 2019 relating to the Patient-Centered Outcomes Research Institute (PCORI). As a result of this finding, the Plan subsequently returned $1,520 to the FEHBP for the PCORI fees that were overcharged to the FEHBP. Since the LII on this overcharge is immaterial, we did not question LII for this audit finding.

As previously cited from Contract CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable.

Section 6301 of the Affordable Care Act imposes a fee on health insurance providers to help fund the PCORI. The PCORI assists individuals in making informed health decisions by advancing the quality and relevance of evidence-based medicine. The PCORI fee is effective for policy or plan years ending after September 30, 2012, and before October 1, 2029. The yearly amount of the PCORI fee is equal to the average number of lives covered during the policy or plan year multiplied by a dollar amount (e.g., $2.45 for 2018, $2.54 for 2019, and $2.66 for 2020), as determined by the Secretary of Health and Human Services.

For contract years 2018 through 2020, the Plan allocated and charged the FEHBP $1,162,801 ($361,451 in 2018, $386,917 in 2019, and $414,433 in 2020) for the PCORI fees. Based on our review, we determined that the Plan properly allocated and charged PCORI fees to the FEHBP for contract years 2018 and 2020. However, the Plan did not correctly charge the FEHBP for PCORI fees in contract year 2019.

For contract year 2019, we determined that the Plan should have only charged the FEHBP $385,397 for PCORI fees, resulting in an overcharge of $1,520 ($386,917 minus $385,397) to the FEHBP. We calculated the PCORI fees by multiplying FEP's average number of lives covered for the policy year by the applicable rate (i.e., $2.54) for the policy year ending December 31, 2019. The variance of $1,520 is a result of the Plan inadvertently using a different rate than required to calculate the allowable fees. The Plan returned this overcharge to the FEHBP on March 23, 2022, because of our audit. We did not question LII on this overcharge since the applicable LII amount is immaterial.

Association/Plan Response:

The Plan agrees with the finding and recommendation.

OIG Comments:

We verified that the Plan returned $1,520 to the FEHBP on March 23, 2022, for the questioned PCORI fees that were overcharged to the FEHBP.

Recommendation 10:

We recommend that the contracting officer disallow $1,520 for the PCORI fees that were overcharged to the FEHBP in contract year 2019. However, since we verified that the Plan subsequently returned $1,520 to the FEHBP for this questioned overcharge, no further action is required for this amount.

C. Cash Management

The audit disclosed no findings pertaining to the Plan's cash management activities and practices related to FEHBP funds. Overall, we concluded that the Plan handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations concerning cash management in the FEHBP.

D. Fraud and Abuse Program

The Plan timely entered fraud and abuse cases into the Association's FSTS.

The audit disclosed no findings pertaining to the Plan's Fraud and Abuse Program activities and practices. For contract year 2020 through June 30, 2021, the Plan opened 26 fraud and abuse cases with potential FEP exposure. From this universe, we selected and reviewed all these cases and determined if the Plan timely entered these fraud and abuse cases into the Association's FEP Special Investigations Unit Tracking System (FSTS) and if the Association timely reported these cases to the OIG.[5] Based on our review, we identified no exceptions with the Plan timely entering cases into the Association's FSTS and the Association timely reporting cases to the OIG. Overall, we determined that the Plan complied with the communication and reporting requirements for fraud and abuse cases that are set forth in Contract CS 1039 and FEHBP Carrier Letter 2017-13.

[5] FSTS is a multi-user, web-based FEP case-tracking database application and storage warehouse administered by the Association's FEP Special Investigations Unit (SIU). FSTS is used by the local BCBS plans' SIUs, the FEP Pharmacy Benefit Managers' SIUs, and the Association's FEP SIU to store, track and report potential fraud and abuse activities.

IV. Schedule A – Questioned Charges

Premera BlueCross
Mountlake Terrace, Washington
Questioned Charges

Audit Findings	2016	2017	2018	2019	2020	2021	2022	Total
A. Miscellaneous Health Benefit Payments and Credits								
1. Indian Health Service Claim Overpayments	$0	$0	$0	$0	$0	$0	$3,198,939	$3,198,939
2. Health Benefit Refunds and Recoveries*	22,095	174	1,577	14,420	417	18	0	38,701
Total Miscellaneous Health Benefit Payments and Credits	$22,095	$174	$1,577	$14,420	$417	$18	$3,198,939	$3,237,640
B. Administrative Expenses								
1. Unallocable Cost Center and Natural Account Costs*	$28,144	$26,010	$84,999	$96,470	$21,100	$3,227	$0	$259,950
2. BlueCross BlueShield Association Dues*	7,854	854	261	266	139	72	0	9,446
3. Affordable Care Act Fees	0	0	0	1,520	0	0	0	1,520
Total Administrative Expenses	$35,998	$26,864	$85,260	$98,256	$21,239	$3,299	$0	$270,916
C. Cash Management								
Total Cash Management	$0	$0	$0	$0	$0	$0	$0	$0
D. Fraud and Abuse Program								
Total Fraud and Abuse Program	$0	$0	$0	$0	$0	$0	$0	$0
Total Questioned Charges	$58,093	$27,038	$86,837	$112,676	$21,656	$3,317	$3,198,939	$3,508,556

*** We included lost investment income (LII) within audit findings A2 ($38,701), B1 ($13,549), and B2 ($929). Therefore, no additional LII is applicable.**

Appendix

BlueCross BlueShield Association
1310 G Street, N.W.
Washington, D.C. 20005
202.626.4800
www.BCBS.com

November 1, 2022

John A. Hirschmann
Group Chief, Experienced Rated Audits Group
Office of the Inspector General
U.S. Office of Personnel Management
1900 E. Street, Room 6400
Washington, D.C. 20415-1100

Reference: OPM Draft AUDIT REPORT
Premera BlueCross BlueShield
Audit Report Number 2022-ERAG-0011
July 21, 2022

Dear Mr. Hirschmann:

This is the Premera Blue Cross Blue Shield response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Federal Employees Health Benefits Program (FEHBP). Our comments concerning the findings in the report are as follows:

Our comments concerning the findings in the report are as follows:

A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

1. Indian Health Service Claim Overpayments $3,198,939

Recommendation 1

We recommend that the contracting officer require the Plan to return $3,198,939 to the FEHBP for the questioned IHS claim overpayments that were considered uncollectible by the Plan, whether recovered or not, as prompt and diligent efforts to recover, including provider offsets (voucher deductions), were not made timely. However, since we verified that the Plan subsequently returned $393,354 of these questioned claim overpayments to the FEHBP, the contracting officer only needs to ensure that the Plan returns the remaining questioned overpayments of $2,805,585 to the FEHBP. (Note: Based on reasonable expectations, we believe that these questioned IHS claim overpayments should be easy and very cost effective to recover via provider offsets (voucher deductions) by the Plan.)

Plan Response

The Plan agrees with this recommendation and will continue to pursue recovery of all IHS overpayments greater than $500 as agreed to with the OIG. As of October 28, 2022, $1,442,418 has been recovered and returned to the Program. The Plan will continue to recover the amount due and will provide an update once the final report is issued. Please see Attachment A for a listing of claims recovered and amounts.

Recommendation 2

We recommend that the contracting officer require the Association to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that FEP claim overpayments are adequately pursued, monitored, recovered, and returned to the FEHBP, as required by Section 2.3(g) of Contract CS 1039.

BCBSA Response

BCBSA will work with the Plan to provide evidence demonstrating that the Plan implemented the necessary corrective actions to ensure that FEP IHS claim overpayments are adequately pursued, monitored, recovered, and returned to the FEHBP. Documentation will be provided once the Final Report is issued.

Recommendation 3

We recommend that the contracting officer require the Association to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to (1) reduce the significant outstanding balance of IHS claim overpayments and (2) minimize the IHS claim overpayments from occurring in the future.

Plan Response

The Plan agrees to work with BCBSA to implement the necessary corrective actions to reduce the outstanding balance of IHS claim overpayments. The Plan does not agree that any additional action is necessary to minimize IHS overpayments from occurring in the future. The $3.2 million in overpayments represents 1% of the total claim payments made to IHS during the audit timeframe. The 1,103 overpayment claims represent 0.02% of the total claims paid to IHS during the audit timeframe. We will continue to look for efficiencies in our process to avoid overpayments but do not believe it to be an issue at this time, based on the IHS processing and payments.

BCBSA Response

BCBSA will work with the Plan to provide evidence and supporting documentation to demonstrate that the Plan has implemented the necessary corrective actions to reduce claim outstanding overpayments to IHS providers. Documentation will be provided once the Final Report is issued.

2. Health Benefit Refunds and Recoveries $38,701

Recommendation 4

We recommend that the contracting officer require the Plan to return $38,701 to the FEHBP for the questioned LII on health benefit refunds and recoveries returned untimely to the FEHBP and LII on the LOCA overdraw. However, since we verified that the Plan returned $37,131 of this questioned LII to the FEHBP, the contracting officer only needs to ensure that the Plan returns $1,570 to the FEHBP

Plan Response

The Plan partially agreed with this recommendation. The Plan disagrees with the $1,570 for LII on the LOCA overdraw. FAM Vol III – Chapter 5 – FEP Cash Management – Lost Investment Income outlines:

> "FEHBAR 1652.215-71 requires Plans to invest excess FEP funds and credit FEP for the interest earned. The FEHBAR specifically lists unreturned refunds as an example of excess FEP funds. Plans may be liable for lost investment income if they fail to deposit funds in the FEP Investment Account while they research and process FEP refunds.
>
> FEP policy requires all refunds to be deposited in the FEP Investment Account promptly upon being received by the Plan. The identification and deposit process should be completed within 30 days of the Plan's initial receipt of the funds. Plans are liable for lost investment income on refunds that are not invested in the FEP Investment Account within 30 days of receipt."

The Plan withdrew $3,935,005 on July 10, 2018 and returned the funds via LOCA drawdown adjustments from July 11 through 13, 2018. As the Plan returned the funds in accordance with the refund process and within 30 days of receipt, it is the Plan's position that no interest is owed.

Recommendation 5

We recommend that the contracting officer require the Association to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that health benefit refunds and recoveries are timely returned to the FEHBP (i.e., returned to the letter of credit account via drawdown adjustment). The contracting officer should also require the Association to provide a certification that the Plan has implemented these corrective actions.

BCBSA Response

BCBSA will work with the Plan to provide evidence demonstrating that the Plan implemented the necessary corrective actions to ensure that health benefit refunds and recoveries are timely returned to the FEHBP (i.e., returned to the letter of credit account via drawdown adjustment). Documentation and a certification will also be provided once the Final Report is issued.

B. ADMINISTRATIVE EXPENSES

1. Unallocable Costs $259,950

Recommendation 6

We recommend that the contracting officer disallow $246,401 for the questioned unallocable costs that were charged to the FEHBP for contract years 2016 through 2020. However, since we verified that the Plan subsequently returned $246,401 to the FEHBP for these questioned charges, no further action is required for this amount.

Plan Response

The Plan agreed with this recommendation as stated. No additional action is necessary.

Recommendation 7

We recommend that the contracting officer require the Plan to return $13,549 to the FEHBP for the questioned LII calculated on the unallocable charges. However, since we verified that the Plan subsequently returned $13,549 to the FEHBP for the questioned LII, no further action is required for this LII amount.

Plan Response

The Plan agreed with this recommendation as stated. No additional action is necessary.

2. BlueCross BlueShield Association Dues $9,446

Recommendation 8

We recommend that the contracting officer disallow $8,517 for the Association dues that were overcharged to the FEHBP in contract years 2016 and 2017. However, since we verified that the Plan subsequently returned $8,517 to the FEHBP for these questioned Association dues, no further action is required for this amount.

Plan Response

The Plan agreed with this recommendation as stated. No additional action is necessary.

Recommendation 9

We recommend that the contracting officer require the Plan to return $929 to the FEHBP for the questioned LII calculated on the Association dues that were overcharged to the FEHBP. However, since we verified that the Plan subsequently returned $929 to the FEHBP for the questioned LII, no further action is required for this LII amount.

Plan Response

The Plan agreed with this recommendation as stated. No additional action is necessary.

3. **Affordable Care Act Fees** **$1,520**

Recommendation 10

We recommend that the contracting officer disallow $1,520 for the PCORI fees that were overcharged to the FEHBP in contract year 2019. However, since we verified that the Plan subsequently returned $1,520 to the FEHBP for this questioned overcharge, no further action is required for this amount.

Plan Response

The Plan agreed with this recommendation as stated. No additional action is necessary.

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], FEP Program Assurance

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: https://oig.opm.gov/contact/hotline

By Phone: Toll Free Number: (877) 499-7295

By Mail: Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, NW
Room 6400
Washington, DC 20415-1100