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US OFFICE OF PERSONNEL MANAGEMENT  
OFFICE OF THE INSPECTOR GENERAL  
OFFICE OF AUDITS

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# Final Audit Report

**Subject:**

**AUDIT OF COVENTRY HEALTH CARE  
AS UNDERWRITER AND ADMINISTRATOR FOR THE  
MAIL HANDLERS BENEFIT PLAN  
ROCKVILLE, MARYLAND**

**Report No. 1B-45-00-08-016**

**Date: March 26, 2009**

**--CAUTION--**

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Office of the  
Inspector General

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT  
Washington, DC 20415

**AUDIT REPORT**

Federal Employees Health Benefits Program  
Employee Organization Plan

Coventry Health Care  
as Underwriter and Administrator for the  
Mail Handlers Benefit Plan

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Contract CS 1146                      Plan Codes 45 and 48  
Rockville, Maryland

REPORT NO. 1B-45-00-08-016

DATE: March 26, 2009

A handwritten signature in black ink, appearing to read "Michael R. Esser".

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

Coventry Health Care  
as Underwriter and Administrator for the  
Mail Handlers Benefit Plan

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Contract CS 1146                      Plan Codes 45 and 48  
Rockville, Maryland

REPORT NO. 1B-45-00-08-016      DATE: March 26, 2009

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at Coventry Health Care (Plan), as underwriter and administrator for the Mail Handlers Benefit Plan, questions \$7,813,325 in health benefit charges, \$6,000,000 in excess working capital funds, and \$108,015 in administrative expenses. The Plan agreed (**A**) with \$11,921,340 and disagreed (**D**) with \$2,000,000 of the questioned charges. Lost investment income (LII) on the questioned charges amounts to \$31,454.

Our audit was conducted in accordance with Government Auditing Standards. The audit covered claim payments from 2005 through September 30, 2007, as well as miscellaneous payments and credits and administrative expenses from 2002 through 2006 as reported in the Annual Accounting Statements. In addition, we reviewed the Plan's cash management practices related to FEHBP funds for contract years 2002 through 2006.

Questioned items are summarized as follows:

## HEALTH BENEFIT CHARGES

### Claim Payments

- **Coordination of Benefits with Medicare (A)** **\$4,392,402**

The Plan incorrectly paid 7,378 claim lines, resulting in overcharges of \$4,392,402 to the FEHBP. Specifically, the Plan did not properly coordinate 6,550 claim line payments with Medicare as required by the FEHBP contract. As a result, the FEHBP paid as the primary insurer for these claims when Medicare was the primary insurer. Therefore, we estimate that the FEHBP was overcharged by \$4,279,856 for these claim lines. The remaining 828 claim line payments were not coordination of benefit errors but contained other Plan payment errors, resulting in overcharges of \$112,546 to the FEHBP.

- **Claims Paid for Ineligible Patients (A)** **\$2,529,912**

The Plan paid 10,275 claim lines that were incurred during gaps in patient coverage or after termination of patient coverage with the Mail Handlers Benefit Plan, resulting in overcharges of \$2,411,097 to the FEHBP. In addition, the Plan paid 2,167 claim lines for patients with no enrollment identification numbers, resulting in overcharges of \$118,815 to the FEHBP. In total, the FEHBP is due \$2,529,912 for claim overcharges.

- **Omnibus Budget Reconciliation Act of 1990 Review (A)** **\$443,265**

The Plan incorrectly paid 13 claims that were priced or potentially should have been priced under the Omnibus Budget Reconciliation Act of 1990 pricing guidelines, resulting in net overcharges of \$443,265 to the FEHBP. Specifically, the Plan overpaid 11 claims by \$446,625 and underpaid 2 claims by \$3,360.

- **Duplicate Claim Payments (A)** **\$335,561**

The Plan improperly charged the FEHBP for 527 duplicate claim payments.

- **Claim Payment Errors (A)** **\$98,608**

The Plan incorrectly paid 36 claims, resulting in overcharges to the FEHBP.

### Miscellaneous Payments and Credits

- **Health Benefit Recovery (A)** **\$13,577**

The Plan did not return one health benefit recovery to the FEHBP. As a result, the FEHBP is due \$13,577, consisting of \$12,607 for the recovery not returned and \$970 for LII on this recovery.

## ADMINISTRATIVE EXPENSES

- Unallowable and/or Unallocable CNA Overhead Costs (A) \$108,015

CNA (former underwriter of the Mail Handlers Benefit Plan) charged the FEHBP for unallowable and/or unallocable costs that were included in overhead cost pools, resulting in overcharges to the FEHBP for 2002.

## CASH MANAGEMENT

- Working Capital Deposit \$6,000,000

At the end of the audit scope (as of December 31, 2006), the Plan held a working capital (WC) deposit with an excess amount of \$4,000,000 over the amount needed to meet the Plan's daily cash needs for FEHBP claim payments and administrative expenses. In response to our initial audit inquiry, the Plan provided a WC calculation showing that the Plan held an excess amount of \$6,000,000 in FEHBP funds as of August 31, 2008.

The Plan agreed (A) with \$4,000,000 and disagreed (D) with \$2,000,000 of the questioned charges. Although the Plan made an adjustment of \$6,000,000 to the WC deposit as a result of our audit, the Plan did not agree with the inclusion of the additional \$2,000,000 in the audit finding because the amount was not related to the current audit period.

## LOST INVESTMENT INCOME ON AUDIT FINDINGS

As a result of the audit findings presented in this audit report, the FEHBP is due LII of \$31,454, calculated through December 31, 2008.

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# **I. INTRODUCTION AND BACKGROUND**

## **INTRODUCTION**

This final audit report details the findings, conclusions, and recommendations resulting from our audit of the Federal Employees Health Benefits Program (FEHBP) operations at Coventry Health Care (Plan) as underwriter and administrator for the Mail Handlers Benefit Plan (MHBP). The Plan is located in Rockville, 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 Center for Retirement and Insurance Services 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.

MHBP is an experience-rated employee organization plan offering health care benefits to its subscribers. MHBP is open to all Federal employees and annuitants who are eligible to enroll in the FEHBP and who are, or become, members or associate members of the National Postal Mail Handlers Union (Union). The Union is the sponsor of the MHBP, operating under Contract CS 1146 to provide a health benefits plan authorized by the FEHB Act.

The following contractual relationships existed during the audit period:

- The Union contracted with Niagara Fire Insurance Company (Niagara) to perform the underwriting and administrative responsibilities through June 30, 2002. Niagara was part of a group of companies, referred to collectively as CNA. Niagara delegated the administrative functions to an affiliate, Claims Administration Corp (CAC), and CAC entered into contracts for pharmacy benefit management and managed care services for the MHBP.
- Effective July 1, 2002, First Health Life and Health Insurance Company and Cambridge Life Insurance Company (jointly referred to as First Health Life) assumed the responsibilities for underwriting and administering the contract. In addition, First Health Group Corporation (First Health), the parent company of First Health Life, acquired CAC.
- Effective January 1, 2003, the Union contracted with First Health Life to underwrite the MHBP and with CAC to perform the administrative functions. In addition, the Union contracted with First Health to provide pharmacy benefit management and health benefit services.

- On January 28, 2005, First Health was acquired by Coventry Health Care. The Union has the following contractual arrangements with affiliates of Coventry Health Care:
  - First Health Life underwrites the MHBP;
  - CAC performs the administrative functions; and
  - First Health provides pharmacy benefit management and health benefit services.

The MHBP's contract (CS 1146) with OPM is experience-rated. Thus, the costs of providing service benefits in the prior years are reflected in current and future year's premium rates. In addition, the contract provides that in the event of termination, unexpended program funds revert to the Federal Government (FEHBP Trust Fund). In recognition of these provisions, the contract requires an accounting of program funds to 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.

The findings from our previous audit of the MHBP (Report No. 1B-45-02-02-069, dated September 22, 2004), covering CNA administrative expenses for contract years 1999 through 2001, have been satisfactorily resolved. During this period, CNA was the underwriter for the MHBP.

The results of our 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 October 23, 2008. 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:

#### **Health Benefit Charges**

- To determine whether the Plan complied with contract provisions relative to benefit payments.
- 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.

### **SCOPE**

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.

We reviewed the MHBP's FEHBP Annual Accounting Statements for contract years 2002 through 2006. During this period, the Plan paid approximately \$9.8 billion in health benefit charges and \$977 million in administrative expenses (See Figure 1 and Schedule A). The Plan also paid approximately \$88 million in other expenses and retentions (See Schedule A).

Specifically, we reviewed approximately \$54 million in claim payments made from 2005 through September 30, 2007 for coordination of benefits, duplicate payments, and proper adjudication. In addition, we reviewed miscellaneous payments and credits (i.e., refunds, subrogation recoveries, provider audit recoveries, fraud recoveries, and pharmacy drug rebates), administrative expenses, and cash management for 2002 through 2006.

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.

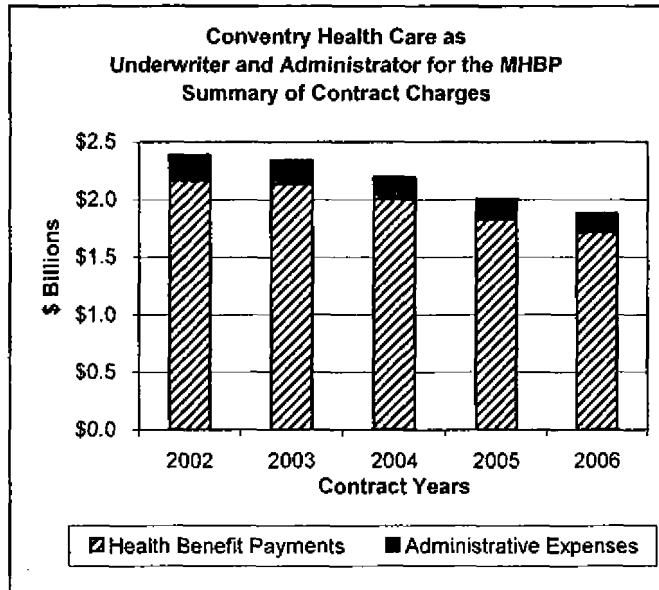


Figure 1 – Contract Charges

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 and the Centers for Medicare and Medicaid Services. Due to time constraints, we did not verify the reliability of the data generated by the various information systems involved. However, while utilizing the computer-generated data during our audit testing, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

The audit was performed at the Plan’s office in Rockville, Maryland from May 13, 2008 through June 20, 2008. Audit fieldwork was also performed at our offices in Washington, D.C. and Cranberry Township, Pennsylvania through October 23, 2008.

The Plan did a great job supporting our audit and promptly responded to our questions, samples, information requests, and audit inquiries. Also, the Plan was very cooperative and well prepared for our audit.

## **METHODOLOGY**

We obtained an understanding of the internal controls over the Plan's claims processing, financial, and cost accounting systems by inquiry of Plan officials.

To test the Plan's compliance with the FEHBP health benefit provisions, we selected and reviewed samples of 11,121 claims.<sup>1</sup> We used the FEHBP contract, the benefit plan brochure, and the Plan's provider agreements to determine the allowability of benefit payments. The results of these samples were not projected to the universe of claims.

We interviewed Plan personnel and reviewed the Plan's policies, procedures, and accounting records during our audit of miscellaneous payments and credits. We also selected and reviewed health benefit refunds, subrogation recoveries, provider audit recoveries, fraud recoveries, and pharmacy drug rebates to determine if refunds, recoveries, and rebates were returned to the FEHBP in a timely manner.<sup>2</sup>

We judgmentally reviewed administrative expenses charged to the FEHBP for contract years 2002 through 2006. Specifically, we reviewed administrative expenses relating to cost centers, departments, natural accounts, out-of-system adjustments, prior period adjustments, pension, employee health benefits, post-retirement benefits, executive compensation, gains and losses, return on investment, subcontracts, benefit plan brochure costs, and Health Insurance Portability and Accountability Act of 1996 compliance. We used the FEHBP contract, the FAR, and the FEHBPBAR to determine the allowability, allocability, and reasonableness of charges.

We also reviewed the Plan's cash management to determine whether the Plan handled FEHBP funds in accordance with Contract CS 1146 and applicable laws and regulations.

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<sup>1</sup> See the audit findings for "Coordination of Benefits with Medicare" (A1.a), "Claims Paid for Ineligible Patients" (A1.b), "Omnibus Budget Reconciliation Act of 1990 Review" (A1.c), "Duplicate Claim Payments" (A1.d), and "Claim Payment Errors" (A1.e) on pages 6 through 18 for specific details of our sample selection methodologies.

<sup>2</sup> See the audit finding for "Health Benefit Recovery" (A2.a) on pages 18 through 20 for specific details of our sample selection methodologies.

### **III. AUDIT FINDINGS AND RECOMMENDATIONS**

#### **A. HEALTH BENEFIT CHARGES**

##### **1. Claim Payments**

###### **a. Coordination of Benefits with Medicare** **\$4,392,402**

The Plan incorrectly paid 7,378 claim lines, resulting in overcharges of \$4,392,402 to the FEHBP. Specifically, the Plan did not properly coordinate 6,550 claim line payments with Medicare as required by the FEHBP contract. As a result, the FEHBP paid as the primary insurer for these claims when Medicare was the primary insurer. Therefore, we estimate that the FEHBP was overcharged by \$4,279,856 for these claim lines. The remaining 828 claim line payments were not coordination of benefit errors but contained other Plan payment errors, resulting in overcharges of \$112,546 to the FEHBP.

The 2007 Mail Handlers Benefit Plan brochure, page 126, Primary Payer Chart, illustrates when Medicare is the primary payer. In addition, page 22 of that brochure states, "We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays."

Contract CS 1146, Part II, section 2.6 states, "(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare, . . . (b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier . . ." Also, Part III, section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable . . ."

In addition, Contract CS 1146, Part II, section 2.3(g) states, "If the Carrier or OPM determines that a Member's claim has been paid in error for any reason . . . the Carrier shall make a prompt and diligent effort to recover the erroneous payment . . ."

For claims incurred and paid from October 1, 2005 through September 30, 2007, we performed a computer search and identified 362,781 claim lines, totaling \$28,315,090 in payments, that potentially were not coordinated with Medicare. From this universe, we selected for review a sample of 19,571 claim lines, totaling \$12,599,311 in payments, to determine whether the Plan complied with the contract provisions relative to coordination of benefits (COB) with Medicare. When we submitted our sample of potential COB errors to the Plan on November 15, 2007, the claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits.

The following table is a summary of the claim lines that were selected for review:

Claim Type	Claim Lines	Amounts Paid	Sample Selection Methodology
Medicare Part A Primary for Inpatient (I/P) Facility	1,181	\$6,017,539	Patients with cumulative claims of \$750 or more
Medicare Part A Primary for Skilled Nursing, Home Health Care (HHC), and Hospice Care	337	\$428,114	Patients with cumulative claims of \$2,500 or more
Medicare Part B Primary for Certain I/P Facility Charges	168	\$1,234,806	Patients with cumulative claims of \$5,000 or more
Medicare Part B Primary for Skilled Nursing, HHC, and Hospice Care	0	\$0	The potential COB errors were immaterial. Therefore, no claim lines were selected.
Medicare Part B Primary for Outpatient Charges	3,029	\$2,548,641	Patients with cumulative claims of \$2,500 or more
Medicare Part B Primary for Professional Charges	14,856	\$2,370,211	Patients with cumulative claims of \$4,000 or more
Total	19,571	\$12,599,311	

Generally, Medicare Part A covers 100 percent of inpatient care in hospitals, skilled nursing facilities, hospice care, and home health care. For each Medicare Benefit Period, there is a one-time deductible, followed by a daily copayment beginning with the 61<sup>st</sup> day. Beginning with the 91<sup>st</sup> day of the Medicare Benefit Period, Medicare Part A benefits may be exhausted, depending on whether the patient elects to use their Lifetime Reserve Days. For the uncoordinated Medicare Part A claims, we estimate that the FEHBP was overcharged for the total claim payment amounts. When applicable, we reduced the questioned amount by the Medicare deductible and/or Medicare copayment.

Medicare Part B pays 80 percent of most outpatient charges and professional claims after the calendar year deductible has been met. Also, Medicare Part B covers a portion of inpatient facility charges for ancillary services such as durable medical equipment, medical supplies, diagnostic tests, and clinical laboratory services. Based on our experience, ancillary items account for approximately 30 percent of the total inpatient claim payment. Therefore, we estimate that the FEHBP was overcharged 25 percent for these inpatient claim lines ( $0.30 \times 0.80 = 0.24 \sim 25$  percent).

Based on our review of the potential COB errors in our sample, we identified 7,378 claim lines that were paid incorrectly, resulting in overcharges of \$4,392,402 to the FEHBP.<sup>3</sup>

<sup>3</sup> In addition, there were 225 claim lines, totaling \$405,042 in payments, with COB errors that were identified and adjusted by the Plan prior to receiving our sample of potential COB errors. Since these COB errors were identified and adjusted by the Plan prior to receiving our sample, we did not question these COB errors in the final report.

The following table details the questioned payments by claim type:

Claim Type	Claim Lines	Amounts Paid	Amounts Questioned
Medicare Part A Primary for I/P Facility	201	\$3,093,263	\$2,725,919
Medicare Part A Primary for Skilled Nursing, HHC, and Hospice Care	32	\$28,608	\$28,608
Medicare Part B Primary for Certain I/P Facility Charges	4	\$79,170	\$18,890
Medicare Part B Primary for Skilled Nursing, HHC, and Hospice Care	0	\$0	\$0
Medicare Part B Primary for Outpatient Charges	1,038	\$966,989	\$731,476
Medicare Part B Primary for Professional Charges	6,103	\$972,347	\$887,509
Total	7,378	\$5,140,377	\$4,392,402

Our audit disclosed the following for the claim payment errors:

- For 6,243 (85 percent) of the claim lines questioned, there was incorrect or no Medicare COB information on the Plan's claims system to identify Medicare as the primary payer when the claims were paid. However, when the correct Medicare COB information was subsequently added to the claims system, the Plan did not review and/or adjust the patient's prior claims back to the Medicare effective dates. As a result, we estimate that the FEHBP was overcharged \$4,238,407 for these claim lines that were not coordinated with Medicare.
- For 828 (11 percent) of the claim lines questioned, we found that these claim lines were not actually COB errors but contained other Plan payment errors. As a result, we determined that the FEHBP was overcharged \$112,546 for these claim payment errors.
- For 307 (4 percent) of the claim lines questioned, the correct Medicare information was present on the Plan's claims system to identify Medicare as the primary payer when the claims were paid. The exact reason(s) why these claims were not coordinated with Medicare could not be identified. As a result, we estimate that the FEHBP was overcharged \$41,449 for these claim lines that were not coordinated with Medicare.

Of the \$4,392,402 in questioned charges, \$150,950 or 3 percent were identified by the Plan prior to receiving our sample of potential COB errors on November 15, 2007. However, since the Plan had not completed the recovery process and/or adjusted these

claims by November 15, 2007, we are continuing to question these COB errors. The remaining questioned charges of \$4,241,452 (97 percent) were identified as a result of our audit.

**Plan's Response:**

The Plan agrees with this finding and states that these payments were good faith erroneous benefit payments. The Plan immediately initiated efforts to recover these overpayments in accordance with CS 1146, Part II, section 2.3(g). As part of the Plan's recovery process, the Plan returns all overpayment recoveries to the FEHBP promptly after being received.

The Plan also states, "a significant majority of the claim lines paid in error . . . involved coordination of benefits with a member's Medicare Part B primary coverage. Unlike Medicare Part A, in which the MHBP can assume a member is enrolled as of the month they turn age 65, enrollment in Medicare Part B not only is voluntary, but can be deferred at the enrollee's election. In addition, the MHBP's ability to determine COB status with Medicare Part B depends on its timely receipt of conversion to annuitant status from the government payroll offices. In other words, obtaining credible evidence demonstrating both (1) a member's annuitant status, and (2) his/her enrollment in Medicare Part B is largely outside the MHBP's control, making COB errors extremely difficult to avoid where that evidence is not timely furnished.

To facilitate it in avoiding Medicare COB errors to the greatest extent possible, the MHBP participates in a Voluntary Data Sharing Agreement ("VDSA") with CMS. Through that arrangement, the MHBP obtains the most up-to-date Medicare Part B enrollment information available from CMS for uploading into its member eligibility files."

**Recommendation 1**

We recommend that the contracting officer disallow \$4,279,856 for uncoordinated claim payments, and verify that the Plan returns all amounts recovered to the FEHBP.

**Recommendation 2**

We recommend that the contracting officer ensure that the Plan has procedures in place to review all claims incurred back to the Medicare effective dates when updated, other party liability information is added to the Plan's claims system. When Medicare eligibility is subsequently reported, the Plan is expected to immediately determine if already paid claims are affected and, if so, to initiate the recovery process within 30 days.

### **Recommendation 3**

We recommend that the contracting officer disallow \$112,546 in claim overcharges resulting from other Plan payment errors, and verify that the Plan returns all amounts recovered to the FEHBP.

#### **b. Claims Paid for Ineligible Patients \$2,529,912**

The Plan paid 10,275 claim lines that were incurred during gaps in patient coverage or after termination of patient coverage with the Mail Handlers Benefit Plan, resulting in overcharges of \$2,411,097 to the FEHBP. In addition, the Plan paid 2,167 claim lines for patients with no enrollment identification (ID) numbers, resulting in overcharges of \$118,815 to the FEHBP. In total, the FEHBP is due \$2,529,912 for claim overcharges.

As previously cited from Contract CS 1146, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments.

#### **Enrollees with No Coverage during Dates of Service**

We performed a computer search to identify claims that were incurred and paid during gaps in patient coverage or after termination of patient coverage with the Mail Handlers Benefit Plan. For the period January 1, 2005 through September 30, 2007, we identified claim payments, totaling \$5,716,775, for 7,472 patients that met this search criterion.

From this universe of 7,472 patients, we selected all patients with cumulative claim lines of \$2,500 or more. This sample included 15,865 claim line payments, totaling \$4,212,231, for 330 patients. Our review of the sample identified 10,275 claim lines, totaling \$2,411,097 in payments, that were incurred and paid during gaps in patient coverage or after termination of coverage. As a result, the FEHBP is due \$2,411,097 for these improper payments.

#### **Patients with No Enrollment Record**

We performed a computer search to identify claims incurred and paid for patients with no enrollment ID numbers. For the period January 1, 2005 through September 30, 2007, our search identified claim payments, totaling \$5,386,641, for 1,174 patients with no enrollment ID numbers.

From this universe of 1,174 patients, we selected all patients with cumulative claim lines of \$2,000 or more. This sample included 26,826 claim line payments, totaling \$4,995,049, for 285 patients. Our review of the sample identified 2,167 claim lines, totaling \$118,815 in payments, that were made for patients with no enrollment ID number. As a result, the FEHBP is due \$118,815 for these improper payments.



### Summary of Claims Paid to Ineligible Patients

In total, the Plan charged the FEHBP \$2,529,912 for 12,442 claim line payments made for ineligible patients.<sup>4</sup> Our audit disclosed the following reasons for the errors:

- For 12,217 of the claim lines questioned, the Plan received retroactive termination of patient coverage from the Federal agency's payroll office. However, when the termination dates were subsequently received, the Plan did not review and/or adjust the patient's prior claims back to the termination date. As a result, the FEHBP was overcharged \$2,415,908 in claim payments for patients not eligible for benefits.
- For 63 of the claim lines questioned, there were various eligibility errors. For example, we identified an instance where the patient's coverage terminated during an inpatient hospital stay and the Plan erroneously paid for all dates of service under this claim. As a result, the FEHBP was overcharged \$90,665 in claim payments for patients not eligible for benefits.
- For 21 of the claim lines questioned, the claim processors entered incorrect data. As a result, the FEHBP was overcharged \$19,108 in claim payments for patients not eligible for benefits.
- For 141 of the claim lines questioned, the Plan used incorrect social security numbers to determine whether the patients were eligible for coverage. As a result, the FEHBP was overcharged \$4,231 in claim payments for patients not eligible for benefits.

Of the \$2,529,912 in questioned charges, \$841,711 (33 percent) was identified by the Plan prior to receiving our samples on February 28, 2008. However, since the Plan had not completed the recovery process and/or adjusted these claim lines by February 28, 2008, we are continuing to question these eligibility errors. The remaining questioned charges of \$1,688,201 (67 percent) were identified as a result of our audit.

### Plan's Response:

The Plan agrees with this finding and states, "12,217 of the 12,422 claim lines that we concur were paid erroneously but in good faith, or 98%, were attributable to Government agency payroll office delays in notifying the MHBP of an individual's termination of MHBP coverage. Section 1.5 of Contract No. CS 1146 provides that benefit payments made as a result of such payroll office errors are valid charges against that Contract." The Plan immediately began making efforts to recover the

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<sup>4</sup> In addition, there were 1,160 claim lines, totaling \$733,453 in payments, with eligibility errors that were identified and adjusted or voided by the Plan prior to receiving our samples on February 28, 2008. Since these eligibility errors were identified and adjusted or voided prior to receiving our samples, we did not question these claim line payments in the final report.

overpayments as required by CS 1146, Part II, section 2.3(g). As part of the Plan's recovery process, all amounts recovered on these overpayments will be credited to the FEHBP promptly upon receipt.

The Plan also states, "payment of the overwhelming majority of the questioned claim lines is attributable to payroll office reporting delays. In short, the MHBP did not receive agency notification of the member's termination until after the date on which it adjudicated and issued payment on the claim line, *i.e.*, circumstances that are beyond the MHBP's ability to control and/or correct. That said, we plan to implement procedures to ensure that upon receiving payroll office notice of an individual's termination of coverage, the MHBP identifies any and all post-termination claims paid under that enrollment and initiates overpayment recovery efforts on them as required under Section 2.3(g) of Contract No. CS 1146, as supplemented by our OPM-approved overpayment recovery guidelines."

#### **Recommendation 4**

We recommend that the contracting officer disallow \$2,529,912 in claim overcharges, and verify that the Plan returns all amounts recovered to the FEHBP.

#### **Recommendation 5**

We recommend that the contracting officer verify that the Plan implemented procedures to ensure that when a payroll office notice of an individual's termination of coverage is received, the Plan identifies all post-termination claims paid under that enrollment and immediately initiates overpayment recovery efforts.

#### **c. Omnibus Budget Reconciliation Act of 1990 Review \$443,265**

The Plan incorrectly paid 13 claims that were priced or potentially should have been priced under the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) pricing guidelines, resulting in net overcharges of \$443,265 to the FEHBP. Specifically, the Plan overpaid 11 claims by \$446,625 and underpaid 2 claims by \$3,360.

As previously cited from Contract CS 1146, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments. Also, the Plan must coordinate the payment of benefits with Medicare.

OBRA 90 limits the benefit payments for certain inpatient hospital services provided to annuitants age 65 or older who are not covered under Medicare Part A. The FEHBP fee-for-service plans are required to limit the claim payment to the amount equivalent to the Medicare Part A payment.

Using a program developed by the Centers for Medicare and Medicaid Services (CMS) to price OBRA 90 claims, we recalculated the claim payment amounts for the claims in our samples that were subject to and/or processed as OBRA 90.

The following summarizes the claim payment errors.

#### Claims Not Priced Under OBRA 90

For the period 2005 through September 30, 2007, we identified 5,374 claims, totaling \$37,583,828 in payments, that were potentially subject to OBRA 90 pricing guidelines but appeared to be paid under the Plan's standard pricing procedures. From this universe, we selected and reviewed a judgmental sample of 274 claims, totaling \$19,424,926 in payments, to determine if the Plan paid these claims properly. Our sample included all possible OBRA 90 claims with amounts paid of \$30,000 or more. Based on our review, we determined that nine of these claims were paid incorrectly, resulting in overcharges of \$396,381 to the FEHBP.

These claim payment errors resulted from the following:

- The Plan did not properly coordinate four claims with Medicare, resulting in overcharges of \$195,008 to the FEHBP. We determined that these claims should not have been priced under OBRA 90 but should have been coordinated with Medicare. These claim payment errors occurred because the Plan's claims system contained incorrect Medicare COB information to identify Medicare as the primary payer when the claims were paid. (These questioned overcharges are not included in the "Coordination of Benefits with Medicare" finding (A1.a).)
- The Plan did not price four claims under OBRA 90, resulting in overcharges of \$177,290 to the FEHBP. These claim errors occurred because the Plan's claims system contained incorrect Medicare COB or subscriber retirement information when the claims were paid.
- The Plan inadvertently did not price one claim under OBRA 90, resulting in an overcharge of \$24,083 to the FEHBP. The exact cause of this claim payment error could not be identified.

#### OBRA 90 Claim Pricing Errors

For the period 2005 through September 30, 2007, we identified 2,075 claims, totaling \$18,366,598 in payments, that were subject to OBRA 90 pricing guidelines. From this universe, we selected and reviewed a judgmental sample of 100 claims, totaling \$4,522,005 in payments, to determine if these claims were correctly priced and paid by the Plan. Our sample included all OBRA 90 claims with amounts paid of \$23,400 or more.

Based on our review, we determined that four of these claims were paid incorrectly, resulting in net overcharges of \$46,884 to the FEHBP. Specifically, the Plan overpaid two claims by \$50,244 and underpaid two claims by \$3,360.

These claim payment errors resulted from the following:

- The Plan did not properly coordinate one claim with Medicare, resulting in an overcharge of \$47,599 to the FEHBP. We determined that this claim should not have been priced under OBRA 90 but should have been coordinated with Medicare. This claim payment error was identified by the Plan prior to receiving our sample on December 14, 2007. However, since the Plan did not complete the recovery process and/or adjust this claim prior to receiving our sample, we are continuing to question this claim payment error. (This questioned overcharge is not included in the “Coordination of Benefits with Medicare” finding (A1.a).)
- The Plan priced two claims using an earlier version of the CMS Pricer, resulting in net undercharges of \$210 to the FEHBP. Specifically, the Plan overpaid one claim by \$2,645 and underpaid one claim by \$2,855.
- The Plan incorrectly priced one claim due to a manual pricing error, resulting in an undercharge of \$505 to the FEHBP. Specifically, the Plan incorrectly reduced the diagnostic related grouping (DRG) payment by subtracting the difference between the private room rate and the semi-private room rate. Under DRG pricing guidelines, this difference should not be excluded from the total billed amount.

**Plan’s Response:**

The Plan agrees with this finding and states that these payments were good faith erroneous benefit payments. The Plan immediately began making efforts to recover the overpayments as required by CS 1146, Part II, section 2.3(g). As part of the Plan’s recovery process, all amounts recovered on these overpayments will be credited to the FEHBP promptly upon receipt.

The Plan also states that to the extent that several of the subject claims involve Medicare COB issues, those claims will be subject to the corrective measures the Plan implements as recommended under the “Coordination of Benefits with Medicare” finding (A1.a).

**Recommendation 6**

We recommend that the contracting officer disallow \$446,625 in claim overcharges, and verify that the Plan returns all amounts recovered to the FEHBP.

## **Recommendation 7**

We recommend that the contracting officer allow the Plan to charge the FEHBP \$3,360 if additional payments are made to the providers to correct the underpayment errors.

### **d. Duplicate Claim Payments**

**\$335,561**

The Plan improperly charged the FEHBP \$335,561 for 527 duplicate claim payments from 2005 through September 30, 2007. These payments were unnecessary and unallowable charges to the FEHBP.

As previously cited from Contract CS 1146, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments.

Section 6(h) of the FEHB Act provides that rates should reasonably and equitably reflect the costs of benefits provided.

We performed a computer search for potential duplicate payments on claims paid during the period January 1, 2005 through September 30, 2007. We selected and reviewed 1,159 groups, totaling \$1,625,030 (out of 25,959 groups, totaling \$1,758,856) in potential duplicate payments, under our “best matches” criteria. We also selected and reviewed 658 groups, totaling \$1,170,820 (out of 91,985 groups, totaling \$3,258,561) in potential duplicate payments, under our “near matches” criteria. Our samples included all groups with potential duplicate payments of \$250 or more under the “best matches” criteria and \$500 or more under the “near matches” criteria.

Based on our review, we determined that 468 claim payments in our “best matches” sample were duplicates, resulting in overcharges of \$291,526 to the FEHBP. Also, we determined that 59 claim payments in our “near matches” sample were duplicates, resulting in overcharges of \$44,035 to the FEHBP. In total, the Plan charged the FEHBP \$335,561 for these 527 duplicate claim payments from 2005 through September 30, 2007.<sup>5</sup> These duplicate claim payments occurred when the claims were deferred as potential duplicates on the claims system, but were overridden by the processors.

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<sup>5</sup> In addition, there were 35 duplicate claim payments, totaling \$36,747, that were identified and adjusted or voided by the Plan prior to receiving our samples on November 15, 2007. Since these duplicate claim payments were identified and adjusted or voided by the Plan prior to receiving our samples, we did not question these duplicate claim payments in the final report.

**Plan's Response:**

The Plan agrees with this finding and states that these payments were good faith erroneous benefit payments. The Plan immediately began making efforts to recover the overpayments as required by CS 1146, Part II, section 2.3(g). As part of the Plan's recovery process, all amounts recovered on these overpayments will be credited to the FEHBP promptly upon receipt.

**Recommendation 8**

We recommend that the contracting officer disallow \$335,561 for duplicate claim payments charged to the FEHBP, and verify that the Plan returns all amounts recovered to the FEHBP.

**Recommendation 9**

We recommend that the contracting officer instruct the Plan to identify the root cause(s) of the claim payment errors and develop an action plan to prevent these types of errors in the future.

**e. Claim Payment Errors \$98,608**

The Plan incorrectly paid 36 claims, resulting in overcharges of \$98,608 to the FEHBP.

As previously cited from Contract CS 1146, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments.

The following summarizes the claim payment errors.

**Assistant Surgeon Review**

For the period January 1, 2005 through September 30, 2007, we identified 2,883 assistant surgeon claim groups, totaling \$564,728 in potential overpayments, that may not have been paid in accordance with the Plan's assistant surgeon pricing procedures. From this universe, we selected and reviewed a judgmental sample of 86 assistant surgeon claim groups, totaling \$174,812 in potential overpayments, to determine if the Plan paid these claims properly. Our sample included all assistant surgeon claim groups with potential overpayments of \$1,000 or more. The majority of these claim groups contained one primary surgeon and one assistant surgeon claim. Based on our review, we determined that 23 claims were paid incorrectly, resulting in overcharges of \$53,611 to the FEHBP.

The claim payment errors resulted from the following:

- The Plan paid 12 claims to non-covered providers, resulting in overcharges of \$35,514 to the FEHBP. Specifically, these providers were physician assistants that were not covered for surgery.
- The Plan incorrectly paid six claims due to various manual pricing errors, resulting in overcharges of \$7,965 to the FEHBP. For example, the Plan paid one claim without applying the 10 percent co-insurance amount.
- The Plan did not limit the allowable charge to the Plan's allowance when pricing three Non-Preferred Provider Organization (non-PPO) claims, resulting in overcharges of \$7,465 to the FEHBP.
- The Plan incorrectly paid two assistant surgeon claims, resulting in overcharges of \$2,667 to the FEHBP. These overcharges were due to errors in the calculation of the assistant surgeon fee, which should have been priced at 16 percent of the primary surgeon allowed amount.

In addition to the above sample, the Plan identified six additional assistant surgeon claims that were paid incorrectly due to errors in the calculation of the assistant surgeon fee. As a result, the FEHBP was overcharged an additional \$3,802.

### System Review

For health benefit claims reimbursed during the period January 1, 2007 through September 30, 2007, we identified 7,025,774 claim lines, totaling \$899,648,442 in payments, using a standard criteria based on our audit experience. From this universe, we selected and reviewed a judgmental sample of 125 claims (representing 323 claim lines), totaling \$5,106,844 in payments, to determine if the Plan adjudicated these claims properly.<sup>6</sup> Based on our review, we determined that seven claims were paid incorrectly, resulting in overcharges of \$41,195 to the FEHBP.

The claim payment errors resulted from the following:

- The Plan did not limit the allowable charge to the Plan's allowance when pricing three non-PPO claims, resulting in overcharges of \$34,738 to the FEHBP.

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<sup>6</sup> We selected our sample from an OIG-generated "Place of Service Report" (SAS application) that stratified the claims by place of service (POS), such as provider's office and payment category, such as \$50 to \$99.99. We judgmentally determined the number of sample items to select from each POS stratum based on the stratum's total claim dollars paid.

- The Plan incorrectly paid three claims due to various manual pricing errors, resulting in overcharges of \$4,963 to the FEHBP. As an example, the Plan entered an incorrect allowable amount when pricing a claim.
- In one instance, the Plan erroneously adjusted a claim that was priced correctly, resulting in an overcharge of \$1,494 to the FEHBP.

**Plan’s Response:**

The Plan agrees with this finding and states that these payments were good faith erroneous benefit payments. The Plan immediately began making efforts to recover the overpayments as required by CS 1146, Part II, section 2.3(g). As part of the Plan’s recovery process, all amounts recovered on these overpayments will be credited to the FEHBP promptly upon receipt.

**Recommendation 10**

We recommend that the contracting officer disallow \$98,608 in claim overcharges, and verify that the Plan returns all amounts recovered to the FEHBP.

**2. Miscellaneous Payments and Credits**

**a. Health Benefit Recovery \$13,577**

The Plan did not return one health benefit recovery to the FEHBP. As a result, the FEHBP is due \$13,577, consisting of \$12,607 for the recovery not returned and \$970 for lost investment income (LII) on this recovery.

48 CFR 31.201-5 states, “The applicable portion of any income, rebate, allowance, or other credit relating to any allowable cost and received by or accruing to the contractor shall be credited to the Government either as a cost reduction or by cash refund.” Based on insurance industry practice, the Plan should have returned the recovery to the FEHBP within 30 days after being received.

48 CFR 1652.215-71 (e) states that investment income lost on these funds should be credited to the FEHBP. In addition, section (f) of this regulation states, “All lost investment income payable shall bear simple interest at the quarterly rate determined by the Secretary of the Treasury . . . .”

For the period 2002 through 2006, there were 255,937 health benefit refunds and recoveries (i.e., claim overpayment refunds, subrogation recoveries, provider audit recoveries, fraud recoveries, and pharmacy drug rebates) totaling \$259,807,213. From this universe, we judgmentally selected and reviewed 161 health benefit refunds and recoveries, totaling \$63,994,475, to determine if the Plan returned these funds to the FEHBP in a timely manner.



Our sample selections included the following:

- From 2002 through 2004, we selected the 30 highest recovery check amounts for each year.
- During 2005, the Plan changed the reporting format of tracking health benefit refunds and recoveries. Therefore, we adjusted our sample selection methodology as follows:
  - From January 2005 through May 2005, we selected the 10 highest recovery check amounts.
  - From June 2005 through December 2005, we selected the 10 highest recovery check amounts, all pharmacy drug rebates, the 5 highest subrogation recovery amounts, and the 5 highest provider audit recovery amounts.
  - From 2005, we also judgmentally selected six high dollar fraud recovery amounts.
- From 2006, we selected the 10 highest recovery check amounts, all pharmacy drug rebates, the 5 highest subrogation recovery amounts, and the 5 highest provider audit recovery amounts. We also judgmentally selected six high dollar fraud recovery amounts.

Based on our review, we determined that the Plan did not return one health benefit recovery of \$12,607 to the FEHBP. The Plan did not return this amount to the FEHBP because it inadvertently did not cash the provider's refund check. As a result, the FEHBP is due \$13,577, consisting of \$12,607 for the recovery not returned and \$970 for LII on this recovery. Subsequent to our identification of this oversight, the Plan requested and received a replacement check from the provider, and returned the funds to the FEHBP on July 10, 2008.

As part of this finding, we calculated LII through December 31, 2006 on the health benefit recovery that was not returned to the FEHBP. In schedule C of this report, we calculated additional LII from January 1, 2007 through July 9, 2008.

**Plan's Response:**

The Plan agrees with this finding.

**Recommendation 11**

We verified that the Plan returned \$12,607 to the FEHBP on July 10, 2008 for the questioned health benefit recovery. Therefore, no further action is required for this questioned amount.

## **Recommendation 12**

We recommend that the contracting officer direct the Plan to credit the FEHBP \$970 for LII on the questioned health benefit recovery.

### **B. ADMINISTRATIVE EXPENSES**

#### **1. Unallowable and/or Unallocable CNA Overhead Costs** **\$108,015**

CNA (the former underwriter of the Mail Handlers Benefit Plan) charged the FEHBP for unallowable and/or unallocable costs that were included in overhead cost pools, resulting in overcharges of \$108,015 to the FEHBP for 2002.<sup>7</sup>

Contract CS.1146, Part III, section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable."

48 CFR 31.201-4 states, "A cost is allocable if it is assignable or chargeable to one or more cost objectives on the basis of relative benefits received or other equitable relationship. Subject to the foregoing, a cost is allocable to a Government contract if it-

- a) Is incurred specifically for the contract;
- b) Benefits both the contract and other work, and can be distributed to them in reasonable proportion to the benefits received; or
- c) Is necessary to the overall operation of the business, although a direct relationship to any particular cost objective cannot be shown."

48 CFR 31 205-27(a)(1) states, "planning or executing the organization or reorganization of the corporate structure of a business, including mergers and acquisitions . . . are unallowable. . . ."

We reviewed the prior audit of the MHBP (Report No. 1B-45-02-02-069, dated September 22, 2004), covering contract years 1999 through 2001, and determined if CNA continued to allocate any of the previously disallowed costs to the FEHBP. Based on our review, we found that CNA charged \$108,015 to the FEHBP for unallowable and/or unallocable costs in 2002. Specifically, CNA charged the following unallowable and/or unallocable costs to the FEHBP:

- Cost Center "0006252" (Casualty Actuarial): CNA allocated \$79,252 to the FEHBP through service codes "1630" (Corporate Finance G&A) and "1640" (Corporate Finance Insurance).

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<sup>7</sup> Prior to July 1, 2002, CNA was the underwriter for the Mail Handlers Benefit Plan.

- Cost Center “0009009” (Business Decision Support - Mergers and Acquisitions): CNA allocated \$25,016 to the FEHBP through service code “1640” (Corporate Finance Insurance).
- Natural Account “6306371” (Corporate Indemnity Expense): CNA allocated \$3,747 to the FEHBP through service code “1700” (Corporate Services).

These unallowable and/or unallocable costs were charged to the FEHBP through overhead cost pools that were allocated to the FEHBP. Although these costs were disallowed on the prior audit, CNA did not remove these costs from the 2002 cost filings. As a result, the FEHBP is due \$108,015 for unallowable and/or unallocable costs charged to the FEHBP.

**Plan’s Response:**

The Plan agrees with this finding.

**Recommendation 13**

We recommend that the contracting officer disallow \$108,015 for unallowable and/or unallocable costs that were charged to the FEHBP.

**C. CASH MANAGEMENT**

**1. Working Capital Deposit \$6,000,000**

At the end of the audit scope (as of December 31, 2006), the Plan held a working capital (WC) deposit with an excess amount of \$4,000,000 over the amount needed to meet the Plan’s daily cash needs for FEHBP claim payments and administrative expenses.

Based on our audit experience of other FEHBP fee-for-service plans, the WC deposit should be recalculated on an ongoing basis to determine if the amount currently maintained is adequate to meet the Plan’s daily cash needs for FEHBP claim payments and/or administrative expenses. If the deposit is not adequate, the Plan should make an appropriate adjustment.

During the audit scope, the Plan evaluated the WC deposit amount on several occasions, and made one adjustment. This adjustment was made by the Plan in March 2004 to increase its WC balance to \$47,000,000. To determine if the Plan maintained an adequate WC deposit, we recalculated what the Plan’s fourth quarter 2006 WC balance should have been and determined that, as of December 31, 2006, the Plan should have maintained a WC balance of \$43,000,000. Therefore, at the end of the audit scope, the Plan held a WC balance with an excess amount of \$4,000,000 over the amount needed to meet the Plan’s daily cash needs for FEHBP claim payments and administrative expenses.

In response to our initial audit inquiry, the Plan provided a more recent WC calculation of claims clearing and administrative expenses showing that the Plan held an excess amount of \$6,000,000 in FEHBP funds as of August 31, 2008. We reviewed and agreed with the Plan's WC calculation.

Since the Plan maintained these excess funds in an interest-bearing account and timely credited the interest earned on these funds to the FEHBP, no LII is due the FEHBP. However, the Plan needs to make an adjustment to return the excess WC funds of \$6,000,000 to the FEHBP letter of credit (LOC) account.

**Plan's Response:**

The Plan agrees that on the last day of the period under audit, December 31, 2006, the WC deposit was approximately \$4,000,000 greater than the amount needed to satisfy daily cash requirements at that time. The Plan also agrees that the \$6,000,000 amount later credited to the FEHBP reflects the extent to which the WC deposit exceeded the Plan's daily cash requirements as of August 31, 2008. However, for purposes of historical accuracy, the Plan does not agree that \$6,000,000 should be reported in this final report since the additional amount of \$2,000,000 was not related to the current audit period.

The Plan currently has procedures in place to monitor the WC balance ensuring that sufficient cash is available to meet the Plan's cash obligations. In addition, the Plan states, "as part of its resolution of OPM OIG Audit No. 1B-45-00-00-064 for the period ending December 31, 2001, the MHBP agreed to recalculate that balance requirement annually and readjust it as necessary, which we in fact did during the initial years of the current audit period, typically during the first calendar year quarter. We inadvertently failed to do this recalculation in 2006, however, because the first quarter time frame coincided with a change in the MHBP's underwriter and administrator that resulted in attentions being focused elsewhere. . . ."

**OIG Comments:**

We will continue to question \$6,000,000 since this was the excess amount held by the Plan as of August 31, 2008, which was determined as a result of our audit and during our audit fieldwork. In the audit finding, we also clearly point out the excess amounts held by the Plan as of December 31, 2006 and August 31, 2008.

**Recommendation 14**

We verified that the Plan returned the excess WC funds of \$6,000,000 (as of August 31, 2008) to the LOC account on October 8, 2008. Therefore, no further action is required for these funds.

**Recommendation 15**

We recommend that the contracting officer verify that the Plan has proper procedures in place to evaluate and adjust the WC deposit on an annual basis, or more frequently should a material change occur in the amount needed to meet the Plan's daily cash requirements.

**D. LOST INVESTMENT INCOME ON AUDIT FINDINGS \$31,454**

As a result of the audit findings presented in this report, the FEHBP is due LII of \$31,454 from January 1, 2003 through December 31, 2008.

48 CFR 1652.215-71 requires the carrier to invest and reinvest all excess FEHBP funds on hand, and to credit all investment income earned on those funds to the Special Reserve on behalf of the FEHBP. When the carrier fails to comply with these requirements, the carrier shall credit the Special Reserve with investment income that would have been earned at the rates specified by the Secretary of the Treasury. LII payable on questioned costs bears simple interest.

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 \$31,454 from January 1, 2003 through December 31, 2008 on questioned costs for contract years 2002 through 2006 (see Schedules B and C).

**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 16**

We recommend that the contracting officer direct the Plan to credit \$31,454 (plus interest accruing after December 31, 2008) to the Special Reserve for LII on audit findings.

## IV. MAJOR CONTRIBUTORS TO THIS REPORT

### Experienced-Rated Audits Group

[REDACTED], Auditor-In-Charge

[REDACTED], Auditor

[REDACTED], Auditor

[REDACTED], Auditor

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[REDACTED] Chief [REDACTED]

[REDACTED] Senior Team Leader

## V. SCHEDULES

COVENTRY HEALTH CARE AS UNDERWRITER AND ADMINISTRATOR  
FOR THE MAIL HANDLERS BENEFIT PLAN  
ROCKVILLE, MARYLAND

CONTRACT CHARGES AND AMOUNTS QUESTIONED

CONTRACT CHARGES*	2002	2003	2004	2005	2006			TOTAL
A. HEALTH BENEFIT CHARGES	\$2,164,583,386	\$2,134,300,262	\$2,000,969,679	\$1,825,275,686	\$1,713,363,109			\$9,838,492,122
B. ADMINISTRATIVE EXPENSES	225,911,478	206,070,709	196,764,755	180,395,104	168,147,032			977,289,078
C. OTHER EXPENSES AND RETENTIONS	18,464,509	19,689,041	17,512,269	17,357,200	15,224,427			88,247,446
<b>TOTAL CONTRACT CHARGES</b>	<b>\$2,408,959,373</b>	<b>\$2,360,060,012</b>	<b>\$2,215,246,703</b>	<b>\$2,023,027,990</b>	<b>\$1,896,734,568</b>			<b>\$10,904,028,646</b>
AMOUNTS QUESTIONED (PER SCHEDULE B)	2002	2003	2004	2005	2006	2007	2008	TOTAL
A. HEALTH BENEFIT CHARGES	\$0	\$0	\$0	\$821,277	\$2,408,758	\$4,583,290	\$0	\$7,813,325
B. ADMINISTRATIVE EXPENSES	108,015	0	0	0	0	0	0	108,015
C. CASH MANAGEMENT	0	0	0	0	0	0	6,000,000	6,000,000
D. LOST INVESTMENT INCOME ON AUDIT FINDINGS	0	3,983	4,590	4,725	5,873	6,634	5,649	31,454
<b>TOTAL QUESTIONED CHARGES</b>	<b>\$108,015</b>	<b>\$3,983</b>	<b>\$4,590</b>	<b>\$826,002</b>	<b>\$2,414,631</b>	<b>\$4,589,924</b>	<b>\$6,005,649</b>	<b>\$13,952,794</b>

\* We did not review claim payments for contract years 2002 through 2004 and other expenses and retentions for 2002 through 2006.

COVENTRY HEALTH CARE AS UNDERWRITER AND ADMINISTRATOR  
FOR THE MAIL HANDLERS BENEFIT PLAN  
ROCKVILLE, MARYLAND

QUESTIONED CHARGES

AUDIT FINDINGS	2002	2003	2004	2005	2006	2007	2008	TOTAL
<b>A. HEALTH BENEFIT CHARGES</b>								
1. Claim Payments								
a. Coordination of Benefits with Medicare	\$0	\$0	\$0	\$363,327	\$2,160,699	\$1,868,376	\$0	\$4,392,402
b. Claims Paid for Ineligible Patients	0	0	0	0	0	2,529,912	0	2,529,912
c. Omnibus Budget Reconciliation Act of 1990 Review	0	0	0	295,118	100,758	47,389	0	443,265
d. Duplicate Claim Payments	0	0	0	123,790	126,354	85,417	0	335,561
e. Claim Payment Errors	0	0	0	26,150	20,262	52,196	0	98,608
<b>Total Claim Payments</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$808,385</b>	<b>\$2,408,073</b>	<b>\$4,583,290</b>	<b>\$0</b>	<b>\$7,799,748</b>
2. Miscellaneous Payments and Credits								
a. Health Benefit Recovery*	\$0	\$0	\$0	\$12,892	\$685	\$0	\$0	\$13,577
<b>Total Miscellaneous Payments and Credits</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$12,892</b>	<b>\$685</b>	<b>\$0</b>	<b>\$0</b>	<b>\$13,577</b>
<b>TOTAL HEALTH BENEFIT CHARGES</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$821,277</b>	<b>\$2,408,758</b>	<b>\$4,583,290</b>	<b>\$0</b>	<b>\$7,813,325</b>
<b>B. ADMINISTRATIVE EXPENSES</b>								
1. Unallowable and/or Unallocable CNA Overhead Costs	\$108,015	\$0	\$0	\$0	\$0	\$0	\$0	\$108,015
<b>TOTAL ADMINISTRATIVE EXPENSES</b>	<b>\$108,015</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$108,015</b>
<b>C. CASH MANAGEMENT</b>								
1. Working Capital Deposit**	\$0	\$0	\$0	\$0	\$0	\$0	\$6,000,000	\$6,000,000
<b>TOTAL CASH MANAGEMENT</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$6,000,000</b>	<b>\$6,000,000</b>
<b>D. LOST INVESTMENT INCOME ON AUDIT FINDINGS</b>								
	\$0	\$3,983	\$4,590	\$4,725	\$5,873	\$6,634	\$5,649	\$31,454
<b>TOTAL QUESTIONED CHARGES</b>	<b>\$108,015</b>	<b>\$3,983</b>	<b>\$4,590</b>	<b>\$826,002</b>	<b>\$2,414,631</b>	<b>\$4,589,924</b>	<b>\$6,005,649</b>	<b>\$13,952,794</b>

\* Only the principal amount of this audit finding is subject to lost investment income.

\*\* Audit finding is not subject to lost investment income since the Plan maintained the questioned funds in an interest-bearing account and credited the interest earned on these funds to the letter of credit account.



COVENTRY HEALTH CARE AS UNDERWRITER AND ADMINISTRATOR  
FOR THE MAIL HANDLERS BENEFIT PLAN  
ROCKVILLE, MARYLAND

LOST INVESTMENT INCOME CALCULATION

	2002	2003	2004	2005	2006	2007	2008	TOTAL
<b>A. QUESTIONED CHARGES (Subject to Lost Investment Income)</b>								
Miscellaneous Payments and Credits*	\$0	\$0	\$0	\$0	\$12,607	\$0	\$0	\$12,607
Administrative Expenses	108,015	0	0	0	0	0	0	108,015
<b>TOTAL</b>	<b>\$108,015</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$12,607</b>	<b>\$0</b>	<b>\$0</b>	<b>\$120,622</b>
<b>B. LOST INVESTMENT INCOME CALCULATION</b>								
a. Prior Years Total Questioned (Principal)	\$0	\$108,015	\$0	\$0	\$0	\$12,607	\$0	
b. Cumulative Total	0	0	108,015	108,015	108,015	108,015	120,622	
c. Total	\$0	\$108,015	\$108,015	\$108,015	\$108,015	\$120,622	\$120,622	
d. Treasury Rate: January 1 - June 30	5.500%	4.250%	4.000%	4.250%	5.125%	5.250%	4.750%	
e. Interest (d * c)	\$0	\$2,295	\$2,160	\$2,295	\$2,768	\$3,166	\$2,865	\$15,549
f. Treasury Rate: July 1 - December 31	5.250%	3.125%	4.500%	4.500%	5.750%	5.750%	5.125%	
g. Interest (f * c)	\$0	\$1,688	\$2,430	\$2,430	\$3,105	\$3,468	\$2,784	\$15,905
<b>Total Interest By Year (e + g)</b>	<b>\$0</b>	<b>\$3,983</b>	<b>\$4,590</b>	<b>\$4,725</b>	<b>\$5,873</b>	<b>\$6,634</b>	<b>\$5,649</b>	<b>\$31,454</b>

\* Only the principal amount of the audit finding for miscellaneous payments and credits on Schedule B is subject to lost investment income. Also, we only calculated lost investment income through July 9, 2008 on the principal amount since the Plan returned the questioned funds to the letter of credit account on July 10, 2008.

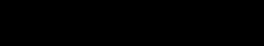
# CAC

Claims Administration Corp


15400 Calhoun Drive, Rockville, Maryland 20855

Thomas R. Kirkpatrick  
CFO, Group Health Services  
Telephone: 301-517-2012  
Facsimile: 301-517-2122

December 18, 2008

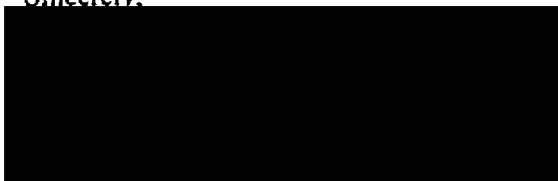
 Chief  
Experience-Rated Audits Group  
U.S. Office of Personnel Management  
Office of the Inspector General  
1900 E Street, NW, Room 6400  
Washington, DC 20415

Dear :

Enclosed is the response of the Mail Handlers Benefit Plan ("MHBP") to the U.S. Office of Personnel Management Office of the Inspector General's Draft Audit Report No. 1B-45-00-08-016 for the MHBP dated October 23, 2008. A copy of this report is also being furnished electronically on the enclosed flash drive. As we recently have advised OPM OIG Auditor-in-Charge  the enclosed flash drive also contains the documentary support that constitutes Appendix A to said response. Please let me know if you have any problems using the flash drive, or questions concerning the MHBP's response.

The MHBP appreciates the courtesy and professionalism the entire OIG audit team displayed during the audit, and looks forward to its resolution. On the MHBP's behalf, I wish all of you a happy holidays.

Sincerely,



Enclosure

cc: 

**I. AUDIT FINDINGS AND RECOMMENDATIONS**

# I. AUDIT FINDINGS AND RECOMMENDATIONS

## A. HEALTH BENEFIT CHARGES

### I. Claim Payments

#### a. Coordination of Benefits with Medicare

\$4,609,490

*The Plan incorrectly paid 10,027 claim lines, resulting in overcharges of \$4,609,490 to the FEHBP. Specifically, the Plan did not properly coordinate 6,555 claim line payments with Medicare as required by the FEHBP contract. As a result, the FEHBP paid as the primary insurer for these claims when Medicare was the primary insurer. Therefore, we estimate that the FEHBP was overcharged by \$4,280,737 for these claim lines. The remaining 3,472 claim line payments were not coordination of benefit errors but contained other Plan payment errors, resulting in overcharges of \$328,753 to the FEHBP.*

*The 2007 Mail Handlers Benefit Plan brochure, page 126, Primary Payer Chart, illustrates when Medicare is the primary payer. In addition, page 22 of that brochure states, "We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays."*

*Contract CS 1146, Part II, section 2.6 states, "(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare. . . . (b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier . . . ." Also, Part III, section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable . . . ."*

*In addition, Contract CS 1146, Part II, section 2.3(g) states, "If the Carrier or OPM determines that a Member's claim has been paid in error for any reason . . . the Carrier shall make a prompt and diligent effort to recover the erroneous payment . . . ."*

*For claims incurred and paid from October 1, 2005 through September 30, 2007, we performed a computer search and identified 362,781 claim lines, totaling \$28,315,090 in payments that potentially were not coordinated with Medicare. From this universe, we selected for review a sample of 19,571 claim lines, totaling \$12,599,311 in payments, to determine whether the Plan complied with the contract provisions relative to coordination of benefits (COB) with Medicare. When we submitted our sample of potential COB errors to the Plan on November 15, 2007, the claims were within the*

*Medicare timely filing requirement and could be filed with Medicare for coordination of benefits.*

*The following table is a summary of the claim lines that were selected for review:*

<i>Claim Type</i>	<i>Claim Lines</i>	<i>Amounts Paid</i>	<i>Sample Selection Methodology</i>
<i>Medicare Part A Primary for Inpatient (I/P) Facility</i>	<i>1,181</i>	<i>\$6,017,539</i>	<i>Patients with cumulative claims of \$750 or more</i>
<i>Medicare Part A Primary for Skilled Nursing, Home Health Care (HHC), and Hospice Care</i>	<i>337</i>	<i>\$428,114</i>	<i>Patients with cumulative claims of \$2,500 or more</i>
<i>Medicare Part B Primary for Certain I/P Facility Charges</i>	<i>168</i>	<i>\$1,234,806</i>	<i>Patients with cumulative claims of \$5,000 or more</i>
<i>Medicare Part B Primary for Skilled Nursing, HHC, and Hospice Care</i>	<i>0</i>	<i>\$0</i>	<i>The potential COB errors were immaterial. Therefore, no claim lines were selected.</i>
<i>Medicare Part B Primary for Outpatient Charges</i>	<i>3,029</i>	<i>\$2,548,641</i>	<i>Patients with cumulative claims of \$2,500 or more</i>
<i>Medicare Part B Primary for Professional Charges</i>	<i>14,856</i>	<i>\$2,370,211</i>	<i>Patients with cumulative claims of \$4,000 or more</i>
<i>Total</i>	<i>19,571</i>	<i>\$12,599,311</i>	

*Generally, Medicare Part A covers 100 percent of inpatient care in hospitals, skilled nursing facilities, hospice care, and home health care services. For each Medicare Benefit Period, there is a one-time deductible, followed by a daily copayment beginning with the 61<sup>st</sup> day. Beginning with the 91<sup>st</sup> day of the Medicare Benefit Period, Medicare Part A benefits may be exhausted, depending on whether the patient elects to use their Lifetime Reserve Days. For the uncoordinated Medicare Part A claims, we estimate that the FEHBP was overcharged for the total claim payment amounts. When applicable, we reduced the questioned amount by the Medicare deductible and/or Medicare copayment.*

*Medicare Part B pays 80 percent of most outpatient charges and professional claims after the calendar year deductible has been met. Also, Medicare Part B covers a portion of inpatient facility charges for ancillary services such as durable medical equipment, medical supplies, diagnostic tests, and clinical laboratory services. Based on our experience, ancillary items account for approximately 30 percent of the total inpatient claim payment. Therefore, we estimate that the FEHBP was overcharged 25 percent for these inpatient claim lines ( $0.30 \times 0.80 = 0.24 \sim 25$  percent).*

Based on our review of the potential COB errors in our sample, we identified 10,027 claim lines that were paid incorrectly, resulting in overcharges of \$4,609,490 to the FEHBP.<sup>1</sup>

The following table details the questioned payments by claim type:

Claim Type	Claim Lines	Amounts Paid	Amounts Questioned
Medicare Part A Primary for Inpatient (I/P) Facility	201	\$3,093,263	\$2,725,919
Medicare Part A Primary for Skilled Nursing, HHC, and Hospice Care	32	\$28,608	\$28,608
Medicare Part B Primary for Certain I/P Facility Charges	4	\$79,170	\$18,890
Medicare Part B Primary for Skilled Nursing, HHC, and Hospice Care	0	\$0	\$0
Medicare Part B Primary for Outpatient Charges	1,038	\$966,989	\$731,476
Medicare Part B Primary for Professional Charges	8,752	\$1,189,788	\$1,104,597
<b>Total</b>	<b>10,027</b>	<b>\$5,357,818</b>	<b>\$4,609,490</b>

Our audit disclosed the following for the claim payment errors:

- For 6,248 (62 percent) of the claim lines questioned, there was incorrect or no Medicare COB information on the Plan's claims system to identify Medicare as the primary payer when the claims were paid. However, when the correct Medicare information was subsequently added to the claims system, the Plan did not review and/or adjust the patient's prior claims back to the Medicare effective dates. As a result, we estimate that the FEHBP was overcharged \$4,239,288 for these claims that were not coordinated with Medicare.
- For 3,472 (35 percent) of the claim lines questioned, we found that these claim lines were not COB errors but contained other Plan payment errors. As a result, we determined that the FEHBP was overcharged \$328,753 for these claim payment errors.
- For 307 (3 percent) of the claim lines questioned, the correct Medicare COB information was present on the Plan's claims system to identify

<sup>1</sup> In addition, there were 232 claim lines with COB errors, totaling \$409,981 in payments, that were identified and adjusted by the Plan prior to the date of our information request (i.e., November 15, 2007). Since these COB errors were identified and adjusted by the Plan prior to the date of our information request, we did not question these COB errors in the draft report.

*Medicare as the primary payer when the claims were paid. The exact reason(s) for these claim payment errors could not be identified. As a result, we estimate that the FEHBP was overcharged \$41,449 for these claims that were not coordinated with Medicare.*

*Of the \$4,609,490 in questioned charges, \$150,950 (3 percent) were identified by the Plan prior to the date of our information request (i.e., November 15, 2007). However, since the Plan had not completed the recovery process and/or adjusted these claims by November 15, 2007, we are continuing to question these COB errors. The remaining questioned charges of \$4,458,540 (97 percent) were identified as a result of our audit.*

**Plan's Response:**

*The Plan agrees with this finding.*

**Recommendation 1**

*We recommend that the contracting officer disallow \$4,280,737 for uncoordinated claim payments, and have the Plan return all amounts recovered to the FEHBP.*

**MHBP Response:** Following its investigation of the questioned claim lines and identification of those on which it determined benefits were issued erroneously but in good faith, the MHBP immediately initiated efforts to recoup those overpayments in accordance with Section 2.3(g) of Contract No. CS 1146, and the procedures stated in its OPM-approved overpayment recovery guidelines.<sup>2</sup> As part of that established recovery process, which is ongoing, the MHBP returns all overpayment recoveries to the FEHBP promptly following their receipt.

Moreover, in the course of reexamining the 10,027 claim lines referenced in the above table, the MHBP has concluded that it must revise its prior agreement that 8,752 claim lines totaling \$1,104,597 described as "Medicare Part B Primary for Professional Charges," were paid erroneously. The MHBP has determined that 2,613 of those 8,752 claim lines, totaling \$217,088 in payments, were processed correctly, thus reducing the number of claim lines and dollar amounts in this category that it agrees were paid in error to 6,139 and \$887,509, and the total number of Medicare COB claim lines and dollar amounts that it agrees were paid in error to 7,414 and \$4,392,402. The MHBP

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<sup>2</sup> We disagree with the Inspector General's characterization of the questioned health benefit charges referenced in this Section A. of the Draft Audit Report payments as "unallowable." Section 2.3(g)(7)(i) states that "[t]he Carrier may charge the contract for benefit payments made erroneously but in good faith provided that it can document that it acted with prompt and due diligence as described above." The MHBP has acted in the prescribed manner here.

has enclosed with this response (as Appendix A) a revised spreadsheet itemizing these changes in its position, together with extensive supporting documentation from the individual claims themselves. The MHBP therefore requests that the OIG modify the dollar amount specified in this recommendation to reflect this change.<sup>3</sup>

**Recommendation 2**

*We recommend that the contracting officer require the Plan to ensure that the Plan has procedures in place to review all claims incurred back to the Medicare effective dates when updated, other party liability information is added to the Plan's claims system. When Medicare eligibility is subsequently reported, the Plan is expected to immediately determine if already paid claims are affected and, if so, to initiate the recovery process within 30 days.*

**MHBP Response:** The MHBP concurs with this recommendation.

**Recommendation 3**

*We recommend that the contracting officer disallow \$328,753 for claim overcharges resulting from other Plan payment errors, and have the Plan return all amounts recovered to the FEHBP.*

<sup>3</sup> By way of brief explanation, the 8,752 claim lines referred to above were the cumulative totals enumerated in the categories denoted as "Category F" and "Category F Expanded" on the attached spreadsheet. The 2,613 claim lines totaling \$217,088 on which the MHBP has changed its position are all part of Category F Expanded, which questioned 3,469 claim lines totaling \$322,071 in payments. The revised Category F Expanded totals, then, are 856 claim lines totaling \$104,983 that the MHBP concurs were paid in error. Set forth below is how the revised table should read:

Claim Type	Claim Lines	Amounts Paid	Amounts Questioned
Medicare Part A Primary for Inpatient (I/P) Facility	201	\$3,093,263	\$2,725,919
Medicare Part A Primary for Skilled Nursing, HHC, and Hospice Care	32	\$28,608	\$28,608
Medicare Part B Primary for Certain I/P Facility Charges	4	\$79,170	\$18,890
Medicare Part B Primary for Skilled Nursing, HHC, and Hospice Care	0	\$0	\$0
Medicare Part B Primary for Outpatient Charges	1,038	\$966,989	\$731,476
Medicare Part B Primary for Professional Charges	6,139	\$1,189,788	\$887,509
<b>Total</b>	<b>7,414</b>	<b>\$5,357,818</b>	<b>\$4,392,402</b>



**MHBP Response:** Following its investigation of the questioned claim lines and identification of those on which it determined benefits were issued erroneously but in good faith, the MHBP immediately initiated efforts to recoup those overpayments in accordance with Section 2.3(g) of Contract No. CS 1146, and the procedures stated in its OPM-approved overpayment recovery guidelines. As part of that established recovery process, which is ongoing, the MHBP returns all overpayment recoveries to the FEHBP promptly following their receipt.

**Recommendation 4**

*We recommend that the contracting officer instruct the Plan to identify the root cause(s) of the claim payment errors and develop an action plan to prevent these types of errors in the future.*

**MHBP Response:** As evidenced by the above responses, a significant majority of the claim lines paid in error here (7,138 out of 7,414, or 96.3%) involved coordination of benefits with a member's Medicare Part B primary coverage. Unlike Medicare Part A, in which the MHBP can assume a member is enrolled as of the month they turn age 65, enrollment in Medicare Part B not only is voluntary, but can be deferred at the enrollee's election. In addition, the MHBP's ability to determine COB status with Medicare Part B depends on its timely receipt of conversion to annuitant status from the government payroll offices. In other words, obtaining credible evidence demonstrating both (1) a member's annuitant status, and (2) his/her enrollment in Medicare Part B is largely outside the MHBP's control, making COB errors extremely difficult to avoid where that evidence is not timely furnished.

To facilitate it in avoiding Medicare COB errors to the greatest extent possible, the MHBP participates in a Voluntary Data Sharing Agreement ("VDSA") with CMS. Through that arrangement, the MHBP obtains the most up-to-date Medicare Part B enrollment information available from CMS for uploading into its member eligibility files. It therefore is unclear to the MHBP what additional steps are available to it that might further assist it in preventing future Medicare COB errors from occurring. It likewise is unclear to the MHBP what kind of additional action, if any, the OIG contemplates in its recommendation.

That said, the MHBP reiterates its concurrence with the OIG's Recommendation 2 concerning the retrospective handling of such claims payments when evidence of a member's Medicare Part B coverage comes to its attention at a later date.

**b. Claims Paid for Ineligible Patients**

**\$2,529,912**

*The Plan paid 10,275 claim lines that were incurred during gaps in patient coverage or after termination of patient coverage with the Mail Handlers Benefit Plan, resulting in overcharges of \$2,411,097 to the FEHBP. In addition, the Plan paid 2,167 claim lines for patients with no enrollment identification (ID) numbers, resulting in overcharges of \$118,815 to the FEHBP. In total, the FEHBP is due \$2,529,912.*

*Contract CS 1146, Part III, section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable." Part II, section 2.3(g) states, "If the Carrier or OPM determines that a Member's claim has been paid in error for any reason . . . the Carrier shall make a prompt and diligent effort to recover the erroneous payment . . . ."*

**Enrollees with No Coverage during Dates of Service**

*We performed a computer search to identify claims paid during gaps in patient coverage or claims paid after termination of patient coverage with the Mail Handlers Benefit Plan. The search covered the period January 1, 2005 through September 30, 2007. The search identified claim payments, totaling \$5,716,775, for 7,472 patients with gaps in coverage or patients that were terminated.*

*From this universe of 7,472 patients, we selected all patients with cumulative claim lines of \$2,500 or more. This sample included 15,865 claim line payments, totaling \$4,212,231, for 330 patients. Our review of the sample identified 10,275 claim lines, totaling \$2,411,097 in payments, that were paid during gaps in patient coverage or after termination of coverage. As a result, the FEHBP is due \$2,411,097 for these improper payments.*

**Patients with No Enrollment Record**

*We performed a computer search to identify claims paid for patients with no enrollment ID numbers. The search covered the period January 1, 2005 through September 30, 2007. The search identified claim payments, totaling \$5,386,641, for 1,174 patients with no enrollment ID numbers.*

*From this universe of 1,174 patients, we selected all patients with cumulative claim lines of \$2,000 or more. This sample included 26,826 claim line payments, totaling \$4,995,049, for 285 patients. Our review of the sample identified 2,167 claim lines, totaling \$118,815 in payments, that were made for patients with no enrollment ID number. As a result, the FEHBP is due \$118,815 for these improper payments.*

### Summary of Claims Paid to Ineligible Patients

*In total, the Plan charged the FEHBP \$2,529,912 for 12,442 claim line payments made for ineligible patients.<sup>4</sup> Our audit disclosed the following errors:*

- *For 12,217 of the claim lines questioned, the Plan received retroactive termination of patient coverage from the Federal agency's payroll office. However, when termination dates were subsequently received, the Plan did not review and/or adjust the patient's prior claims back to the termination date. As a result, the FEHBP was overcharged \$2,415,908 in claim payments for patients not eligible for benefits.*
- *For 63 of the claim lines questioned, there were various eligibility errors. For example, we identified one patient where coverage terminated during an inpatient hospital stay and the Plan erroneously paid for all dates of service under this claim. As a result, the FEHBP was overcharged \$90,665 in claim payments for patients not eligible for benefits.*
- *For 21 of the claim lines questioned, the claim processors entered incorrect data. As a result, the FEHBP was overcharged \$19,108 in claim payments for patients not eligible for benefits.*
- *For 141 of the claim lines questioned, the Plan utilized incorrect social security numbers to determine whether the patient was eligible for coverage. As a result, the FEHBP was overcharged \$4,231 in claim payments for patients not eligible for benefits.*

*Of the \$2,529,912 in questioned charges, \$841,711 (33 percent) were identified prior to the date we issued our information request (i.e., February 28, 2008). However, since the Plan had not completed the recovery process and/or adjusted these claim lines by February 28, 2008, we are continuing to question these eligibility errors. The remaining questioned charges of \$1,688,201 (67 percent) were identified as a result of our audit.*

### Plan's Response:

*The Plan agrees with this finding.*

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<sup>4</sup> In addition, there were 1,160 eligibility errors, totaling \$733,453 in payments, that were identified and adjusted or voided prior to the date of our information request (i.e., February 28, 2008). Since these eligibility errors were identified and adjusted or voided prior to the date of our information request, we did not question these claim line payments in the draft report.

**Recommendation 5**

*We recommend that the contracting officer disallow \$2,529,912 for claim overcharges, and have the Plan return all amounts recovered to the FEHBP.*

**MHBP Response:** As illustrated in our Audit Inquiry #3 response, 12,217 of the 12,422 claim lines that we concur were paid erroneously but in good faith, or 98%, were attributable to Government agency payroll office delays in notifying the MHBP of an individual's termination of MHBP coverage. Section 1.5 of Contract No. CS 1146 provides that benefit payments made as a result of such payroll office errors are valid charges against that Contract.

Notwithstanding that fact, following investigation of the questioned claim lines and identification of those on which benefits were issued erroneously but in good faith, the MHBP, as required by Section 2.3(g) of Contract No. CS 1146, immediately began making efforts to recoup those overpayments pursuant to the procedures enumerated in our OPM-approved overpayment recovery guidelines. As a routine part of that established process, which is ongoing, the overpayments were introduced into the MHBP's normal exception processing workstream, and all amounts recovered on them will be credited to the FEHBP promptly upon receipt.

**Recommendation 6**

*We recommend that the contracting officer instruct the Plan to identify the root cause(s) of the claim payment errors and develop an action plan to prevent these types of errors in the future.*

**MHBP Response:** As evidenced in our response to Recommendation 5 above, payment of the overwhelming majority of the questioned claim lines is attributable to payroll office reporting delays. In short, the MHBP did not receive agency notification of the member's termination until after the date on which it adjudicated and issued payment on the claim line, *i.e.*, circumstances that are beyond the MHBP's ability to control and/or correct. That said, we plan to implement procedures to ensure that upon receiving payroll office notice of an individual's termination of coverage, the MHBP identifies any and all post-termination claims paid under that enrollment and initiates overpayment recovery efforts on them as required under Section 2.3(g) of Contract No. CS 1146, as supplemented by our OPM-approved overpayment recovery guidelines.

**c. Omnibus Budget Reconciliation Act of 1990 Review**

**\$443,265**

*The Plan incorrectly paid 13 claims that were priced or potentially should have been priced under the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) pricing guidelines, resulting in net overcharges of \$443,265 to the FEHBP. Specifically, the Plan overpaid 11 claims by \$446,625 and underpaid 2 claims by \$3,360.*

*Contract CS 1146, Part III, section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable." Part II, section 2.3(g) states, "If the Carrier or OPM determines that a Member's claim has been paid in error for any reason . . . the Carrier shall make a prompt and diligent effort to recover the erroneous payment . . . ."*

*In addition, Contract CS 1146, Part II, section 2.6 states, "(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare. . . . (b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier . . . ."*

*OBRA 90 limits the benefit payments for certain inpatient hospital services provided to annuitants age 65 or older who are not covered under Medicare Part A. The FEHBP fee-for-service plans are required to limit the claim payment to the amount equivalent to the Medicare Part A payment.*

*Using a program developed by the Centers for Medicare and Medicaid Services (CMS) to price OBRA 90 claims, we recalculated the claim payment amounts for the claims in our samples that were subject to and/or processed as OBRA 90.*

*The following summarizes the claim payment errors.*

**Claims Not Priced Under OBRA 90**

*For the period 2005 through September 30, 2007, we identified 5,374 claims, totaling \$37,583,828 in payments, that were potentially subject to OBRA 90 pricing guidelines but appeared to be paid under the Plan's standard pricing procedures. From this universe, we selected and reviewed a judgmental sample of 274 claims, totaling \$19,424,926 in payments, to determine if the Plan paid these claims properly. Our sample included all possible OBRA 90 claims with amounts paid of \$30,000 or more. Based on our review, we determined that nine of these claims were paid incorrectly, resulting in overcharges of \$396,381 to the FEHBP.*

*These claim payment errors resulted from the following:*

- *The Plan did not properly coordinate four claims with Medicare, resulting in overcharges of \$195,008 to the FEHBP. We determined that these claims should not have been priced under OBRA 90 but should have been coordinated with Medicare. These claim errors occurred because the Plan's claims system contained incorrect Medicare COB information to identify Medicare as the primary payer when the claims were paid.*
- *The Plan did not price four claims under OBRA 90, resulting in overcharges of \$177,290 to the FEHBP. These claim errors occurred because the Plan's claims system contained incorrect Medicare COB or subscriber retirement information when the claims were paid.*
- *The Plan inadvertently did not price one claim under OBRA 90, resulting in an overcharge of \$24,083 to the FEHBP. The exact cause of this claim payment error could not be identified.*

#### OBRA 90 Claim Pricing Errors

*For the period 2005 through September 30, 2007, we identified 2,075 claims, totaling \$18,366,598 in payments, that were subject to OBRA 90 pricing guidelines. From this universe, we selected and reviewed a judgmental sample of 100 claims, totaling \$4,522,005 in payments, to determine if these claims were correctly priced and paid by the Plan. Our sample included all OBRA 90 claims with amounts paid of \$23,400 or more.*

*Based on our review, we determined that four of these claims were paid incorrectly, resulting in net overcharges of \$46,884 to the FEHBP. Specifically, two claims were overpaid by \$50,244 and two claims were underpaid by \$3,360.*

*These claim payment errors resulted from the following:*

- *The Plan did not properly coordinate one claim with Medicare, resulting in an overcharge of \$47,599 to the FEHBP. We determined that this claim should not have been priced under OBRA 90 but should have been coordinated with Medicare. This claim payment error was identified by the Plan before receiving our information request (audit sample) on December 14, 2007. However, since the Plan did not complete the recovery process and/or adjust the claim prior to the date of our information request, we are continuing to question this error.*
- *The Plan priced two claims using an earlier version of the CMS Pricer, resulting in net undercharges of \$210 to the FEHBP. Specifically, the Plan overpaid one claim by \$2,645 and underpaid one claim by \$2,855.*

- *The Plan incorrectly priced one claim due to a manual pricing error, resulting in an undercharge of \$505 to the FEHBP. Specifically, the Plan incorrectly reduced the diagnostic related grouping (DRG) payment by subtracting the difference between the private room rate and the semi-private room rate. Under DRG pricing guidelines, this difference should not be excluded from the total billed amount.*

**Plan's Response:**

*The Plan agrees with this finding.*

**Recommendation 7**

*We recommend that the contracting officer disallow \$446,625 for claim overcharges, and have the Plan return all amounts recovered to the FEHBP.*

**MHBP Response:** Following investigation of the questioned claim lines and identification of those on which benefits were issued erroneously but in good faith, the MHBP, as required by Section 2.3(g) of Contract No. CS 1146, immediately began making efforts to recoup those overpayments pursuant to the procedures enumerated in our OPM-approved overpayment recovery guidelines. As a routine part of that established process, which is ongoing, the overpayments were introduced into the MHBP's normal exception processing workflow, and all amounts recovered on them will be credited to the FEHBP promptly upon receipt.

**Recommendation 8**

*We recommend that the contracting officer allow the Plan to charge the FEHBP \$3,360 if additional payments are made to the providers to correct the underpayment errors.*

**MHBP Response:** We concur with this recommendation.

**Recommendation 9**

*We recommend that the contracting officer instruct the Plan to identify the root cause(s) of the claim payment errors and develop an action plan to prevent these types of errors in the future.*

**MHBP Response:** As the above narrative illustrates, the 13 erroneous claims payments that comprise this proposed audit finding generally cannot be attributed to a discrete, identifiable cause (or set of causes), and consequently

do not lend themselves to an action plan of the kind the OIG contemplates in this Recommendation.<sup>5</sup>

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<sup>5</sup> To the extent that several of the subject claims involve Medicare COB issues, those claims will be subject to the corrective measures the MHPB implements as recommended in Section 1.a of this draft report.



**d. Duplicate Claim Payments**

**\$335,561**

*The Plan improperly charged the FEHBP \$335,561 for 527 duplicate claim payments from 2005 through September 30, 2007. These payments were unnecessary and unallowable charges to the FEHBP.*

*Contract CS 1146, Part III, section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable." Part II, section 2.3(g) states, "If the Carrier or OPM determines that a Member's claim has been paid in error for any reason . . . the Carrier shall make a prompt and diligent effort to recover the erroneous payment . . . ."*

*Section 6(h) of the FEHB Act provides that rates should reasonably and equitably reflect the costs of benefits provided.*

*We performed a computer search for potential duplicate payments on claims paid during the period January 1, 2005 through September 30, 2007. We selected and reviewed 1,159 groups, totaling \$1,625,030 (out of 25,959 groups, totaling \$1,758,856) in potential duplicate payments, under our "best matches" criteria. We also selected and reviewed 658 groups, totaling \$1,170,820 (out of 91,985 groups, totaling \$3,258,561) in potential duplicate payments, under our "near matches" criteria. Our samples included all groups with potential duplicate payments of \$250 or more under the "best matches" criteria and \$500 or more under the "near matches" criteria.*

*Based on our review, we determined that 468 claim payments in our "best matches" sample were duplicates, resulting in overcharges of \$291,526 to the FEHBP. Also, we determined that 59 claim payments in our "near matches" sample were duplicates, resulting in overcharges of \$44,035 to the FEHBP. In total, the Plan charged the FEHBP \$335,561 for these 527 duplicate claim payments from 2005 through September 30, 2007.<sup>6</sup> These duplicate claim payments occurred when the claims were deferred as potential duplicates on the claims system, but were overridden by the processors.*

**Plan's Response:**

*The Plan agrees with this finding.*

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<sup>6</sup> In addition, there were 35 duplicate claim payments, totaling \$36,747 that were identified and adjusted or voided by the Plan prior to the date of our information request (i.e., November 15, 2007). Since these duplicate claim payments were identified and adjusted or voided by the Plan prior to the date of our information request, we did not question these duplicate claim payments in the draft report.

**Recommendation 10**

*We recommend that the contracting officer disallow \$335,561 for duplicate claim payments charged to the FEHBP, and have the Plan return all amounts recovered to the FEHBP.*

**MHBP Response:** Following investigation of the questioned claim lines and identification of those on which benefits were issued erroneously but in good faith, the MHBP, as required by Section 2.3(g) of Contract No. CS 1146, immediately began making efforts to recoup those overpayments pursuant to the procedures enumerated in our OPM-approved overpayment recovery guidelines. As a routine part of that established process, which is ongoing, the overpayments were introduced into the MHBP's normal exception processing workstream, and all amounts recovered on them will be credited to the FEHBP promptly upon receipt.

**Recommendation 11**

*We recommend that the contracting officer instruct the Plan to identify the root cause(s) of the claim payment errors and develop an action plan to prevent these types of errors in the future.*

**MHBP Response:** We concur with this recommendation.

e. Claim Payment Errors

\$98,608

*The Plan incorrectly paid 36 claims, resulting in overcharges of \$98,608 to the FEHBP.*

*Contract CS 1146, Part III, section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable." Part II, section 2.3(g) states, "If the Carrier or OPM determines that a Member's claim has been paid in error for any reason . . . the Carrier shall make a prompt and diligent effort to recover the erroneous payment . . . ."*

*The following summarizes the claim payment errors.*

Assistant Surgeon Review

*For the period January 1, 2005 through September 30, 2007, we identified 2,883 assistant surgeon claim groups, totaling \$564,728 in potential overpayments, that may not have been paid in accordance with the Plan's assistant surgeon pricing procedures. From this universe, we selected and reviewed a judgmental sample of 86 assistant surgeon claim groups, totaling \$174,812 in potential overpayments, to determine if the Plan paid these claims properly. Our sample included all assistant surgeon claim groups with potential overpayments of \$1,000 or more. The majority of these claim groups contained one primary surgeon and one assistant surgeon claim. Based on our review, we determined that 23 claims were paid incorrectly, resulting in overcharges of \$53,611 to the FEHBP.*

*The claim payment errors resulted from the following:*

- The Plan paid 12 claims to non-covered providers, resulting in overcharges of \$35,514 to the FEHBP. Specifically, these providers were physician assistants and were not covered for surgery.*
- The Plan incorrectly paid six claims due to various manual pricing errors, resulting in overcharges of \$7,965 to the FEHBP. For example, the Plan did not apply a 10 percent co-insurance to a claim.*
- The Plan did not limit the allowable charge to the Plan's allowance when pricing three Non-Preferred Provider Organization (non-PPO) claims, resulting in overcharges of \$7,465 to the FEHBP.*
- The Plan incorrectly paid two assistant surgeon claims, resulting in overcharges of \$2,667 to the FEHBP. These overcharges were due to errors in the calculation of the assistant surgeon fee, which should have*

*been priced at 16 percent of the primary surgeon allowed amount.*

*In addition to the above sample, the Plan identified six additional assistant surgeon claims that were paid incorrectly for this same reason as the above two claims. As a result, the FEHBP was overcharged an additional \$3,802.*

#### System Review

*For health benefit claims reimbursed during the period January 1, 2007 through September 30, 2007, we identified 7,025,774 claim lines, totaling \$899,648,442 in payments, using a standard criteria based on our audit experience. From this universe, we selected and reviewed a judgmental sample of 125 claims (representing 323 claim lines), totaling \$5,106,844 in payments, to determine if the Plan adjudicated these claims properly.<sup>7</sup> Based on our review, we determined that seven claims were paid incorrectly, resulting in overcharges of \$41,195 to the FEHBP.*

*The claim payment errors resulted from the following:*

- *The Plan did not limit the allowable charge to the Plan's allowance when pricing three non-PPO claims, resulting in overcharges of \$34,738 to the FEHBP.*
- *The Plan incorrectly paid three claims due to various manual pricing errors, resulting in overcharges of \$4,963 to the FEHBP. As an example, the Plan entered an incorrect allowable amount for a claim.*
- *In one instance, the Plan erroneously adjusted a claim that was priced and paid correctly, resulting in an overcharge of \$1,494 to the FEHBP.*

#### Plan's Response:

*The Plan agrees with this finding.*

#### Recommendation 12

*We recommend that the contracting officer disallow \$98,608 for claim overcharges, and have the Plan return all amounts recovered to the FEHBP.*

**MHBP Response:** Following investigation of the questioned claim lines and identification of those on which benefits were issued erroneously but in good

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<sup>7</sup> We selected our sample from an OIG-generated "Place of Service Report" (SAS application) that stratified the claims by place of service (POS), such as provider's office and payment category, such as \$50 to \$99.99. We judgmentally determined the number of sample items to select from each POS stratum based on the stratum's total claim dollars paid.

faith, the MHBP, as required by Section 2.3(g) of Contract No. CS 1146, immediately began making efforts to recoup those overpayments pursuant to the procedures enumerated in our OPM-approved overpayment recovery guidelines. As a routine part of that established process, which is ongoing, the overpayments were introduced into the MHBP's normal exception processing workstream, and all amounts recovered on them will be credited to the FEHBP promptly upon receipt.

**Recommendation 13**

*We recommend that the contracting officer instruct the Plan to identify the root cause(s) of the claim payment errors and develop an action plan to prevent these types of errors in the future.*

**MHBP Response:** As the above narrative illustrates, the erroneous claims payments that comprise this proposed audit finding generally are not attributable to a discrete, identifiable cause (or set of causes), but rather were primarily the result of manual error by individual claims processors. Correction of those errors therefore does not lend itself to a specific action plan of the kind the OIG contemplates in this recommendation. Nonetheless, MHBP claims processors will be furnished with additional training in order to minimize the likelihood of similar claims payment errors in the future.

## 2. Miscellaneous Payments and Credits

### a. Health Benefit Recoveries

\$15,270

*The Plan did not return or support the return of two health benefit recoveries, totaling \$14,159, to the FEHBP. As a result, the FEHBP is due \$15,270, consisting of \$14,159 for recoveries not returned or supported and \$1,111 for lost investment income (LII) on these recoveries.*

*Contract CS 1146, Part III section 3.8 states, "the carrier will retain and make available all records applicable to a contract term . . . ."*

*48 CFR 31.201-5 states, "The applicable portion of any income, rebate, allowance, or other credit relating to any allowable cost and received by or accruing to the contractor shall be credited to the Government either as a cost reduction or by cash refund." Based on insurance industry practice, the Plan should have returned the recoveries to the FEHBP within 30 days after being received.*

*48 CFR 1652.215-71 (e) states that investment income lost on these funds should be credited to the FEHBP. In addition, section (f) of this regulation states, "All lost investment income payable shall bear simple interest at the quarterly rate determined by the Secretary of the Treasury . . . ."*

*For the period 2002 through 2006, there were 255,937 health benefit recoveries (e.g., claim overpayment refunds, subrogation recoveries, and pharmacy drug rebates) totaling \$259,807,213. From this universe, we judgmentally selected and reviewed 161 health benefit recoveries, totaling \$63,994,475, to determine if the Plan returned these recoveries to the FEHBP in a timely manner. Our sample selections included the following:*

- *From 2002 through 2004, we selected the 30 highest recovery check amounts for each year.*
- *During 2005, the Plan's reporting format of tracking health benefit recoveries changes. Therefore, we adjusted our sampling methodology.*
  - *From January 2005 through May 2005, we selected the 10 highest recovery check amounts.*
  - *From June 2005 through December 2005, we selected the 10 highest recovery check amounts, all pharmacy drug rebates, the 5 highest subrogation recovery amounts, and the 5 highest provider audit recovery amounts.*
  - *From 2005, we also judgmentally selected six high dollar fraud recovery amounts.*

- *From 2006, we selected the 10 highest recovery check amounts, all pharmacy drug rebates, the 5 highest subrogation recovery amounts, and the 5 highest provider audit recovery amounts. We also judgmentally selected six high dollar fraud recovery amounts.*

*Based on our review, we noted the following exceptions:*

- *In one instance, the Plan did not return a health benefit recovery of \$12,607 to the FEHBP. The Plan did not return this amount to the FEHBP because it inadvertently did not cash the provider's refund check. Subsequent to our identification of this oversight, the Plan requested and received a replacement check from the provider, and returned the funds to the FEHBP on July 10, 2008.*
- *In one instance, the Plan did not provide sufficient documentation to support the return of a health benefit recovery of \$1,552 to the FEHBP.*

*In total, the FEHBP is due \$15,270, consisting of \$14,159 for recoveries not returned or supported and \$1,111 for LII on these recoveries. As part of this finding, we calculated LII through December 31, 2006 on the questioned health benefit recoveries. In the final audit report, we will calculate additional LII accruing after December 31, 2006.*

**Plan's Response:**

*The Plan agrees with this finding.*

**Recommendation 14**

*We verified that the Plan returned \$12,607 to the FEHBP on July 10, 2008 for one of the questioned health benefit recoveries. Therefore, no further action is required for this questioned amount.*

**MHBP Response:** The MHBP concurs with this recommendation.

**Recommendation 15**

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

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

**Recommendation 16**

*We recommend that the contracting officer direct the Plan to credit the FEHBP \$1,111 (plus interest accruing after December 31, 2006) for LII on the questioned health benefit recoveries.*

**MHBP Response:** We concur with the OIG's recommendation that the Contracting Officer assess lost investment income against the \$12,607 amount referenced in its Recommendation 14. Based on its Recommendation 15 response, however, lost investment income should not be assessed against the \$1,522 refund that the MHBP timely credited to the FEHBP. The OIG therefore should modify its proposed finding of \$1,111 in lost investment income to reflect that fact.



## **B. ADMINISTRATIVE EXPENSES**

### **1. Unallowable and/or Unallocable CNA Overhead Costs** **\$108,015**

*CNA (the former underwriter of the Mail Handlers Benefit Plan) charged the FEHBP for unallowable and/or unallocable costs that were included in overhead cost pools, resulting in overcharges of \$108,015 to the FEHBP for 2002.*

*Contract CS 1146, Part III, section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable."*

*48 CFR 31.201-4 states, "A cost is allocable if it is assignable or chargeable to one or more cost objectives on the basis of relative benefits received or other equitable relationship. Subject to the foregoing, a cost is allocable to a Government contract if it-*

- a) Is incurred specifically for the contract;*
- b) Benefits both the contract and other work, and can be distributed to them in reasonable proportion to the benefits received; or*
- c) Is necessary to the overall operation of the business, although a direct relationship to any particular cost objective cannot be shown."*

*48 CFR.31 205-27(a) (1), "Planning or executing the organization or reorganization of the corporate structure of a business, including mergers and acquisitions, . . . are unallowable. . . ."*

*We reviewed the prior CNA audit report (Report #1B-45-02-02-069), covering contract years 1999 through 2001, and determined if CNA continued to charge any of the previously disallowed costs. Based on our review, we found that CNA charged to the FEHBP \$108,015 for unallowable and/or unallocable costs in 2002. Specifically, CNA charged the following unallowable and/or unallocable costs to the FEHBP:*

- Cost Center 0006252 (Casualty Actuarial) – CNA allocated \$79,252 to the FEHBP through service code 1630 (Corporate Finance G&A) and service code 1640 (Corporate Finance Insurance).*
- Cost Center 0009009 (Business Decision Support Lead - Mergers & Acquisitions) – CNA allocated \$25,016 to the FEHBP through service code 1640 (Corporate Finance Insurance).*
- Account 6306371 (Corporate Indemnity Expense) – CNA allocated \$3,747 to the FEHBP through service code 1700 (Corporate Services).*

*The above unallowable and/or unallocable costs were charged to the FEHBP through overhead cost pools that were allocated to the FEHBP. Although these costs were disallowed on the prior audit, CNA did not remove these costs from the 2002 cost filings. As a result, the FEHBP is due \$108,015 for unallowable and/or unallocable costs charged to the FEHBP.*

**Plan's Response:**

*The Plan agrees with this finding.*

**Recommendation 17**

*We recommend that the contracting officer disallow \$108,015 for unallowable and/or unallocable costs.*

**MHBP Response:** We concur with this recommendation.

## **C. CASH MANAGEMENT**

### **1. Working Capital Deposit \$6,000,000**

*At the end of the audit scope (as of December 31, 2006), the Plan held a working capital (WC) deposit with an excess amount of \$4 million over the amount needed to meet the Plan's daily cash needs for FEHBP claim payments and administrative expenses.*

*Based on our audit experience of other FEHBP fee-for-service plans, the WC deposit should be recalculated on an ongoing basis to determine if the amount currently maintained is adequate to meet the Plan's daily cash needs for FEHBP claim payments and/or administrative expenses. If the deposit is not adequate, the Plan should make an appropriate adjustment.*

*During the audit scope, the Plan evaluated the WC deposit amount on several occasions, and made one adjustment. This adjustment was made by the Plan in March 2004 to increase its WC balance to \$47 million. To determine if the Plan maintained an adequate WC deposit, we recalculated what the Plan's fourth quarter 2006 WC balance should have been and determined that, as of December 31, 2006, the Plan should have maintained a WC balance of \$43 million. Therefore, at the end of the audit scope, the Plan held a WC balance with an excess amount of \$4 million over the amount needed to meet the Plan's daily cash needs for FEHBP claim payments and administrative expenses.*

*In response to our audit finding, the Plan provided a more recent WC calculation of claims clearing and administrative expenses showing that the Plan currently holds an excess amount of \$6 million in FEHBP funds as of August 31, 2008. We agree with the Plan's recent WC calculation.*

*Since the Plan maintained these excess funds in an interest-bearing account and timely credited the interest earned on these funds to the FEHBP, no LII is due the FEHBP. However, the Plan needs to make an adjustment to return the excess WC funds of \$6 million to the FEHBP letter of credit (LOC) account.*

#### **Plan's Response:**

*The Plan agrees with this finding.*

**MHBP Response:** For clarification purposes, in our September 30, 2008, response to Audit Inquiry #8 concerning this issue we concurred with the OIG's determination that on the last day of the period under audit, December 31, 2006, the MHBP's working capital deposit was approximately \$4,000,000 greater than the amount needed to satisfy daily cash requirements at that time. As further reflected in both that Audit Inquiry #8 response and the above narrative, the \$6,000,000 amount later credited to the FEHBP reflects the extent to which the

MHBP's working capital deposit exceeded its daily cash requirements as of August 31, 2008, i.e., some 20 months after this audit's closing date. For purposes of historical accuracy, then, we request that the OIG modify this finding in the Final Audit Report to reflect the correct amount of \$4,000,000.<sup>8</sup>

**Recommendation 18**

*We verified that the Plan returned the excess WC funds of \$6,000,000 to the LOC account on October 8, 2008. Therefore, no further action is required for these funds.*

**MHBP Response:** As clarified above, we concur with this recommendation.

**Recommendation 19**

*We recommend that the contracting officer instruct the Plan to implement procedures to ensure that adjustments are made to the WC deposit when the Plan's cash requirements change.*

**MHBP Response:** While we concur generally with this recommendation, we are concerned that as worded – i.e., that the MHBP should adjust the amount of its working capital deposit “when [its] cash requirements change” – the recommendation is unduly vague and open-ended. As our Audit Inquiry #8 response demonstrated, the MHBP needs to – and does – monitor its working capital balance daily in the routine course of business to ensure that it always has sufficient cash on hand to meet its obligations. Furthermore, as part of its resolution of OPM OIG Audit No. 1B-45-00-00-064 for the period ending December 31, 2001, the MHBP agreed to recalculate that balance requirement annually and readjust it as necessary, which we in fact did during the initial years of the current audit period, typically during the first calendar year quarter. We inadvertently failed to do this recalculation in 2006, however, because the first quarter time frame coincided with a change in the MHBP's underwriter and administrator that resulted in attentions being focused elsewhere. In other words, the procedure the OIG recommends already exists, though in 2006 and subsequent years the MHBP did not adhere to it. We further believe that except in the event of an intervening material change in financial circumstances, it would be inefficient and not in accordance with standard business practice to recalculate and readjust that amount more frequently than annually. This is particularly true given the fact that we continue to maintain those funds in an interest-bearing account and credit 100% of the interest thereon to the FEHBP (see n. 8 below).

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<sup>8</sup> The MHBP appreciates the OIG's recognition in the Draft Audit Report of the fact that because (1) it maintained the MHBP's working capital balance in an interest-bearing account, and (2) it credited 100% of the interest earned on that account to the FEHBP, the FEHBP sustained no financial harm as a consequence of the MHBP's retention of these excess funds.

The MHBP therefore suggests that the OIG modify this recommendation to reiterate its prior recommendation that the MHBP recalculate and adjust its working capital balance as needed on an annual basis, or more frequently should an intervening material change in financial circumstances dictate that it do so.