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

Final Audit Report

Audit of the Federal Employees Health Benefits Program's Pharmacy Operations as Administered by Blue Shield of California Access+ HMO For Contract Years 2011 through 2013

Report Number 1H-03-00-15-045
July 19, 2016

-- CAUTION --

EXECUTIVE SUMMARY

Audit of the Federal Employees Health Benefits Program's Pharmacy Operations as Administered by Blue Shield of California Access+ HMO

Report No. 1H 03-00-15-045 **July 19, 2016**

Why Did We Conduct the Audit?

The objective of the audit was to determine whether costs charged to the Federal Employees Health Benefits Program (FEHBP) and services provided to its members were in accordance with the U.S. Office of Personnel Management Contract Number CS 2639 and applicable Federal regulations.

What Did We Audit?

The Office of the Inspector General has completed a performance audit of Blue Shield of California Access+ HMO's (Plan) fraud and abuse program, pharmacy claims eligibility and pricing, and pharmacy rebates as they related to the FEHBP's pharmacy operations for contract years 2011 through 2013. Our audit was conducted from August 17 through August 21, 2015, at the Plan's offices in San Francisco, California. Additional audit work was completed at our offices in Washington, D.C. and Cranberry Township, Pennsylvania.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

We determined that the Plan needs to strengthen its procedures and controls related to dependent eligibility and the reporting of pharmacy claims.

Specifically, our audit identified the following two deficiencies that require corrective action:

1. The Plan paid $12,748 in pharmacy claims for 11 dependents age 26 and older whose eligibility to participate in the FEHBP could not be supported.

2. The Plan overstated pharmacy claims paid by $2,974,655 in its 2011 through 2013 annual accounting statements.

ABBREVIATIONS

AAS	**Annual Accounting Statements**
Carrier	**Blue Shield of California**
Contract	**Contract Number CS 2639**
FEHBP	**Federal Employees Health Benefits Program**
HIO	**HealthCare and Insurance Office**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**Blue Shield of California Access+ HMO**

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I. BACKGROUND

This report details the results of our audit of the Federal Employees Health Benefits Program (FEHBP) pharmacy operations as administered by Blue Shield of California Access+ HMO (Plan) for contract years 2011 through 2013. This audit was conducted pursuant to the provisions of Contract Number CS 2639 (Contract) and Title 5, Code of Federal Regulations, Chapter 1, Part 890 (5 CFR 890). 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 audit was performed at the Plan's office in San Francisco, California from August 17 through August 21, 2015.

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

OPM entered into the Contract with Blue Shield of California (Carrier) to provide health insurance benefits, including prescription drug coverage, to enrollees under the Plan. The Plan is an experience rated Health Maintenance Organization offering benefits to Federal employees and retirees in the Southern California region. The Carrier also participates in the FEHBP through the Blue Cross and Blue Shield Service Benefit Plan. Section 1.6 of the Contract includes a provision which allows for audits of the program's operations.

This was the OIG's first audit of the Plan's pharmacy operations. The initial results of this audit were discussed with Plan officials during an exit conference on December 8, 2015. A draft report was provided to the Plan on February 24, 2016, for its review and comment. The Plan's response to the draft report was considered in preparation of this final report and is included as an Appendix to the report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The primary objective of the audit was to determine whether pharmacy costs charged to the FEHBP and services provided to its members were in accordance with the contract and applicable Federal regulations.

Specifically, our audit objectives were to determine if:

Fraud and Abuse Program Review

- The Plan had a fraud and abuse program, reported fraud cases to OPM, and properly accounted for its Special Investigations Unit expenses and recoveries for 2011 through 2013.

Pharmacy Claims Eligibility Review

- Claims were paid for dependents over age 26.
- Claims were paid for deceased members.
- Claims were paid for non-FEHBP members or members enrolled in an alternative plan code under Blue Shield of California.
- Claims were paid for any drugs excluded by the Plan.
- Claims were paid that had a zero quantity.
- Mail order prescriptions were being filled within the allowable day supply as stated in the benefit brochure.
- Any scripts were filled with an unusually high quantity.
- The Plan paid claims to debarred pharmacies.
- High dollar claims were valid and properly supported.

Pharmacy Claims Pricing Review

- The Plan accurately reported the claims paid in its annual accounting statements (AAS) submitted to OPM for contract years 2011 through 2013.
- The pricing elements for retail pharmacy claims were transparent and the claims were properly paid.
- The pricing elements for mail order pharmacy claims were properly paid and transparent.

Pharmacy Rebates Review

- Rebates billed to manufacturers were accurate and if the rebates were returned to the FEHBP.

Scope and Methodology

We conducted this 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 the audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on the audit objectives.

This performance audit included, but was not limited to, a review of the Plan's fraud and abuse program, pharmacy claims eligibility and pricing, and pharmacy rebates for contract years 2011 through 2013. An audit survey was conducted at the Plan's office in San Francisco, California, from August 17 through 21, 2015. Additional audit work was completed at our Cranberry Township, Pennsylvania, and Washington, D.C. offices.

The Plan is responsible for providing FEHBP members with medical and prescription drug benefits. To meet this responsibility, the Plan collected premiums totaling approximately $309 million from 2011 through 2013, of which two-thirds was paid by the government on behalf of Federal employees. In addition to the premium collected, program income was also generated from the investment of program funds. From the premiums collected and investment income earned during this time period, the Plan reported the following amounts disbursed for prescription drug benefits:

Year	Premium Collected	Pharmacy Benefits Paid	Pharmacy Claim Lines
2011	$92,388,211	$	
2012	$103,660,119	$	
2013	$112,912,202	$	
Total	**$308,960,532**	**$**	

In planning and conducting the 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. Additionally, 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 complied with the Contract and 5 CFR 890. Exceptions noted in the areas reviewed are set forth in the "Audit Findings and Recommendations" section of this 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 the audit, we relied to varying degrees on computer-generated data provided by the Plan. Due to the time constraints, we did not verify the reliability of the data generated by the various information systems involved. However, while utilizing the computer-generated data during our audit, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

To determine whether costs charged to the FEHBP and services provided to its members were in accordance with the terms of the Contract and Federal regulations, we performed the following audit steps for contract years 2011 through 2013, unless noted otherwise:

Fraud and Abuse Program Review

- We reviewed the Plan's fraud and abuse program and reconciled its list of fraud cases to those referred to the OIG's Office of Investigations to ensure that fraud cases were reported and costs were properly accounted for.

Pharmacy Claims Eligibility Review

- We reviewed all dependents age 26 and older with pharmacy claims to determine if they were incapable of self-support due to a disability.

- We selected the 50 oldest members, out of the universe of 50,806 members, to determine if any claims were paid for deceased members.

- We reviewed all claims to ensure that none were paid for non-FEHBP members or members enrolled in an alternative plan code under the Carrier.

- We selected a judgmental sample of 10 generic drugs and 10 brand drugs not covered by the Plan, out of a total universe of 53 excluded generic drugs and 97,625 excluded brand drugs, to determine if any claims were paid for the excluded drugs. Our sample was based on the first 10 alphabetical generic drugs and the lowest 10 National Drug Codes for brand drugs that were on the exclusions list provided by the Plan.

- We reviewed all claims to ensure that none were paid with a zero quantity dispensed.

- We selected all pharmacy claims with a supply over 90 days to determine if the prescriptions were being filled within the allowable time limit stated in the benefit brochure.

- We reviewed all claims with a quantity greater than 1,000 to determine if the Plan paid the claims appropriately.

- We obtained a list of debarred pharmacies from the OIG's Administrative Sanctions Group and compared all debarred pharmacies located in California to the Plan's claims data to determine if any payments were made to debarred pharmacies.

- We judgmentally selected all claims with a total paid amount greater than $10,000 to determine if the high dollar claims were allowable and properly supported.

Pharmacy Claims Pricing Review

- We reconciled the pharmacy claims reported in the Plan's AAS to the actual claims data generated from the Plan's claims system and followed up on any discrepancies.

- From a retail pharmacy universe of [redacted] claims totaling approximately $[redacted] million, we randomly selected a sample of 50 claims from each contract year from the top four retail pharmacies (as provided by the Plan), for a total of 150 retail claims, totaling $38,762, to determine if the claims were paid correctly.

- From a mail order pharmacy universe of [redacted] claims totaling approximately $[redacted] million, we randomly selected a sample of 50 claims from each contract year, for a total of 150 mail order claims, totaling $51,907, to determine if the claims were paid correctly.

Pharmacy Rebates Review

- We selected all 2012 pharmacy rebates from one manufacturer for review to determine if they were billed in accordance with the manufacturer rebate agreements and properly credited to the FEHBP. This manufacturer was judgmentally selected due to it having the largest decrease in quarterly rebates.

The samples that were selected and reviewed in performing the audit were not statistically based. Consequently, the results could not be projected to the universe since it is unlikely that the results are representative of the universe taken as a whole.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. FRAUD AND ABUSE PROGRAM REVIEW

The results of our review showed that the Plan had sufficient policies and procedures in place to help prevent fraud and abuse.

B. PHARMACY CLAIMS ELIGIBILITY REVIEW

1. Overage Dependents $12,748

The Plan paid $12,748 in pharmacy claims for 11 dependents age 26 and older whose eligibility to participate in the FEHBP could not be supported.

We found 11 ineligible dependents age 26 or older enrolled in the FEHBP.

Title 5, Code of Federal Regulations, Section 890.302 allows dependent children under the age of 26 and dependents age 26 or older who are incapable of self-support due to a disability to be covered by the enrollment of a Federal employee or annuitant in the FEHBP. The regulation also requires certification from a physician and a decision by the Federal employment office showing that the dependent is incapable of self-support due to a disability in order for the Plan to continue providing coverage to that member beyond their 26th birthday.

Section 3.8 of the Contract, Contractor Records Retention, requires the Plan to maintain documentation that supports costs for a period of six years after the end of the contract term for which the records relate.

We reviewed the pharmacy claims paid for 2011 through 2013 to determine if any dependents remained enrolled in the FEHBP beyond their 26th birthday. Our review showed that the Plan paid claims for 16 dependents age 26 or older which the Plan stated were designated as permanently disabled in its system. The Plan provided sufficient support for 5 of the 16 dependents that showed the member as incapable of self-support due to a disability. However, the Plan was unable to provide evidence to support that the other 11 dependents were eligible for FEHBP coverage beyond their 26th birthday.

Without adequate controls in place to terminate ineligible dependents at age 26, or to maintain the necessary documentation to show dependent eligibility beyond age 26, the risk of overcharges to the FEHBP is significant.

Recommendation 1

We recommend that the contracting officer require the Plan to provide evidence to support that the 11 dependents were eligible to remain enrolled in the FEHBP due to a disability and incapable of self-support, or return $12,748 to the program.

Plan Response:

The Plan partially agreed with our recommendation and provided, what it believed to be, documentation for 9 of the 11 dependents in question. It will continue to pursue the eligibility information for the final two members and will reach out to OPM for assistance.

OIG Comment:

We reviewed the additional documentation provided by the Plan and found it to be inadequate since it belonged to the wrong members or did not show the dependent as being incapable of self-support due to a disability. OPM should work with the Plan to obtain documentation showing each of the 11 dependents are incapable of self-support due to a disability. A certification from a physician or the subscriber's employing agency should have been provided.

Recommendation 2

We recommend that the contracting officer require the Plan to review its system controls for terminating dependents upon turning age 26 to ensure that ineligible members are not enrolled in the FEHBP.

Plan Response:

The Plan disagreed with this recommendation and provided its policies and procedures for terminating members.

OIG Comment:

We understand that the Plan has policies and procedures in place, but we cannot determine if the processes are being followed until we verify the eligibility for the 11 dependents being questioned.

Recommendation 3

We recommend that the contracting officer require the Plan to maintain proof of dependent eligibility for a period of six years after claims are paid in accordance with its records retention clause. This means it should maintain evidence to support the eligibility for disabled dependents for up to six years after they are no longer enrolled in the FEHBP.

Plan Response:

The Plan agrees with this recommendation and updated its policy to maintain a copy of the Disabled Certificate and have it readily available.

C. PHARMACY CLAIMS PRICING REVIEW

1. Overstated Pharmacy Claims — Procedural

The Plan overstated pharmacy claims by $2,974,655 in its 2011 through 2013 AAS reported to OPM.

Section 3.2 of the Contract requires the Plan to submit AAS to OPM that accurately summarize FEHBP operations.

During our audit, we reconciled the pharmacy claims reported in the Plan's AAS to the actual claims data generated from the Plan's claims system for contract years 2011 through 2013. Our review found that the Plan overstated the pharmacy claims in its AAS by $2,974,655 over all three years.

Pharmacy claims were overstated by approximately $3 million.

When we identified the overstatement, the Plan admitted that it misreported the AAS and provided a revised breakout of the pharmacy claims for 2011 through 2013. The error was due to the Plan accidently including ancillary and other paid claims within the pharmacy claims total. Additionally, the Plan stated that it erroneously used a proration for reporting the pharmacy claims in the 2011 through 2013 AAS when the exact dollar amount for paid drugs was available. To ensure that the pharmacy claims were only misstated, and that the questioned costs were not unsupported charges, we matched the total health benefit charges (medical and pharmacy) reported in the AAS to the Plan's audited financial statements and found the Plan's explanation to be reliable.

As a result of the Plan overstating its pharmacy claims by $2,974,655 from 2011 to 2013, OPM relied on inaccurate information in its administration of the FEHBP, which might have adversely affected FEHBP members and other carriers.

Recommendation 4

We recommend that the contracting officer ensure that the Plan implements new policies and procedures to properly report pharmacy claims in its AAS.

Plan Response:

"The Plan agrees with this recommendation and has initiated a corrective action to report actual and verifiable drug claims paid on its 2015 and all future AAS reports."

D. PHARMACY REBATES REVIEW

The results of our review showed that pharmacy rebates were calculated correctly and remitted to the FEHBP in accordance with the Contract and prescription drug manufacturer agreements.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Special Audits Group

[redacted], Auditor-In-Charge

[redacted], Group Chief [redacted]

[redacted], Senior Team Leader

APPENDIX

blue of california

Received March 23, 2016

[redacted]
OPM - Office of the Inspector General
800 Cranberry Woods Drive, Suite 270
Cranberry Township, PA 16066

Dear [redacted]:

The following is our response to the recent audit of our FEHBP Access+ HMO Pharmacy claims operations. We have received and reviewed OPM's draft report, which contained two potential findings.

Below are Blue Shield of California's responses to these findings.

1. **OVERAGE DEPENDENTS:**

   Recommendation 1:

   The Plan partially agrees with this recommendation. The Plan was able to find documentation for 9 of the 11 outstanding unidentified members. Blue Shield sent the documentation for the 9 members to OPM on March 22, 2016.

   The Plan continues to pursue documentation for the final 2 members and will provide as soon as possible. Previous efforts to contact both members and providers for documentation have been unsuccessful. The Plan will reach out to OPM for assistance.

   Recommendation 2:

   The Plan disagrees with this recommendation. The Plan has attached its "Terminations and Voids" Policy and Procedure Document, which details Blue Shield of California's process for termination off all members. Page 10 of the document details the process necessary for the disenrollment of ineligible members.

   Recommendation 3:

   The Plan AGREES with this recommendation and has instituted a corrective action plan. Rather than rely on a members payroll office to be the sole possessor of the eligible

dependent documentation, the Plan has updated its policy to require a copy of the Disabled Certificate for our records. We will house this information on an internal share drive were it will be readily available when needed.

2. OVERSTATED PHARMACY CLAIMS

Deleted by OIG
Not Relevant to Final Report

Recommendation 4 (draft report recommendation 5):

The Plan AGREES with this recommendation and has initiated a corrective action to report actual and verifiable drug claims paid on its 2015 and all future AAS reports.

Deleted by OIG
Not Relevant to Final Report

Please don't hesitate to contact me with any further questions at [redacted] or at [redacted]@blueshieldca.com.

Sincerely,

[redacted]

[redacted]

Senior Manager, FEP
Blue Shield of California

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