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

# Final Audit Report

**Subject:**

## AUDIT OF AMERICAN POSTAL WORKERS UNION HEALTH PLAN GLEN BURNIE, MARYLAND

**Report No. 1B-47-00-11-002**

**Date:** September 1, 2011

**--CAUTION--**

This audit report has been distributed to Federal officials who are responsible for the administration of the audited program. This audit report may contain proprietary data which is protected by Federal law (18 U.S.C. 1905). Therefore, while this audit report is available under the Freedom of Information Act and made available to the public on the OIG webpage, caution needs to be exercised before releasing the report to the general public as it may contain proprietary information that was redacted from the publicly distributed copy.

Office of the
Inspector General

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

# AUDIT REPORT

Federal Employees Health Benefits Program
Employee Organization Plan

American Postal Workers Union Health Plan
Contract CS 1370 Plan Code 47
Glen Burnie, Maryland

REPORT NO. 1B-47-00-11-002 DATE: September 1, 2011

Michael R. Esser
Assistant Inspector General
for Audits

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

# EXECUTIVE SUMMARY

Federal Employees Health Benefits Program
Employee Organization Plan

American Postal Workers Union Health Plan
Contract CS 1370 Plan Code 47
Glen Burnie, Maryland

REPORT NO. 1B-47-00-11-002 DATE: September 1, 2011

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at the American Postal Workers Union Health Plan (Plan) in Glen Burnie, Maryland, questions $17,314 in administrative expense charges and includes procedural findings regarding the Plan's Fraud and Abuse (F&A) program. The Plan agreed (***A***) with this questioned amount and disagreed (***D***) with the procedural findings. Lost investment income (LII) on the questioned charges amounts to $2,642.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered miscellaneous health benefit payments and credits and administrative expenses from 2005 through 2009 as reported in the Annual Accounting Statements. In addition, we reviewed the Plan's cash management practices related to FEHBP funds for contract years 2005 through 2009.

Questioned items are summarized as follows:

## MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

The audit disclosed no findings pertaining to miscellaneous health benefit payments and credits. Overall, we concluded that the Plan returned health benefit refunds and recoveries, including prescription drug rebates, to the FEHBP in a timely manner.

## ADMINISTRATIVE EXPENSES

- **Travel Costs (*A*)** **$17,314**

  The Plan charged the FEHBP actual travel costs incurred without limiting these charges to the maximum per diem rates, as required by the federal regulations. As a result, the Plan overcharged the FEHBP $17,314 for travel costs from 2005 through 2009.

## CASH MANAGEMENT

The audit disclosed no findings pertaining to cash management. Overall, we concluded that the Plan handled FEHBP funds in accordance with Contract CS 1370 and applicable laws and regulations.

## FRAUD AND ABUSE PROGRAM

- **Notification of Fraud and Abuse Cases (*D*)** **Procedural**

  The Plan has not fully implemented a comprehensive F&A program. As a result, the Plan did not refer any potential F&A cases from 2005 through 2009 to the Office of Personnel Management's Office of the Inspector General (OPM/OIG).

- **Fraud and Abuse Annual Reports (*D*)** **Procedural**

  The Plan did not provide the OPM/OIG complete F&A annual reports from 2005 through 2009. By not including all F&A reporting requirements, we could not determine the overall outcome of the Plan's prevention, detection, and F&A program activities.

## LOST INVESTMENT INCOME ON AUDIT FINDINGS

As a result of our audit finding presented in this audit report, the FEHBP is due LII of **$2,642**, calculated through June 30, 2011.

## CONTENTS

**PAGE**


EXECUTIVE SUMMARY ..... i

I. INTRODUCTION AND BACKGROUND ..... 1

II. OBJECTIVES, SCOPE, AND METHODOLOGY ..... 3

III. AUDIT FINDINGS AND RECOMMENDATIONS ..... 6

A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS ..... 6

B. ADMINISTRATIVE EXPENSES ..... 6

1. Travel Costs ..... 6

C. CASH MANAGEMENT ..... 7

D. FRAUD AND ABUSE PROGRAM ..... 7

1. Notification of Fraud and Abuse Cases ..... 7
2. Fraud and Abuse Annual Reports ..... 12

E. LOST INVESTMENT INCOME ON AUDIT FINDINGS ..... 13

IV. MAJOR CONTRIBUTORS TO THIS REPORT ..... 15

V. SCHEDULES

A. CONTRACT CHARGES AND AMOUNTS QUESTIONED
B. LOST INVESTMENT INCOME CALCULATION

APPENDIX (The American Postal Workers Union Health Plan reply, dated April 6, 2011, to the draft audit report)

# 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 American Postal Workers Union Health (Plan). The Plan is located in Glen Burnie, Maryland.

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 Plan is a fee-for-service plan. The Plan enrollment is open to all postal service employees who are members of the American Postal Workers Union (APWU) and all other federal employees and annuitants that elect to become associate members of APWU. APWU is the sponsor of the Plan, operating under Contract CS 1370 to provide a health benefits plan authorized by the FEHB Act. Members have a choice of enrollment in a High Option or a Consumer Driven Health Plan.

APWU's contract with OPM is experience-rated. Thus, the costs of providing benefits in the prior year, including underwritten gains and losses which have been carried forward, are reflected in current and future years' premium rates. In addition, the contract provides that in the event of termination, unexpended program funds revert to the FEHBP Trust Fund. In recognition of these provisions, the contract requires an accounting of program funds be submitted at the end of each contract year. The accounting is made on a statement of operations known as the Annual Accounting Statement.

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

All findings from our previous audit of the Plan (Report No. 1B-47-00-01-080, dated August 20, 2002) for contract years 1998 through 2000 have been satisfactorily resolved.

The results of this audit were provided to the Plan in written audit inquiries; were discussed with Plan officials throughout the audit and at an exit conference; and were presented in detail in a draft report, dated March 4, 2011. The Plan'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 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 if the Plan operates an effective Fraud and Abuse (F&A) program for the prevention, detection, and/or recovery of fraudulent claims as required by the FEHBP contract.

## 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 Plan's Annual Accounting Statements for contract years 2005 through 2009. During the period, the Plan paid approximately $2.6 billion in health benefit charges and $249 million in administrative expenses (See Figure 1 and Schedule A). The Plan also paid approximately $24 million in other expenses and retentions (See Schedule A).[1]

Specifically, we reviewed miscellaneous health benefit payments and credits (e.g., refunds, subrogation recoveries, fraud recoveries, and prescription drug rebates), administrative expenses, and cash management activities from 2005 through 2009.

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 operation. 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.

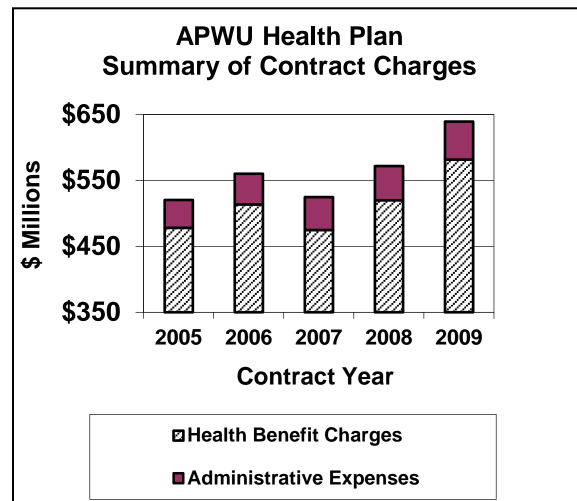


Figure 1 – Contract Charges

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 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.

[1] We did not review other expenses and retentions for contract years 2005 through 2009, except for the cash management of these funds.

The audit was performed at the Plan's office in Glen Burnie, Maryland from October 25 through November 19, 2010 and December 6 through December 17, 2010. Audit fieldwork was also performed at our offices in Washington, D.C. and Cranberry Township, Pennsylvania.

In addition, we would like to note that the Plan did a great job supporting the audit by promptly responding to our information requests, samples, questions, and audit inquiries (findings). Also, the Plan was very cooperative and well prepared for this audit.

## 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 115 high dollar health benefit refunds, totaling $6,952,946 (from a universe of 38,445 refunds, totaling $27,186,311); 27 high dollar subrogation recoveries, totaling $1,493,507 (from a universe of 819 recoveries, totaling $3,452,572); 6 high dollar fraud recoveries, totaling $32,438 (from a universe of 83 recoveries, totaling $39,345); and 10 quarterly drug rebates, totaling $27,416,858 (from a universe of 37 quarterly retail and mail order drug rebates, totaling $64,898,370) to determine 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 2005 through 2009. Specifically, we reviewed administrative expenses relating to cost centers, natural accounts, out-of-system adjustments, prior period adjustments, pension, post-retirement, executive compensation, lobbying, vendor cost containment, and Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance. 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 to determine whether the Plan handled FEHBP funds in accordance with Contract CS 1370 and applicable laws and regulations.

We also interviewed the Plan's Special Investigations Unit regarding the effectiveness of the Plan's F&A program.

[2] The sample of health benefit refunds included all refunds greater than $25,000. For subrogation, the sample consisted of all recoveries greater than $25,000. The sample of fraud recoveries consisted of the three highest dollar recoveries from each year in 2008 and 2009. For drug rebates, the sample consisted of the two highest dollar quarterly drug rebates from each year.

# III. AUDIT FINDINGS AND RECOMMENDATIONS

## A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

The audit disclosed no findings pertaining to miscellaneous health benefit payments and credits. Overall, we concluded that the Plan returned health benefit refunds and recoveries, including prescription drug rebates, to the FEHBP in a timely manner.

## B. ADMINISTRATIVE EXPENSES

### 1. Travel Costs $17,314

The Plan did not calculate travel costs in accordance with the FAR. The FAR limits the amount of travel costs for lodging, meals, and incidental expenses that may be charged to a government contract to the maximum federal per diem rates on a daily basis. Despite the regulation, the Plan charged the FEHBP actual travel costs incurred without limiting these charges to the maximum federal per diem rates. As a result, the Plan overcharged the FEHBP $17,314 for travel costs from 2005 through 2009.

48 CFR 31.205-46(a)(2) states that "costs incurred for lodging, meals, and incidental expenses . . . shall be considered to be reasonable and allowable only to the extent that they do not exceed on a daily basis the maximum per diem rates in effect at the time of travel as set forth in the . . . Federal Travel Regulation, prescribed by the General Services Administration . . . ."

In 2009, the Plan charged administrative expenses of $57,606,837 to the FEHBP. From this universe, we selected a judgmental sample of 62 general ledger transactions to review, which totaled $3,662,046 in expenses charged to the FEHBP. We judgmentally selected these transactions from the five highest dollar cost centers charged to the FEHBP. In addition, we judgmentally selected six transactions, totaling $7,470, to review from the largest HIPAA cost center charged to the FEHBP from 2005 through 2009. We reviewed these general ledger transaction expenses for allowability, allocability, and reasonableness.

Based on our review, we determined that the Plan's travel costs were based on actual costs incurred without consideration to the maximum daily federal per diem rates. As a result of this finding, we expanded our general ledger transaction review to include all travel vouchers from 2005 through 2009. From 2007 through 2009, the Plan processed 211 travel vouchers, totaling $540,185, which were charged to the FEHBP. Because of time and cost considerations, we did not have the Plan pull documentation for the 2005 and 2006 travel costs, but instead we averaged the unallowable travel costs identified for 2007 through 2009 and applied this average to 2005 and 2006.

Our review of documentation concluded that the Plan did not properly calculate 72 travel vouchers (2007 through 2009), resulting in overcharges of $10,388 to the FEHBP. In addition, based on the three-year average (i.e., $3,463) of unallowable travel costs

identified from 2007 through 2009, we estimate that the FEHBP was overcharged $6,926 for 2005 and 2006. In total, the FEHBP is due $17,314 for travel costs that exceeded the maximum federal per diem rates.

**Plan's Response:**

The Plan agrees with this finding. The Plan states, "APWU Health Plan . . . has established policies and procedures to comply with this regulation in the future. The funds will be reimbursed to FEHBP once the lost investment income is calculated in the final report."

**Recommendation 1**

We recommend that the contracting officer disallow $17,314 for travel costs overcharged to the FEHBP.

## C. CASH MANAGEMENT

The audit disclosed no findings pertaining to cash management. Overall, we concluded that the Plan handled FEHBP funds in accordance with Contract CS 1370 and applicable laws and regulations.

## D. FRAUD AND ABUSE PROGRAM

### 1. Notification of Fraud and Abuse Cases — Procedural

The Plan has not fully implemented a comprehensive Fraud and Abuse (F&A) program. As a result, the Plan did not refer any potential F&A cases from 2005 through 2009 to the Office of Personnel Management's Office of the Inspector General (OPM/OIG).

The Plan has developed policies and procedures that represent components of an F&A program to address health care fraud and abuse. However, the Plan's F&A program does not appear to follow written procedures or all elements of a comprehensive F&A program, as required by Carrier Letter 2003-23 ("Industry Standards for Fraud & Abuse Programs").

Furthermore, the Plan has not fully adopted Carrier Letter 2007-12 ("Notifying OPM's Office of the Inspector General Concerning Fraud and Abuse Cases in the FEHBP Program"), which states, "All carriers must send a written notification/referral to the OPM-OIG within 30 days of becoming aware of any cases involving suspected false, fictitious, fraudulent, or misleading insurance claims, when . . . conditions are met . . . All carriers must also send a prompt written notification/referral to their Contracting Officer and OPM-OIG for any cases, regardless of the dollar amount of claims paid, if there is an indication of patient harm, potential for significant media attention, or other exceptional circumstances."

Carrier Letter 2003-23 defines indicators of areas that contain patient harm or patient safety issues to include, but not limited to: (1) pharmaceuticals, such as altered prescriptions, illegal refills, prescription splitting, and abuse of controlled substances, (2) medical errors in both inpatient and outpatient care, resulting in unfavorable outcomes, and (3) improper settings for procedures and services that result in poor outcomes.

For the period 2005 through 2009, we reviewed the Plan's F&A program to determine if the Plan had complied with Carrier Letters 2003-23 and 2007-12. Based on our review, we determined that the Plan did not refer any cases to the OPM/OIG during this period nor follow all of the Carrier Letter 2007-12 guidelines for notification of potential fraud issues. Specifically, the Plan's F&A program does not include complete program management of potential F&A issues regarding the referral of cases to OPM/OIG indicating areas of patient harm or safety issues, member related issues, including pharmaceutical F&A, and other pharmacy benefit manager referrals.

The following summarizes our concerns with the Plan's F&A program.

Program Management

In a meeting to discuss the Plan's F&A program, the Plan provided an overview of the services performed by Ingenix, a contractor that performs claim review services. The Plan stated that Ingenix does not provide any post-payment reviews, collection services, or recovery/repayment collections. Furthermore, the Plan stated that the F&A program only includes post-payment reviews for providers on a claim-by-claim basis. The Plan did not recognize that a post-payment review of all claims should be performed when a provider's claims are identified as potentially fraudulent to determine the potential maximum loss or dollar exposure.

The Plan's entire F&A program consists of only one analyst and the program is based solely on pre-payment claim-by-claim reviews performed by an outside source (Ingenix). The analyst tracks potential fraud cases using a spreadsheet. There is no evidence that proactive investigations are being performed by the Plan's analyst. The Plan's analyst handles the OPM/OIG data requests and reviews potential F&A issues from internal sources, which are then referred to Ingenix.

From the information provided by the Plan, the analyst performs very limited, if any, actual fraud investigation. Since the Plan's F&A program does not review providers or members for post-payments nor collect overpayments as a result, no actual fraud investigation can be taking place. While Ingenix may find a provider to be billing for medically unnecessary services, the Plan does not act on that information to review the provider for potential overpayments or potential F&A issues. By focusing on medical necessity issues only, potential F&A practices are going unnoticed that may lead to areas of weaknesses within the F&A program at the Plan.

Since the Plan has not reported any potential member related F&A cases on the annual reports to OPM from 2005 through 2009, there appears to be no actual program in place

for the detection and prevention of member related F&A issues, such as doctor shopping for pharmaceuticals/drugs and/or membership eligibility issues.

The services provided by Ingenix to identify potential F&A cases and the post-payment reviews performed on a claim-by-claim basis do not constitute an entire F&A program. Carrier Letter 2003-23 states that the FEHBP plans should use fraud protection software to analyze claims data, which includes evaluating on a prospective claim-by-claim basis (i.e., pre-payment review) and through the retrospective analysis of claim trends from either providers and/or members (i.e., post-payment review).

Patient Harm or Safety Issues

The Plan suggested a reason for the lack of fraud referrals was that cases did not meet the following notification thresholds: "the suspected health care provider has been paid over $20,000 in claims for the FEHB Program Enrollees, or . . . the suspected FEHB Program enrollee has been paid over $10,000, or . . . the entire scope of the investigation exceeds $50,000 and includes claims for FEHB Program enrollees and the carrier is coordinating its investigation with any other Federal law enforcement agency," as described in Carrier Letter 2007-12.

The Plan should refer potential patient harm or patient safety cases, regardless of monetary amounts, to the OPM/OIG so that issues related to pharmaceutical abuse and medical errors do not go undetected.

Pharmacy Benefit Manager

The Plan stated that Medco Health (Medco) is the contracted Pharmacy Benefit Manager (PBM). The Plan's Fraud Detection and Prevention Program Manual (Manual) describes Medco's Special Investigations Unit (SIU) as investigating "cases of suspected fraud by members and physicians on behalf of our clients." The Plan's Manual also states that Medco's SIU works closely with the Federal, state and local law enforcement to ensure the successful prosecution of individuals involved with fraudulent activity.

We recognize the existence and capabilities of Medco's F&A program. However, the Plan did not report any member fraud case during the audit scope and it appears that the Plan does not obtain any information from Medco related to Medco's F&A activities on the Plan's behalf. Furthermore, the Plan stated that even though they contract directly with Medco, they believed Medco communicated directly to OPM and OPM/OIG related to the notification/referral of potential F&A cases. As far as pharmacy-related cases, there was no evidence or indication that Medco had provided notification or referral of any pharmacy-related fraud issue to OPM and OPM/OIG on behalf of the Plan.

General Comments

The Plan did implement some of the requirements in Carrier Letter 2007-12, such as the requirement to respond to OPM/OIG requests for information, and the requirement in Carrier Letter 2003-23 to establish written policies and procedures to be followed by all personnel for the deterrence and detection of fraud.

However, by failing to implement all elements of a comprehensive F&A program, issues related to F&A may have gone undetected because the Plan did not do the following:

- Incorporate an F&A program within the Plan to proactively prevent, detect and investigate all potential F&A;
- Incorporate a process for obtaining, tracking and reporting information related to all Medco F&A activities;
- Incorporate a review process to determine if notification to the OPM/OIG is required; and
- Require its PBM to report any potential F&A cases related to pharmacies, abnormally high prescribing physicians of narcotics, member drug misuse/abuse, and other potential fraud related reporting issues.

Until the Plan adopts all of their F&A program policies and procedures, they will not be able to implement all components of Carrier Letter 2007-12.

**Plan's Response:**

The Plan disagrees with the audit finding. The Plan states**,** "The primary reason cases were not referred to the OPM/OIG was because they did not meet the reporting threshold as detailed in Carrier Letter 2007-12. If the plan had identified cases that met the OPM/OIG criteria it would have referred them directly to the OIG."

The Plan also states, "The report above also highlights that the Plan did not refer cases to the OPM/OIG in regard to 'patient harm and safety issues: (1) pharmaceuticals, such as altered prescriptions, illegal refills, prescription splitting, and abuse of controlled substances, (2) medical errors in both inpatient and outpatient care, resulting in unfavorable outcomes, and (3) improper settings for procedures and services that result in poor outcomes.' The APWU Health Plan's Pharmacy Benefit Manager, Medco Health, has a robust fraud and abuse program in place to ensure patient safety. While no cases were referred to the OPM/OIG concerning patient harm, any investigation or review relating to this issue was handled by Medco Health through preventative measures and continued monitoring. Medco has several complementary programs and initiatives to identify and deter potential abuse patterns by members; over prescribing by doctors; and fraud by dispensers and/or consumers."

Program Management

The Plan states, "APWU Health Plan's post payment reviews are performed on a claim by claim basis. Referrals to the Fraud and Abuse Analyst come from APWUHP internal sources, customer service, claims, quality assurance audits, etc. Leads on suspected providers also come from external fraud prevention organizations and are investigated for potential exposure. The recovery of benefit dollars that should not have been paid are pursued internally and reported in the yearly OPM Fraud and Abuse report. When these types of providers are identified, they are then flagged in our system and their claims are reviewed on a pre-payment review basis."

Patient Harm or Safety Issues

The Plan states, "APWU Health Plan acknowledges that claims that could cause patient harm, potential for significant media attention or other exceptional circumstances should be referred to OPM/OIG. In the future, the APWU Health Plan will proactively refer any questionable issue to the OPM/OIG regardless of dollar value."

Pharmacy Benefit Manager

The Plan states that the "Pharmacy Benefit Manager, Medco Health, has a robust F&A program in place to ensure patient safety. While no cases were referred to the OPM/OIG concerning patient harm, any investigation or review relating to this issue was handled internally by Medco Health through preventative measures and continued monitoring. From 2005-2009, APWUHP authorized Medco to place 17 members on pharmacy restriction (limit to one pharmacy) as part of this program. During the defined time period, we had one member related fraud case that was not reported to OPM/OIG because it did not meet the dollar threshold criteria set forth by OPM in the 2007-12 Carrier Letter. In the future, all cases identified through Medco Health will be sent to OPM/OIG regardless of dollar threshold."

**OIG Comments:**

We continue to question whether the Plan has implemented all components of a complete and comprehensive F&A program, as described in Carrier Letters 2003-23 and 2007-12, and whether the Plan has proper program management over F&A program components related to patient safety issues and its' contracted PBM. The Plan's F&A program is managed by only one F&A analyst. The Plan provided no notifications/referrals to the OPM/OIG during the audit period from 2005 through 2009, although the Plan stated that during this period it had authorized its PBM to put 17 members on pharmacy restriction. None of those 17 members were referred to OPM/OIG for pharmaceutical abuse issues, as required by Carrier Letters 2003-23 and 2007-12. The Plan only performs post-payment reviews on a claim-by-claim basis, and not on a total historical claim basis as required in Carrier Letter 2003-23.

**Recommendation 2**

We recommend that the contracting officer ensure that the Plan implements all components of Carrier Letters 2003-23 ("Industry Standards for Fraud & Abuse Programs") and 2007-12 ("Notifying OPM's Office of the Inspector General Concerning Fraud and Abuse Cases in the FEHBP Program").

**2. Fraud and Abuse Annual Reports** **Procedural**

The Plan did not provide the OPM/OIG complete F&A annual reports from 2005 through 2009.

Carrier Letter 2007-12 states that F&A annual reports, as described in Carrier Letter 2003-25 ("Revised FEHB Quality Assurance and Fraud and Abuse Reports"), are required.

Carrier Letter 2003-25 ("Revised FEHB Quality Assurance and Fraud and Abuse Reports") states, "The . . . F&A Report will now include collecting the following information:

- Cases Opened – only cases opened within report period
- Total Dollars Identified as Loss – total dollar amount verified as a loss
- Total Dollars Recovered – dollars actually received
- Actual Savings – dollars saved due to a claim rejection, prepayment review, etc.
- Projected Savings – calculated based on the amount of loss that would have been incurred had the fraudulent conduct not been stopped due to anti-fraud efforts – 12 month period
- Number of Cases referred to Law Enforcement – total cases referred to local, state, or federal law enforcement agencies
- Number of Cases Resolved through negotiated settlement – cases resolved via settlement negotiation
- Number of Arrests – number of cases that resulted in an arrest
- Number of Criminal Convictions – number of cases that resulted in criminal convictions"

Although the Plan implemented some of the F&A report requirements, we could not find any information related to "Projected Savings" and "Cases Resolved through Negotiated Settlement", except for comments stating that these items were not required. While the Plan is not required to provide totals by the provider, member, and other categories, this does not release the Plan from reporting the total "Projected Savings" and "Cases Resolved through Negotiated Settlement" by year. The F&A report provided by OPM to the Carriers includes instructions on how to calculate the required fields and a legend that provides formatting for user entries. From 2005 through 2009, the Plan reported 1,765 cases that were opened, none of which resulted in referrals to law enforcement, including the OPM/OIG.

By not including all F&A report requirements, we could not determine the overall outcome of the Plan's prevention, detection, and F&A program activities.

**Plan's Response:**

The Plan disagrees with this finding because the report supplied by OPM, for the sections "Projected Savings" and "Cases Resolved Through Negotiated Settlement," was preprinted "Not Required." Therefore, the Plan did not complete these sections. In the future, the Plan will report on all data elements outlined in Carrier Letter 2003-25.

**OIG Comments:**

We accept the Plan's response to report on all data elements in the future that are required in the annual F&A report.

**Recommendation 3**

We recommend that the contracting officer ensure that the Plan implements all components of the F&A report, as required and described in Carrier Letter 2003-25 ("Revised FEHB Quality Assurance and Fraud and Abuse Reports").

### D. LOST INVESTMENT INCOME ON AUDIT FINDINGS $2,642

As a result of the monetary audit finding presented in this report, the FEHBP is due lost investment income (LII) of $2,642 from January 1, 2006 through June 30, 2011.

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."

We computed investment income that would have been earned using the semiannual rates specified by the Secretary of the Treasury. Our computations show that the FEHBP is due LII of $2,642 from January 1, 2006 through June 30, 2011 on questioned costs for contract years 2005 through 2009 (see Schedule B).

**Plan's Response:**

The draft audit report did not include an audit finding for LII. Therefore, the Plan did not address this item in its reply.

**Recommendation 4**

We recommend that the contracting officer direct the Plan to credit $2,642 (plus interest accruing after June 30, 2011) to the Special Reserve for LII on audit findings.

## IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

[redacted], Auditor-In-Charge

[redacted], Auditor

[redacted], Auditor

---

[redacted], Chief ([redacted]

[redacted], Senior Team Leader

Office of Investigations

[redacted], Special Agent-In-Charge

[redacted], Special Agent

SCHEDULE A

## V. SCHEDULES

### AMERICAN POSTAL WORKERS UNION HEALTH PLAN
### GLEN BURNIE, MARYLAND

### CONTRACT CHARGES AND AMOUNTS QUESTIONED

| CONTRACT CHARGES* | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | TOTAL |
|---|---|---|---|---|---|---|---|---|
| HEALTH BENEFIT CHARGES | $477,980,320 | $513,568,644 | $474,705,231 | $519,681,548 | $581,657,312 | | | $2,567,593,055 |
| ADMINISTRATIVE EXPENSES | 42,378,215 | 46,686,009 | 50,204,487 | 52,139,963 | 57,606,837 | | | 249,015,511 |
| OTHER EXPENSES AND RETENTIONS | 4,435,903 | 4,764,872 | 5,141,852 | 4,677,849 | 4,719,698 | | | 23,740,174 |
| TOTAL CONTRACT CHARGES | $524,794,438 | $565,019,525 | $530,051,570 | $576,499,360 | $643,983,847 | | | $2,840,348,740 |

| AMOUNTS QUESTIONED | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | TOTAL |
|---|---|---|---|---|---|---|---|---|
| A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| B. ADMINISTRATIVE EXPENSES | | | | | | | | |
| 1. Travel Costs | 3,463 | 3,463 | 4,849 | 1,788 | 3,751 | 0 | 0 | 17,314 |
| C. CASH MANAGEMENT | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| D. FRAUD AND ABUSE PROGRAM (Procedural) | | | | | | | | |
| 1. Notification of Fraud and Abuse Cases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2. Fraud and Abuse Annual Reports | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| E. LOST INVESTMENT INCOME ON AUDIT FINDINGS | 0 | 188 | 381 | 581 | 712 | 552 | 227 | 2,642 |
| TOTAL AMOUNTS QUESTIONED | $3,463 | $3,651 | $5,230 | $2,369 | $4,463 | $552 | $227 | $19,956 |

* We did not review claim payments and other expenses and retentions, except for the cash management of these funds.

SCHEDULE B

**AMERICAN POSTAL WORKERS UNION HEALTH PLAN**
**GLEN BURNIE, MARYLAND**

**LOST INVESTMENT INCOME CALCULATION**

| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | TOTAL |
|---|---|---|---|---|---|---|---|---|
| **A. QUESTIONED CHARGES (Subject to Lost Investment Income)** | | | | | | | | |
| Administrative Expenses | $3,463 | $3,463 | $4,849 | $1,788 | $3,751 | $0 | $0 | $17,314 |
| TOTAL | $3,463 | $3,463 | $4,849 | $1,788 | $3,751 | $0 | $0 | $17,314 |
| **B. LOST INVESTMENT INCOME CALCULATION** | | | | | | | | |
| a. Prior Years Total Questioned (Principal) | $0 | $3,463 | $3,463 | $4,849 | $1,788 | $3,751 | $0 | |
| b. Cumulative Total | 0 | 0 | 3,463 | 6,926 | 11,775 | 13,563 | 17,314 | |
| c. Total | $0 | $3,463 | $6,926 | $11,775 | $13,563 | $17,314 | $17,314 | |
| d. Treasury Rate: January 1 - June 30 | 4.250% | 5.125% | 5.250% | 4.750% | 5.625% | 3.250% | 2.625% | |
| e. Interest (d * c) | $0 | $89 | $182 | $280 | $381 | $281 | $227 | $1,440 |
| f. Treasury Rate: July 1 - December 31 | 4.500% | 5.750% | 5.750% | 5.125% | 4.875% | 3.125% | | |
| g. Interest (f * c) | $0 | $100 | $199 | $302 | $331 | $271 | | $1,202 |
| Total Interest By Year (e + g) | $0 | $188 | $381 | $581 | $712 | $552 | $227 | $2,642 |

# APPENDIX

799 Cromwell Park Drive, Suites K-Z
Glen Burnie, MD 21061

**American Postal Workers Union, AFL-CIO**

**Health Plan Department**

Chief Operating Manager

April 6, 2011

Office of Personnel Management
Office of Inspector General
Attn:
800 Cranberry Woods Drive, Suite 130
Cranberry Township, PA 16066

Dear

Enclosed is the APWU Health Plan's response to the audit report 1B-47-00-11-002 dated March 4, 2011, issued by the Office of Inspector General. We have incorporated our response within the text of the audit report to provide continuity for the reader. If after you review the enclosed responses, you are not in agreement with the Plan's stated position, we respectfully request that the APWU Health Plan be afforded the opportunity to meet with you or the OIG staff regarding those items on which we disagree. We believe that this will assure fair resolution of differences at the lowest cost to all parties and allow for the final report to be complete, accurate, fair and as free from errors of fact or omission as our combined efforts can make them.

Since the findings and recommendations in the draft report may change, the APWU reserves the right to review and modify its responses prior to the issuance of the final report.

I would like to reaffirm the American Postal Workers Union's commitment to responsible administration of the FEHB Program. If you have any questions, please contact Division Managers for Finance and Administrative Services at the APWU Health Plan, at

Chief Operating Manager

Attachments

cc:
Chief of Health Insurance Group II

Chief of Program Planning and Evaluation

Health Plan
Board of Directors

Cliff Guffey
President

Greg Bell
Executive Vice President

Elizabeth "Liz" Powell
Secretary-Treasurer

Mike Morris
Director, Industrial Relations

William J. Kaczor, Jr.
Director, Health Plan

Rob Strunk
Director, Clerk Division

Steven G. Raymer
Director, Maintenance Division

Robert C. "Bob" Pritchard
Director, MVS Division

Bill Manley
Director, Support Services Division

Regional Coordinators

Sharyn M. Stone
Central Region

Mike Gallagher
Eastern Region

John H. Dirzius
Northeast Region

Princella Vogel
Southern Region

Omar M. Gonzalez
Western Region

*Deleted by the Office of the Inspector General – Not Relevant to the Final Report*

# I. AUDIT FINDINGS AND RECOMMENDATIONS

## A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

The audit disclosed no findings pertaining to miscellaneous health benefit payments and credits. Overall, we concluded that the Plan returned health benefit refunds and recoveries, including prescription drug rebates, to the FEHBP in a timely manner.

## B. ADMINISTRATIVE EXPENSES

### 1. Travel Costs — $17,314

*Deleted by the Office of the Inspector General – Not Relevant to the Final Report*

**Plan's Response:**

The Plan agreed with this finding. The Plan states that it has updated the company's travel policy to incorporate the language stated in 48 CFR 31.205-46(a)(2) and setup new procedures to verify compliance with this regulation.

**Recommendation 1**

We recommend that the contracting officer disallow $17,314 for travel costs overcharged to the FEHBP.

**APWU Health Plan's Response to Draft Report**

As stated above the APWU Health Plan agrees with this finding and has established policies and procedures to comply with this regulation in the future. The funds will be reimbursed to FEHBP once the lost investment income is calculated in the final report.

## C. CASH MANAGEMENT

The audit disclosed no findings pertaining to cash management. Overall, we concluded that the Plan handled FEHBP funds in accordance with Contract CS 1370 and applicable laws and regulations.

## D. FRAUD CONTROL

### 1. Special Investigations Unit — Procedural

#### A. Notifying OPM/OIG Concerning Fraud and Abuse Cases

*Deleted by the Office of the Inspector General – Not Relevant to the Final Report*

**APWU Health Plan's Response to Draft Report**

The APWU Health Plan strongly disagrees with the OPM/OIG Fraud Investigators conclusion that the APWU Health Plan's F&A program is inadequate or improperly managed. The primary reason cases were not referred to the OPM/OIG was because they did not meet the reporting threshold as detailed in Carrier Letter 2007-12. If the plan had identified cases that net the OPM/OIG criteria it would have referred them directly to the OIG.

The report above also highlights that the Plan did not refer cases to the OPM/OIG in regard to "patient harm and safety issues: (1) pharmaceuticals, such as altered prescriptions, illegal refills, prescription splitting, and abuse of controlled substances, (2) medical errors in both inpatient and outpatient care, resulting in unfavorable outcomes, and (3) improper settings for procedures and services that result in poor outcomes." The APWU Health Plan's Pharmacy Benefit Manager, Medco Health, has a robust fraud and abuse program in place to ensure patient safety. While no cases were referred to the OPM/OIG concerning patient harm, any investigation or review relating to this issue was handled by Medco Health through preventative measures and continued monitoring. Medco has several complementary programs and initiatives to identify and deter potential abuse patterns by members; over prescribing by doctors; and fraud by dispensers and/or consumers.

Program Management

***Deleted by the Office of the Inspector General – Not Relevant to the Final Report***

**APWU Health Plan's Response to Draft Report**

APWU Health Plan's post payment reviews are performed on a claim by claim basis. Referrals to the Fraud and Abuse Analyst come from APWUHP internal sources, customer service, claims, quality assurance audits, etc. Leads on suspected providers also come from external fraud prevention organizations and are investigated for potential exposure. The recovery of benefit dollars that should not have been paid are pursued internally and reported in the yearly OPM Fraud and Abuse report. When these types of providers are identified, they are then flagged in our system and their claims are reviewed on a pre-payment review basis.

Patient Harm or Safety Issues

***Deleted by the Office of the Inspector General – Not Relevant to the Final Report***

**APWU Health Plan's Response to Draft Report**

APWU Health Plan acknowledges that claims that could cause patient harm, potential for significant media attention or other exceptional circumstances should be referred

to OPM/OIG. In the future, the APWU Health Plan will proactively refer any questionable issue to the OPM/OIG regardless of dollar value.

Pharmacy Benefit Manager

***Deleted by the Office of the Inspector General – Not Relevant to the Final Report***

**APWU Health Plan's Response to Draft Report**

The APWU Health Plan's Pharmacy Benefit Manager, Medco Health, has a robust fraud and abuse program in place to ensure patient safety. While no cases were referred to the OPM/OIG concerning patient harm, any investigation or review relating to this issue was handled internally by Medco Health through preventative measures and continued monitoring. From 2005-2009, APWUHP authorized Medco to place 17 members on pharmacy restriction (limit to one pharmacy) as part of this program. During the defined time period, we had one member related fraud case that was not reported to OPM/OIG because it did not meet the dollar threshold criteria set forth by OPM in the 2007-12 Carrier Letter. In the future, all cases identified through Medco Health will be sent to OPM/OIG regardless of dollar threshold.

***Deleted by the Office of the Inspector General – Not Relevant to the Final Report***

**APWU Health Plan's Response to Draft Report**

If OPM/OIG's only issue regarding the APWU Health Plan's Fraud and Abuse program as stated above in the "OIG Comments" are specifically, that the Plan does not perform retrospective analysis and does not provide patient harm issues (which in APWU Health Plan's case are Medco identified patients that are being cut-off from attempting to obtain too many pain killer) and that the Health Plan does not get Medco's fraud and abuse activity, then the other unsubstantiated acquisitions about the quality and integrity of the Plan's fraud and abuse program should be removed from the written final report.

**B. Fraud and Abuse Annual Reports**

***Deleted by the Office of the Inspector General – Not Relevant to the Final Report***

**Plan's Response:**

The Plan disagreed with this finding because the report supplied by OPM, for the sections "Projected Savings" and "Cases Resolved through Negotiated Settlement," was preprinted "Not Required." Therefore, the Plan did not complete these sections. In the future, the Plan will report on all data elements outlined in the Carrier Letter.

***Deleted by the Office of the Inspector General – Not Relevant to the Final Report***

**APWU Health Plan's Response to Draft Report**

The APWU Health Plan contends that it has implemented the components of a Fraud and Abuse program as outlined in Carrier Letter 2007-12 and Carrier Letter 2003-23. The only item absent is reporting patient harm issues to the Contracting Officer and OPM-OIG which became effective March 30, 2007. The fact that patient harm issues were not reported to the Contracting Officer or OPM-OIG does not mean that the APWU Health Plan did not have a program in place to detect and prevent these situations. As explained in detail throughout this document, the APWU Health Plan and its subcontractor, Medco, perform a robust patient safety and abuse program. Throughout this audit inquiry the OPM Fraud SIU auditors have made unsubstantiated conclusion about the quality and integrity of APWU Health Plan's fraud and abuse program. This recommendation and the contents of audit inquiry should not be included in the final audit report.