



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

Final Audit Report

**AUDIT OF THE MULTI-STATE PLAN PROGRAM
OPERATIONS AT BLUE CROSS BLUE SHIELD OF
ALABAMA**

**Report Number 1M-0G-00-17-034
January 16, 2018**

EXECUTIVE SUMMARY

Audit of the Multi-State Plan Program Operations at Blue Cross Blue Shield of Alabama

Report No. 1M 0G-00-17-034

January 16, 2018

Why Did We Conduct The Audit?

The primary objective of our audit was to obtain reasonable assurance that Blue Cross Blue Shield of Alabama (BCBSAL) complied with the provisions of Contract MSP-BCBS-2017-04 (Contract) and applicable Federal regulations for contract year 2017.

What Did We Audit?

The Office of the Inspector General has completed a performance audit of the Multi-State Plan (MSP) Program operations at BCBSAL. Our audit of BCBSAL's compliance with the 2017 Contract and applicable regulations was conducted from July 17, 2017, through October 24, 2017, at BCBSAL's headquarters in Birmingham, Alabama, and our offices in Cranberry Township, Pennsylvania, and Washington, D.C.



Michael R. Esser
*Assistant Inspector General
for Audits*

What Did We Find?

Our audit of the 2017 MSP Program operations at BCBSAL disclosed two procedural findings pertaining to enrollment. Specifically, we identified the following:

- BCBSAL processed six Healthcare Insurance Casework System cases untimely.
- BCBSAL processed four enrollment form 834 errors untimely, which resulted in three members overpaying approximately \$982 for their health insurance premiums.

Our audit did not disclose any findings related to rates and benefits.

ABBREVIATIONS

Affordable Care Act	The Patient Protection and Affordable Care Act
APTC	Advanced Premium Tax Credit
Association	Blue Cross Blue Shield Association
BCBS	Blue Cross Blue Shield
BCBSAL	Blue Cross Blue Shield of Alabama
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
Contract	Contract MSP-BCBS-2017-04
HICS	Healthcare Insurance Casework System
MSP	Multi-State Plan
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
U.S.C.	United States Code

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I. BACKGROUND

This final report details the results of our performance audit of the Multi-State Plan (MSP) Program operations at Blue Cross Blue Shield of Alabama (BCBSAL). The audit covered contract year 2017. It was performed by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

The audit was conducted pursuant to the provisions of Contract MSP-BCBS-2017-04 (Contract); the Patient Protection and Affordable Care Act (Affordable Care Act); Title 45 Code of Federal Regulations (CFR), Chapter VIII, Part 800; and other applicable Federal regulations. Compliance with the Contract as well as laws and regulations applicable to the MSP Program is the responsibility of the Blue Cross Blue Shield Association (Association) and BCBSAL's management. Additionally, BCBSAL's management is responsible for establishing and maintaining a system of internal controls that provides reasonable assurance that:

- (1) the provision and payments of benefits and other expenses comply with legal, regulatory and contractual guidelines;
- (2) MSP funds, property, and other assets are safeguarded against waste, loss, unauthorized use, or misappropriation; and
- (3) data is accurately and fairly disclosed in all reports required by OPM.

Due to inherent limitations in any system of internal controls, errors or irregularities may nevertheless occur and not be detected.

The MSP Program was established by Section 1334 of the Affordable Care Act. Under the Affordable Care Act, OPM was directed to contract with private health insurers to offer MSP products in each state and the District of Columbia. OPM negotiates contracts with MSP Program Issuers, including rates and benefits, in consultation with states and marketplaces. In addition, OPM will monitor the performance of MSP Program Issuers and oversee compliance with legal requirements and contractual terms. OPM's office of National Healthcare Operations has overall responsibility for program administration.

The Association, on behalf of participating Blue Cross Blue Shield (BCBS) plans, entered into a contract with OPM to participate in the MSP Program. Along with its participating licensees, the Association offers 201 MSP options in 21 states. BCBSAL is one of 21 BCBS plans, or State-Level Issuers, participating in the MSP Program in 2017.

The Association is a national federation of 36 independent, community-based and locally operated BCBS companies. The Association grants licenses to independent companies to use the trademarks and names in exclusive geographic areas. It operates and offers health care coverage in all 50 states, the District of Columbia, and Puerto Rico, covering nearly 106 million Americans. Nationally, BCBS companies contract with more than 96 percent of hospitals and 93 percent of doctors and specialists.

BCBSAL is the largest provider of healthcare benefits in Alabama and administers health, dental, and pharmacy programs that cover over 3 million members, including 2.2 million Alabamians. With a commitment to offering the best value for its members, BCBSAL invests over 92 cents of every premium dollar on medical care expenses. In 2017, BCBSAL offered two MSPs on the Exchange, including both a gold and a silver plan.

This is our first audit of the MSP Program at BCBSAL. We selected BCBSAL because it reported some of the highest enrollment numbers in the program in 2016. Additionally, BCBSAL is a large independent Plan that joined the program in 2016 and has not been audited.

The preliminary results of this audit were discussed with BCBSAL and the Association officials at an exit conference. Audit Inquiries were also provided to the Association and BCBSAL for review and comment. BCBSAL's comments were considered in preparation of this report and are included as Appendices to the report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The primary objective of this performance audit was to obtain reasonable assurance that BCBSAL is in compliance with the provisions of its Contract with OPM and applicable laws and regulations governing the MSP Program for contract year 2017. Specifically, we reviewed enrollment, as well as rates and benefits.

SCOPE

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, 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.

The audit fieldwork was performed from July 17, 2017, through October 24, 2017, at BCBSAL's headquarters in Birmingham, Alabama, and our offices in Cranberry Township, Pennsylvania, and Washington, D.C.

We obtained an understanding of BCBSAL's internal control structure and used this information to determine the nature, timing, and extent of our audit procedures. Our audit of internal controls was limited to the procedures that BCBSAL has in place for enrollment processing and prescription drug benefits. Because our audit was focused on internal controls over specific MSP processes, we will not express an opinion on the issuer's system of internal controls as a whole.

In conducting the audit, we relied to varying degrees on computer-generated data provided by BCBSAL and the Association. We did not verify the reliability of the data generated by the various information systems involved. However, based on the OIG's experience with BCBS plans, nothing has come to our attention during our previous audit testing to cause us to doubt the reliability of their computer generated data. We believe that the available data will be sufficient to achieve our audit objectives.

METHODOLOGY

We reviewed a judgmental sample of enrollment form 834 transaction errors to determine if these errors were processed timely and accurately. The 834 transaction errors universe, samples, and selection methodology are summarized in Exhibit A.

We also reviewed a judgmental sample of MSP Health Insurance Casework System (HICS) cases to determine if these actions were processed timely and accurately. The HICS case universe, samples, and selection methodology are summarized in Exhibit B.

Finally, we interviewed BCBSAL personnel regarding the Formulary Inadequate Category/Class/Count Justification Form and reviewed supporting documentation for the drugs listed on the form to verify that they are otherwise covered under medical benefits or generic and over-the-counter options.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. ENROLLMENT

Procedural

1. Enrollment Form 834 Error Processing Timeliness

BCBSAL processed four enrollment form 834 errors untimely, resulting in MSP member overpayments of approximately \$982.

Contract Section 1.6(a) requires the issuer to "comply with Federal laws, regulations, and guidance"

Additionally, 45 CFR 800.106(b) requires issuers to "ensure that an eligible individual receives the benefit of advance payments of premium tax credits ... and the cost-sharing reductions" prescribed by applicable laws and regulations.

Furthermore, 45 CFR 800.401(c)(8)(i) states that issuers are responsible for "Establishing and maintaining a system of internal controls that provides reasonable assurance that ... [t]he provision and payments of benefits and other expenses comply with legal, regulatory, and contractual guidelines"

Finally, 45 CFR 156.460(a)(1) requires the issuer to reduce members' premiums by the advanced premium tax credit (APTC), as applicable. 45 CFR 156.460(c) also requires the issuer to notify the member within 45 calendar days of identifying that the APTC was not applied as required and to "refund any excess premium paid by or for the enrollee"

We reviewed a judgmental sample of 24 MSP enrollment form 834 errors that occurred from January 1, 2017, through April 30, 2017. Based on our review, we determined that four enrollment form 834 errors involved changes to the plan, APTC, and/or cost-sharing reduction amounts that impacted the amount of premium to be paid by the affected MSP members. However, these errors were resolved between 91 and 190 calendar days after the date of the error report. As a result, three of the four members overpaid approximately \$982 for their health insurance premiums.

We verified that BCBSAL subsequently took the appropriate actions to process the errors. In addition, we verified that BCBSAL has begun to credit the affected members for the applicable overpayments, which had an outstanding credit balance of

Untimely resolution of enrollment errors resulted in three members overpaying approximately \$982 for health insurance premiums.

approximately \$539 at the time of our review. Although BCBSAL stated that the delays did not impact claims, we are unable to verify that claims adjustments were not necessary without supporting documentation.

BCBSAL explained that the delay in processing the enrollment form 834 errors was generally due to the high volume of errors reported, a lack of resources to process the errors, and priority placed on processing other errors and manual files, such as HICS cases. Inadequate internal controls and procedures over the error resolution process may also have contributed to the timeliness issues.

Although BCBSAL has elected not to participate in the MSP Program beyond 2017, the issues with the enrollment form 834 error resolution process will continue to have an impact on BCBSAL's Federally Facilitated Marketplace membership, if left unaddressed. In the case of the errors that we reviewed, the overpayments would not have been as extensive, or may not have occurred at all, if the errors had been worked within 45 calendar days of the error report. Moreover, BCBSAL did not work these errors until after we issued our sample selection, which raises broader concerns about how much longer these members may have been overpaying for their coverage if we had not selected these errors for review.

Issuer Response:

BCBSAL acknowledged that it processed four enrollment form 834 errors untimely, which resulted in the identified MSP member overpayments. BCBSAL stated that all balances due to the members have either been refunded or credited. Although BCBSAL also asserted that existing controls over error processing are adequate considering the small percentage of errors requiring manual intervention, it also stated that it will continue to work to strengthen procedures and controls around the enrollment form 834 error resolution timeliness.

OIG Comment

Based on our review of BCBSAL's response to our audit finding, we could not verify that the outstanding credit balance had been refunded or credited to the members. In addition, the existing controls that BCBSAL referenced encourage increased automation to reduce the number of errors requiring manual intervention as well as accurate manual processing of errors. However, the controls do not adequately address timely processing of errors when they do occur, which continues to put members at risk of overpayment.

Recommendation 1

We recommend that BCBSAL continue to monitor application of the outstanding credit balance totaling approximately \$539 for the members impacted by the overpayments.

Recommendation 2

We recommend that BCBSAL continue to develop adequate internal controls and procedures over the enrollment form 834 error resolution process to ensure that errors are addressed more timely and to minimize potential member impact.

2. HICS Case Processing Timeliness

BCBSAL processed six MSP HICS cases untimely from January 1, 2017, through April 30, 2017.

Contract Section 1.6(a) requires the issuer to "comply with Federal laws, regulations, and guidance"

Additionally, 45 CFR §156.1010(b) requires an issuer "in a Federally-facilitated Exchange [to] investigate and resolve, as appropriate, cases ... forwarded to the issuer by HHS."

Untimely processing of HICS cases could lead to delays in a member's ability to access coverage.

Furthermore, 45 CFR §156.1010(d) states that the issuer must generally resolve cases within 15 calendar days of receipt unless it is an urgent case, which must be resolved within 72 hours of receipt.

Finally, the Centers for Medicare and Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight Guidance entitled, "Casework Guidance for Issuers in Federally-facilitated Marketplaces, including State Partnership Marketplaces," dated March 13, 2014, notes that cases provided to issuers under CFR §156.1010(b) will be provided via the HICS web application. It also defines urgent cases as Level 1 and all other cases as Level 2.

We reviewed a judgmental sample of 24 MSP HICS cases received from January 1, 2017, through April 30, 2017. Based on our review, we determined that six Level 2 HICS cases were resolved between 2 and 9 days after the 15 calendar days required by 45 CFR §156.1010(d). The cases were processed untimely due to a variety of issues, including: extensive manual intervention necessary to address enrollment form 834

errors; waiting for required member payments or guidance from CMS; and holiday business closures.

Although the untimely resolution of HICS cases could potentially lead to delays in the affected member's ability to access necessary coverage, we did not observe these issues in any of the cases that we reviewed. BCBSAL took the appropriate action to accurately address each of the cases and had policies and procedures in place to meet HICS case timeliness requirements. The delays in meeting these requirements were largely beyond BCBSAL's control. Moreover, BCBSAL has elected not to participate in the MSP Program beyond 2017. As such, we are reporting this as an area of non-compliance but will make no recommendation.

Issuer Response:

BCBSAL acknowledged that it processed the six identified HICS cases untimely, noting that it is committed to processing HICS cases timely and will continue to work to ensure compliance with all applicable regulations.

OIG Comment:

While we acknowledge BCBSAL's commitment to ensure that HICS cases are processed timely in compliance with applicable regulations, we cannot verify BCBSAL's compliance in future audits since BCBSAL will not participate in the MSP program beyond 2017.

B. RATES AND BENEFITS

Based on our review, we concluded that BCBSAL is in compliance with the Contract and applicable criteria for pharmacy drug benefits.

EXHIBIT A

Enrollment Form 834 Transaction Errors Sample Selection Criteria and Methodology

Review	Universe Criteria	Universe (Number)	Sample (Number)	Sample Selection Methodology	Sample Type	Results Projected to the Universe?
Enrollment Form 834 Transaction Errors	Enrollment Form 834 Transaction Errors associated with MSP and Unidentified Contracts from January 1, 2017, through April 30, 2017	1,150	24	<p>We assigned a number to each MSP on-exchange contract and used a random number generator from Random.org to select a sample of 14 contracts with error codes that had 20 or more occurrences.</p> <p>We assigned a number to each MSP off-exchange contract associated with one error code and used a random number generator from Random.org to select a sample of four contracts with errors. We selected one additional contract based on error code nomenclature for a total of five sampled transactions.</p> <p>We assigned a number to each enrollment form 834 transaction error for unidentified contracts and used the random number generator from Random.org to select five transaction errors.</p>	Random and Judgmental	No

EXHIBIT B

Healthcare Insurance Casework System (HICS) Cases Sample Selection Criteria and Methodology

Review	Universe Criteria	Universe (Number)	Sample (Number)	Sample Selection Methodology	Sample Type	Results Projected to the Universe?
HICS Cases	2017 MSP HICS Cases from January 1, 2017, through April 30, 2017	2,367	28 ¹	<p>We assigned each case in the universe a number and used a random number generator from Random.org to select 5 cases from each month, resulting in 20 sampled cases.</p> <p>We selected an additional eight HICS cases by identifying all cases that were processed over 15 days.</p>	Random and Judgmental	No

¹ Although we originally sampled 28 HICS cases, we subsequently determined as part of our review that four of the cases were related to non-MSP plans/members and had been erroneously included in the universe. Therefore, we only reviewed 24 of the cases that were confirmed to be related to MSP plans/members.

APPENDIX 1



BlueCross BlueShield of Alabama

September 22, 2017

[REDACTED]
U.S. Office of Personnel Management
Office of the Inspector General
800 Cranberry Woods Drive, Suite 130
Cranberry Township, PA 16066

Dear [REDACTED]:

Blue Cross and Blue Shield of Alabama (Blue Cross) appreciates the opportunity to respond to the HICS Case Processing Timeliness finding (Audit Inquiry #1) identified during the recent Multi-State Plan (MSP) Audit and concurs with the audit issue, as stated by the U.S. Office of Personnel Management (OPM).

Blue Cross acknowledges that six Multi-State Plan (MSP) Healthcare Insurance Casework System (HICS) cases were processed untimely from January 1, 2017 through April 30, 2017.

Of the 24 MSP HICS cases received from January 1, 2017 through April 30, 2017 that were judgmentally selected by OPM for review, six Level 2 HICS cases were resolved between two and nine days after the 15 calendar days required by 45 CFR §156.1010(d). The cases were processed untimely due to a variety of issues, including: extensive manual intervention necessary to address enrollment form 834 errors; waiting for guidance from CMS; and holiday business closures. The delays in meeting the requirements were largely beyond Blue Cross' control.

Blue Cross further acknowledges the following requirements:

- "Contract MSP-BCBS-2017-04 Section 1.6(a) requires the issuer to "comply with Federal laws, regulations, and guidance..."
- 45 CFR §156.1010(b) requires an issuer "in a Federally-facilitated Exchange to investigate and resolve, as appropriate, cases... forwarded to the issuer by HHS."

APPENDIX 1

- 45 CFR §156.1010(d) states that the issuer must generally resolve cases within 15 calendar days of receipt unless it is an urgent case, which must be resolved within 72 hours of receipt.

Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight Guidance entitled, "Casework Guidance for Issuers in Federally-facilitated Marketplaces, including State Partnership Marketplaces," dated March 13, 2014, notes that cases provided to issuers under

CFR §156.1010(b) will be provided via the HICS web application. It also defines urgent cases as Level 1 and all other cases as Level 2.”

As noted in Audit Inquiry #1, Blue Cross made every effort to take the appropriate action to accurately address each of the cases and had policies and procedures in place to meet HICS case timeliness requirements. Blue Cross further acknowledges a recommendation or corrective action was not requested by OPM due to the efforts made and the dissolution of the Blue Cross MSP program. Blue Cross is committed to processing HICS cases timely and will continue to work to ensure compliance with applicable regulations.

Sincerely,

Blue Cross and Blue Shield of Alabama

<Email Only>

450 Riverchase Parkway East
Birmingham, Alabama 35226

APPENDIX 2



BlueCross BlueShield of Alabama

October 13, 2017

[REDACTED]
U.S. Office of Personnel Management
Office of the Inspector General
800 Cranberry Woods Drive, Suite 130
Cranberry Township, PA 16066

Dear [REDACTED]:

Blue Cross and Blue Shield of Alabama (Blue Cross) appreciates the opportunity to respond to the Enrollment Form 834 Errors Processing Timeliness finding (Audit Inquiry #2) identified by the U.S. Office of Personnel Management (OPM) during the recent Multi-State Plan (MSP) Audit and acknowledges the following:

- Blue Cross processed four enrollment form 834 errors untimely, resulting in MSP member overpayments of approximately \$982.
- 45 CFR 800.106(b) requires issuers to "ensure that an eligible individual receives the benefit of advance payments of premium tax credits...and the cost-sharing reductions" prescribed by applicable laws and regulations.
- 45 CFR 800.401(c)(8)(i) states that issuers are responsible for "establishing and maintaining a system of internal controls that provides reasonable assurance that the provision and payments of benefits and other expenses comply with legal, regulatory, and contractual guidelines."
- 45 CFR 156.460(a)(1) requires the issuer to reduce members' premiums by the advanced premium tax credit (APTC), as applicable. 45 CFR 156.460(c) also requires the issuer to notify the member within 45 calendar days of identifying that the APTC was not applied as required and to "refund any excess premium paid by or for the enrollee."

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Of the 24 MSP enrollment form 834 errors reviewed that occurred from January 1, 2017 through April 30, 2017, there were four Enrollment Form 834 errors that involved changes to the plan, APTC, and/or cost-sharing reduction amounts that impacted the amount of premium to be paid by the affected MSP members.

Blue Cross concurs with OPM that these errors were resolved, appropriate actions were subsequently taken to process the errors, and refunds/credits were provided to the affected members for the applicable over/underpayments. Additional information necessary for OPM to verify the resolution of these 834 errors is available upon request.

Although participation in the MSP Program will end December 31, 2017, Blue Cross is committed to ensuring that all 834 errors are processed timely and in compliance with aforementioned regulatory standards as it relates to Blue Cross' Federally Facilitated Marketplace membership.

Recommendation 1: We recommend that BCBSAL continue to monitor application of the outstanding credit balance totaling approximately \$539 for the members impacted by the overpayments.

Blue Cross Response: All balances owed have been either refunded or credited to the member.

Recommendation 2: We recommend that BCBSAL develop internal controls and procedures over the enrollment form 834 error resolution processes to ensure that errors are addressed more timely and to minimize potential member impact.

Blue Cross Response: For monitoring purposes, five meetings occur each week to ensure enrollment continues to be effectively processed systematically. One meeting is dedicated to document 834 enrollment requirements based on CMS weekly calls. Another meeting and three status meetings are held each week with the Blue Cross team (comprised of system developers and business area partners supporting the 834 error resolution process) to communicate, develop, and implement requirements to ensure successful automated enrollment.

Approximately [REDACTED] Enrollment Form 834 errors have been received to date. With [REDACTED] on-exchange contracts as of 8/31/17, approximately 98% of contracts enrolled have processed systematically based upon weekly efforts to automate 834 enrollments. Of the [REDACTED] on-exchange contracts enrolled, approximately 61% ([REDACTED]) can be attributed to Blue Cross' Multi-State Plans products (Exhibit A).

These routinely scheduled meetings have occurred since the Affordable Care Act (ACA) was implemented. As a result of the tremendous efforts to automate 834 enrollments, significant strides have been made to systematically process 834 enrollment. Additionally, Blue Cross has procedures to guide associates while working 834 errors. These documented procedures help to ensure

APPENDIX 2

consistency and accuracy amongst associates. The errors are worked using procedures outlined in the 834 Failed Transaction Error Instructions provided to Blue Cross staff (Exhibit B).

There have been numerous improvements on both the part of CMS and the issuer to increase the number of 834 records that process systematically without manual intervention. The resources work proactively to determine additional programming updates to further increase the amount of records being processed. Because the majority of the records are being processed systematically, the resources in place to ensure timely processing are adequate.

Blue Cross is committed to ensuring that all 834 errors are processed accurately and timely, in compliance with aforementioned regulatory standards; and will continue to work to strengthen procedures and controls around the 834 error resolution timeliness.

Sincerely,

Blue Cross and Blue Shield of Alabama

450 Riverchase Parkway East
Birmingham, Alabama 35226

<Email Only>



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