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

Final Audit Report

Audit of Enrollment at All Blue Cross and Blue Shield Plans for Contract Years 2018-2019

Report Number 1A-99-00-20-018

March 12, 2021

EXECUTIVE SUMMARY

Audit of Enrollment at All Blue Cross and Blue Shield Plans
for Contract Years 2018-2019

Report No. 1A-99-00-20-018 **March 12, 2021**

Why Did We Conduct the Audit?

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

What Did We Audit?

The Office of the Inspector General has completed a performance audit of the FEHBP operations at all BCBS plans related to enrollment eligibility. Specifically, we reviewed enrollment and claim payments from January 1, 2018, through December 31, 2019, to determine if any were paid erroneously due to incorrect member eligibility. Our audit was conducted virtually with the assistance of the Association by our audit staff located in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

Overall, this report showed a significant reduction in enrollment errors ($7.3 million for a 32-month audit period, to $412,570 for a 24-month audit period) from what was reported in our previous audit (the Global Audit of Claims-to-Enrollment Match for BCBS Plans – issued August 28, 2018). We commend the Association for corrective actions taken since the last audit to reduce the errors identified.

During this audit, we identified the following:

- There were 42 members ineligible for coverage at the time claims were incurred. For these members, we found 436 claims (medical and pharmacy), totaling $412,570, which were erroneously paid due to retroactive enrollment updates or system errors.

- Included in those reported above were 13 members identified as former spouses or ineligible family members, who on average used benefits for 10 years after they were ineligible. Once identified, the local BCBS plans failed to identify these as cases of possible fraud, waste, and abuse and refer them to their Special Investigation Units.

ABBREVIATIONS

5 CFR 890	**Title 5, Code of Federal Regulations, Chapter 1, Part 890**
Act	**Federal Employees Health Benefits Act**
Association	**BlueCross BlueShield Association**
BCBS	**Blue Cross and Blue Shield**
CAMT	**FEPDirect Claims Audit Monitoring Tool**
Contract	**Contract CS 1039 – The contract between the Association and OPM**
FEHB	**Federal Employees Health Benefits**
FEHBP	**Federal Employees Health Benefits Program**
FEP	**Federal Employee Program**
FEPDirect	**The Association's nation-wide claims and enrollment database**
FWA	**Fraud, Waste, and Abuse**
HIO	**OPM's Healthcare and Insurance Office**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
PBM	**Pharmacy Benefit Manager**
SIU	**Special Investigations Unit**
SBP	**Service Benefit Plan**

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REPORT FRAUD, WASTE, AND MISMANAGEMENT

I. BACKGROUND

This final report details the results of our performance audit of the Federal Employees Health Benefits Program (FEHBP) enrollment at all Blue Cross and Blue Shield (BCBS) plans for the period January 1, 2018, through December 31, 2019. The audit was performed at the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG) offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida.

The audit was conducted pursuant to the provisions of contract CS 1039 (Contract) between OPM and the BlueCross BlueShield Association (Association); Title 5, United States Code, Chapter 89; and Title 5, Code of Federal Regulations, Chapter 1, Part 890 (5 CFR 890). The audit was performed by OPM's OIG, as authorized by the Inspector General Act of 1978, as amended.

The FEHBP was established by the Federal Employees Health Benefits Act (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 Act are implemented by OPM through regulations codified in 5 CFR 890.

The Association, on behalf of participating BCBS plans, has entered into a Government-wide Service Benefit Plan (SBP) contract with OPM to provide a health benefit plan authorized by the Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its Federal subscribers.

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

The Association has also established an FEP Operations Center. CareFirst BCBS, located in Owings Mills, Maryland, performs the activities of the FEP Operations Center. 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.

[1] Throughout this report, when we refer to FEP, we are referring to the SBP lines of business at the local BCBS plans. 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 management at the local BCBS plans. In addition, the local BCBS plans are responsible for establishing and maintaining a system of internal controls.

OPM receives daily electronic enrollment information from Federal employment offices and payroll offices. OPM creates a database of that information and transmits it weekly to the Association. The Association then updates its nation-wide claims and enrollment database (FEPDirect) with the updated information. FEPDirect is responsible for determining the eligibility of FEHBP members enrolled with BCBS coverage prior to payment being approved. When updated enrollment information is provided directly to the Association or local BCBS plans, outside of OPM's electronic transmissions, then the information is manually updated in FEPDirect.

Once eligibility has been updated, FEPDirect produces a retroactive enrollment report that identifies claims impacted by enrollment changes. The claims identified are then loaded to the FEPDirect Claims Audit Monitoring Tool (CAMT) for the local BCBS plans to review and determine if recoveries are necessary. The Association requires that the local BCBS plans complete their reviews in the CAMT within 30 days and initiate any recoveries or offsets that are needed. The process continues until the claim is recovered or it is determined to be uncollectible. Each quarter the Association reviews the retroactive enrollment reports to determine if the local BCBS plans responded within the required timeframe.

The most recent audit report issued that covered enrollment for all BCBS plans was report number 1A-99-00-17-048, dated August 28, 2018, which covered claim payments from October 1, 2014, through May 31, 2017. All findings from the previous audit have been satisfactorily resolved.

The results of our audit were discussed with Association officials throughout the audit and at an exit conference on December 14, 2020. We issued a draft report, dated December 23, 2020, to solicit the Association's comments to the findings. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as an appendix to this report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

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

SCOPE AND METHODOLOGY

We conducted our 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.

The focus of this performance audit was to identify any claims paid for ineligible members that occurred from January 1, 2018, through December 31, 2019. Our audit fieldwork was performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida from April 2020 through December 2020.

In planning and conducting our audit, we obtained an understanding of the Association's internal control structure to help determine the nature, timing, and extent of our auditing procedures. Our audit approach consisted mainly of substantive tests of transactions and not tests of controls. Based on our testing, we did not identify any significant matters involving the Association's internal control structure and its operations. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Association's system of internal controls taken as a whole.

We also conducted tests to determine whether the local BCBS plans and Association had complied with the Contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations and Federal Employees Health Benefits Acquisition Regulations, as appropriate), and the laws and regulations governing the FEHBP as they relate to claim payments. With the exception of those areas noted in the "Audit Findings and Recommendations" section of this audit report, we found that the local BCBS plans and Association were in compliance with the health benefit provisions of the Contract. With respect to any areas not tested, nothing came to our attention that caused us to believe that the local BCBS plans and Association had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP Director's Office, the FEP Operations Center, and the Association. Through the performance of audits and an in-house claims data reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify the potential ineligible members and associated claims selected in our samples. The BCBS claims

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

To identify the ineligible members, we performed a cross match of the claims paid in 2018 and 2019 from all local BCBS plans against the Association's enrollment database and identified universes of members with claims paid that did not appear to be eligible.

Specifically, we identified a universe of 125,233 patients, with 5,639,172 claim lines totaling $1,038,012,295, with enrollment conflicts (paid during an apparent gap in coverage or before or after coverage dates). From this universe we judgmentally selected all patients with claims totaling $100,000 or greater. This resulted in a sample of 1,664 patients, with 616,117 claim lines, totaling $412,413,293.

Additionally, we identified a universe of 1,221 patients, with 22,118 claim lines totaling $3,515,336, where no enrollment record was identified. From this universe we judgmentally selected all patients with claims totaling $2,500 or greater. This resulted in a sample of 85 patients, with 15,068 claim lines, totaling $3,148,180.

Finally, we identified a universe of 25,533 patients, with 1,441,282 claim lines totaling $320,094,615, who were dependents age 26 or older at the time of service. From this universe we selected two separate samples:

- We judgementally selected all dependents with claim lines totaling $350,000 or greater. This resulted in a sample of 116 patients, with 94,649 claim lines, totaling $103,378,834.

- We judgementally selected all dependents aged 65 or older with claim lines totaling $30,000 or greater. This resulted in a sample of eight patients, with 1,536 claim lines, totaling $433,387.

The samples selected and reviewed were not statistically based. Consequently, the results were not projected to their respective universes since it is unlikely that the results are representative of the universes taken as a whole.

We provided the above samples to the Association for it to determine and support if the members were eligible or ineligible at the time services were rendered. We verified a subset of the Association's responses for accuracy by reviewing all those it identified as ineligible and a portion of those it concluded were eligible. For those members identified as ineligible we identified all medical and pharmacy claims paid for each member.

III. AUDIT FINDINGS AND RECOMMENDATIONS

Overall, this report showed a significant reduction in enrollment errors ($7.3 million for a 32-month audit period, to $412,570 for a 24-month audit period) from what was reported in our previous audit (the Global Audit of Claims-to-Enrollment Match for BCBS Plans – issued August 28, 2018). We commend the Association for corrective actions taken since the last audit to reduce the errors identified. This report's identified errors are detailed below.

1. Erroneous Claims Paid for Ineligible Members $412,570

42 members with claims totaling $412,570 were found to be ineligible due to retro activity and system errors.

Our review identified 42 members that were ineligible for FEHBP coverage due to retroactive changes or system errors. For those members, we found 436 claims (medical and pharmacy), totaling $412,570 in 2018 and 2019 that were erroneously paid.

Section 2.3(g) of the Contract states that "[i]t is the Carrier's responsibility to proactively identify overpayments through comprehensive, statistically valid reviews and a robust internal control program."

Section 2.3(g) also states that "[i]f the Carrier determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment" from the member or provider "regardless of any time period limitations in the written agreement with the provider."

Additionally, Section 1.9(a) states "The Carrier shall operate a system designed to detect and eliminate FWA [fraud, waste, and abuse] … by individual [Federal Employees Health Benefits] FEHB Members. In addition, FEHBP Carriers must demonstrate they have submitted written notification to OPM-OIG within 30 business days of identifying potential FWA issues impacting the FEHBP regardless of dollar value."

We specifically identified two types of errors in our eligibility review (1) those related to retroactive eligibility updates (38 members with $388,704 in claims paid) and (2) claim payment errors (4 members with $23,866 in claims paid).

Retroactive Eligibility Updates

Our review identified 38 members that were ineligible for coverage at the time claims were incurred, based on retroactive eligibility updates. Retroactive eligibility updates are cases where the eligibility information in FEPDirect is received and updated after the effective date of the change. These members incurred 388 claims (medical and pharmacy), totaling $388,704 in erroneous payments.

The claims of these 38 members were paid correctly by the local BCBS plans based on the eligibility information in FEPDirect at the time the claim was submitted. However, once the

eligibility updates in FEPDirect showed that these members were in fact ineligible, the local BCBS plans should have been working the claims incurred by these members within the Claims Audit Monitoring Tool (CAMT) to determine if any recoveries were warranted.

Of particular interest, our review showed that 13 of these members appeared to be either former spouses or ineligible dependents. These members are not eligible for coverage based on specific FEHB Program guidance.

The FEHB Handbook describes family members eligible for coverage as spouses; children under 26, including legally adopted children; step-children; foster children meeting requirements; and children over 26 that are incapable of self-support. It should be noted that a former spouse is immediately ineligible for FEHBP coverage after a divorce no matter what the divorce decree states. Additionally, after a divorce, step-children remain eligible only if they continue to live with the enrolled member in a regular parent-child relationship. An ineligible dependent may be removed from an FEHB policy on the date the local BCBS plan is notified.

Our review not only identified the improper payments incurred for these 13 members, but it also showed that, on average, coverage continued for the ineligible members for 10 years after FEHBP guidance deemed them ineligible. Unfortunately, many members are unaware of the FEHB rules for eligibility and inappropriately maintain former spouses and/or dependents on their coverage as a result of court mandates or simply not understanding the eligibility rules. However, were members aware of this criteria, the decision to maintain ineligible family members could be considered a fraudulent action. Therefore, we asked the Association if these ineligible members were investigated by its Special Investigations Unit (SIU) for possible FWA. The Association responded that none had been referred to an SIU for investigation prior to our bringing them to its attention.

The Association informed us that the best way to detect these types of cases is through the above mentioned CAMT application in FEPDirect. Through the CAMT, processors would have access to reasons for termination and how long benefits were used while ineligible. The Association's FEP Standards Manual also includes instructions to the local BCBS plans on using the CAMT's retroactive enrollment information to develop enrollment fraud leads.

When this issue was first brought to the Association's attention it agreed this was an area of weakness where it could improve. The Association stated that it would develop additional guidance for local BCBS plan SIU departments to provide to processors responsible for reviewing these types of claims and for determining when ineligible former family members should be referred to SIUs for potential FWA reporting.

However, when formally notified of the finding, the Association stated that additional guidance for local BCBS plan SIUs is unnecessary at this time because it has been advised that direction from OPM on these types of claims is forthcoming and that it would implement any necessary

procedures required. While we appreciate the Association's willingness to update its current procedures based on any forthcoming guidance from OPM, until such guidance is provided, it is still accountable to the current contract terms regarding FWA. These terms currently hold the local BCBS plans accountable for detection and elimination of FWA, so it is our position that the Association should take any needed actions now to address the issues identified in this review.

Recommendation 1

We recommend that the contracting officer disallow $388,704 for claim overpayments. As of the date of this report $303,679 has been recovered, leaving a remaining amount due to the FEHBP of $85,025.

Association's Response:

Of the unrecovered amount, the Association stated that $78,895 is uncollectable and that $6,130 is still in recovery. Additionally, the Association states that it will continue to coordinate with the local BCBS plans to ensure all recovered claims are returned to the FEHBP and that any uncollectible claims are supported by due diligence recovery documentation in accordance with the Contract.

OIG Comments:

The OIG continues to question the remaining amount of $85,025. For the claims identified as uncollectable by the Association, our review has determined that recoveries have not been initiated for claims totaling $12,059 due to provider contract limitations. However, per section 2.3(g) of the Contract, the local BCBS plans are required to attempt recoveries from the member or provider regardless of any time period limitations in the written agreement with the provider.

For the remaining claims identified as uncollectable, we were only provided evidence of the recovery letters sent. However, we were not provided any additional information that would support that any other recovery efforts, as described in section 2.3(g) of the Contract, have been attempted (such as offsets or collections attempts for high dollar claims).

For the recoveries still in process, we were only provided documentation that recoveries had begun on claims totaling $1,347.

Recommendation 2

We recommend that the contracting officer verify that all recovered amounts were returned to the FEHBP.

Association's Response:

The Association stated that it will provide documentation to support all recovered overpayments to OPM once the final report is received.

Recommendation 3

We recommend that the Association direct its local BCBS plan SIUs to instruct processors on how to identify, review, and report the type of potential enrollment fraud identified in this finding as possible FWA cases.

Association's Response:

The Association states that the cases referred to in the draft report represent ineligible members that were terminated by a request from OPM, the local BCBS plans, or the member without any indication that fraud was involved. Once these ineligible members are removed from FEP enrollment, all claims paid to these members or their providers are provided to the local BCBS plans or its Pharmacy Benefit Managers (PBM) to initiate recovery of the overpayments. Currently, these cases are not referred to SIUs for fraud investigation.

Additionally, the Association states that it's FEP SIU has provided guidance to its local BCBS plan and PBM SIUs when potential enrollment FWA is identified and that it will continue to work with them to ensure that guidance is followed.

OIG Comments:

We find the Association's response to the recommendation concerning because, cases like these should warrant additional investigation to determine why coverage was not terminated once the member became ineligible. As mentioned above, claim processors are the initial group who receive these requests for terminations. When they are presented with cases like these, they should be trained to forward them to their respective SIUs for further review. Of equal importance, our audit samples focused on members with potential eligibility issues who incurred claims totaling $100,000 or more. This leaves a remaining universe of over $600 million in claims (encompassing approximately 124,000 members) where this issue could be more widely spread.

It is for these reasons we maintain that additional policies, procedures, and guidance is needed to proactively identify and report these potential FWA cases.

Claim Payment Errors

Our eligibility review identified four members whose claims continued to pay after their coverage had been terminated and updated in FEPDirect and were, thereby, known to be ineligible within the system. Nonetheless, these four members incurred 48 medical claims, resulting in FEHB Program overpayments of $23,866.

Section 2.3(g)(12) of the Contract states that "[i]n compliance with the provisions of the Contract Disputes Act, the Carrier shall return to the Program an amount equal to the uncollected

erroneous payment where the Contracting Officer determines that (a) the Carrier's failure to appropriately apply its operating procedure caused the erroneous payment and (b) that the Carrier failed to make a prompt and diligent effort to recover an erroneous payment."

We made inquiries to the Association as to why claims for these ineligible members were paid when the eligibility system showed that they had been terminated and the system had been updated prior to the claims being incurred. Specifically, the Association stated:

- 46 Claims, totaling $20,818, paid for three ineligible members were improperly paid due to a system error within FEPDirect. This problem, identified by the Association in September 2019, caused dependent claims with a dependent termination code to bypass a master file edit in FEPDirect. The Association stated that this appears to be the only termination code impacted and correction was scheduled to be implemented in the FEPDirect system on July 31, 2020.

- One member had two claims, totaling $3,048, erroneously paid due to a system error. The error involved claims that were submitted after the timely filing deadline (within one year after the claim was incurred). Typically these types of claims can only be processed with approval from local BCBS plan management. However, these claims bypassed master file edits in FEPDirect, which allowed them to be paid without approval. The Association stated that as of May 2, 2020, it has updated the FEPDirect edits to fix the error.

In accordance with Contract section 2.3 (g), as these system errors were caused by internal control weaknesses within the Association's FEPDirect system, all monies in question should be returned to the FEHBP regardless of the Association's recovery efforts.

Recommendation 4

We recommend that the contracting officer disallow $23,866 for claim overpayments due to system errors. As of the date of this report $11,371 has been recovered, leaving the remaining amount due to the FEHBP of $12,495.

Association's Response:

Of the unrecovered amount, the Association stated that claims totaling $9,374 are uncollectible and that $3,121 is still in the recovery process.

Additionally, the Association stated that it will continue to coordinate with the local BCBS plans to ensure all recovered claims are returned to the FEHBP and that any uncollectible claims are supported by due diligence recovery documentation in accordance with the Contract.

OIG Comments:

As stated above, it is the OIG's position that these overpayments were caused by weaknesses in the Plan's internal controls over its claims processing system. Specifically, the Association's FEPDirect system deemed the members ineligible prior to the claims being incurred, yet the claims were paid anyway due to errors in the system's master file edits. Consequently, it is our position that these overpayments should be returned in their entirety to the FEHBP, regardless of the Association's ability to collect these overpayments from the provider or the member.

Recommendation 5

We recommend that the contracting officer verify that all recovered amounts were returned to the FEHBP.

Association's Response:

The Association stated that it will provide documentation to support all recovered overpayments to OPM once the final report is received.

APPENDIX

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January 22, 2021

Ms. Stephanie Oliver, Group Chief
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U.S. Office of Personnel Management
1900 E Street, Room 6400
Washington, DC 20415-11000

Reference: OPM DRAFT AUDIT REPORT
Global Enrollment Audit of Blue Cross Blue Shield Plans for Contract Years 2018-2019
Audit Report Number 1A-99-00-20-018
Issued December 23, 2020

Dear Ms. Oliver:

Below is the Blue Cross and Blue Shield Association (BCBSA) response to the recommendations included in the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report.

Recommendation 1

We recommend that the Association return the remaining $136,309 in overcharges to the FEHB Program due to retroactive eligibility changes.

BCBSA Response

Of the remaining overcharges of $136,309 noted above, BCBSA determined the following:

- $40,712 has been recovered
- $78,895 has been determined uncollectible
- $10,574 is contested
- $6,130 is still in process for recovery

BCBSA will continue to coordinate with Plans to ensure, where possible, that all recovered claims are returned to the Program and that all uncollectible claims are supported by due diligence recovery documentation in accordance with CS1039 Section 2.3g. The documentation to support the recovered, uncollectible and contested claims are included with this response. Documentation to support the final disposition of claims still in the recovery

process will be provided to OPM Audit Resolution and Compliance once the final report is received.

Recommendation 2

We recommend that the contracting officer verify that all recovered amounts were returned to the FEHBP.

BCBSA Response

BCBSA will provide documentation to support all recovered overpayments to OPM Audit Resolution and Compliance once the final report is received.

Recommendation 3

We recommend that the Association direct its local BCBS plan SIUs to instruct processors on how to identify, review and report the type of potential enrollment fraud identified in this finding as possible FWA cases.

BCBSA Response

The cases referred to in the draft report represent retroactive terminated ineligible members that were terminated either by a request from OPM, the Plan or the member without any indication that fraud was involved. Once these ineligible members are removed from FEP enrollment, all claims paid to these members are provided to Plans to review and initiate recovery of the overpayments on the Claims Audit Monitoring Tool (CAMT) or to Pharmacy Benefit Managers (PBM) via the retroactive enrollment notice process. Although identification and recovery of the overpayments is initiated, the ineligible members are not referred to Plan and PBM SIUs for fraud investigation, at this time.

BCBSA FEP SIU has provided guidance to Plan and PBM SIUs as stated in the current FEP Standards for Fraud Waste and Abuse (FWA) Identification, Prevention and Reporting Manual (Manual) when potential enrollment FWA is identified and will continue to work with the Plans and PBMs to ensure that guidance is followed.

Redacted by the OPM-OIG
Not Relevant to the Final Report

Recommendation 4

We recommend that the Association return the remaining $15,816 in overcharges to the FEHB Program due to system errors.

BCBSA Response

Of the remaining overcharges totaling $15,816 noted above, BCBSA determined the following:

- $3,321 has been recovered

- $9,374 has been determined uncollectible
- $3,121 is still in process to recover

BCBSA will continue to coordinate with Plans to ensure, where possible, that all recovered claims are returned to the Program and that all uncollectible claims are supported by due diligence recovery documentation in accordance with CS1039 Section 2.3g. Documentation to support recovered and uncollectible claims are included with this response. Documentation to support the final disposition of claims still in the recovery process will be provided to OPM Audit Resolution and Compliance once the final report is received.

Recommendation 5

We recommend that the contracting officer verify that all recovered amounts were returned to the FEHBP.

BCBSA Response

BCBSA will work with OPM Audit Resolution and Compliance to provide documentation to ensure all recovered amounts are returned to the FEHBP.

Redacted by the OPM-OIG
Not Relevant to the Final Report

Thank you for this opportunity to respond to the recommendations included in this Draft Report. If you have any questions, please contact me at [redacted] or [redacted] at [redacted].

Sincerely,

[redacted]

Managing Director, FEP Program Assurance

cc: [redacted], Director, FEP Program Assurance
[redacted], Manager, FEP Program Assurance
[redacted], Senior Consultant, FEP Program Assurance

Attachments

Report Fraud, Waste, and Mismanagement

Fraud, waste, and mismanagement in Government concerns everyone: Office of the Inspector General staff, agency employees, and the general public. We actively solicit allegations of any inefficient and wasteful practices, fraud, and mismanagement related to OPM programs and operations. You can report allegations to us in several ways:

By Internet: http://www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse

By Phone: Toll Free Number: (877) 499-7295
Washington Metro Area (202) 606-2423

By Mail: Office of the Inspector General
U.S. Office of Personnel Management
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