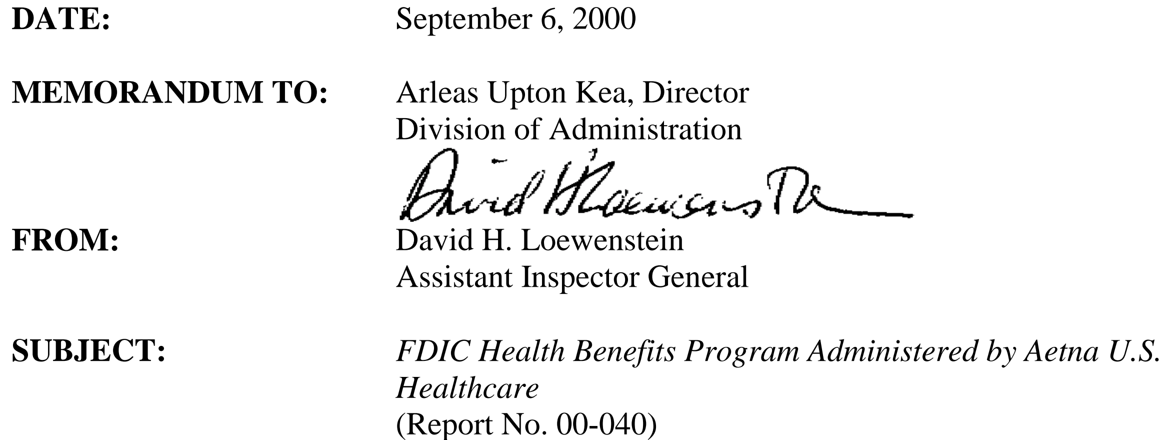
Office of Inspector General

September 6, 2000
Audit Report No. 00-040

FDIC Health Benefits Program Administered by Aetna U.S. Healthcare

FDIC
Federal Deposit Insurance Corporation
Washington, D.C. 20434

Office of Audits
Office of Inspector General



DATE: September 6, 2000

MEMORANDUM TO: Arleas Upton Kea, Director
Division of Administration

FROM: David H. Loewenstein
Assistant Inspector General

SUBJECT: *FDIC Health Benefits Program Administered by Aetna U.S. Healthcare*
(Report No. 00-040)

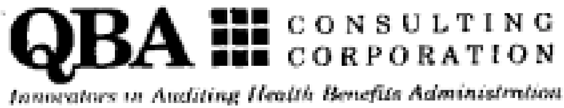
This report presents the results of an audit of the Federal Deposit Insurance Corporation's (FDIC) contract with Aetna U.S. Healthcare (Aetna). Aetna provided services to FDIC as a third-party health plan administrator from March 1994 through March 2000. The OIG previously completed a similar audit of Aetna for the period March 1994 through June 1995 (Audit Report Number 96-111, dated October 8, 1996). As was the case with the prior Aetna audit, the OIG contracted with the firm QBA Consulting Corporation of Richardson, Texas, to conduct the audit under the OIG's direction.

The audit covered health claims processed for the period January 1997 through February 1999 and Aetna monthly administrative invoices for the period January 1997 through March 2000. During the respective audit periods, Aetna processed $61 million in health claims and FDIC paid Aetna $6.6 million in administrative fees.

The objectives of the audit were to determine whether Aetna (1) complied with contract provisions and amendments for administering FDIC's health benefits program; (2) adjudicated health benefits claims in accordance with FDIC's benefits plans; and (3) made disbursements, as FDIC's third-party administrator, that were adequately supported. The audit also included follow-up on FDIC corrective actions taken in response to the prior Aetna audit.

The Division of Administration (DOA) provided us with a written response dated August 30, 2000 (see Appendix II) to a draft report. In this response, DOA disallowed questioned costs totaling $822,307 and outlined its plan of corrective action. This response provided the requisites for a management decision on our four recommendations. The OIG's evaluation of management's comments is presented in Appendix I.

If you have any questions, please call me at (202) 416-2412 or Marilyn Rother Kraus at (202) 416-2426.



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Office of Inspector General
Federal Deposit Insurance Corporation

QBA Consulting Corporation was awarded a contract by the Federal Deposit Insurance Corporation (FDIC) Office of Inspector General (OIG) to conduct an audit of Aetna's administration of the FDIC health insurance program.

We applied audit procedures enumerated in our contract with the OIG and other procedures deemed appropriate to achieve the audit objectives. The attached audit report, which was written with the assistance of the OIG, presents the results of the audit.

Richard M. Stohl
President

May 26, 2000

BACKGROUND

From January 1982 to March 1994, the Federal Deposit Insurance Corporation's (FDIC) health insurance program was administered by Blue Cross and Blue Shield under a separate health insurance program adopted as an alternative to the Federal Employees Health Benefits (FEHB) program. In September 1993, the FDIC Board of Directors approved a comprehensive change in the FDIC's health insurance to include a triple-option health benefits program to provide enrollees with a broader range of health benefits options. In October 1993, FDIC awarded Aetna U.S. Healthcare[1] a contract to administer FDIC's health benefits program.[2] Aetna's claims processing responsibilities began March 6, 1994. The contract was effective for 1 year with a series of 1-year renewal options. FDIC's contract with Aetna expired March 31, 2000.

Aetna provided services to FDIC as a third-party administrator for health care claims submitted by providers and enrollees under FDIC's triple-option health benefits program.[3] This program included three health plan options that allowed enrollees to balance benefit levels, freedom of choice in providers, and cost. The three health plans consisted of the Traditional Choice, Open Choice, and Elect Choice plans.

The Traditional Choice plan permitted FDIC enrollees to obtain health care services from health care providers of their choosing and, as such, was flexible but also the most expensive of the three plan options. Enrollees were reimbursed a percentage of the reasonable and customary cost of services, generally at a lower percentage than the other two plans.

Unlike the Traditional Choice plan, both the Open and Elect Choice plans had managed care features designed to make health care more affordable. Under both the Open and Elect Choice plans, providers submitted health care claims for payment to Aetna on behalf of the enrollees. The Open Choice plan allowed the enrollee to receive care from a nationwide network of physicians, hospitals, and other health care providers at predetermined negotiated fees with lower deductibles than the Traditional Choice plan. Alternatively, enrollees could obtain health care services from a source outside the network but were required to pay a higher percentage of the non-negotiated fees than if the source was from a network provider.

The Elect Choice plan also provided enrollees access to a network of selected physicians. However, when enrolling in the Elect Choice plan, the enrollee selected a primary care physician who provided and coordinated all the enrollee's health care. Enrollees only received benefits when their care was provided or coordinated by the primary care physician. The Elect Choice plan had the least freedom of choice of the three plans but

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[1] During 1996, Aetna merged with U.S. Healthcare and was renamed Aetna U.S. Healthcare.
[2] Aetna was awarded separate contracts to administer the FDIC health benefits program and to administer the FDIC Flexible Spending Accounts. The contract to administer the Flexible Spending Accounts expired on December 31, 1996. Beginning January 1, 1997, FDIC contracted with Custom Benefits to administer the FDIC Flexible Spending Accounts.
[3] FDIC contracted separately with other contractors for its prescription card benefits plan and mental health and substance abuse benefits plan.

was also the least expensive as enrollees paid no deductible and co-payments were less than in the Open Choice Plan.

Health claims submitted for FDIC enrollees were received and adjudicated by Aetna's Dover, Delaware claims processing office. Claims adjudication involves determining the amount of a claim that is authorized for payment based on the defined service and dollar amount of the respective health benefit plan. The Dover office entered claims into one of two computerized claims processing systems. The Aecclaim system processed Traditional Choice and Open Choice plan claims, and the Managed Choice claim system processed Elect Choice plan claims. The Dover office answered enrollee and provider inquiries and administered processing adjustments. Aetna's Hartford office issued provider payments, updated enrollee eligibility records, prepared and mailed Explanation of Benefit (EOB) statements to enrollees, and performed the accounting and billing activities on the FDIC's behalf. Aetna was compensated primarily on a per capita fee structure based on the number of eligible participants enrolled in each of the health plan options.

FDIC's health insurance program was primarily self-insured. FDIC reimbursed Aetna daily for paid claims via wire transfer. However, FDIC purchased stop-loss coverage from Aetna to limit FDIC's annual liability for the total dollar amount of claims paid for an enrollee. The stop-loss insurance amount varied over the contract period. In 1997 and 1998, the amounts were $300,000 and $150,000, respectively. Aetna was liable for paying claims for enrollees whose annual claims in total exceeded the stop-loss amounts.

As of December 31, 1997, the FDIC discontinued its separate health benefits program for most of its enrollees. FDIC concluded it was no longer cost-effective to continue providing comprehensive health insurance as a primarily self-insured entity. Health insurance premiums for many of the FEHB program plans were much less than the FDIC could obtain on its own. In addition, FDIC management wanted the FDIC to be comparable with other bank regulatory agencies, which had already discontinued their agency-sponsored health programs.

Nonetheless, during 1998 the FDIC was required to maintain an agency-sponsored interim health insurance program administered by Aetna for about 2,600 enrollees that were ineligible to enroll in the FEHB program during retirement. FEHB program regulations required that an employee be enrolled in the FEHB program for 5 continuous years immediately preceding retirement to take FEHB coverage into retirement. The time enrolled in the FDIC health benefits program was not recognized for the purposes of retiree health benefits under the FEHB program. Therefore, under the existing regulations, the 2,600 enrollees in FDIC's sponsored health program were ineligible to participate in the FEHB program during retirement.

During 1997 and 1998, FDIC sought legislation to allow participation in the FDIC health program to be accepted as credit towards participation in the FEHB program. On October 19, 1998, the President signed Public Law 105-266 allowing FDIC employees' continuous participation in the FDIC health insurance program to count as participation in the FEHB

program. As a result, substantially all enrollees in the FDIC interim health insurance program were enrolled in an FEHB plan effective January 3, 1999.

Nonetheless, one enrollee was not eligible to transfer into the FEHB program. Under FEHB program regulations, spouses of deceased enrollees who did not elect a survivor's annuity could not participate or continue participation in the FEHB program. Public Law 105-266 did not specifically address covering FDIC health plan enrollees whose deceased spouses did not elect a survivor's annuity. As a result, FDIC extended its contract with Aetna until March 31, 2000, to continue providing health coverage to the one FDIC enrollee and another estimated 45 FEHB enrollees in a similar situation. FDIC expects to adopt a policy by December 31, 2000, for addressing enrollees who lose their health insurance coverage as a result of their spouses not electing a survivor's annuity.

This is the second audit the Office of Inspector General (OIG) has conducted of Aetna on behalf of the FDIC. On October 8, 1996, the OIG issued an audit report (Audit Report Number 96-111) covering claims processed and paid for the period March 6, 1994 through June 30, 1995. The 1996 OIG audit determined that Aetna adequately administered FDIC's health benefits program. However, the audit identified several areas in which improvements could be made to program administration and identified $754,700 in questioned costs.

As part of the current audit, the OIG reviewed FDIC corrective actions taken in response to the 1996 audit. The OIG concluded that the FDIC was responsive to the prior report's recommendations. FDIC collected $448,421 and executed a substantive contract modification with Aetna to clarify and strengthen its contractual position. Only one corrective action was unresolved involving the practice of provider withholdings, which is discussed in more detail in the audit report section "Other Matters."

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of the audit were to determine whether Aetna (1) complied with contract provisions and amendments between FDIC and Aetna for administering FDIC's health benefits program; (2) adjudicated health benefits claims in accordance with the FDIC's benefits plans; and (3) made disbursements, as FDIC's third-party administrator, that were adequately supported. The OIG selected Aetna for this audit because of the significant dollar amount of health care claims funded by the FDIC, our prior audit had identified weaknesses, and FDIC management specifically requested the audit.

The scope of the audit included claims adjudicated between January 1, 1997, and February 28, 1999,[4] under each of the three FDIC health benefits plans. January 1, 1997 was selected as the audit starting period because that was the effective date of a substantive contract modification between FDIC and Aetna that addressed recommendations from the 1996 OIG Aetna audit. During the audit period, Aetna adjudicated 242,180 claims totaling

[4] Although its contract expired March 31, 2000, Aetna had substantially completed processing claims as of February 28, 1999, because enrollees were transferred to the FEHB program as of December 31, 1998.

approximately $61 million. FDIC funded $59.4 million of these claims and Aetna funded $1.6 million of these claims as a result of the stop-loss insurance coverage FDIC purchased. Aetna processed claims totaling $28 million for the Traditional Choice Plan, $20.6 million for the Open Choice Plan, and $12.4 million for the Elect Choice Plan.

The audit also covered administrative invoices and other direct charges billed by Aetna and paid by FDIC for the period January 1, 1997, through March 31, 2000 (the contract expiration date). During this period, the FDIC paid Aetna $6.6 million for administering FDIC's health insurance program.[5] The FDIC paid $4.2 million in per capita administrative fees calculated and billed monthly based on the number of FDIC enrollees in each of the three FDIC health plans. In addition, the FDIC paid $1.7 million for the stop-loss insurance coverage and $0.7 million in direct charges related primarily to costs associated with administering FDIC retirees' and TCC enrollees' health care claims.

Finally, in connection with a recommendation from our prior audit, the FDIC rejected Aetna's provider withholding settlement for 1995 and 1996. Therefore, the current audit reviewed provider withholdings for the period January 1995 through February 1999.

Table 1 shows the number of claims processed by dollar amount and year. Table 2 shows the dollar amount of claims processed by plan type and year. The average paid claim under FDIC's health program during 1997 and 1998 was $252. Approximately 68 percent of all claims were $100 or less, with 4 percent of the claims in excess of $1,000.

Table 1: Number of FDIC Claims Processed by Dollar Amount and Year

Dollar Range of Processed Claims					
Plan Year	**< $100**	**$100 – $500**	**$500 – $1000**	**> $1,000**	**Total**
1997	112,935	40,399	5,526	6,144	165,004
1998	48,755	18,066	2,623	2,974	72,418
1/99 – 2/99	3,077	1,257	207	217	4,758
Total	**164,767**	**59,722**	**8,356**	**9,335**	**242,180**

Source: QBA Consulting Corporation analysis of Aetna claims funding tapes.

[5] The administrative fees do not include $4.0 million in credits Aetna provided FDIC for funds Aetna collected on FDIC's behalf. Each month Aetna credited FDIC's administrative invoices for funds it collected from participants enrolled under Temporary Continuation of Coverage (TCC) and retirees' share of health plan premiums. Under TCC, former employees and dependents who lost health coverage could stay enrolled in FDIC's health program for up to 18 months but had to pay the total employer and employee health plan cost plus a 2 percent administrative fee.

Table 2: Dollar Amount of FDIC Claims Processed by Plan Type and Year

Year	Traditional	Open	Elect	Total
1997	$17,863,114	$14,026,444	$8,118,443	$40,008,001
1998	9,325,258	6,140,392	4,082,371	19,548,021
01/99 – 02/99	788,512	419,960	160,006	1,368,478
Total	**$27,976,884**	**$20,586,796**	**$12,360,820**	**$60,924,500**

Source: QBA Consulting Corporation analysis of Aetna claims funding tapes.

With the OIG's assistance, QBA performed the following audit procedures to achieve the audit objectives:

- Reviewed the FDIC and Aetna contract, contract modifications executed since the 1996 OIG audit, the October 1996 OIG audit report, and corrective actions taken in response to the prior OIG audit.

- Met with OIG and FDIC officials to obtain input regarding high-risk areas to emphasize during the audit.

- Performed a risk assessment based on the contract, results of the prior audit, input from OIG and FDIC officials, and the extent of corrective actions taken in response to the prior audit.

- Interviewed Aetna and FDIC officials to obtain an understanding of the claims processing and accounting systems used for the FDIC's account as a basis for planning and conducting our audit tests.

- Obtained Aetna's electronic claims processing and claims funding tapes for FDIC's account for the period January 1, 1997, through February 28, 1999.

- Electronically analyzed Aetna's claims processing and funding tapes using QBA's Medical Analysis and Review System (MARS). MARS tested claims for possible payment errors and assigned a probability factor for potential overpayment. Claims identified by MARS as having a high probability of overpayment were selected for detailed testing.

- Using output from MARS, tested 734 claims for various attributes including duplicate payments, coordination of benefits with other health insurance including Medicare, the accuracy of pricing and discounts, provider withholdings, interim billings for hospital stays or other long-term illnesses, unassigned benefits (i.e., claim payments made directly to the enrollee), paid amounts that exceeded covered charges, and high dollar claims.

- Tested Aetna's refund procedures by verifying that a sample of 17 claims reported as refunded had actually been credited to FDIC.

- Reviewed, sorted, and electronically merged Aetna monthly overpayment logs to evaluate contract compliance related to collection procedures.

- Verified the mathematical accuracy of administrative invoices and whether rate charges were in accordance with the terms of the FDIC contract with Aetna.

- Verified the accuracy of Aetna's 1997 and 1998 annual accounting summaries prepared for the FDIC account by tracing summary amounts to monthly invoices.

- Tested the adequacy and reasonableness of supporting documentation for Aetna direct charges for 1997 and 1998.

- Tested the adequacy of supporting documentation for TCC and retiree premium credits for 6 months during 1997 and 1998.

- Tested 214 Elect Choice claims to determine whether Aetna engaged in provider withholdings.

- Reviewed 8 Aetna contracts and 13 provider withholding settlements.

The audit was conducted between November 8, 1999, and May 26, 2000. QBA conducted work at FDIC headquarters in Washington, D.C.; Aetna's claims processing center in Dover, Delaware; and Aetna's headquarters office in Hartford, Connecticut. We conducted the audit in accordance with generally accepted government auditing standards.

The scope of our work with respect to verifying the enrollees eligible to receive health benefits and the accuracy of the monthly enrollee numbers Aetna used to compute administrative fees was limited. In response to the 1996 OIG Aetna audit, FDIC provided Aetna throughout 1997 with electronic bi-weekly updates from its Benefits Logging System (BLS) identifying enrollees eligible to receive health benefits. Based on discussions with both FDIC and Aetna officials and selected testing, the BLS updates could not be relied upon as accurate due to compatibility problems between BLS and Aetna's enrollment system. Therefore, FDIC utilized other means to update Aetna on eligibility including phone calls, e-mails, and facsimiles, which fragmented the overall updating process. Further, during 1998, FDIC discontinued using BLS and, rather, used a manual process for updating Aetna as to enrollee eligibility. Aetna stated that it did not maintain the eligibility records or documentation provided by the FDIC.

Lacking consistent and reliable eligibility information, we could not verify the accuracy of enrollee numbers used by Aetna to compute monthly administrative fees. In addition, we could not verify whether FDIC enrollee terminations were timely processed by Aetna and, therefore, whether health claims were paid to ineligible enrollees following their termination dates.

Nonetheless, the weaknesses in the eligibility tracking and reporting systems do not represent an existing FDIC internal control vulnerability. Under the FEHB program administered by the Office of Personnel Management, FDIC enrollee eligibility is linked to the National Finance Center payroll system. Therefore, as FDIC employees are added or terminated from the payroll system, their eligibility for health benefits is automatically updated.

Finally, we did not review Aetna's internal or management controls relating to its claims processing systems and financial reporting activities. Rather, the OIG instructed QBA Consulting to focus its audit procedures on evaluating contract compliance and performing tests to identify possible overcharges. The OIG concluded that evaluating Aetna's controls as a basis for identifying operational improvements would have little value since FDIC no longer uses Aetna as its health plan administrator.

The OIG conducted an exit conference by phone with Aetna on May 22, 2000. Throughout the audit, Aetna officials provided comments in response to audit findings and inquiries. Aetna's comments are incorporated throughout the remaining sections of the audit report.

RESULTS OF AUDIT

Aetna generally complied with contract terms and amendments. Aetna's monthly administrative invoices were mathematically accurate and rates were billed in accordance with contract terms. Although we could not verify the accuracy of the enrollee numbers used by Aetna to compute administrative fees on a month-to-month basis, the average numbers used during 1997 and 1998 appeared reasonable compared with FDIC estimates.

In addition, the results of our MARS testing indicated that Aetna generally adjudicated health claims in accordance with FDIC's benefits plans. Finally, Aetna disbursements for claims and administrative fees were supported by adequate documentation. For example, Aetna provided documentation substantially supporting each of the 734 tested claims and 1997 and 1998 direct charges. Aetna also provided documentation supporting FDIC TCC and retiree premium credits for 6 test months during 1997 and 1998 and that 17 refunded test claims had been credited to FDIC's account.

However, Aetna overcharged FDIC $822,307. Most significantly, Aetna overcharged FDIC $442,103 resulting primarily from errors in its 1997 and 1998 annual reconciliation of FDIC administrative fees and direct charges. In addition, based on electronic tests of claims paid and detailed tests of 734 claims identified by MARS as high-probability overpayments, we determined that Aetna overpaid 132 claims totaling $183,100. Finally, Aetna did not follow contract provisions for collecting $197,104 in overpaid claims.

The following schedule summarizes questioned costs by audit finding and dollar amount.

Summary of Questioned Costs

Description	Amount
Overcharged Administrative Fees and Direct Charges	$442,103
Overpaid Claims from Audit Tests	183,100
Overpaid Claims Not Collected as Required	197,104
Total	**$822,307**

Aetna agreed with the $442,103 in administrative fee and direct charge errors. Aetna agreed with $98,635 and disagreed with $84,465 of the $183,100 in claims overpayments. Aetna also agreed with the $197,104 in uncollected overpayments. However, pending a more detailed review of the FDIC/Aetna contract, Aetna did not necessarily agree that it failed to comply with contract provisions for collecting the overpayments.

Finally, as part of closing out the FDIC/Aetna contract, the OIG suggests that FDIC settle an unresolved recommendation from the 1996 OIG Aetna audit and address record-keeping requirements. The OIG's suggestions are discussed in more detail in the report section "Other Matters."

AETNA OVERCHARGED ADMINISTRATIVE FEES AND DIRECT CHARGES

Aetna overcharged FDIC $442,103 for administrative fees and direct charges during 1997 and 1998, consisting of $426,459 in reconciliation errors, $12,378 in unauthorized charges for preparing EOB statements, and $3,266 in miscellaneous errors.

Specifically, Aetna overcharged FDIC $64,256 during 1997 and $362,203 during 1998 resulting from errors in reconciling estimated monthly administrative fees and direct charges to actual fees and charges. The FDIC/Aetna contract, modification 4, attachment 1, states that Aetna "shall perform an annual accounting to reconcile these estimated fees and/or charges to actual fees and/or charges to determine appropriate year-end adjustments due to either party to this contract." For contract years 1997 and 1998, Aetna prepared Annual Accounting Packages for FDIC to summarize the required reconciliation. Aetna had not completed the 1999 Annual Accounting Package as of the completion of our audit work.

The 1997 Annual Accounting Package did not consider a reconciliation adjustment from the July 1997 invoice covering the January through June 1997 period. Consequently, Aetna overstated the number of FDIC enrollees for this period resulting in overcharges of $64,256. In addition, the 1998 Annual Accounting Package did not credit FDIC $362,203 in estimated direct charges paid monthly by FDIC throughout 1998.

In addition, Aetna billed FDIC $12,378 in unauthorized direct charges for preparing EOB statements on FDIC's Open Choice Plan. Specifically, Aetna's annual summary of direct charges for 1997 and 1998 indicated Aetna billed FDIC $9,387 and $2,991, respectively, for

"EOB Charge on Open Choice."

FDIC's contract with Aetna required that Aetna prepare EOB statements as part of administering FDIC's health benefits program. Section A.3.b.(5) under "Claims Processing Requirements" states that Aetna must provide EOB statements. Further, in responding to FDIC's Request for Proposal (RFP), Aetna stated that its "claim system automatically produces a detailed EOB overnight and mails it to the employee the following day." Aetna's response to the RFP was incorporated by reference to the FDIC/Aetna contract.

As a result of a recommendation from the 1996 OIG Aetna audit, Aetna stated that it reinstated preparing EOBs in August 1996. Aetna had previously decided to suspend production of EOBs when enrollees had no liability. However, Aetna did not obtain the FDIC's authorization to begin charging for EOB preparation.

Finally, Aetna overcharged FDIC $3,266 in miscellaneous direct charges. In its 1998 Annual Accounting Summary, Aetna charged FDIC $99,327 for costs associated with retiree billings when supporting documentation showed that the correct charges should have been $96,327, resulting in a $3,000 overcharge. In addition, Aetna erroneously computed stop-loss insurance charges for January 1998 resulting in a $266 overcharge. We provided Aetna with schedules summarizing all the administrative errors for 1997 and 1998. Aetna responded that it agreed with the amount of the errors.

Recommendation

The Associate Director, Acquisition and Corporate Services Branch (ACSB), Division of Administration (DOA), should:

(1) Disallow $442,103 in overcharges for administrative fees and direct charges.

(2) Review the 1999 Annual Accounting Package (once completed by Aetna) to ensure that FDIC administrative invoice payments were properly considered and reconciled, any direct charges are reasonable, and any unusual charges are explained, supported, and authorized by FDIC.

AETNA OVERPAID CLAIMS

Based on the results of electronic tests of all paid claims and detailed tests of 734 sampled claims, we determined that Aetna overpaid 132 claims totaling $183,100. The overpayments consisted of $67,888 in duplicate paid claims, $99,165 in claims not coordinated correctly with other insurance coverage, $5,407 in claims where discounts were not properly applied, and $10,640 for miscellaneous errors. In general, the overpayments occurred either because Aetna's claims processing systems did not detect the errors or claims processors made mistakes in processing claims. In total, Aetna agreed with $98,635 and disagreed with $84,465 of the claims overpayments. Aetna stated that it has initiated collection efforts for the agreed-upon overpayment errors.

The following sections describe the four categories of overpayment errors. Traditional and Open Choice errors are presented separately from Elect Choice errors because Aetna used two different systems to process these claims.

Duplicate Paid Claims

Aetna made $67,888 in duplicate payments involving 66 claims. These duplicate payments consisted of 16 Elect Choice claims totaling $4,636 and 50 Traditional and Open Choice claims totaling $63,252. Aetna agreed with all of the $4,636 in Elect Choice duplicate payments. Aetna agreed with $55,235 and disagreed with $8,017 of the Traditional and Open Choice duplicate payments. Specifically, Aetna disagreed that four claims were paid twice because its systems indicated the claims payments may have been voided or stop payments requested. However, Aetna was unable to provide documentation supporting this position and, therefore, we will continue to question the $8,017.

The duplicate payments occurred for a variety of reasons. Aetna sometimes paid the same provider claim twice when a claim was submitted both on paper and electronically. Also, claims processors processed the same claim twice for providers that had two distinct identification numbers, entered the incorrect provider identification number, or entered an excess payment amount when reprocessing partially paid claims.

In its response to the FDIC 1993 RFP, Aetna stated that its automated claims system contained "automatic duplicate bill edits comparing the types of service and service dates of new expenses to the service codes and dates of previously processed expenses." In addition, Aetna stated that FDIC claims would be processed by a trained staff dedicated primarily to processing FDIC claims. Also, Aetna stated that it used a series of pre- and post-disbursement audits to verify that claims are paid for the correct amount and to the correct person and in accordance with the client's benefits plan.

Claims Not Properly Coordinated With Other Insurance Coverage

Aetna paid $99,165 for 54 claims where benefits were not properly coordinated with other insurance. These claims should have been partially or fully paid by other insurance, with Aetna paying as the secondary insurer. The 54 claims consisted of 5 Elect Choice claims and 49 Traditional and Open Choice claims. Aetna agreed that 22 claims totaling $29,771 were improperly coordinated and disagreed that 32 claims totaling $69,394 were improperly coordinated. Although primary insurance may have paid up to 100 percent of a claim, the percentage can vary widely. Lacking specific knowledge of the amounts other insurance coverage would have paid, we questioned all $99,165 represented by the 54 claims.

The improperly coordinated claims occurred for one of three reasons. In 19 instances (5 Elect and 14 Traditional/Open Choice claims), Aetna claims processors did not consider claim amounts already paid by other insurers or Medicare that were identified in EOB statements attached to the claim or on the claim itself. For three Traditional and Open Choice claims, claims processors entered an incorrect payment amount from another insurer's EOB. Aetna agreed with these 22 errors totaling $29,771. For 32 Traditional and Open Choice claims totaling $69,394, Aetna did not adequately investigate the claims for other primary insurance. Aetna disagreed because the claims did not identify other coverage at the time of original claims processing. More specifically:

- Aetna paid a $17,637 claim for a spouse of an employee whom Aetna did not believe had other insurance coverage because the claim did not indicate other insurance. However, QBA's examination of other claims paid for the spouse with service dates overlapping those of the questioned claim indicated that Aetna paid as the secondary insurer. Therefore, Aetna should have been aware that other primary insurance coverage existed.

- Aetna paid a $7,725 claim directly to an employee based on another insurer's rejection of the claim. However, the claim indicates the covered services were for an accident that should have been at least partially covered by other insurance. Given the high dollar amount of the claim and the fact that the claim was paid directly to an employee (referred to as an unassigned benefit), we believe Aetna should have taken actions to verify the claim amount and payee. Specifically, Aetna should have contacted the other insurer to inquire about the claim rejection and also the provider to verify that the claim should be paid to the employee and not the provider. By doing so, Aetna may have determined that the claim was at least partially covered by other insurance.

- Aetna paid four claims totaling $22,186 for which Aetna subsequently became aware that enrollees had other primary insurance. However, Aetna took no actions to investigate and coordinate the four previously paid claims. Aetna did not believe it had a responsibility to retroactively coordinate prior paid claims when it did not have knowledge of other insurance coverage at the time the claims were originally processed.

- Aetna paid 26 additional claims totaling $21,846 for which QBA determined enrollees had other insurance coverage. Specifically, QBA performed an analysis of Aetna's electronic claims processing records and identified claims paid for enrollees whom QBA determined through detailed claims tests had other coverage. Similar to its position on the prior paid claims, Aetna disagreed because it did not have knowledge of the other coverage at the time of claims processing.

The FDIC/Aetna contract, Section A.3.b.(3) and (4) under "Claims Processing Requirements" states that Aetna is required to investigate claims for coordination of benefits and subrogation" and "administer Medicare coverage using the current coordination of benefits approach."

Further, in responding to FDIC's RFP, Aetna stated that its automated claims processing system identifies and calculates coordination of benefits. Aetna further stated that it investigates the availability of other primary benefits before issuing benefits. Aetna stated that its system requires entry of the primary carrier's payment if other coverage is available to properly determine benefits. If adequate information is not presented on the provider's bill, Aetna's claims processors will suspend payment of the submitted expenses and ask the enrollee to submit the primary carrier's EOB. Aetna also stated that with regard to Medicare claims, secondary benefits would be paid based on FDIC's benefit plans.

With regard to unassigned benefits, Aetna stated in its RFP response that "we audit all unassigned in-hospital claims for accuracy and legitimacy and to determine whether other insurance or third-party liability exists. We also randomly audit other unassigned transactions each week."

Finally, when Aetna discovered other enrollee insurance coverage through routine claims processing, we believe Aetna claims processors should have taken steps to verify whether the other insurance was applied or should have been applied to previously paid claims. We believe Aetna's contractual requirement to "investigate claims for coordination of benefits" would cover such a validation approach.

Claims Not Properly Discounted

Aetna processed six claims in which Elect or Open Choice pricing discounts totaling $5,407 were not given to FDIC. The six errors consisted of four Elect Choice and two Open Choice claims with discounts totaling $3,704 and $1,703, respectively. Aetna's response to the FDIC RFP stated that its claim system "maintains provider and network specific data under various contractual and financial arrangements" and "automatically retrieves negotiated fees for network providers." However, five of the six claims were not discounted because the claim processor did not consider the negotiated fee when processing the claim and calculated the amount to pay based on billed charges. One claim was not discounted because the wrong type of service code was entered and Aetna's system did not alert the processor of a possible discount. Aetna agreed with all six of the discount errors.

Miscellaneous Errors

Aetna made six miscellaneous claims processing errors resulting in $10,640 in overpaid claims. The six claims consisted of one Elect Choice claim for $3,213 and five Traditional and Open Choice claims with overpayments of $7,427. Aetna agreed with the Elect Choice claim error and four of the five Traditional and Open Choice errors totaling $3,586. The errors occurred because claims processors did not calculate the correct benefit payment or made a data entry mistake.

Aetna disagreed that one claim for $7,054 was paid in error. Specifically, Aetna paid an enrollee $7,054 based on an itemized collection agency notice. Aetna stated that this was the only bill or statement received to support the payment. The FDIC/Aetna contract, Section A.3.b.(1) under "Claims Processing Requirements" states that Aetna will "process all FDIC claims on a direct claims certification and payment basis." Because Aetna could not produce evidence of a completed claim form to support the payment, we could not determine the accuracy or validity of the charges or verify that the charges had not already been paid under another claim.

Recommendation

The Associate Director, ACSB, DOA, should:

(3) Disallow $183,100 for overpaid claims.

AETNA DID NOT COMPLY WITH CONTRACT PROCEDURES FOR COLLECTING OVERPAID CLAIMS

Aetna did not follow procedures outlined in the FDIC/Aetna contract for collecting $197,689 in overpaid claims. The $197,689 consisted of $31,029 and $74,981 in Elect and Open Choice overpaid claims, respectively, where Aetna did not use provider offsets to collect overpayments, and $62,354 in Traditional Choice claim overpayments that resulted from Aetna processing errors. In addition, Aetna had not credited FDIC with a $29,325 overpayment reported as recovered by Aetna's collection agency.

The following schedule summarizes the questioned uncollected overpayments, adjusted for overlapping questioned costs from our claims testing:

Summary of Questioned Uncollected Overpayments

Description	Amount
Elect Choice – No Use of Provider Offset	$31,029
Open Choice – No Use of Provider Offset	74,981
Traditional Choice – Aetna Processing Errors	62,354
Recovered Overpayment Not Credited to the FDIC	29,325
Less: Overlapping Questioned Costs With Claims Tests	(585)
Total	**$197,104**

During 1997 and 1998, Aetna submitted monthly overpayment logs to the FDIC summarizing total overpaid FDIC health claims, amounts recovered, amounts written off as uncollectible, and outstanding balances. During this time period, Aetna referred uncollected overpayments to its collection agency, Accent Insurance Recovery Solutions (Accent). Aetna's overpayment logs provided an error code for each overpayment that corresponded to a description of the reason for the overpayment.

Aetna's response to the 1993 FDIC RFP, which was incorporated into the FDIC/Aetna contract, stated that its claims system has an overpayment recovery feature that automatically deducted overpayments from future claims payments without manual intervention. Aetna also stated that in selecting the appropriate method of collection, it used a variety of methods including "lump sum reimbursement," and "in some cases, deducting from future claims. This method is generally used for overpayments which are below $100 or overpayments which we have not been successful in recovering. We would also use this method for provider overpayments, if we have not been successful in recovering the overpaid amount after 3 attempts…"

In its RFP response, Aetna further stated that it had a 99 percent success ratio in recovering overpayments. Aetna stated that unrecovered overpayments would be discussed with its customers and an agreement made in terms of the appropriate course of action.

In addition, the FDIC/Aetna contract, modification 4, attachment 1, states that Aetna will establish and maintain standardized internal procedures to ensure identification of overpayments and for collecting refunds in a timely manner. Modification 4 also states that Aetna shall make all reasonable and timely efforts, including initiating lawsuits determined by Aetna as appropriate, to recover overpayments.

We obtained and combined Aetna's electronic spreadsheets summarizing FDIC overpaid claims. We merged, sorted, and analyzed the electronic spreadsheets to develop a composite of all overpayments, collections, and write-offs during the period January 1997 through December 1999.

In addition, the OIG and QBA selected 15 high-dollar overpayments for testing. Specifically, the OIG requested that Aetna provide documentation supporting collection activities related to 10 open and 5 closed overpayments. The OIG and QBA reviewed Aetna and Accent responses for conformance with the FDIC/Aetna contract, and provided a follow-up list of questions to Aetna regarding its collection procedures. Finally, we reviewed Aetna overpayment error codes in light of the results of our claims testing and Aetna's RFP response as a basis for estimating Traditional Choice overpayments that resulted from Aetna processing errors.

Based on sorting and analyzing the overpayment logs, we determined that Aetna overpaid $289,399 in claims. Aetna collected $63,646, or 22 percent of the overpayments, and wrote off $4,607, thereby leaving an uncollected open balance of $221,146. The uncollected open balance consisted of $31,029 in Elect Choice claims, $74,981 in Open Choice claims, and $115,136 in Traditional Choice claims. As indicated, Aetna stated in its RFP response that it had a 99-percent success ratio in recovering overpayments.

In addition, Aetna and Accent indicated that all 15 of the tested overpayments were closed, which is contrary to the overpayment log status. Aetna explained that the overpayment logs had not been updated with Accent activity. In addition, Accent indicated that a Traditional Choice overpayment for $29,325 had been "paid in full." In following up, Aetna stated that it had no record of receiving the $29,325. However, we believe Aetna

should have followed up with Accent to either confirm receipt of the collection or to have Accent correct its position that the overpayment had been recovered.

In response to our tests and contrary to its RFP response, Aetna stated that "due to system constraints, we are unable to offset future payments to a particular provider to recoup an existing overpayment." Aetna also did not indicate that it had initiated any lawsuits to recover uncollected overpayments. Further, the FDIC indicated that Aetna had not discussed any arrangement or course of action regarding uncollected overpayments.

Based on the cumulative audit tests, we concluded that Aetna did not take contractually agreed-upon actions to recover FDIC overpaid claims. As a result, we questioned the $31,029 and $74,981 in uncollected overpayments in the Elect and Open Choice plans, respectively, primarily because Aetna did not deduct overpaid claims from future provider claims. This overpayment recovery method would typically be used with providers with which an administrator has a contractual relationship, as was the case with the FDIC Elect and Open Choice plans. In addition, lacking evidence from Accent to contradict its position, we questioned the $29,325 Traditional Choice overpayment that Accent stated was paid in full.

Finally, we questioned $62,354 in open overpayments from the Traditional Choice plan. The amounts questioned were determined based on an evaluation of the overpayment error codes Aetna provided. In those instances where the error codes suggested Aetna was responsible for the overpayment, the associated overpayment amounts were questioned. For example, we questioned duplicate payments and coordination of benefit errors because, as our claims tests support, Aetna was generally responsible for these errors. In addition, we questioned errors such as incorrect provider identification, non-covered charges, and negotiated fee not entered which indicate either processor errors or claims system weaknesses.

Aetna agreed that it made $197,104 in uncollected overpayments. However, pending a more detailed review of the FDIC/Aetna contract, Aetna did not necessarily agree that it failed to comply with contract provisions for collecting the overpayments. Similar to its position on the overpayments identified through our detailed claims tests, Aetna stated that it plans to refund overpaid claims as they are collected.

Recommendation

The Associate Director, ACSB, DOA, should:

(4) Disallow $197,104 for overpaid claims not collected as contractually required.

OTHER MATTERS

The 1996 OIG Aetna audit report recommended that FDIC instruct Aetna to identify and remit the amount of provider withholdings due to the FDIC for 1995 and 1996. Provider withholdings is a practice whereby Aetna sometimes withheld a percentage of an Elect Choice claim payment to a provider. The withheld payments were used as an incentive for providers to meet specified network utilization goals. Depending on the performance of the providers, Aetna returned all or a portion of the withheld amounts to the providers. Any remaining withheld amounts by Aetna were due to the FDIC.

On March 30, 1999, Aetna sent the FDIC a check for $2,693 to settle the provider withheld amounts due the FDIC for 1995 and 1996. On July 14, 1999, FDIC rejected Aetna's proposed settlement and returned the check because FDIC believed the proposed settlement did not accurately reflect the amounts Aetna withheld from providers.

Aetna re-examined the amounts withheld and, at the conclusion of our audit work, calculated that the FDIC was due a credit of $8,536 related to provider withholdings for contract years 1995 through 1999. Based on a review of Aetna's calculations and other tests, we believe the $8,536 credit is reasonable. In total, Aetna withheld $1,077,741 from the FDIC provider claims payments but ultimately returned $1,070,621 to the providers, leaving a retained balance of $7,120. Aetna also owed the FDIC an additional $1,416 related to provider withholdings from 1994. Therefore, the total FDIC credit due is $8,536.

We performed a variety of tests to determine whether the provider withholding amounts reported by Aetna were reasonable. Specifically, we determined that just 1 of 214 Elect Choice claims had provider withholdings, indicating the withholding practice was not pervasive. Further, based on a review of 13 Aetna provider withholding settlement statements, Aetna returned most or all of the amounts withheld to providers, further supporting Aetna's calculations. Finally, we reviewed eight Aetna provider contracts and determined that withholdings were mentioned in just three of the contracts. Aetna explained that it is eliminating the withholding language from provider contracts as they are renewed.

In light of our results and to resolve the one open issue from the 1996 OIG Aetna audit, we suggest that the FDIC settle with Aetna on the provider withholding amounts due to the FDIC for contract years 1995 through 1999.

Finally, although the FDIC/Aetna contract expired March 31, 2000, FDIC and Aetna will remain liable for responding to potential enrollee disputes or lawsuits regarding the payment of health claims. As such, we also suggest that FDIC make arrangements with Aetna as part of contract close-out to ensure enrollee health claim records and supporting documentation are maintained as long as statutorily necessary in the event of disputes or lawsuits.

MANAGEMENT COMMENTS AND OIG EVALUATION

The Director, Division of Administration (DOA), provided us with a written response dated August 30, 2000 to the draft report. The response is presented in Appendix II to this report.

DOA management agreed to disallow all of the questioned costs in recommendations 1, 3, and 4, totaling $822,307. With regard to recommendation 2, DOA stated that it would review the 1999 FDIC Annual Accounting Package once completed by Aetna.

The Corporation's response to the draft report provided the elements necessary for management decisions on the report's recommendations. Therefore, no further response to this report is necessary. Appendix III presents management's proposed action on our recommendations and shows that there is a management decision for each recommendation in this report.

Based on the audit work, the OIG will report questioned costs of $822,307 in its *Semiannual Report to the Congress*.

FDIC
Federal Deposit Insurance Corporation
550 17th Street, NW, Washington, DC 20429
Division of Administration

August 30, 2000

MEMORANDUM TO: Sharon M. Smith
Assistant Inspector General

FROM: Arleas Upton Kea
Director, Division of Administration

SUBJECT: Management Response to Draft Report: *FDIC Health Benefits Program Administered by Aetna U.S Healthcare*

The Acquisition and Corporate Services Branch (ACSB) has completed its review of the subject Office of Inspector General (OIG) draft report. The OIG identified three findings and four recommendations, including $822,307 in questioned costs. The corrective actions will be accomplished according to the timetable in Exhibit A. Exhibit A summarizes the three audit findings and four recommendations and provides expected completion dates and the documentation that will confirm completion.

Management Decision:

Finding #1: Aetna Overcharged Administrative Fees and Direct Charges

Recommendation #1: Disallow $442,103 in overcharges for administrative fees and direct charges.

Management Response #1: We agree with the recommendation. DOA will disallow and pursue recovery of amounts that cannot be adequately supported by the contractor. A decision memorandum and a demand letter, if necessary, will confirm our completion of corrective action.

Recommendation #2: Review the 1999 Annual Accounting Package (once completed by Aetna) to ensure that FDIC administrative invoice payments were properly considered and reconciled, any direct charges are reasonable, and any unusual charges are explained, supported, and authorized by FDIC.

Management Response #2: We agree with the recommendation. We will review the Package once completed.

Finding #2: Aetna Overpaid Claims

Recommendation #3: Disallow $183,100 for overpaid claims.

Management Response #3: We agree with the recommendation. We will disallow and pursue recovery of the overpaid claims that cannot be adequately supported by the contractor, as appropriate.

Finding #3: Aetna did not Comply with Contract Procedures for Collecting Overpaid Claims

Recommendation #4: Disallow $197,104 for overpaid claims not collected as contractually required.

Management Response #4: We agree with the recommendation. We will disallow and pursue recovery of the overpaid claims that cannot be adequately supported by the contractor, as appropriate.

If you have any questions regarding the response, you may Andrew O. Nickle, Audit Liaison for the Division of Administration at (202) 942-3190.

Attachment

cc: Howard Furner
Andrew Nickle
Mary Rann

EXHIBIT A

SUMMARY OF ACQUISITION AND CORPORATE SERVICES BRANCH MANAGEMENT DECISIONS

NO.	*FINDING DESCRIPTION*	*QUESTIONED COST/OTHER FINANCIAL ADUSTMENT*	*MANAGE-MENT RESPONSE*	*DESCRIPTION OF CORRECTIVE ACTION*	*EXPECTED COMPLETION DATE*	*DOCUMENT VERIFYING COMPLETION*
1	Aetna Overcharged Administrative Fees and direct charges.	**$442,103**	**Agree**	**CORRECTIVE ACTION FOR REC #1:** We will disallow and pursue recovery of the overcharged amounts.	March 31, 2001	Decision Memorandum or Demand Letter
				CORRECTIVE ACTION FOR REC #2: We will review the Package once completed.	March 31, 2001	Decision Memorandum or Demand Letter
2	Aetna Overpaid Claims	**$183,100**	**Agree**	**CORRECTIVE ACTION FOR REC #3:** We will disallow and pursue recovery of the overpaid claims that cannot be adequately supported by the contractor, as appropriate.	March 31, 2001	Decision Memorandum or Demand Letter
3	Aetna did not Comply with Contract Procedures for Collecting Overpaid Claims	**$197,104**	**Agree**	**CORRECTIVE ACTION FOR REC #4:** We will disallow and pursue recovery of the overpaid claims that cannot be adequately supported by the contractor, as appropriate.	March 31, 2001	Decision Memorandum or Demand Letter

APPENDIX III

MANAGEMENT RESPONSES TO RECOMMENDATIONS

The Inspector General Act of 1978, as amended, requires the OIG to report the status of management decisions on its recommendations in its semiannual reports to the Congress. To consider FDIC's responses as management decisions in accordance with the act and related guidance, several conditions are necessary. First, the response must describe for each recommendation

- the specific corrective actions already taken, if applicable;
- corrective actions to be taken together with the expected completion dates for their implementation; and
- documentation that will confirm completion of corrective actions.

If any recommendation identifies specific monetary benefits, FDIC management must state the amount agreed or disagreed with and the reasons for any disagreement. In the case of questioned costs, the amount FDIC plans to disallow must be included in management's response.

If management does not agree that a recommendation should be implemented, it must describe why the recommendation is not considered valid.

Second, the OIG must determine that management's descriptions of (1) the course of action already taken or proposed and (2) the documentation confirming completion of corrective actions are responsive to its recommendations.

This table presents the management responses that have been made on recommendations in our report and the status of management decisions. The information for management decisions is based on management's written response to our report.

Rec. Number	Corrective Action: Taken or Planned/Status	Expected Completion Date	Documentation That Will Confirm Final Action	Monetary Benefits	Management Decision: Yes or No
1	The Corporation agreed to disallow $442,103 and will pursue recovery of amounts that cannot be adequately supported by the contractor.	March 31, 2001	Decision memorandum or demand letter	$442,103 in disallowed costs	Yes
2	The Corporation agreed to review the 1999 Annual Accounting Package once completed by Aetna	March 31, 2001	Decision memorandum or demand letter	Not Quantifiable	Yes
3	The Corporation agreed to disallow $183,100 and will pursue recovery of amounts that cannot be adequately supported by the contractor.	March 31, 2001	Decision memorandum or demand letter	$183,100 in disallowed costs	Yes
4	The Corporation agreed to disallow $197,104 and will pursue recovery of amounts that cannot be adequately supported by the contractor.	March 31, 2001	Decision memorandum or demand letter.	$197,104 in disallowed costs	Yes