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

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# Final Audit Report

## Global Audit of Claims-to-Enrollment Match for BlueCross and BlueShield Plans

Report Number 1A-99-00-17-048  
August 28, 2018

A photograph of a sign for the Office of Personnel Management. The sign is white with a blue border and contains the text "OFFICE OF PERSONNEL MANAGEMENT" in blue capital letters. The sign is positioned in front of a large, multi-story building with many windows. There are trees and a lawn in the foreground.

OFFICE OF  
PERSONNEL MANAGEMENT

# EXECUTIVE SUMMARY

## *Global Audit of Claims-To-Enrollment Match*

Report No. 1A-99-00-17-048

August 28, 2018

### **Why Did We Conduct the Audit?**

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

### **What Did We Audit?**

The Office of the Inspector General (OIG) has completed a limited scope performance audit of the FEHBP operations at all BCBS plans. The audit covered claim payments from October 1, 2014, through May 31, 2017. Specifically, we identified and audited claims from this period for services incurred:

- when no enrollee enrollment record existed;
- during gaps of coverage; or
- after termination of enrollee coverage.



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**Michael R. Esser**  
*Assistant Inspector General  
for Audits*

### **What Did We Find?**

For many years, we have had serious concerns related to the efforts of BCBS plans and the Association to implement corrective actions to prevent enrollment claim payment errors. Our audits (performed since 2009) routinely show that retroactive adjustments are the primary reason for enrollment claim payment errors. Since we began these audits, we have identified \$38 million in claim overpayments related to enrollment errors.

Although the Association has taken several steps to reduce enrollment errors, the results of this audit continue to indicate that these corrective actions have not had a substantial impact in reducing the amount of enrollment payment errors. Our audit determined that in a 32-month period, BCBS plans paid \$12,357,989 in error for ineligible members that should not be participating in the FEHBP. Since the Association initiated recovery for \$5,010,634 of the claim overpayments prior to the start of this audit, this amount is not included in the questioned costs for this audit.

This report questions the remaining **\$7,347,355** in health benefit charges.

# ABBREVIATIONS

|                    |   |
|--------------------|---|
| <b>Association</b> | <b>Blue Cross Blue Shield Association</b>                 |
| <b>BCBS</b>        | <b>Blue Cross Blue Shield</b>                             |
| <b>FEHB</b>        | <b>Federal Employees Health Benefits</b>                  |
| <b>FEHBP</b>       | <b>Federal Employees Health Benefits Program</b>          |
| <b>FEP</b>         | <b>Federal Employee Program</b>                           |
| <b>FEP Express</b> | <b>Association's nation-wide claims processing system</b> |
| <b>FEP OC</b>      | <b>Federal Employee Program Operations Center</b>         |
| <b>OIG</b>         | <b>Office of the Inspector General</b>                    |
| <b>OPM</b>         | <b>U.S. Office of Personnel Management</b>                |
| <b>Plan(s)</b>     | <b>Blue Cross and Blue Shield Plan(s)</b>                 |

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# I. BACKGROUND

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

The FEHBP was established by the Federal Employees Health Benefits (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 codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations. Health insurance coverage is made available through contracts with various health insurance carriers.

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

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

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

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<sup>1</sup> Throughout this report, when we refer to "FEP", we are referring to the Service Benefit Plan lines of business at the Plan(s). When we refer to the "FEHBP", we are referring to the program that provides health benefits to Federal employees.

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

Findings from our previous global claims-to-enrollment match audit of all BCBS plans (Report No. 1A-99-00-15-008, dated January 21, 2016), for claims reimbursed from January 1, 2012, through September 30, 2014, are currently in the process of being resolved. We will continue to report procedural recommendations from the prior audit report until implemented.

Our sample selections, instructions, and preliminary audit results of enrollment errors were presented to the Association in a draft report dated August 8, 2017. 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 BCBS plans on various dates through July 12, 2018, was considered in preparing our final report.

## II. OBJECTIVES, SCOPE, AND METHODOLOGY

### OBJECTIVES

The objectives of our audit were to determine whether the BCBS plans charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract. Specifically, our objective was to determine whether the plans complied with contract provisions relative to claims paid for ineligible enrollees.

### SCOPE

The audit covered health benefit payments from October 1, 2014, through May 31, 2017, as reported in the Blue Cross and Blue Shield Association’s Government-wide Service Benefit Plan FEP Annual Accounting Statements. We performed a computer search on our claims data warehouse to identify all claims that were paid for ineligible enrollees during this period. This search identified 44,709 enrollees who incurred 330,216 claims, totaling \$48,787,071 in payments, when they were not eligible for coverage.

This universe is comprised of claims for two distinct member enrollment issues. The first category, “Conflict with Enrollment Coverage,” consists of claims incurred during gaps in an enrollment coverage or after termination of an enrollee. The second category, “No Enrollment Record on File,” consists of claims incurred when no enrollee records existed. To test each BCBS plan’s compliance with the FEHBP health benefit provisions related to enrollment eligibility, we selected for review *all* claim lines in *both* categories for enrollees with cumulative claim payments *over* \$1,000. The results of this review were not projected to the population. Exhibit I contains a summary of the total population and sample selection for potentially ineligible enrollees.

**Exhibit I – Summary of Total Population and Sample Selection**

| Ineligible Enrollees              |                  |                |                        |   |               |                        |
|-----------------------------------|------------------|----------------|------------------------|---|---------------|------------------------|
| Category                          | Total Population |                |                        | Enrollees with cumulative payments over \$1,000 |               |                        |
|                                   | Enrollees        | Claim Lines    | Potential Overpayments | Enrollees                                       | Claim Lines   | Potential Overpayments |
| Conflict with Enrollment Coverage | 43,102           | 287,403        | \$42,623,610           | 5,735   | 60,730        | \$35,895,097           |
| No Enrollment Record on File      | 1,607            | 42,813         | \$6,163,461            | 597   | 16,673        | \$5,891,447            |
| <b>Total</b>                      | <b>44,709</b>    | <b>330,216</b> | <b>\$48,787,071</b>    | <b>6,332</b>                                    | <b>77,403</b> | <b>\$41,786,544</b>    |

## **METHODOLOGY**

The claims selected for review were submitted to each BCBS plan for their analysis and response. We then conducted a limited review of the responses by selecting a small sample of claims that the plans determined were paid correctly, and a larger sample of claims determined to be paid incorrectly. Specifically, we verified supporting documentation and the accuracy and completeness of the plans' responses. We also determined if the claims were paid correctly, and if not, calculated the amount of the claim payment errors. On a limited test basis, we also verified whether the BCBS plans had initiated recovery efforts, adjusted or voided the claims, and/or completed the recovery process by the audit request due date (i.e., September 29, 2017) for the claim payment errors in our sample. The determination of the claim payment errors questioned in this report was based on the FEHBP contract, the 2014 through 2017 Service Benefit Plan brochures, and the Association's FEP Administrative Procedures Manual.

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 did not consider each BCBS plan's internal control structure in planning and conducting our auditing procedures. Our audit approach consisted mainly of substantive tests of transactions and not tests of controls. Therefore, we do not express an opinion on each BCBS plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the BCBS plans had complied with the contract and the laws and regulations governing the FEHBP as they relate to claims paid for ineligible enrollees. The results of our tests indicate that, with respect to the items tested, the BCBS plans did not fully comply with the provisions of the contract relative to claims paid for ineligible enrollees. Exceptions noted are explained 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 BCBS plans had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP Director's Office, the FEP Operations Center, and the BCBS plans. Through audits and a reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify the universe of potential enrollment claim payment



errors. The BCBS claims data is provided to us on a monthly basis by the FEP Operations Center, and after a series of internal steps, uploaded into our data warehouse. However, due to time constraints, we did not verify the reliability of the data generated by the BCBS plans' local claims systems. While utilizing the computer-generated data during our audit, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

Audit fieldwork was performed at our offices in Washington, D.C., Cranberry Township, Pennsylvania and Jacksonville, Florida through July 2018.

# III. AUDIT FINDINGS AND RECOMMENDATIONS

The section below details the results of our Global Claims-to-Enrollment Match audit. The results reflect claims paid for ineligible enrollees who did not have active FEP enrollment coverage on the date the service was incurred.

## **Global Claims-to-Enrollment Match Review**

**\$7,347,355**

As mentioned in the Scope section above, our sample of claims selected for review included all claim lines in both categories of enrollment issues for enrollees with cumulative claim payments more than \$1,000. We determined that the BCBS plans incorrectly paid 35,827 claim lines, totaling \$7,347,355 in payments for ineligible enrollees. See Exhibit II for a summary of our review by category.

### **Exhibit II – Summary of Review**

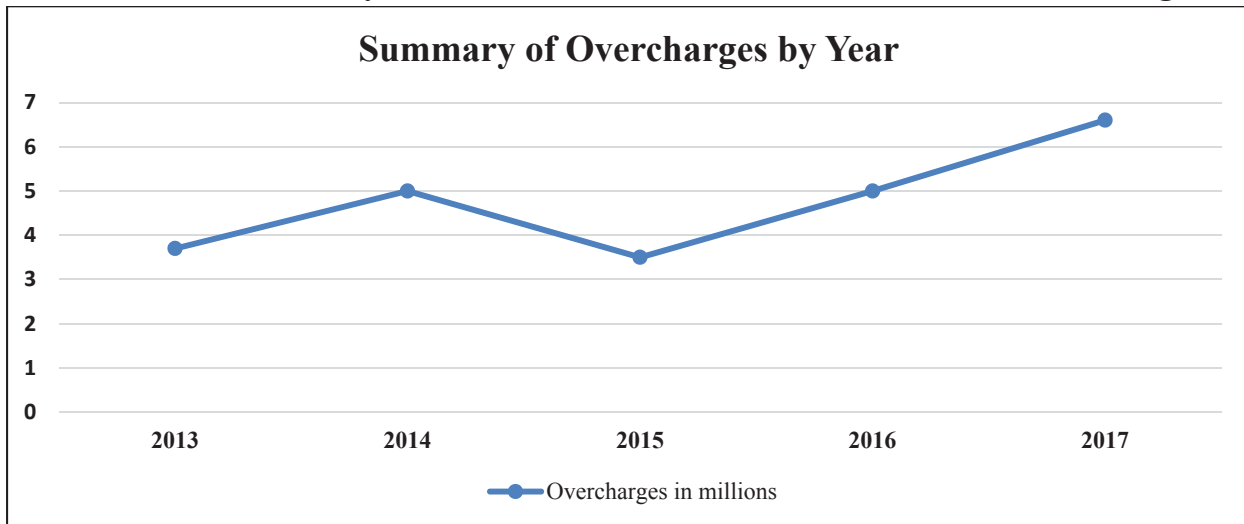
| <b>Category</b>                   | <b>Reviewed</b> |                     | <b>Paid in Error</b> |                    |
|-----------------------------------|-----------------|---------------------|----------------------|--------------------|
| Conflict with Enrollment Coverage | 60,730          | \$35,895,097        | 31,953               | \$6,553,512        |
| No Enrollment Record on File      | 16,673          | \$5,891,447         | 3,874                | \$793,843          |
| <b>Total</b>                      | <b>77,403</b>   | <b>\$41,786,544</b> | <b>35,827</b>        | <b>\$7,347,355</b> |

These 35,827 claim payment errors are comprised of the following:

- 33,830 claim lines, totaling \$6,848,022, were incorrectly paid because the FEP Operation’s Center (FEP OC) did not have accurate enrollment information. Enrollees whose coverage was, or should have been, terminated remained active in the Association’s nation-wide claims processing system (FEP Express). Our review identified the most common reasons for these retroactive enrollment errors:
  - 1) Several months or years passed before removal of a former spouse;
  - 2) Untimely removal of a dependent over the age of 26; and
  - 3) Untimely cancelation or termination of a contract holder.
- The remaining 1,997 claim lines, totaling \$499,333, were paid in error for various reasons including manual processing errors, system processing errors, and/or provider billing errors.

The BCBS plans acknowledge that \$12,357,989 in claim overpayments were made during the scope of our audit.<sup>2</sup> As previously cited, we determined that a majority of these enrollment errors occurred because the Association did not promptly update the FEP Express system when there were changes in the enrollment status of contract holders and their dependents. Due to the nature of the enrollment process, we recognize that some retroactive enrollment errors will occur; however, the results of this audit indicate that enrollment errors continue to increase. We recognize the Association’s efforts to substantially reduce errors by 42 percent from 2014 to 2015; however, our audit has identified a 27 percent average increase in errors per year from 2015 to 2017.<sup>3</sup> See Exhibit III for a summary of recognized overpayments from 2014 to 2017.

**Exhibit III – Summary of Global Audits Claims-to-Enrollment Match Overcharges**



As part of the FEP OC’s efforts to decrease enrollment errors, it performs quarterly reconciliations with the employing payroll offices. This process only includes reconciliation of contract holders. Therefore, our recommendations mainly focus on the Association’s implementation of controls to identify ineligible family members. We believe the Association’s corrective actions should promptly focus on maintaining current enrollee record files to prevent member fraud, waste and abuse.

We used the following criteria to evaluate the Association’s management of the FEHBP enrollment process:

<sup>2</sup> Of this \$12,357,989 in overcharges, \$5,010,634 represents recoveries that were identified by the BCBS plans before our audit notification date (i.e., July 31, 2017), and adjusted or voided by the draft report response due date (i.e., September 29, 2017). We did not consider these as questionable claim payment errors in the final report based on CS 1039 guidelines.

<sup>3</sup> To estimate the overall impact for 2017, we calculated a monthly average using January through May 2017 overpayments and applied this average to the remaining months.

- 5 CFR 890.308-(a)(1) states, “Carrier Disenrollment: Enrollment reconciliation . . . a carrier that cannot reconcile its record of an individual’s enrollment with agency enrollment records or does not receive documentation necessary to resolve the discrepancy from the employing office within 31 days of a request must provide written notice to the individual that the employing office of record does not show him or her as enrolled in the carrier’s plan and that he or she will be disenrolled 31 calendar days after the date of the notice . . . (e) Carrier removal from enrollment: Ineligible individuals. (1) A carrier may request verification of eligibility from the enrollee at any time of an individual who is covered as a family member . . . To verify eligibility, the carrier shall send the enrollee a request for appropriate documentation of the individual’s relationship to the enrollee with a copy to the enrollee’s employing office of record. The request shall contain a written notice that the individual will no longer be covered 60 calendar days after the date of the notice unless the enrollee or employing office provides appropriate documentation as requested.”
- Contract CS 1039, Part III, section 2.3 (8)(i) states, “The Carrier may charge the contract for benefit payments made erroneously but in good faith . . . .”
- Contract CS 1039, Part II, section 2.3(g) states, “[i]f 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 . . . regardless of any time period limitations in the written agreement with the provider.”
- Contract CS 1039, Part III, section 3.16(b) states, “Claim payment findings (i.e., claim overpayments) in the scope of an OIG audit are reportable as questioned charges unless the Carrier provides documentation supporting that these findings were already identified (i.e., documentation that the plan initiated recovery efforts) prior to audit notification and corrected (i.e., claims were adjusted and/or voided and overpayments were recovered and returned to the FEHBP) by the original due date of the draft report response.”
- Contract CS 1039, Part I, section 1.9 (a) states, “Detection of Fraud, Waste, and Abuse (FWA). The Carrier shall conduct a program to assess its vulnerability to FWA to include but not limited to performing post-payment reviews and audits of providers identified either proactively or reactively. . . . In addition, FEHBP Carriers must demonstrate they have submitted written notification to OPM-OIG within 30 business days of identifying potential FWA issues impacting the FEHB Program regardless of dollar value. The program must specify provisions in place for cost avoidance, not just fraud detection, along with criteria for follow-up actions.”

### **Association Response:**

In response to the \$41,786,544 potential overpayments questioned in the draft report, the Association agrees with \$14,493,450 in recognized overpayments and states, *“For these payment errors, the members initially had coverage before the claim payment; however, the payment subsequently became an overpayment due to retroactive enrollment notices received from an OPM Payroll Office and processed in the FEP enrollment system after the claim was paid.”*

For the remaining balance of potential overcharges questioned in the draft report, the Association contests \$27,293,094 and states, *“Plans determined the claims were paid correctly because the member either had coverage when the claim was incurred or had coverage under another member id.”*

In regards to corrective actions to reduce enrollment errors the Association states, *“BCBSA [Association] is in the process of reviewing claims identified as overpayments and expects to have the analysis completed (including completion of a root cause analysis) by 1<sup>st</sup> quarter 2018.”*

### **OIG Comments:**

Based on the Association’s response and documentation provided by the BCBS plans, we determined that the Association and/or plans acknowledge \$12,357,989 in claim overpayments for ineligible enrollees. If claim overpayments were identified by the BCBS plans before our audit notification date (i.e., July 31, 2017), and adjusted or voided by the draft report due date (i.e., September 29, 2017), we did not consider these as claim payment errors in the final report. This report questions the remaining **\$7,347,355** in health benefit charges that were paid for ineligible enrollees.

#### **Acknowledged claim payment overpayments:**

The Association agrees with \$7,347,355 in claim overpayments. This amount is comprised of the following:

- \$4,665,736 represents claim overpayments for which the BCBS plans have committed to pursue recovery.
- \$2,667,114 represents claim overpayments for which the BCBS plans did not initiate recovery because a) they believed they were restricted by contract limitations or b) that

recovery efforts had been exhausted. However, we continue to question these costs because the BCBS plans are required by contract CS 1039 to attempt recovery regardless of provider contract limitations, or because they have not provided us with documentation supporting that all recovery efforts have been exhausted.

- \$14,505 represents claim overpayments for which the BCBS plans did not initiate recovery because the individual claim lines questioned were under \$100, and the Association does not consider this material. However, the entire overpayment for each of these claims (the sum of all claim lines) is greater than \$100, and therefore we continue to question these costs.

### **Recommendation 1**

We recommend that the contracting officer disallow \$7,347,355 for claim overpayments and verify that the BCBS plans return all amounts recovered to the FEHBP.

### **Recommendation 2 (Rolled-forward from Enrollment Report No. 1A-99-00-15-008 - Open)**

We recommend that the contracting officer require the Association to perform a cost analysis to determine the benefit of automating the process of updating the FEP Express system when identifying enrollment discrepancies between the FEP OC and employing agencies. If determined cost effective, we recommend that the contracting officer require the Association to implement these automated procedures.

### **Recommendation 3**

We recommend that the contracting officer require the Association to implement automated procedures to include family members in the FEP OC's quarterly reconciliation to identify enrollment discrepancies between the FEP OC and employing agencies.

### **Recommendation 4**

We recommend that the contracting officer require the Association to educate contract holders about the rules and regulation requirements for having a qualified family member in the FEHBP.

### **Recommendation 5**

We recommend that the contracting officer require the Association to report any contract holder that misrepresents or provides false enrollment information over a 12-month period. Per contract

CS 1039 Section 1.9(a) and Carrier Letter 2017-13, the Association should report these instances to the applicable employing agency's OIG and OPM OIG's Office of Investigations.

### **Recommendation 6**

We recommend that the contracting officer ensure that the Association's FEP enrollment website contains sufficient controls to detect and identify member eligibility requests for inconsistencies, fraud, and misrepresentation before enrolling in the FEHBP. The FEP OC or BCBS plans should report these member eligibility requests to the appropriate employing federal office or agency. If any request for enrollment is identified as fraud and/or misrepresentation, the Association must report the issue to OPM OIG's Office of Investigations per Carrier Letter 2017-13, as well as the employing agency's OIG.

### **Recommendation 7**

We recommend that the contracting officer ensure that the Association implements a process and procedure to detect and identify fraud and misrepresentation related to online eligibility requests. If any request for enrollment is identified as fraud and/or misrepresentation, the Association must report the issue to OPM OIG's Office of Office of Investigations per Carrier Letter 2017-13, as well as the employing agency's OIG.

## APPENDIX



**BlueCross BlueShield  
Association**

An Association of Independent  
Blue Cross and Blue Shield Plans

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

October 27, 2017

[REDACTED]  
Senior Team Leader  
Experience-Rated Audits Group  
Office of the Inspector General  
U.S. Office of Personnel Management  
1900 E Street, N.W., Room 6400  
Washington, D.C. 20415

**Reference: OPM DRAFT AUDIT REPORT  
Global Claims-to-Enrollment Match  
Audit Report 1A-99-00-17-048**

Dear [REDACTED]:

This attached letter is in response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report concerning the Global Claims-to-Enrollment Match Audit of the FEP Blue Cross Blue Shield Plans. Our comments concerning the recommendations in the report are as follows:

### **Recommendation 1**

We recommend that the contracting officer disallow \$41,786,544 for claims paid on behalf of ineligible patients, and have the BCBS plans return all amounts recovered to the FEHBP.

### **BCBSA Response:**

#### **IR#1A Conflict with Enrollment**

The Plans' completed a review of potential claim overpayments totaling \$35,895,097 paid on behalf of ineligible patients, and determined that claims totaling \$22,742,526 were paid correctly. Plans determined the claims were paid correctly because the member either had coverage when the claim was incurred or had coverage under another member id.

The Plans' review also identified claims totaling \$13,152,572 that were paid in error. For these payment errors, the members initially had coverage before the claim payment; however, the payment subsequently became an overpayment due to retroactive enrollment notices received



from an OPM Payroll Office and processed in the FEP enrollment system after the claim was paid. Of the claims paid in error, the Plans' noted the following:

- Claims totaling \$2,826,395 were determined to be paid in error after a retroactive enrollment change was received and processed and recovery was initiated after the audit began. Recovery has been initiated in accordance with CS1039, Section 2.3(g).
- Claims totaling \$5,312,077 were determined to be paid in error after a retroactive enrollment change was received and processed; however, the claims were recovered before the audit started.
- Claims totaling \$325,631 were determined to be paid in error after a retroactive enrollment change was received and processed; however, recovery was not initiated because the claim payment was less than \$100. CS1039, Section 2.6 (g) states "The benefits payable by this Plan shall be determined, on a claim by claim basis, only for those claims in excess of \$100, except where Medicare is the primary payer of benefits, claims in excess of \$50".
- Claims totaling \$4,688,469 were determined to be paid in error after a retroactive enrollment change was received and processed; however, recovery was initiated before the audit began and the overpayment was determined to be uncollectible or not recovered by the time the response to the Draft Report was submitted. Recovery documentation was also provided to support that Plans completed due diligence overpayment recovery procedures as required by CS1039, Section 2.3g, where applicable.

#### **IR#1B No Enrollment Record on File**

The Plans' completed a review of potential claim overpayments totaling \$5,891,447 paid for members where there appeared to be no record of enrollment on file, and determined that claims totaling \$4,550,569 were paid correctly. Plans determined the claims were paid correctly because the member either had coverage when the claim was incurred or had coverage under another member id.

The Plans' review also identified claims totaling \$1,340,878 that were paid in error. For these payment errors, the members initially had coverage before the claim payment; however, the payment subsequently became an overpayment due to retroactive enrollment notices received from an OPM Payroll Office and processed in the FEP enrollment system after the claim was paid. Of the claims paid in error, the Plans' noted the following:

- Claims totaling \$371,672 were determined to be paid in error after a retroactive enrollment change was received and processed; however recovery was not initiated on these overpayments before the audit began. Recovery has been initiated in accordance with CS1039, Section 2.3(g), where applicable.

- Claims totaling \$370,987 were determined to be paid in error after a retroactive enrollment change was received and processed; however, the claims were recovered before the audit started.
- Claims totaling \$36,671 were determined to be paid in error after a retroactive enrollment change was received and processed; however, recovery was not initiated because the claim payment was less than \$100. CS1039, Section 2.6 (g) states “The benefits payable by this Plan shall be determined, on a claim by claim basis, only for those claims in excess of \$100, except where Medicare is the primary payer of benefits, claims in excess of \$50”.
- Claims totaling \$561,548 were determined to be paid in error after a retroactive enrollment change was received and processed; however, recovery was initiated before the audit began and the overpayment was determined to be uncollectible or not recovered by the time the response to the Draft Report was submitted. Recovery documentation was also provided to support that Plans completed due diligence overpayment recovery procedures as required by CS1039, Section 2.3g, where applicable.

## **Recommendation 2**

We recommend that the contracting officer instruct the Association perform an analysis to identify the root cause(s) of the claim payment errors and implement corrective actions/procedures to prevent these types of errors from occurring in the future.

### **BCBSA Response:**

BCBSA is in the process of reviewing claims identified as overpayments and expects to have the analysis completed (including completion of a root cause analysis) by 1<sup>st</sup> quarter 2018.

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

If you have any question, please contact [REDACTED] at [REDACTED].

Sincerely,

[REDACTED]  
Executive Director, FEP Program Integrity



## **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:

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Washington Metro Area: (202) 606-2423

**By Mail:** Office of the Inspector General  
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