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

Final Audit Report

Subject:

AUDIT OF
HEALTH CARE SERVICE CORPORATION
CHICAGO, ILLINOIS

Report No. 1A-10-17-13-019

Date: March 28, 2014

--CAUTION--

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AUDIT REPORT

Federal Employees Health Benefits Program
Service Benefit Plan Contract CS 1039
BlueCross BlueShield Association
Plan Code 10

Health Care Service Corporation
Plan Codes 121/621, 290/790, 340/840, and 400/900
Illinois, New Mexico, Oklahoma, and Texas

REPORT NO. 1A-10-17-13-019 DATE: March 28, 2014

Michael R. Esser
Assistant Inspector General
for Audits

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EXECUTIVE SUMMARY

Federal Employees Health Benefits Program
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Plan Codes 121/621, 290/790, 340/840, and 400/900
Illinois, New Mexico, Oklahoma, and Texas

REPORT NO. 1A-10-17-13-019 DATE: March 28, 2014

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at the Health Care Service Corporation (Plan), which included the BlueCross BlueShield (BCBS) plans of Illinois, New Mexico, Oklahoma and Texas, questions $14,413,248 in health benefit charges, cash management activities, and lost investment income (LII). The report also includes a procedural finding regarding the Plan's Fraud and Abuse (F&A) Program. The BlueCross BlueShield Association (Association) agreed ***(A)*** with $12,776,725 and disagreed ***(D)*** with $1,636,523 of the questioned amounts, and partially agreed with the procedural finding regarding the Plan's F&A Program.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered miscellaneous health benefit payments and credits from 2009 through September 30, 2012, as well as administrative expenses from 2009 through 2011 as reported in the Annual Accounting Statements for the BCBS plans of Illinois, New Mexico, Oklahoma, and Texas. In addition, we reviewed the Plan's cash management activities and practices related to FEHBP funds from 2009 through September 30, 2012 and the Plan's F&A Program from January 1, 2013 through June 30, 2013. Due to a significant error identified in the Plan's letter of credit account (LOCA) drawdown adjustment process, we expanded our scope for this specific LOCA drawdown error to cover the period April 1, 2002 through June 30, 2013.

The audit results are summarized as follows:

MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

- **Unidentified Refunds *(A)*** **$81,555**

  Our audit determined that the Plan had not returned unidentified refunds of $75,472 to the FEHBP. As a result of this finding, the Plan returned $81,555 to the FEHBP, consisting of $75,472 for the questioned unidentified refunds and $6,083 for applicable LII on these funds not previously returned to the FEHBP.

- **Medical Drug Rebates *(A)*** **$14,642**

  Our audit determined that the Plan returned medical drug rebates, totaling $2,373,700, to the FEHBP in an untimely manner during the audit scope. As a result of this finding, the Plan returned $14,642 to the FEHBP for applicable LII on these medical drug rebates.

ADMINISTRATIVE EXPENSES

The audit disclosed no findings pertaining to administrative expenses. Overall, we concluded that the Plan's administrative expenses charged to the FEHBP were actual, allowable, necessary, and reasonable expenses incurred in accordance with Contract CS 1039 and applicable laws and regulations.

CASH MANAGEMENT

- **Letter of Credit Account Overdraws** **$14,317,051**

  The Plan inadvertently overdrew $12,236,424 in funds from the LOCA during the period April 1, 2002 through June 12, 2013. In addition, LII totaled $2,080,627 on these LOCA overdraws. As a result of this finding, the Plan returned $12,680,528 to the FEHBP, consisting of $12,236,424 for the questioned LOCA overdraws and $444,104 of the questioned LII. However, the Plan still owes the FEHBP $1,636,523, which is the remaining balance of the questioned LII. The Association agreed with $12,680,528 ***(A)*** and disagreed with $1,636,523 ***(D)*** of these questioned amounts.

FRAUD AND ABUSE PROGRAM

- **Special Investigations Department** **Procedural**

  The Plan is not in compliance with the communication and reporting requirements for fraud and abuse cases that are set forth in Contract CS 1039 and FEHBP Carrier Letter 2011-13. Specifically, the Plan did not report, or did not timely report, all fraud and abuse cases to the Office of Personnel Management's Office of the Inspector General (OIG). The Plan's non-compliance may be due in part to incomplete and/or untimely reporting of fraud and abuse cases to the Association's Federal Employee Program Director's Office (FEPDO), as well as inadequate controls at the FEPDO to monitor and communicate the Plan's cases to the OIG.

Without awareness of these existing potential fraud and abuse issues, the OIG cannot investigate the broader impact of these potential issues on the FEHBP as a whole. The Association partially agreed with this procedural finding.

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I. INTRODUCTION AND BACKGROUND

INTRODUCTION

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 the Health Care Service Corporation (HCSC or Plan) pertaining to the BlueCross BlueShield (BCBS) plans of Illinois, New Mexico, Oklahoma, and Texas. The Plan's headquarters are located in Chicago, Illinois.

The audit was performed by the Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

BACKGROUND

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), 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. HCSC includes 4 of the 64 local BCBS plans participating in the FEHBP.

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 BlueCross and BlueShield plans, and OPM.

The Association has also established an FEP Operations Center. The activities of the FEP Operations Center are performed by CareFirst BlueCross BlueShield, located in Washington, D.C. 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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[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.

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

The following were the most recent audit reports issued for HCSC pertaining to the BCBS plans of Illinois, New Mexico, Oklahoma, and/or Texas:

- Report No. 1A-10-83-08-018, HCSC (BCBS of Oklahoma), dated January 9, 2009
- Report No. 1A-99-00-07-043, HCSC (BCBS of Illinois and Texas), dated September 5, 2008
- Report No. 1A-10-03-06-079, HCSC (BCBS of New Mexico), dated June 5, 2007

All findings from these previous audits of HCSC, covering various contract years from 2002 through 2007, 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 September 26, 2013; and were presented in detail in a draft report, dated October 9, 2013. The Association's comments offered in response to this 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 Plan on various dates through January 27, 2014 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 promptly 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 regulations.

Cash Management

- To determine whether the Plan handled FEHBP funds in accordance with 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 were in compliance with the terms of Contract CS 1039 and the applicable FEHBP Carrier Letters.

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 as they pertain to Plan codes 121/621 (BCBS of Illinois), 290/790 (BCBS of New Mexico), 340/840 (BCBS of Oklahoma), and 400/900 (BCBS of Texas) for contract years 2009 through 2012. During this period, the Plan paid approximately $10.3 billion in health benefit charges and $536 million in administrative expenses for these four BCBS plans (See Figure 1 and Schedule A).

Specifically, we reviewed miscellaneous health benefit payments and credits (e.g., refunds, medical drug rebates, and fraud recoveries) and cash management activities from 2009 through September 30, 2012 for these four BCBS plans, as well as administrative expenses from 2009 through 2011. We also reviewed the Plan's F&A Program practices for the BCBS plans of Illinois and Texas from January 1, 2013 through June 30, 2013. Due to a significant error identified in the Plan's letter of credit account (LOCA) drawdown adjustment process, we expanded our audit scope for this specific LOCA drawdown adjustment error to cover the period April 1, 2002 through June 30, 2013.

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 any significant matters involving the Plan's internal control structure and its operations, except for the Plan's processing of LOCA drawdown adjustments (See the audit finding for the "Letter of Credit Account Overdraws" (C1) on pages 9 through 13).

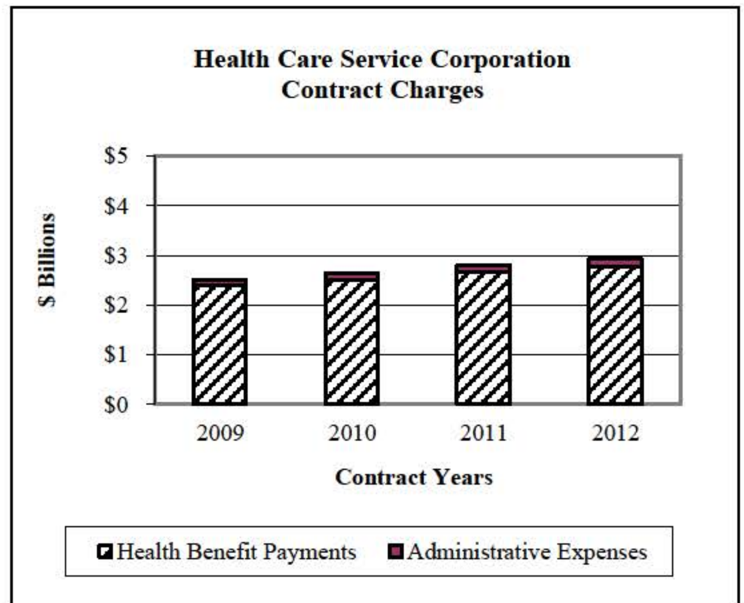

Figure 1 - Contract Charges

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 procurement 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 FEP Director's Office and the Plan. Due to time constraints, we did not verify the reliability of the data generated by the various information systems involved. However, while utilizing the

computer-generated data during our audit testing, 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 was performed at the Plan's offices in Chicago, Illinois and Richardson, Texas on various dates from May 7, 2013 through July 26, 2013. Audit fieldwork was also performed at our offices in Jacksonville, Florida; Cranberry Township, Pennsylvania; and Washington, D.C.

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. We also judgmentally selected and reviewed 300 high dollar health benefit refunds, totaling $37,026,330 (from a universe of 354,308 refunds, totaling $260,417,858); 16 special plan invoices (SPI), totaling $23,930,051 in net FEP credits (from a universe of 513 SPI's, totaling $33,787,193 in net FEP credits); all FEP medical drug rebate amounts, totaling $3,259,340; 10 high dollar fraud recoveries, totaling $1,001,106 (from a universe of 66 recoveries, totaling $1,364,903); and all unidentified refunds allocated to the FEP, totaling $230,813, for the purpose of determining if refunds and recoveries were promptly returned to the FEHBP and if miscellaneous payments were properly charged to the FEHBP.[2] The results of these samples were not projected to the universe of miscellaneous health benefit payments and credits.

We judgmentally reviewed administrative expenses charged to the FEHBP for contract years 2009 through 2011. Specifically, we reviewed administrative expenses relating to cost centers, natural accounts, out-of-system adjustments, prior period adjustments, pension, post-retirement, executive compensation, non-recurring projects, mergers and acquisitions, gains and losses, return on investment, inter-company profits, subcontracts, and the Health Insurance Portability and Accountability Act of 1996. We used the FEHBP contract, the FAR, and the FEHBAR 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 regulations. We also interviewed the Plan's Special Investigations Department regarding the effectiveness of the F&A Program. For the BCBS plans of Illinois and Texas, we also reviewed the Plan's communication and reporting of fraud and abuse cases to test compliance with Contract CS 1039 and the applicable FEHBP Carrier Letters.

[2] The sample of health benefit refunds included the 15 highest dollar refund receipts and the 5 highest dollar provider offsets from each year in the audit scope for each of the BCBS plans in Illinois, Oklahoma, and Texas. The sample of health benefit refunds also included the 10 highest dollar refund receipts and the 5 highest dollar provider offsets from each year in the audit scope for BCBS of New Mexico. For the SPI sample, we selected the SPI with highest miscellaneous FEP payment or credit amount from each year in the audit scope for each BCBS plan. For the sample of fraud recoveries, we selected all recoveries of $40,000 or more.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

1. Unidentified Refunds $81,555

Our audit determined that the Plan had not returned unidentified refunds of $75,472 to the FEHBP. As a result of this finding, the Plan returned $81,555 to the FEHBP, consisting of $75,472 for the questioned unidentified refunds and $6,083 for applicable LII on these funds.

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

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

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 as provided in Section 611 of the Contract Disputes Act of 1978 (Public Law 95-563), which is applicable to the period in which the amount becomes due, as provided in paragraph (e) of this clause, and then at the rate applicable for each six-month period as fixed by the Secretary until the amount is paid."

For the period January 1, 2009 through September 30, 2012, the Plan's unidentified refunds totaled $3,191,182. The Plan allocates the unidentified refunds to all lines of business, including FEP on a quarterly basis. For the scope of the audit, the Plan allocated a total of $230,813 of these unidentified refunds to the FEHBP. We selected and reviewed all of the unidentified refunds for the purpose of determining if the Plan properly allocated and promptly returned these refunds to the FEHBP.

Based on our review, we determined that the Plan had not returned $75,472 in quarterly unidentified refund amounts to the FEHBP. The following summarizes the questioned unidentified refund amounts and applicable LII by BCBS plan:

- For BCBS of Texas, the Plan had not returned five quarterly unidentified refund allocation amounts, totaling $35,840, to the FEHBP. As a result of this finding, the Plan returned $38,725 to the FEHBP, consisting of $35,840 for these questioned unidentified refunds and $2,885 for applicable LII. We reviewed and accepted the Plan's LII calculation.

- For BCBS of Illinois, the Plan had not returned five quarterly unidentified refund allocation amounts, totaling $26,273, to the FEHBP. As a result of this finding, the Plan returned $28,391 to the FEHBP, consisting of $26,273 for these questioned unidentified refunds and $2,118 for applicable LII. We reviewed and accepted the Plan's LII calculation.

- For BCBS of Oklahoma, the Plan had not returned five quarterly unidentified refund allocation amounts, totaling $10,514, to the FEHBP. As a result of this finding, the Plan returned $11,365 to the FEHBP, consisting of $10,514 for these questioned unidentified refunds and $851 for applicable LII. We reviewed and accepted the Plan's LII calculation.

- For BCBS of New Mexico, the Plan had not returned five quarterly unidentified refund allocation amounts, totaling $2,845, to the FEHBP. As a result of this finding, the Plan returned $3,074 to the FEHBP, consisting of $2,845 for these questioned unidentified refunds and $229 for applicable LII. We reviewed and accepted the Plan's LII calculation.

In total, the Plan returned $81,555 to the FEHBP as a result of this finding, consisting of $75,472 ($35,840 plus $26,273 plus $10,514 plus $2,845) for the questioned unidentified refunds and $6,083 ($2,885 plus $2,118 plus $851 plus $229) for applicable LII on these funds not previously returned to the FEHBP.

Association's Response:

The Association agrees with this finding. The Association states that the Plan returned the questioned unidentified refunds to the FEHBP on October 11, 2013. The Association also states that the Plan submitted SPI's to the Association on December 18, 2013 to return the applicable LII to the FEHBP.

OIG Comments:

The Plan provided documentation supporting that the questioned unidentified refunds of $75,472 were returned to the LOCA on October 9, 2013. Also, the Plan wire transferred LII of $6,083 to the Association's FEP joint operating account on January 15, 2014. The Association then wired transferred this LII amount to OPM on January 23, 2014.

Recommendation 1

Since we verified that the Plan returned $75,472 to the FEHBP for the questioned unidentified refunds, no further action is required for this amount.

Recommendation 2

Since we verified that the Plan returned $6,083 to the FEHBP for the questioned LII on the unidentified refunds, no further action is required for this LII amount.

2. Medical Drug Rebates **$14,642**

Our audit determined that the Plan returned medical drug rebates, totaling $2,373,700, to the FEHBP in an untimely manner during the audit scope. As a result of this finding, the Plan returned $14,642 to the FEHBP for applicable LII on these medical drug rebates.

As previously stated under A1, the Plan is required to promptly return these medical drug rebates to the FEHBP with applicable LII.

The Plan participates in a medical drug rebate program with the manufacturers of the [redacted]. [redacted] rebates are determined based on medical claims for these drugs, which are administered in physicians' offices. The medical drug rebates are received multiple times a year (usually on a quarterly basis) by the Plan and credited to the participating groups, including the FEP. From January 1, 2009 through September 30, 2012, the Plan received medical drug rebates totaling [redacted] The Plan allocated $3,259,340 of these medical drug rebates to the FEP. We selected and reviewed all of the FEP medical drug rebate amounts for the purpose of determining if the Plan properly allocated and promptly returned these rebates to the FEHBP.

The following are the exceptions noted (itemized by BCBS plan):

- For BCBS of Texas, the Plan returned medical drug rebates, totaling $1,317,149, untimely to the FEHBP during the audit scope. Therefore, we calculated LII of $8,410 on these medical drug rebates. As a result of this finding, the Plan returned this LII amount to the FEHBP.

- For BCBS of Illinois, the Plan returned medical drug rebates, totaling $504,831, untimely to the FEHBP during the audit scope. Therefore, we calculated LII of $2,960 on these medical drug rebates. As a result of this finding, the Plan returned this LII amount to the FEHBP.

- For BCBS of Oklahoma, the Plan returned medical drug rebates, totaling $459,399, untimely to the FEHBP during the audit scope. Therefore, we calculated LII of $2,740 on these medical drug rebates. As a result of this finding, the Plan returned this LII amount to the FEHBP.

- For BCBS of New Mexico, the Plan returned medical drug rebates, totaling $92,321, untimely to the FEHBP during the audit scope. Therefore, we calculated LII of $532 on these medical drug rebates. As a result of this finding, the Plan returned this LII amount to the FEHBP.

In total, the Plan returned LII of $14,642 ($8,410 plus $2,960 plus $2,740 plus $532) to the FEHBP as a result of this finding.

Association's Response:

The Association agrees with this finding. The Association states that the Plan submitted SPI's on October 29, 2013 to return the questioned LII to the FEHBP. The Association also states that the Plan is reviewing its procedures for the timely allocation of medical drug rebates to the FEP and will make any necessary updates to the procedures by March 31, 2014.

OIG Comments:

The Plan provided documentation supporting that the questioned LII amounts, totaling $14,642, were returned to the FEHBP through LOCA drawdown adjustments on November 18 and November 19, 2013.

Recommendation 3

Since we verified that the Plan returned $14,642 to the FEHBP for the questioned LII on the untimely medical drug rebates, no further action is required for this LII amount.

B. ADMINISTRATIVE EXPENSES

The audit disclosed no findings pertaining to administrative expenses. Overall, we concluded that the Plan's administrative expenses charged to the FEHBP were actual, allowable, necessary, and reasonable expenses incurred in accordance with Contract CS 1039 and applicable laws and regulations.

C. CASH MANAGEMENT

1. Letter of Credit Account Overdraws — $14,317,051

The Plan inadvertently overdrew $12,236,424 in funds from the LOCA during the period April 1, 2002 through June 12, 2013. In addition, LII totaled $2,080,627 on these LOCA overdraws. As a result of this finding, the Plan returned $12,680,528 to the FEHBP, consisting of $12,236,424 for the questioned LOCA overdraws and $444,104 of the questioned LII.

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."

Regarding reportable monetary findings, Contract CS 1039, Part III, section 3.16, 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 identified . . . and corrected (i.e., overcharges returned to the FEHBP) prior to audit notification."

As previously stated under section A1, the Plan is required to promptly return these LOCA overdraws to the FEHBP with applicable LII.

For the period 2009 through September 30, 2012, the Plan withdrew $9,610,317,852 from the LOCA for the BCBS plans of Illinois, New Mexico, Oklahoma, and Texas. From this universe, we selected and reviewed a judgmental sample of 120 LOCA drawdown amounts, totaling $363,456,789 in reimbursements, for the purpose of determining if these drawdown amounts were appropriate and adequately supported.[3]

While reviewing the audit sample and the Plan's LOCA drawdown worksheets, we identified unusual or non-typical adjustments on the drawdown worksheets. These adjustments were referred to as "non-pursue" amounts on the Plan's LOCA drawdown worksheets. We immediately followed-up with the Plan to obtain an understanding of these adjustments as well as applicable supporting documentation. After receiving our follow-up requests on May 15, 2013 regarding these adjustments, the Plan researched and identified an error in the LOCA drawdown adjustment process for the "non-pursue" amounts. This error resulted from the Plan's attempt to reverse non-FEP refunds that were originally credited to the FEHBP. In each instance, while attempting to recover these non-FEP refunds from the LOCA, the Plan inadvertently reversed the amount twice during the LOCA drawdown adjustment process, resulting in a LOCA overdraw.

The Plan performed a thorough analysis of this error and implemented corrective actions immediately in June and July 2013, changing the LOCA drawdown adjustment process and returning $12,236,424 to the FEHBP for the applicable LOCA overdraws. Based on the Plan's analysis, these LOCA overdraws occurred from April 1, 2002 through June 12, 2013 for the BCBS plans of Illinois and New Mexico; July 1, 2003 through June 12, 2013 for BCBS of Texas; and September 1, 2006 through June 12, 2013 for BCBS of Oklahoma.[4] The Plan also calculated LII of $2,080,627 on these LOCA overdraws.

The following is a summary of the Plan's analysis of the LOCA overdraws and calculated LII amounts for the BCBS plans of Illinois, New Mexico, Oklahoma, and Texas.

BCBS Plan	LOCA Overdraws (Apr 2002 – Dec 2008)	LOCA Overdraws (Jan 2009 – Sep 2012)	LOCA Overdraws (Oct 2012 – Jun 2013)	Total LOCA Overdraws (Apr 2002 – Jun 2013)	Total Calculated LII	Total Questioned by OIG (LOCA Overdraws + LII)
Illinois	$2,510,641	$2,619,334	$698,454	$5,828,429	$1,002,809	$6,831,238
Texas	2,315,830	2,416,366	387,081	5,119,277	835,872	5,955,149
New Mexico	369,085	254,323	26,289	649,697	178,983	828,680
Oklahoma	232,080	328,203	78,738	639,021	62,963	701,984
Total	**$5,427,636**	**$5,618,226**	**$1,190,562**	**$12,236,424**	**$2,080,627**	**$14,317,051**

[3] For the BCBS plans of Illinois and Texas, we selected 10 LOCA drawdown amounts from each year in the audit scope for each of these plans. For the BCBS plans of New Mexico and Oklahoma, we selected five LOCA drawdown amounts from each year in the audit scope for each of these plans. In total, we selected 40 LOCA drawdown amounts, totaling $102,633,645 (from a total of $2,299,459,975) for BCBS of Illinois; 20 LOCA drawdown amounts, totaling $9,328,213 (from a total of $421,155,270) for BCBS of New Mexico; 20 LOCA drawdown amounts, totaling $29,838,831 (from a total of $1,521,613,941) for BCBS of Oklahoma; and 40 LOCA drawdown amounts, totaling $221,656,100 (from a total of $5,368,088,666) for BCBS of Texas.

[4] Although we initially expanded the audit scope to also include the LOCA drawdowns from January 2007 through December 2008 and October 2012 through June 2013 with this specific type of LOCA drawdown adjustment error, the Plan took the initiative to also identify all LOCA overdraws from April 2002 through December 2006 with this error.

We reviewed and accepted the Plan's analysis of the LOCA overdraws for the BCBS plans of Illinois, New Mexico, Oklahoma, and Texas as well as the Plan's calculated LII amounts. As part of our review, we also verified the following corrective actions by the Plan:

- For BCBS of Illinois, the Plan returned the questioned overdraws of $5,828,429 to the FEHBP through LOCA drawdown adjustments on July 8 and July 10, 2013. Also, the Plan returned LII of $153,940 to the FEHBP through multiple LOCA drawdown adjustments from August 6 through October 18, 2013.

- For BCBS of Texas, the Plan returned the questioned overdraws of $5,119,277 to the FEHBP through LOCA drawdown adjustments on July 5 and July 10, 2013. Also, the Plan returned LII of $229,449 to the FEHBP through multiple LOCA drawdown adjustments from August 22 through October 18, 2013.

- For BCBS of New Mexico, the Plan returned the questioned overdraws of $649,697 to the FEHBP through multiple LOCA drawdown adjustments from July 5 through July 15, 2013. Also, the Plan returned LII of $22,849 to the FEHBP through multiple LOCA drawdown adjustments from August 6 through October 18, 2013.

- For BCBS of Oklahoma, the Plan returned the questioned overdraws of $639,021 to the FEHBP through multiple LOCA drawdown adjustments from July 5 through July 15, 2013. Also, the Plan returned LII of $37,866 to the FEHBP through multiple LOCA drawdown adjustments from August 6 through October 18, 2013.

As a result of this finding, the Plan returned $12,680,528 to the FEHBP, consisting of $12,236,424 ($5,828,429 plus $5,119,277 plus $649,697 plus $639,021) for the questioned LOCA overdraws and $444,104 ($153,940 plus $229,449 plus $22,849 plus $37,866) for LII. However, the Plan still owes the FEHBP $1,636,523, which is the remaining balance of the questioned LII.

Association's Response:

The Association agrees with $12,236,424 for the questioned LOCA overdraws and $444,104 of the questioned LII. However, the Association disagrees with $1,636,523 ($2,080,627 minus $444,104) of the questioned LII.

The Association states, "The Plan feels it is important to note that HCSC was the party that actually discovered the LOCA draw errors and notified OPM OIG . . . of the issue. While reviewing the requested audit samples and worksheets, the OIG auditors asked some preliminary questions regarding those LOCA worksheets. The Plan provided the answers to these questions and proactively performed some additional research which identified the error in the LOCA draws. The Plan then brought this to the attention of the OIG auditors. If the Plan had not performed this additional research, it is uncertain whether the OIG auditors would have identified this issue. The Plan went beyond the audit inquiry and performed additional research and then voluntarily communicated this

issue to OIG . . . We do not dispute the description of the error. We also do not dispute the calculations of the total LOCA overdraw amounts and associated LII amounts covering the period beginning in April 2002. LII was returned to the FEHBP on October 21, 2013, and based on the contract, we disagree with how much LII OIG claims should be returned to the Program.

Contract CS 1039 requires LII to be paid to FEHBP in the event of an improper allocation or draw from the LOCA. The Plan acknowledges that inadvertent overdraws occurred, and agrees with OIG's calculations of total LII applicable to the mistaken overdraws from April 2002 to June 12, 2013.

To date, the Plan has paid $444,104, representing LII calculations from January 1, 2008 to July 10, 2013 . . . This repayment represents the amount that OPM can legally claim under Contract CS 1039. The Contract does not obligate the return of any funds, whether unsupported LOCA draws or applicable LII, that arose outside the contractual audit disputes limitations period. Specifically, Section 4.4 . . . of CS 1039 provides in pertinent part that a claim seeking money '*shall not be made more than five years following the last day prescribed by the contract for filing the calendar year Annual Accounting Statement for the year with respect to which the claim arises*.' Based on this contractual limitation, the correct starting point for return of mistaken LOCA overdraws as well as payment of associated LII would be for claims subject to and contained in the Annual Accounting Statement for calendar year beginning January 1, 2008, the last date to file such statement being April 30, 2009. As such, the Plan has paid all that is recoverable by OPM relating to LII on the inadvertent LOCA overdraws, and the LOCA overdraws and LII prior to January 1, 2008, are contractually barred from claim by OPM. Notwithstanding, the Plan has already returned the LOCA overdraws for the entire time frame extending back to April 2002, and we do not intend to disturb that repayment. However, the clear terms of the contract with respect to the non-recoverable LII for dates preceding January 1, 2008 bar further claim by OPM for such amounts."

OIG Comments:

Just to reiterate, these questioned LOCA overdraws by the Plan were identified as a result of our audit. It is true that these LOCA overdraw errors were found by the Plan while doing additional research. However, this research was a direct result of questions from the OIG auditors.

We verified that the Plan returned the questioned LOCA overdraws of $12,236,424 to the FEHBP via multiple LOCA drawdown adjustments from July 5 through July 15, 2013. Additionally, we verified that the Plan returned $444,104 of the questioned LII to the FEHBP via multiple LOCA drawdown adjustments from August 6 through October 18, 2013 to the FEHBP.

Regarding the contested LII amount of $1,636,523, we disagree with the Plan's position that the LOCA overdraws from April 2002 through December 2007 are not subject to LII repayment because these overdraws occurred outside the contractual "audit disputes"

limitation period. The Association's cited clause from Section 4.4 of Contract CS 1039 does not negate the LII owed by the Plan on these LOCA overdraws, but only limits in most circumstances the government's ability to obtain a judgment. The Plan maintained these LOCA overdraws in a corporate account(s) and earned interest (probably comparable to the contested LII amount) on these FEHBP funds. 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 applicable to the LOCA overdraws that occurred from April 2002 through December 2007.

Recommendation 4

Since we verified that the Plan returned $12,236,424 to the FEHBP for the questioned LOCA overdraws, no further action is required for this amount.

Recommendation 5

We recommend that the contracting officer require the Plan to return $2,080,627 to the FEHBP for LII on the questioned LOCA overdraws. (Note: We already verified that the Plan has returned $444,104 of the questioned LII to the FEHBP. Thus, the remaining amount due is $1,636,523.)

D. FRAUD AND ABUSE PROGRAM

1. Special Investigations Department — Procedural

The Plan is not in compliance with the communication and reporting requirements for fraud and abuse cases that are set forth in Contract CS 1039 and FEHBP Carrier Letter (CL) 2011-13. Specifically, the Plan did not report, or did not timely report, all fraud and abuse cases to the OIG. The Plan's non-compliance may be due in part to incomplete and/or untimely reporting of fraud and abuse cases to the Association's FEP Director's Office (FEPDO), as well as inadequate controls at the FEPDO's Special Investigations Unit (SIU) to monitor and communicate the Plan's FEP fraud and abuse cases to the OIG. Without awareness of existing potential fraud and abuse issues, the OIG cannot investigate the broader impact of these potential issues on the FEHBP as a whole.

Contract CS 1039 Section 1.9 (a) requires the Plan to "operate a system designed to detect and eliminate fraud and abuse . . . by providers providing goods or services to FEHB Members, and by individual FEHB Members." Section 1.10 (a)(12) requires the Carrier to notify the contracting officer of any significant events, which includes instances of fraud, within 10 working days after they become aware of it.

CL 2011-13 (Mandatory Information Sharing via Written Case Notifications to OPM's Office of the Inspector General), dated June 17, 2011, states that all Carriers "are required to submit a written notification to the OPM OIG . . . within 30 working days of becoming aware of a fraud, waste or abuse issue where there is a reasonable suspicion

that a fraud has occurred or is occurring against the Federal Employees Health Benefits (FEHB) Program." There is no dollar threshold for this requirement.

We reviewed the Plan's Special Investigations Department pertaining to the BCBS plans of Illinois and Texas. During the period January 1, 2013 through June 30, 2013, BCBS of Illinois opened 45 fraud and abuse cases. Of these, we identified and reviewed 27 cases with FEP exposure. BCBS of Texas only opened 12 fraud and abuse cases. However, all 12 of these cases were reported as having FEP exposure. For the BCBS plans of Illinois and Texas, we reviewed all of these fraud and abuse cases for the purpose of determining if the cases were properly reported to the OIG as required by Contract CS 1039 and CL 2011-13.

The following exceptions were noted (itemized by BCBS plan):

- For BCBS of Illinois, we determined that notifications for only 2 of the 27 fraud and abuse cases with FEP exposure were sent to the OIG. Because all of these cases had FEP exposure and there is no dollar threshold for reporting suspected fraud against the FEHBP, these cases should have been reported to the OIG as required by CL 2011-13.

  BCBS of Illinois' non-compliance with the reporting and communication requirements in Contract CS 1039 and CL 2011-13 may be due, in part, to this plan's untimely or inadequate communication of potential FEP fraud and abuse cases to the FEPDO's SIU. The FEPDO sends notifications of fraud and abuse cases to the OIG on behalf of the Plan. To that end, the Plan must first report the fraud and abuse cases with FEP exposure to the FEPDO's SIU, which is accomplished via entry of the case into the Fraud Information Management System (FIMS).[5] The FEPDO's internal policies and procedures require the Plan to enter cases into FIMS as soon as an investigation is opened and/or within 30 days of any relevant FEP fraud activity. However, of the 27 cases with FEP exposure, we determined that 11 cases were entered into FIMS untimely. Without timely FIMS case entries by the Plan and/or BCBS of Illinois, the FEPDO's SIU cannot meet the FEHBP's contractual reporting and communication requirements. As a result of our audit, we noted that BCBS of Illinois updated its fraud and abuse policies and procedures to report all FEP fraud and abuse cases to the FEPDO as soon as there is reason to believe that fraud exists.

- For BCBS of Texas, we determined that notifications for only 4 of the 12 fraud and abuse cases with FEP exposure were sent to the OIG. We noted that this plan enters all preliminary inquiries, regardless of dollar amount, into FIMS as required by Contract CS 1039 and CL 2011-13. Although this plan is meeting its contractual obligations, the FEPDO is not notifying the OIG of these cases. Because all of the cases had FEP exposure, and there is no dollar threshold for reporting suspected fraud against the FEHBP, these cases should have been reported to the OIG as required by CL 2011-13.

[5] FIMS is a multi-user, web-based case-tracking database developed in-house by the FEPDO's SIU.

BCBS of Texas' non-compliance with the reporting and communication requirements in Contract CS 1039 and CL 2011-13 may be due, in part, to this plan's untimely or inadequate communication of potential FEP fraud and abuse cases to the FEPDO. Of the 12 cases with FEP exposure, we determined that 2 cases were entered into FIMS untimely. Without timely FIMS case entries by the Plan and/or BCBS of Texas, the FEPDO cannot meet the FEHBP's reporting and communication requirements. We also determined that the remaining 10 cases with FEP exposure were entered into FIMS timely, but the FEPDO did not report most of these cases to the OIG as required by CL 2011-13.

Ultimately, the Plan's untimely reporting of potential FEP cases to the FEPDO's SIU and the FEPDO's inadequate controls to monitor the Plan's FIMS entries and notify the appropriate entities of these cases have resulted in a failure to meet the communication and reporting requirements that are set forth in Contract CS 1039 and CL 2011-13. The lack of referrals and/or untimely case notifications did not allow the OIG to investigate whether other FEHBP carriers are exposed to the identified provider committing fraud against the FEHBP. It also does not allow the OIG's Administrative Sanctions Group to be notified timely. Consequently, this non-compliance by the Plan and FEPDO may result in additional improper payments being made by other FEHBP Carriers.

Association's Response:

The Association states, "The Plan continues to disagree with the statement that it is not in compliance with the communication and reporting requirements set forth in Contract CS 1039 and the Federal Employee Health Benefit Program (FEHBP) Carrier Letter (CL) 2011-13. BCBSA also disagrees that controls to Plans FIMS entries are inadequate.

The FEPDO and the Plan have created a system of controls to monitor, identify, investigate and recover fraudulent and abusive payments of FEHBP funds and is substantially in compliance with the requirements of CS 1039. Further, the Plan's FEP Fraud and Abuse Program is designed to protect patient safety and the health care assets of Federal beneficiaries."

OIG Comments:

We disagree that, during the audit scope, the Plan was in compliance with the communication and reporting requirements that are set forth in the FEHBP contract and CL 2011-13. For example, we identified 39 cases with FEP exposure during the period January 1, 2013 through June 30, 2013 for the BCBS plans of Illinois and Texas. Of these, we determined that 13 cases were entered untimely into FIMS. As a result, these cases were communicated untimely to the OIG. Additionally, many of the cases with FEP exposure were entered timely into FIMS by the plans, but were not communicated to the OIG in a timely manner by the FEPDO. However, we acknowledge that the Plan is implementing corrective actions to improve their policies and procedures.

The Association states that they have created a system of controls and processes that monitor, identify, investigate and recover fraudulent and abusive payments of FEP funds. We disagree. The FEPDO has not provided any specific details as to what oversight function they perform of this Plan, including the timely reporting of cases in FIMS and the reporting of financial impacts in FIMS.

Recommendation 6

We recommend that the contracting officer require the Association to provide evidence or supporting documentation ensuring that the Plan has implemented the necessary procedural changes to meet the communication and reporting requirements of fraud and abuse cases that are set forth in Contract CS 1039 and CL 2011-13. We also recommend that the contracting officer instruct the Association to provide the Plan with more oversight to ensure the timely and complete entry of all FEP fraud and abuse cases into FIMS, and concurrently, timely and complete communication of those cases to the OIG.

Association's Response:

The Association states, "On May 20th, 2013, the Plan's Special Investigations Department (SID) updated their internal Policy and Procedure manual with regard to the notification of investigative activities. Specifically, this approved change will direct SID investigators in all HCSC plans to promptly report information into FIMS wherein there is a reasonable suspicion of fraud involving FEHBP claims. This would include both preliminary and full investigations regardless of the dollar amount of FEHBP claims."

The Association also states, "In order to ensure that the Plan implements policy changes made during the review BCBSA implemented a revised Plan monitoring process as of October 31, 2013. The BCBSA FEPDO will review the Plan's SIU activities and revised policies and procedures by February 15, 2014 and work with the Plan to implement any additional corrective actions necessary."

Recommendation 7

To ensure that all FEHBP Carriers are reporting statistics to OPM based on the same definitions, we recommend that the contracting officers prepare and distribute to all Carriers the definitions for the terms "fraud", "waste", "abuse", and "reasonable suspicion".

Association's Response:

The Association states, "BCBSA agrees with this recommendation and will work with the contracting officer to develop guidance of definitions . . . A meeting was held with OPM on December 4, 2013 to discuss these and other definitions."

Recommendation 8

We recommend that the contracting officer direct the Association to provide OPM and the OIG full access to FIMS.

Association's Response:

The Association states, "BCBSA continues to partially disagree with the recommendation to provide the OPM OIG full access to FIMS. FIMS is an internal management reporting system used by BCBSA and Local Plans to report Fraud, Waste and Abuse cases. Before cases can be forwarded to OPM/OIG, they are reviewed and evaluated by BCBSA consultants. The consultants work with Local Plans to ensure the proper data elements are entered. As such, unlimited access by the OIG to the system at this time would result in potential inefficiencies for both OPM/OIG and FEP. However, in order to provide the OPM OIG investigators with efficient, effective and faster access to cases, BCBSA initiated a process where BCBSA and OPM OIG staff meet on a monthly basis . . . to review case activity."

OIG Comments:

We continue to recommend that the contracting officer direct the Association to provide OPM and the OIG with full access to FIMS, a program fully paid for by OPM with FEHBP funds. Full access is necessary for OPM and the OIG to monitor the Association's fraud and abuse activity and the FEPDO's oversight, and will allow the OIG to make inquiries when we notice non-compliance by a BCBS plan and/or the FEPDO such as untimely reporting. In addition, it will provide necessary information for analysis purposes prior to future OIG audits. This alone will save time and money for the local BCBS plans and the FEPDO.

The analysis of this Plan's fraud and abuse cases showed that the Plan's entries into FIMS had significant timeliness issues. Of the 39 cases with FEP exposure during the period January 1, 2013 through June 30, 2013 for the BCBS plans of Illinois and Texas, we determined that 13 cases were entered into FIMS untimely. If the OIG had full access to FIMS, at least 13 cases would have been reviewed and investigated by us. Also, we would have notified the Plan and FEPDO of the untimely reporting issue in real time and resolved the issue sooner.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

[REDACTED], Lead Auditor

[REDACTED], Auditor

[REDACTED], Auditor

[REDACTED], Auditor

[REDACTED], Auditor

[REDACTED], Chief ([REDACTED]

[REDACTED] Senior Team Leader

SCHEDULE A

V. SCHEDULES

HEALTH CARE SERVICE CORPORATION
CHICAGO, ILLINOIS

CONTRACT CHARGES

CONTRACT CHARGES*	2009	2010	2011	2012	TOTAL
A. HEALTH BENEFIT CHARGES**					
CLAIM PAYMENTS	$2,386,916,498	$2,518,651,684	$2,673,196,131	$2,796,498,433	$10,375,262,746
MISCELLANEOUS PAYMENTS AND CREDITS	93,899	(7,627,227)	(12,124,239)	(16,177,698)	(35,835,265)
TOTAL HEALTH BENEFIT CHARGES	$2,387,010,397	$2,511,024,457	$2,661,071,892	$2,780,320,735	$10,339,427,481
B. ADMINISTRATIVE EXPENSES**					
ADMINISTRATIVE CHARGES	$154,356,215	$149,439,246	$151,764,200	$152,797,620	$608,357,281
PRIOR PERIOD ADJUSTMENTS	45,935	0	0	0	45,935
BUDGET SETTLEMENT REDUCTIONS	(24,437,072)	(25,037,566)	(12,467,843)	(10,469,979)	(72,412,460)
TOTAL ADMINISTRATIVE EXPENSES	$129,965,078	$124,401,680	$139,296,357	$142,327,641	$535,990,756
TOTAL CONTRACT CHARGES	$2,516,975,475	$2,635,426,137	$2,800,368,249	$2,922,648,376	$10,875,418,237

* This audit covered miscellaneous health benefit payments and credits and cash management activities from January 1, 2009 though September 30, 2012 and administrative expenses from 2009 through 2011.

** The health benefit charges and administrative expenses include all amounts reported in the Annual Accounting Statements for Plan codes 121/621 (Illinois), 290/790 (New Mexico), 340/840 (Oklahoma), and 400/900 (Texas).

SCHEDULE B

HEALTH CARE SERVICE CORPORATION
CHICAGO, ILLINOIS

QUESTIONED CHARGES

AUDIT FINDINGS	2009	2010	2011	2012	2013	TOTAL
A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS						
1. Unidentified Refunds	$19,785	$44,616	$17,154	$0	$0	$81,555
2. Medical Drug Rebates	4,936	5,684	2,877	1,145	0	14,642
TOTAL MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS	$24,721	$50,300	$20,031	$1,145	$0	$96,197
B. ADMINISTRATIVE EXPENSES	$0	$0	$0	$0	$0	$0
C. CASH MANAGEMENT						
1. Letter of Credit Account Overdraws*	$6,175,540	$1,713,117	$1,771,482	$1,806,131	$2,850,781	$14,317,051
TOTAL CASH MANAGEMENT	$6,175,540	$1,713,117	$1,771,482	$1,806,131	$2,850,781	$14,317,051
D. FRAUD AND ABUSE PROGRAM						
1. Special Investigations Department (Procedural)	$0	$0	$0	$0	$0	$0
TOTAL FRAUD AND ABUSE PROGRAM	$0	$0	$0	$0	$0	$0
TOTAL QUESTIONED CHARGES	$6,200,261	$1,763,417	$1,791,513	$1,807,276	$2,850,781	$14,413,248

* For simplicity, contract year 2009 includes the questioned overdraws for the period April 1, 2002 through December 31, 2009. Also, contract year 2013 includes the questioned overdraws of $770,154 for the period January 1, 2013 through June 12, 2013 plus the total questioned lost investment income of $2,080,627 for this finding.

BlueCross BlueShield Association

An Association of Independent
Blue Cross and Blue Shield Plans

Federal Employee Program
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December 23, 2013

[REDACTED], Group Chief
Experience-Rated Audits Group
Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, Room 6400
Washington, DC 20415-11000

Reference: **OPM DRAFT AUDIT REPORT**
Health Care Services Corporation (HCSC)
Audit Report No. 1A-10-17-13-019
(Dated September 9, 2013 and Received September 9, 2013)

Dear [REDACTED]:

This is Health Care Service Corporation's (Plan) response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Federal Employees' Health Benefits Program (FEHBP). The Blue Cross and Blue Shield Association (BCBSA) and the Plan are committed to enhancing existing procedures on issues identified by OPM. Please consider this feedback when updating the OPM Final Audit Report.

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

A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

1. Health Benefit Refunds **$75,472**

Recommendation 1:

OPM OIG recommended that $75,472 in unidentified health benefit refunds be returned to the FEHBP.

Plan Response:

The Plan agreed with this recommendation and, on October 11, 2013, returned the entire amount to the FEHBP. Documentation to support the return of these funds to the Program is included as Attachment 1.

Recommendation 2:

OPM OIG also recommended that Lost Investment Income also be assessed and returned to the Program for the unidentified refunds not returned to the Program timely.

Plan Response:

The Plan agreed with this recommendation and submitted Special Plan Invoices to BCBSA on December 18, 2013 to return the recommended LII to the Program.

2. <u>Medical Drug Rebates</u>

Recommendation 3

OPM OIG recommended that the Plan return $14,642 to the FEHBP for LII on medical drug rebates returned untimely to the FEHBP.

Plan Response:

The Plan agreed with this finding and submitted Special Plan Invoices to BCBSA on October 29, 2013 to return the recommended LII to the Program. The Plan also stated that it is reviewing its procedures for the timely allocation to FEP for medical drug rebates and will make any necessary updates to the procedures by the end of 1st quarter 2014.

B. <u>ADMINISTRATIVE EXPENSES – No Findings</u>

C. <u>CASH MANAGEMENT</u>

1. <u>Letter of Credit Overdraws</u> **<u>$14,317,051</u>**

Recommendation 5

OPM OIG recommended that the Plan return $2,080,627 to the FEHBP for LII on the questioned LOCA overdraws.

Plan's Response

The Plan generally concurs with the majority of this audit finding. However, the Plan would like to clarify that it does not agree with the OPM OIG's claim that the FEHBP is due $2,080,627 for Lost Investment Income ("LII") under the parameters of Contract CS1039.

The Plan feels it is important to note that HCSC was the party that actually discovered the LOCA draw errors and notified OPM OIG ("OIG") of the issue. While reviewing the requested audit samples and worksheets, the OIG auditors asked some preliminary questions regarding those LOCA worksheets. The Plan provided the answers to these questions and proactively performed some additional research which identified the error in the LOCA draws. The Plan then brought this to the attention of the OIG auditors. If the Plan had not performed this additional research, it is uncertain whether the OIG auditors would have identified this issue. The Plan went beyond the audit inquiry and performed additional research and then voluntarily communicated this issue to OIG. We feel that the written record should indicate this fact. We do not dispute the description of the error. We also do not dispute the calculations of the total LOCA overdraw amounts and associated LII amounts covering the period beginning in April 2002. LII was returned to the FEHBP on October 21, 2013, and based on the contract, we disagree with how much LII OIG claims should be returned to the Program.

Contract CS 1039 requires LII to be paid to FEHBP in the event of an improper allocation or draw from the LOCA. The Plan acknowledges that inadvertent overdraws occurred, and agrees with OIG's calculations of total LII applicable to the mistaken overdraws from April 2002 to June 12, 2013.

To date the Plan, has paid $444,104.00, representing LII calculations from January 1, 2008 to July 10, 2013. As stated earlier, the Plan provided supporting documentation to OIG on October 4, 2013 to support the return of $380,727 in lost investment income to the FEHBP for Letter of Credit Overdraws. See Attachment 2 for documentation to support the additional return of $63,377 in lost investment income to the FEHBP.
This repayment represents the amount that OPM can legally claim under Contract CS 1039. The Contract does not obligate the return of any funds, whether unsupported LOCA draws or applicable LII, that arose outside the contractual audit disputes limitations period. Specifically, Section 4.4 ("Audit Disputes") of CS 1039 provides in pertinent part that a claim seeking money "*shall not be made more than five years following the last day prescribed by the contract for filing the calendar year Annual Accounting Statement for the year with respect to which the claim arises.*" Based on this contractual limitation, the correct starting point for return of mistaken LOCA overdraws

as well as payment of associated LII would be for claims subject to and contained in the Annual Accounting Statement for calendar year beginning January 1, 2008, the last date to file such statement being April 30, 2009. As such, the Plan has paid all that is recoverable by OPM relating to LII on the inadvertent LOCA overdraws, and the LOCA overdraws and LII prior to January 1, 2008, are contractually barred from claim by OPM. Notwithstanding, the Plan has already returned the LOCA overdraws for the entire time frame extending back to April 2002, and we do not intend to disturb that repayment. However, the clear terms of the contract with respect to the non-recoverable LII for dates preceding January 1, 2008 bar further claim by OPM for such amounts.

It should be noted that the Audit Disputes limitations period has previously been held by the Board of Contract Appeals to apply to limit OPM's recovery of sums outside the 5 year limitations period. See ASBCA, No. 53632, October 28, 2003.

D. FRAUD AND ABUSE PROGRAM

1. Fraud and Abuse Program — Procedural

The Plan continues to disagree with the statement that it is not in compliance with the communication and reporting requirements set forth in Contract CS 1039 and the Federal Employee Health Benefit Program (FEHBP) Carrier Letter (CL) 2011-13. BCBSA also disagrees that controls to Plans FIMS entries are inadequate.

The FEPDO and the Plan have created a system of controls to monitor, identify, investigate and recover fraudulent and abusive payments of FEHBP funds and is substantially in compliance with the requirements of CS 1039. Further, the Plan's FEP Fraud and Abuse Program is designed to protect patient safety and the health care assets of Federal beneficiaries.

Recommendation 6:

OPM OIG recommended that the Association ensure that the Plan is implementing policy changes made during our review of BCBSIL SIU. In addition, OIG recommended that the Association provide the Plan with better oversight regarding compliance with communication and reporting policies and procedures.

Plan Response:

On May 20th, 2013, the Plan's Special Investigations Department (SID) updated their internal Policy and Procedure manual with regard to the notification of investigative activities. Specifically, this approved change will direct SID investigators in all HCSC plans to promptly report information into FIMS wherein there is a reasonable suspicion of fraud involving FEHBP claims. This would include both preliminary and full investigations regardless of the dollar amount of FEHBP claims. See Attachment 3 for a copy of the revised policy.

BCBSA Response:

In order to ensure that the Plan implements policy changes made during the review BCBSA implemented a revised Plan monitoring process as of October 31, 2013. The BCBSA FEPDO will review the Plan's SIU activities and revised policies and procedures by February 15, 2014 and work with the Plan to implement any additional corrective actions 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.

Recommendation 7

The OIG recommended the contracting officer provide or issue guidance on the definitions of Fraud, Waste and Abuse, as well as "reasonable suspicion" in order for the Association and the local BCBS plans to have consistent guidance on the expectations of OPM for reporting purposes.

BCBSA Response:

BCBSA agrees with this recommendation and will work with the contracting officer to develop guidance of definitions of Fraud, Waste and Abuse and reasonable suspicion. A meeting was held with OPM on December 4, 2013 to discuss these and other definitions.

Recommendation 8

We recommend that the contracting officer direct the Association to provide OPM and the OIG full access to FIMS.

BCBSA Response:

BCBSA continues to partially disagree with the recommendation to provide the OPM OIG full access to FIMS. FIMS is an internal management reporting system used by BCBSA and Local Plans to report Fraud, Waste and Abuse cases. Before cases can be forwarded to OPM/OIG, they are reviewed and evaluated by BCBSA consultants. The consultants work with Local Plans to ensure the proper data elements are entered. As such, unlimited access by the OIG to the system at this time would result in potential inefficiencies for both OPM/OIG and FEP. However, in order to provide the OPM OIG investigators with efficient, effective and faster access to cases, BCBSA initiated a process where BCBSA and OPM OIG staff meet on a monthly basis at the FEPOC Director's office to review case activity.

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,

, CISA, CRMA
Managing Director, Program Assurance

cc: , Contracting Officer, OPM
, FEP
HCSC