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

Final Audit Report

Audit of
Blue Cross and Blue Shield of Alabama
Birmingham, Alabama

Report Number 2025-ERAG-004
September 15, 2025

EXECUTIVE SUMMARY

Audit of Blue Cross and Blue Shield of Alabama

Report No. 2025-ERAG-004 **September 15, 2025**

Why did we conduct the audit?

We conducted this limited scope audit to obtain reasonable assurance that Blue Cross and Blue Shield of Alabama (Plan) is complying with the provisions of the Federal Employees Health Benefits Act and regulations that are included, by reference, in the Federal Employees Health Benefits Program (FEHBP) contract. The objectives of our audit were to determine if the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of contract CS 1039.

What did we audit?

Our audit covered miscellaneous health benefit payments and credits, such as cash receipt and provider offset refunds, for contract year 2019 through April 30, 2024, and administrative expense charges for contract years 2019 through 2023, as reported in the Annual Accounting Statements. We also reviewed the Plan's cash management activities and practices related to FEHBP funds from July 1, 2021, through April 30, 2024, and the Plan's Fraud and Abuse Program activities for contract year 2022 through April 30, 2024.

Michael R. Esser
Assistant Inspector General for Audits

What did we find?

We questioned $580,794 in health benefit charges, administrative expense overcharges, and lost investment income (LII), and identified a procedural finding for the Plan's Fraud and Abuse Program. The Blue Cross Blue Shield Association (Association) and/or Plan agreed with these questioned amounts and the procedural finding. As part of our review, we verified that the Plan subsequently returned all of these questioned amounts to the FEHBP because of the audit.

Our audit results are summarized as follows:

- Miscellaneous Health Benefit Payments and Credits – We questioned $175,726 for fraud recoveries and $22,562 for medical drug rebates that had not been returned to the FEHBP as of April 30, 2024, and $13,020 for applicable LII calculated on funds that were returned untimely to the FEHBP.
- Administrative Expenses – We questioned $369,486 in administrative expense overcharges and LII, consisting of $304,244 for unallowable and/or unallocable cost center charges, $21,798 for Affordable Care Act fee overcharges, and $43,444 for applicable LII on these questioned charges.
- Cash Management – The audit disclosed no significant findings pertaining to the Plan's cash management activities and practices related to FEHBP funds. Overall, we determined that the Plan handled FEHBP funds in accordance with contract CS 1039 and applicable laws and regulations.
- Fraud and Abuse Program – In two instances, the Association and Plan were not in compliance with the communication and reporting requirements for fraud and abuse cases set forth in contract CS 1039 and FEHBP Carrier Letter 2017-13.

ABBREVIATIONS

ACA	**Affordable Care Act**
Association	**Blue Cross Blue Shield Association**
BCBS	**Blue Cross and/or Blue Shield**
BCBSA	**Blue Cross Blue Shield Association**
CFR	**Code of Federal Regulations**
FAR	**Federal Acquisition Regulations**
FEHB	**Federal Employees Health Benefits**
FEHBAR	**Federal Employees Health Benefits Acquisition Regulations**
FEHBP	**Federal Employees Health Benefits Program**
FEP	**Federal Employee Program**
FEPDO	**FEP Director's Office**
FSTS	**FEP Special Investigations Unit Tracking System**
LII	**Lost Investment Income**
LOCA	**Letter of Credit Account**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
PCORI	**Patient-Centered Outcomes Research Institute**
Plan	**Blue Cross and Blue Shield of Alabama**
SPI	**Special Plan Invoice**

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I. BACKGROUND

This final report details the findings, conclusions, and recommendations from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at Blue Cross and Blue Shield of Alabama (Plan). The Plan is located in Birmingham, Alabama.

The audit was performed by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

The 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 eligible dependents. OPM's Healthcare and Insurance Office has overall responsibility for administration of the FEHBP. The provisions of the FEHB Act are implemented by OPM through regulations, which are codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations (CFR). Health insurance coverage is made available through contracts with various health insurance carriers.

The Blue Cross Blue Shield Association (Association or BCBSA), on behalf of participating local Blue Cross and/or Blue Shield (BCBS) plans, has entered into a governmentwide Service Benefit Plan contract (contract CS 1039) with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of the FEHBP members. The Plan is one of 33 BCBS companies participating in the FEHBP. These 33 companies include 60 local BCBS plans.

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

The Association has also established an FEP Operations Center. The activities of the FEP Operations Center are performed by the Service Benefit Plan Administrative Services Corporation, an affiliate of CareFirst BlueCross BlueShield, located in Washington, D.C. These activities include acting as intermediary for claims processing between the Association and local BCBS plans, processing and maintaining subscriber eligibility, adjudicating member claims on behalf of BCBS plans, approving or disapproving the reimbursement of local plan payments of FEHBP claims (using computerized system edits), maintaining a history file of FEHBP claims, and maintaining claims payment data.

[1] Throughout this report, when we refer to "FEP," we are referring to the Service Benefit Plan lines of business at the Plan. When we refer to the "FEHBP," we are referring to the program that provides health benefits to federal employees, annuitants, and eligible family members.

Compliance with laws and regulations applicable to the FEHBP is the responsibility of the Association and Plan management. In addition, working in partnership with the Association, the Plan's management is responsible for establishing and maintaining a system of internal controls.

All findings from our prior audit of the Plan (Report No. 1A-10-09-18-050, dated July 11, 2019), covering contract year 2013 through June 30, 2018, have been satisfactorily resolved. We also included this Plan in a recent focused audit (Report No. 2022-ERAG-0012, dated December 13, 2022) that covered cash management activities and practices related to FEHBP funds for contract year 2019 through June 30, 2021, and aging FEP refunds as of June 30, 2021, for a sample of BCBS plans. This focused audit disclosed no audit findings for Blue Cross and Blue Shield of Alabama.

The results of this audit were provided to the Plan in written notifications of findings and recommendations; were discussed with Plan and/or Association officials throughout the audit and at an exit conference on April 30, 2025; and were presented in detail in a draft report, dated May 23, 2025. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as an Appendix to this report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The objectives of our audit were to determine whether the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of contract CS 1039. Specifically, our objectives were as follows:

Miscellaneous Health Benefit Payments and Credits

- To determine whether miscellaneous payments charged to the FEHBP were in compliance with the terms of the contract.
- To determine whether credits and miscellaneous income relating to FEHBP health benefit payments (such as health benefit refunds, subrogation recoveries, and medical drug rebates) were returned timely 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 laws and regulations.

Cash Management

- To determine whether the Plan handled FEHBP funds in accordance with the contract and applicable laws and regulations concerning cash management in the FEHBP.

Fraud and Abuse Program

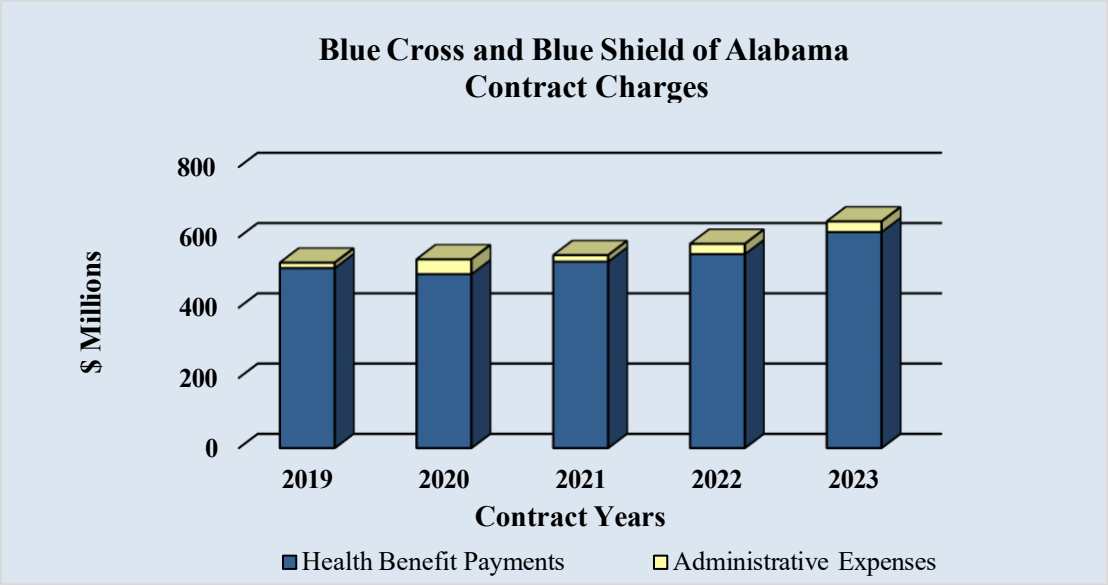
- To determine whether the Plan's communication and reporting of fraud and abuse cases complied with the terms of contract CS 1039 and FEHBP Carrier Letter (Carrier Letter) 2017-13.

SCOPE

We conducted our limited scope performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient and appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We reviewed the Blue Cross and Blue Shield FEHBP Annual Accounting Statements pertaining to Blue Cross and Blue Shield of Alabama (plan codes 010/510) for contract years 2019 through 2023. During this period, the Plan paid approximately $2.7 billion in FEHBP health benefit

payments and charged the FEHBP approximately $136 million in administrative expenses (see chart below).



Specifically, we reviewed miscellaneous health benefit payments and credits (such as cash receipt and provider offset refunds, subrogation recoveries, and medical drug rebates) for contract year 2019 through April 30, 2024, and administrative expense charges for contract years 2019 through 2023, as reported in the Annual Accounting Statements. We also reviewed the Plan's cash management activities and practices related to FEHBP funds from July 1, 2021, through April 30, 2024, and the Plan's Fraud and Abuse Program activities for contract year 2022 through April 30, 2024.

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 significant matters involving the Plan's internal control structure and operations. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Plan's system of internal controls taken as a whole.

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 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 FEP Director's Office. 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, 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 fieldwork was performed by staff in our Jacksonville, Florida; Cranberry Township, Pennsylvania; and Washington, D.C. offices from November 7, 2024, through April 30, 2025, and also at the Plan's office in Birmingham, Alabama during two site visits from January 27 through January 31, 2025, and March 10 through March 14, 2025. Throughout the audit process, the Plan did a great job providing complete and timely responses to our numerous requests for explanations and supporting documentation. We greatly appreciated the Plan's cooperation and responsiveness during the pre-audit and fieldwork phases of this audit.

METHODOLOGY

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

We interviewed Plan personnel and reviewed the Plan's policies, procedures, and accounting records during our audit of miscellaneous health benefit payments and credits. For contract year 2019 through April 30, 2024, we judgmentally selected and reviewed the following FEP items:

Health Benefit Refunds[2]

- A high dollar sample of 85 FEP health benefit refunds returned via provider offsets, totaling $13,595,911 (from a universe of 525,869 FEP refunds returned via provider offsets, totaling $165,687,461 for the audit scope). The Plan's FEP universe of provider offsets included 24,229 solicited amounts, totaling $4,244,030, and 501,640 front-end amounts, totaling $161,443,431, for the audit scope. Our sample consisted of the 25 highest dollar solicited amounts from the audit scope, which included provider offsets from $23,472 through $88,470, and the 10 highest dollar front-end amounts from each

[2] The Plan's FEP universes of cash receipt and provider offset refunds consisted of items such as solicited and/or unsolicited refunds (claim overpayment recoveries). For the solicited provider offsets, the Plan immediately returns the funds to the FEHBP (i.e., within 30 days) by adjusting letter of credit account drawdowns, prior to actually recovering the funds from the applicable providers through the provider offset process. For front-end provider offsets, the Plan returns the funds to the FEHBP by reducing future FEP claim payments to the applicable providers through the provider offset process.

year of the audit scope, which included provider offsets from $115,290 through $425,828.

- A judgmental sample of 75 FEP solicited cash receipt refunds, totaling $1,036,464 (from a universe of 11,904 FEP solicited cash receipt refunds, totaling $3,144,068 for the audit scope). Our sample consisted of the 10 highest dollar solicited cash receipt refunds from each year of the audit scope and 15 additional solicited refunds that were selected from the audit scope based on our nomenclature review of the universe. The sample included solicited cash receipt refunds from $2,000 to $66,115.

- A judgmental sample of 60 FEP unsolicited cash receipt refunds, totaling $640,978 (from a universe of 6,293 FEP unsolicited cash receipt refunds, totaling $1,465,615 for the audit scope). Our sample consisted of the 10 highest dollar unsolicited cash receipt refunds from each year of the audit scope, which included refunds from $2,500 to $121,014.

Other Health Benefit Payments, Credits, and Recoveries

- All eight FEP medical drug rebate amounts, totaling $3,758,515, for the audit scope.

- A judgmental sample of 23 FEP subrogation recoveries, totaling $1,454,000 (from a universe of 19,826 FEP subrogation recoveries, totaling $7,582,750 for the audit scope). Our sample included the 20 highest dollar subrogation recoveries from the audit scope and three additional subrogation recoveries that were selected based on our nomenclature review of the universe. The sample consisted of subrogation recoveries ranging from $26 to $300,000.

- A high dollar sample of 10 FEP fraud recoveries, totaling $655,254 (from a universe of 240 FEP fraud recoveries, totaling $1,389,990 for the audit scope). Our sample consisted of the 10 highest dollar fraud recoveries from the audit scope, which included recoveries from $25,028 to $149,815.

- All 22 FEP provider audit recoveries, totaling $129,695, for the audit scope.

- A judgmental sample of 44 special plan invoices (SPI) for miscellaneous health benefit payments and credits, totaling $308,903 in net FEP payments (from a universe of 223 SPIs, totaling $2,574,537 in net FEP credits for the audit scope). We judgmentally selected these SPIs based on our nomenclature review of high dollar invoice amounts. Specifically, we selected two SPIs with the highest dollar payment amounts and two SPIs with the highest dollar credit amounts (excluding SPIs for medical drug rebates, which we reviewed separately) from each year in the audit scope (if applicable). Additionally, we selected all hospital settlement SPI payment and credit amounts greater than $1,000 from the audit scope. SPIs are used by the Plan to process items such as miscellaneous health benefit payment and credit transactions to the FEHBP that require manual adjustments and do not include primary claim payments.

We reviewed these samples to determine if health benefit refunds and recoveries, medical drug rebates, and miscellaneous credits were timely returned to the FEHBP and if miscellaneous payments were properly charged to the FEHBP. The results of these samples were not projected to the universe of miscellaneous health benefit payments and credits, since we did not use statistical sampling.

We judgmentally reviewed administrative expenses charged to the FEHBP for contract years 2019 through 2023. Specifically, we reviewed administrative expenses relating to cost centers; natural accounts; accounts payable transactions; allocations; pensions; post-retirement benefits; employee health benefits; employee compensation limits; out-of-system adjustments; prior period adjustments; non-recurring items/projects; inter-company profits; Association dues; and Patient Protection and Affordable Care Act fees.[3] We used the FEHBP contract, the FAR, the FEHBAR, and/or the Affordable Care Act (Public Law 111-148) to determine the allowability, allocability, and reasonableness of charges.

We reviewed the Plan's cash management activities and practices to determine whether the Plan handled FEHBP funds in accordance with contract CS 1039 and applicable laws and regulations.[4] Specifically, we reviewed letter of credit account (LOCA) drawdowns and United States Department of Treasury offsets from July 1, 2021, through April 30, 2024. As part of our testing, we selected and reviewed a judgmental sample of 61 LOCA drawdowns, totaling $188,303,440 (from a universe of 609 LOCA drawdowns, totaling $1,613,076,962 from July 1, 2021, through April 30, 2024), for the purpose of determining if the Plan's drawdowns were appropriate and adequately supported. Our sample included 11 weeks of LOCA drawdowns that were selected based on the week with the highest dollar drawdown day within the highest dollar drawdown month from each quarter in the audit scope. The sample also included six additional LOCA drawdowns that were selected based on our nomenclature review of the universe. The sample results were not projected to the universe of LOCA drawdowns, since we did not use statistical sampling.

[3] In general, the Plan records administrative expense transactions to natural accounts that are then allocated through cost centers to the Plan's various lines of business, including the FEP. For contract years 2019 through 2023, the Plan allocated administrative expenses of $157,001,205 (before adjustments) to the FEHBP, from 580 cost centers that contained 160 natural accounts. From this universe, we selected a judgmental sample of 65 cost centers to review, which totaled $55,315,284 in expenses allocated to the FEHBP. We also selected a judgmental sample of 54 natural accounts to review, which totaled $55,487,268 in expenses allocated to the FEHBP through the cost centers. For contract year 2023, we additionally reviewed a sample of 20 accounts payable transactions that were judgmentally selected from cost centers and natural accounts that were charged to the FEHBP. Because of the way we select and review each of these samples, there is a duplication of some of the administrative expenses tested. We selected these cost centers, natural accounts, and accounts payable transactions based on high dollar amounts, our nomenclature review, and/or our trend analysis. We reviewed the expenses from these cost centers, natural accounts, and accounts payable transactions for allowability, allocability, and reasonableness. The results of these samples were not projected to the universe of administrative expenses, since we did not use statistical sampling.

[4] During our audit scope, the Plan did not have a working capital deposit. Therefore, the Plan also did not have a dedicated FEP investment account. Based on OPM's "Letter of Credit System Guidelines" (dated April 2018), a working capital deposit is recommended but not required.

We also interviewed the Plan's Special Investigations Unit regarding the effectiveness of the Fraud and Abuse Program, as well as reviewed the Plan's communication and reporting of fraud and abuse cases for contract year 2022 through April 30, 2024, to test compliance with contract CS 1039 and Carrier Letter 2017-13.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

1. Fraud Recoveries $184,534

Our audit determined that the Plan had not returned two fraud recoveries, totaling $175,726, to the FEHBP as of April 30, 2024. The Plan subsequently returned these questioned fraud recoveries to the FEHBP in April 2025, approximately one year late, after receiving our audit notification letter, and because of our audit. As a result, we are questioning $184,534 for this audit finding, consisting of $175,726 for the questioned fraud recoveries and $8,808 for applicable lost investment income (LII) calculated on these fraud recoveries that were returned untimely to the FEHBP.

Contract CS 1039, Part II, Section 2.3 (i) states, "All health benefit refunds and recoveries, including erroneous payment recoveries, must be deposited into the working capital or investment account within 30 days and returned to or accounted for in the FEHBP letter of credit account [LOCA] within 60 days after receipt by the Carrier."

48 CFR 52.232-17(a) states, "all amounts that become payable by the Contractor . . . shall bear simple interest from the date due . . . The interest rate shall be the interest rate established by the Secretary of the Treasury . . . which is applicable to the period in which the amount becomes due, . . . and then at the rate applicable for each six-month period as fixed by the Secretary until the amount is paid."

Regarding reportable monetary findings, contract CS 1039, Part III, Section 3.16 (a) states, "Audit findings . . . in the scope of an OIG audit are reportable as questioned charges unless the Carrier provides documentation supporting that the findings were already identified and corrected (i.e., . . . untimely health benefit refunds were already processed and returned to the FEHBP) prior to audit notification."

For contract year 2019 through April 30, 2024, the Plan received 240 FEP fraud recoveries, totaling $1,389,990, from various health care providers. From this universe, we selected and reviewed a judgmental sample of the 10 highest dollar fraud recoveries from the audit scope, totaling $655,254, to determine if the Plan timely returned these recoveries to the FEHBP. Our sample consisted of fraud recoveries ranging from $25,028 to $149,815.

Based on our review of this sample, we determined that the Plan had not returned two fraud recoveries, totaling $175,726, to the FEHBP as of April 30, 2024, that were received by the Plan in February and March of 2024. As part of our review, we verified that the Plan subsequently returned these two fraud recoveries to the FEHBP via LOCA drawdown adjustment on April 22, 2025, approximately one year late, after receiving our audit notification letter (dated May 1, 2024), and because of our audit.

The Plan had not returned two fraud recoveries, totaling $175,726, to the FEHBP as of April 30, 2024.

In total, we verified that the Plan subsequently returned $184,534 to the FEHBP in April and May of 2025 for these fraud recovery exceptions, consisting of $175,726 for the two questioned fraud recoveries and $8,808 for applicable LII on these recoveries that were returned untimely to the FEHBP (as calculated by the Plan). We also verified and accepted the Plan's LII calculation.

Recommendation 1

We recommend that the contracting officer require the Plan to return $175,726 to the FEHBP for the questioned fraud recoveries. However, since we verified that the Plan subsequently returned $175,726 to the FEHBP for these questioned fraud recoveries, no further action is required for this amount.

Recommendation 2

We recommend that the contracting officer require the Plan to return $8,808 to the FEHBP for LII calculated on the questioned fraud recoveries that were returned untimely to the FEHBP. However, since we verified that the Plan subsequently returned $8,808 to the FEHBP for the questioned LII, no further action is required for this LII amount.

Recommendation 3

We recommend that the contracting officer require the Association to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that fraud recoveries are returned timely to the FEHBP. The Association should also provide a certification that these corrective actions have been implemented by the Plan.

Association/Plan Response:

The Association and/or Plan agree with the finding and recommendations. To close the procedural recommendation, the Association will provide supporting documentation for the Plan's corrective actions to OPM after the final report is issued.

2. Medical Drug Rebates $24,633

Our audit determined that the Plan had not returned a medical drug rebate amount, totaling $22,562, to the FEHBP as of April 30, 2024. The Plan subsequently returned this questioned medical drug rebate amount to the FEHBP on May 10, 2024, approximately two years late, after receiving our audit notification letter, and/or because of our audit. Additionally, the Plan untimely returned five medical drug rebate amounts, totaling $2,382,936, to the FEHBP during our audit scope. Since the Plan returned these five medical drug rebate amounts and applicable LII to the FEHBP during the audit scope and prior to our audit notification date, we did not question these total principal and LII amounts as a monetary finding. As a result, we are questioning $24,633 for this audit finding, consisting of $22,562 for the questioned medical drug rebate amount and $2,071 for applicable LII calculated on this questioned amount that was subsequently returned untimely to the FEHBP after April 30, 2024.

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."

As previously cited from contract CS 1039, all health benefit refunds and recoveries must be deposited into the dedicated FEP investment account within 30 days and returned to the LOCA within 60 days after receipt by the Carrier. Also, as previously cited from FAR 52.232-17(a), all amounts that become payable by the Contractor should include simple interest from the date due.

Regarding reportable monetary findings, contract CS 1039, Part III, Section 3.16 (a) states, "Audit findings . . . in the scope of an OIG audit are reportable as questioned charges unless the Carrier provides documentation supporting that the findings were already identified and corrected (i.e., . . . untimely health benefit refunds were already processed and returned to the FEHBP) prior to audit notification."

The Plan participates in medical drug rebate programs with various drug manufacturers. The drug rebates are determined based on medical claims for the applicable drugs, which are primarily administered in a physician's office. The Plan receives medical drug rebates multiple times a year (usually on a quarterly basis) and credits them to the participating groups, including the FEP.

For contract year 2019 through April 30, 2024, the Plan received eight FEP medical drug rebate amounts, totaling $3,758,515, from various drug manufacturers.[5] From this

[5] In April 2021, the Association's FEP Director's Office (FEPDO) started submitting the medical claims for pharmaceutical manufacturer rebate reimbursements for certain drugs on behalf of the Plan. Effective January 1, 2024, the Association's FEPDO transitioned all medical drug rebate administration to a vendor, and as a result, the Plan no longer processes medical drug rebates related to the FEP. The Plan received the last medical drug rebate amount for the FEP in February 2022.

universe, we selected and reviewed all medical drug rebate amounts to determine if the Plan timely returned these funds to the FEHBP.

Based on our review, we identified the following exceptions:

- In one instance, the Plan had not returned a medical drug rebate amount, totaling $22,562, to the FEHBP as of April 30, 2024. The Plan subsequently returned this questioned medical drug rebate amount to the FEHBP on May 10, 2024, and applicable LII on June 6, 2024. We noted that the Plan returned this medical drug rebate amount to the FEHBP approximately two years late, after receiving our audit notification letter (dated May 1, 2024), and/or because of our audit. Therefore, we are questioning this medical drug rebate amount as a monetary finding as well as $2,071 for applicable LII on these funds that were subsequently returned untimely to the FEHBP (as calculated by the Plan). We reviewed and accepted the Plan's LII calculation and verified that the Plan subsequently returned this LII amount to the FEHBP.

- The Plan returned five medical drug rebate amounts, totaling $2,382,936, untimely to the FEHBP during the audit scope. Specifically, we noted that the Plan returned these five medical drug rebate amounts to the FEHBP via LOCA drawdown adjustments, ranging from one month to two years late. As a result, the Plan calculated and returned LII, totaling $20,150, to the FEHB via LOCA drawdown adjustments during the audit scope. We reviewed and accepted the Plan's LII calculations. Since the Plan returned these medical drug rebates and applicable LII to the FEHBP during our audit scope and prior to our audit notification date, we did not question these total principal and LII amounts as a monetary finding. We consider these as procedural exceptions.

In total, we verified that the Plan subsequently returned $24,633 to the FEHBP in May and June of 2024 for the questioned medical drug rebate exception, consisting of $22,562 for the questioned medical drug rebate amount and $2,071 for applicable LII calculated on this amount that was returned untimely to the FEHBP after the audit scope.

Recommendation 4

We recommend that the contracting officer require the Plan to return $22,562 to the FEHBP for the questioned medical drug rebate amount. However, since we verified that the Plan subsequently returned $22,562 to the FEHBP for the questioned medical drug rebate amount, no further action is required for this amount.

Recommendation 5

We recommend that the contracting officer require the Plan to return $2,071 to the FEHBP for LII calculated on the questioned medical drug rebate amount that was returned untimely to the FEHBP after April 30, 2024. However, since we verified that the Plan subsequently returned $2,071 to the FEHBP for the questioned LII, no further action is required for this LII amount.

Association/Plan Response:

The Association and/or Plan agree with the finding and recommendations.

3. Special Plan Invoices $2,141

Our audit determined that the Plan untimely returned two SPI amounts, totaling $29,856, to the FEHBP during the audit scope, resulting in questioned LII of $2,141 due to the FEHBP. Since the Plan returned these SPI amounts to the FEHBP during the audit scope and prior to our audit notification date, we did not question this total principal amount as a monetary finding. However, as a result of this audit finding, the Plan subsequently returned $2,141 to the FEHBP in April 2025 for the questioned LII on these SPI exceptions.

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."

As previously cited from contract CS 1039, all health benefit refunds and recoveries must be deposited into the dedicated FEP investment account within 30 days and returned to the LOCA within 60 days after receipt by the Carrier. Also, as previously cited from FAR 52.232-17(a), all amounts that become payable by the Contractor should include simple interest from the date due.

For contract year 2019 through April 30, 2024, there were 223 SPIs, totaling $2,574,537 in net FEP credits, for miscellaneous health benefit payments and credits. From this universe, we selected and reviewed a judgmental sample of 44 SPIs, totaling $308,903 in net FEP payments, to determine if the Plan properly calculated, charged and/or credited these SPI amounts to the FEHBP. We judgmentally selected these SPIs based on our nomenclature review of high dollar invoice amounts. Specifically, we selected two SPIs with the highest dollar payment amounts and two SPIs with the highest dollar credit amounts (excluding SPIs for medical drug rebates, which we reviewed separately) from each year of the audit scope (if applicable). Additionally, our sample included all hospital settlement SPI payment and credit amounts of $1,000 or more from each year of the audit scope.

Based on our review, we determined that the Plan untimely returned two SPI amounts, totaling $29,856, to the FEHBP during the audit scope. Of these exceptions, one SPI amount was for a legal settlement recovery that the Plan received in contract year 2015 and returned to the FEHBP via a LOCA drawdown adjustment in contract year 2022, approximately six years late; and one SPI amount was for a subrogation recovery that the Plan received in contract year 2023 and returned 12 days late to the FEHBP via a LOCA drawdown adjustment. Since the Plan returned these SPI amounts to the FEHBP during the audit scope and prior to our audit notification date, we did not question these SPI principal amounts of $29,856 as a monetary finding. However, since these funds were returned untimely to the FEHBP, we calculated and questioned LII of $2,141 on these two SPI amounts.

Recommendation 6

We recommend that the contracting officer require the Plan to return $2,141 to the FEHBP for the questioned LII calculated on the SPI amounts that were returned untimely to the FEHBP during the audit scope. However, since we verified that the Plan subsequently returned $2,141 to the FEHBP for the questioned LII, no further action is required for this LII amount.

Association/Plan Response:

The Association and/or Plan agree with the finding and recommendation.

B. ADMINISTRATIVE EXPENSES

1. Unallowable and/or Unallocable Cost Center Charges $345,031

The Plan charged $304,244 in unallowable and/or unallocable cost center expenses to the FEHBP for contract years 2020 through 2022. As a result of this audit finding, the Plan subsequently returned $345,031 to the FEHBP, consisting of $304,244 for these unallowable and/or unallocable cost center expenses that were charged to the FEHBP and $40,787 for applicable LII on these questioned charges.

Contract CS 1039, 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 31.205-1(d) states, "The only allowable advertising costs are those that are –

(1) Specifically required by contract, or that arise from requirements of Government contracts, and that are exclusively for – (i) Acquiring scarce items for contract performance; or (ii) Disposing of scrap or surplus materials acquired for contract performance;

(2) Costs of activities to promote sales of products normally sold to the U.S. Government, including trade shows, which contain a significant effort to promote exports from the United States."

As previously cited from FAR 52.232-17(a), all amounts that become payable by the Contractor should include simple interest from the date due.

Regarding reportable monetary findings, contract CS 1039, Part III, Section 3.16 (a) states, "Audit findings . . . in the scope of an OIG audit are reportable as questioned charges unless the Carrier provides documentation supporting that the findings were already identified and corrected (i.e., administrative expense overcharges . . . were already processed and returned to the FEHBP) prior to audit notification."

For contract years 2020 through 2022, the Plan charged unallowable and/or unallocable cost center expenses of $304,244 to the FEHBP.

For contract years 2019 through 2023, the Plan allocated administrative expenses of $157,001,205 (before adjustments) to the FEHBP, from 580 cost centers that contained 160 natural accounts. From this universe, we selected a judgmental sample of 65 cost centers to review, which totaled $55,315,284 in expenses allocated to the FEHBP. We also selected a judgmental sample of 54 natural accounts to review, which totaled $55,487,268 in expenses allocated to the FEHBP through the cost centers. We selected these cost centers and natural accounts based on high dollar amounts, our nomenclature review, and/or our trend analysis. We reviewed the expenses from these cost centers and natural accounts for allowability, allocability, and/or reasonableness.

Based on our review of these cost centers and natural accounts, we determined the Plan charged unallowable marketing expenses to the FEHBP from cost center "3036" (Marketing – Advertising Materials Member) for contract year 2022. Specifically, the Plan allocated and charged $58,421 to the FEHBP for marketing expenses that were

expressly unallowable. 48 CFR 31.205-1 provides specific criteria to the extent that such expenses are expressly unallowable. As a result of this exception, the Plan subsequently returned $64,902 to the FEHBP in May 2025, consisting of $58,421 for the questioned unallowable marketing expenses that were charged to the FEHBP and $6,481 for applicable LII on these questioned charges (as calculated by the OIG).

We also reviewed the Association's Control Performance Review (CPR) report (dated September 11, 2024) and noted that the Plan potentially charged unallocable vendor expenses to the FEHBP for contract years 2020 and 2021. In response to the CPR, the Plan disclosed that these unallocable vendor expenses were inadvertently charged to the FEHBP. Specifically, the Plan charged the FEHBP $245,823 for these unallocable vendor expenses from two cost centers, "5006" (Projects - Health/Clinical Engagement) and "3771" (Oncology Select Program) that did not benefit the FEHBP. As a result of these exceptions, the Plan subsequently returned $280,129 to the FEHBP in March and April of 2025, consisting of $245,823 for unallocable vendor expenses that were charged to the FEHBP and $34,306 for applicable LII on these questioned charges (as calculated by the Plan). We reviewed and accepted the Plan's LII calculation.

The following schedule is a summary of the questioned cost center expenses that were inappropriately charged to the FEHBP for contract years 2020 through 2022.

Questioned Cost Centers			
Cost Center Number	**Cost Center Name**	**Amount Questioned**	**Reason Questioned**
5006	Projects – Health/Clinical Engagement	$171,748	Unallocable
3771	Oncology Select Program	74,075	Unallocable
3036	Marketing – Advertising Materials Member	58,421	Unallowable
Total		**$304,244**	

In total, we are questioning $345,031 for these cost center exceptions, consisting of $304,244 for unallowable and/or unallocable cost center expenses that were inappropriately charged to the FEHBP for contract years 2020 through 2022 and $40,787 ($6,481 plus $34,306) for applicable LII calculated on these questioned charges.

Recommendation 7

We recommend that the contracting officer require the Plan to return $304,244 to the FEHBP for the questioned unallowable and/or unallocable cost center expenses that were charged to the FEHBP for contract years 2020 through 2022. However, since we verified that the Plan subsequently returned $304,244 to the FEHBP for these questioned cost center charges, no further action is required for this amount.

Recommendation 8

We recommend that the contracting officer require the Plan to return $40,787 to the FEHBP for the questioned LII calculated on the unallowable and/or unallocable cost center charges. However, since we verified that the Plan subsequently returned $40,787 to the FEHBP for the questioned LII, no further action is required for this LII amount.

Association/Plan Response:

The Association and/or Plan agree with the finding and recommendations.

2. Affordable Care Act Fees $24,455

For contract years 2019 through 2023, the Plan overcharged the FEHBP $21,798 for Affordable Care Act (ACA) fees that were related to the Patient-Centered Outcomes Research Institute (PCORI). As a result of this audit finding, the Plan subsequently returned $24,455 to the FEHBP, consisting of $21,798 for the questioned PCORI fees that were overcharged to the FEHBP and $2,657 for applicable LII on these questioned overcharges.

As previously cited from contract CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. Also, as previously cited from FAR 52.232-17(a), all amounts that become payable by the Contractor should include simple interest from the date due.

Section 6301 of the ACA imposes a fee on issuers of specified health insurance policies and plan sponsors of self-insured health plans to help fund the PCORI. The PCORI assists individuals in making informed health decisions by advancing the quality and relevance of evidence-based medicine. The PCORI fee is effective for policy or plan years ending after September 30, 2012, and before October 1, 2029. The yearly amount of the PCORI fee is equal to the average number of lives covered during the policy or plan year multiplied by a dollar amount (e.g., $2.54 for 2019, $2.66 for 2020, $2.79 for 2021, $3.00 for 2022, and $3.22 for 2023), as determined by the Secretary of Health and Human Services.

For contract years 2019 through 2023, the Plan allocated and charged $2,069,886 to the FEHBP for PCORI fees. Based on our review, we determined that the Plan used an incorrect FEP average number of covered lives when calculating the PCORI fees for contract years 2019 through 2023. Specifically, the Plan used an average number of covered lives that was manually pulled from internal membership enrollment reports that the Plan generated monthly. Instead, the Plan should have used the FEP average number of covered lives that is available in the Association's membership enrollment totals when calculating the PCORI fees. As a result of this inadvertent oversight, the Plan overcharged the FEHBP $21,798 for PCORI fees from contract years 2019 through 2023.

In total, we are questioning $24,455 for this audit finding, consisting of $21,798 for these PCORI fees that were overcharged to the FEHBP and $2,657 for applicable LII on these questioned overcharges (as calculated by the OIG).

Recommendation 9

We recommend that the contracting officer require the Plan to return $21,798 to the FEHBP for the questioned PCORI fees that were overcharged to the FEHBP for contract years 2019 through 2023. However, since we verified that the Plan subsequently returned $21,798 to the FEHBP for these questioned overcharges, no further action is required for this amount.

Recommendation 10

We recommend that the contracting officer require the Plan to return $2,657 to the FEHBP for the questioned LII calculated on the PCORI fees that were overcharged to the FEHBP. However, since we verified that the Plan subsequently returned $2,657 to the FEHBP for the questioned LII, no further action is required for this LII amount.

Recommendation 11

We recommend that the contracting officer instruct the Plan to calculate the PCORI fees using the average number of FEP enrollees and their eligible dependents that is available in the Association's membership enrollment totals. The contracting officer should also require the Association to provide a certification that this corrective action has been implemented by the Plan.

Association/Plan Response:

The Association and/or Plan agree with the finding and recommendations. Regarding the procedural recommendation, the Association states that the Plan "will change the cost report process to compute PCORI fees using the average number of FEP lives that is available in the Association's membership enrollment totals."

C. CASH MANAGEMENT

The audit disclosed no significant findings pertaining to the Plan's cash management activities and practices related to FEHBP funds. Overall, we concluded that the Plan handled FEHBP funds in accordance with contract CS 1039 and applicable laws and regulations concerning cash management in the FEHBP.

D. FRAUD AND ABUSE PROGRAM

1. Special Investigations Unit — Procedural

In two instances, the Association and Plan were not in compliance with the communication and reporting requirements for fraud and abuse cases.

The Association's FEP Director's Office (FEPDO) and Plan were not in compliance with the communication and reporting requirements for fraud and abuse cases set forth in the FEHBP Carrier Letter 2017-13. Specifically, the FEPDO and Plan did not report two fraud and abuse cases to the OIG prior to reaching settlements. Without awareness of these settlements, the OIG was not given an opportunity to agree with the applicable terms of these settlements.

Carrier Letter 2017-13 (FEHB Fraud, Waste and Abuse), dated November 20, 2017, states that all Carriers "are required to submit a written notification to OPM-OIG within 30 working days when there is a reportable FWA [fraud, waste, and abuse] that has occurred against the FEHB Program. Potential FWA issues become reportable to the OIG if, after a preliminary review of the allegation and/or complaint, the Carrier takes an affirmative step to expand, further investigate, develop and/or close an allegation/complaint."

The FEPDO is primarily responsible for timely reporting fraud and abuse cases to the OIG (i.e., within 30 working days of becoming aware of a fraud, waste, and/or abuse issue). To comply with the timeliness requirement, the FEPDO requires the local BCBS plans to enter fraud and abuse cases into the Association's FEP Special Investigations Unit Tracking System (FSTS).[6] The FEPDO is responsible for the maintenance and oversight of this system as well as reporting to the OIG all fraud and abuse cases that are entered into FSTS by the local BCBS plans. Accordingly, the Plan should also follow up with the FEPDO to ensure that all applicable cases are timely reported to the OIG.

Carrier Letter 2017-13 also states, "When a Carrier (as a sole participant) resolves claims with any type of health care services provider or manufacturer for recovery of overpayments, which resulted from apparent or suspected false, fictitious, fraudulent, or misleading claims submitted to the Carrier and at least $20,000 of the identified overpayments is money paid through the FEHB program, then the Carrier must: (1) Notify the OPM-OIG and provide a five working-day timeframe for the OIG to notify the Carrier if they determine whether they agree with the terms of the settlement."

[6] FSTS is a multi-user, web-based FEP case-tracking database application and storage warehouse administered by the Association's FEP Special Investigations Unit (SIU). FSTS is used by the local BCBS plans' SIUs, the FEP Pharmacy Benefit Managers' SIUs, and the Association's FEP SIU to store, track and report potential fraud and abuse activities.

For contract year 2022 through April 30, 2024, the Plan opened 189 fraud and abuse cases with potential FEP exposure. From this universe, we judgmentally selected and reviewed 19 cases for the purpose of determining if the Plan timely entered these fraud and abuse cases into the Association's FSTS and if the FEPDO and Plan properly and timely reported these cases to the OIG. Our sample included all cases with identified FEP medical exposure of $50,000 or more.

Based on our review, we identified no exceptions with the Plan timely entering cases into the Association's FSTS and then the FEPDO timely reporting the cases to the OIG. However, we noted that the FEPDO and Plan did not properly notify the OIG prior to the settlements and subsequent recoveries of two fraud and abuse cases. In each instance, the amount due to the FEHBP exceeded $20,000, which required the FEPDO and Plan to notify the OIG of the potential case settlement. Since the FEPDO and Plan did not notify the OIG of these potential case settlements, this resulted in a failure to meet the communication and reporting requirements that are set forth in Carrier Letter 2017-13. As a result, this lack of OIG notification by the FEPDO and Plan of potential case settlements may result in unfavorable settlements and/or potentially significant unrecovered amounts for the FEHBP.

Recommendation 12

We recommend that the contracting officer require the Association to provide evidence or supporting documentation demonstrating that the Association and Plan have implemented the necessary corrective actions to meet all communication and reporting requirements of fraud and abuse cases (including properly notifying the OIG of potential settlements) that are contained in Carrier Letter 2017-13.

Association/Plan Response:

The Association and/or Plan agree with the finding and recommendation. To close this recommendation, the Association will provide supporting documentation to OPM after the final report is issued.

IV. SCHEDULE A – QUESTIONED CHARGES

BLUE CROSS AND BLUE SHIELD OF ALABAMA
BIRMINGHAM, ALABAMA

QUESTIONED CHARGES

AUDIT FINDINGS	2019	2020	2021	2022	2023	2024	2025	TOTAL
A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS								
1. Fraud Recoveries*	$0	$0	$0	$0	$0	$181,970	$2,564	$184,534
2. Medical Drug Rebates*	0	0	0	23,163	1,072	398	0	24,633
3. Special Plan Invoices*	1,802	152	82	21	84	0	0	2,141
TOTAL MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS	$1,802	$152	$82	$23,184	$1,156	$182,368	$2,564	$211,308
B. ADMINISTRATIVE EXPENSES								
1. Unallowable and/or Unallocable Cost Center Charges*	$0	$127,312	$119,785	$65,359	$14,439	$14,857	$3,279	$345,031
2. Affordable Care Act Fees*	2,432	4,929	4,719	5,399	5,579	1,066	331	24,455
TOTAL ADMINISTRATIVE EXPENSES	$2,432	$132,241	$124,504	$70,758	$20,018	$15,923	$3,610	$369,486
C. CASH MANAGEMENT								
TOTAL CASH MANAGEMENT	$0	$0	$0	$0	$0	$0	$0	$0
D. FRAUD AND ABUSE PROGRAM								
1. Special Investigations Unit (Procedural)	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL FRAUD AND ABUSE PROGRAM	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL QUESTIONED CHARGES	$4,234	$132,393	$124,586	$93,942	$21,174	$198,291	$6,174	$580,794

*** We included lost investment income (LII) within audit findings A1 ($8,808), A2 ($2,071), A3 ($2,141), B1 ($40,787), and B2 ($2,657). Therefore, no additional LII is applicable.**

APPENDIX

BlueCross BlueShield Association

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July 1, 2025

John A. Hirschmann
Group Chief, Claims Audits and Analytics Group
Office of the Inspector General
U.S. Office of Personnel Management
1900 E. Street, Room 6400
Washington, D.C. 20415-1100

Reference: OPM Draft AUDIT REPORT
Blue Cross and Blue Shield of Alabama
Audit Report Number 2025-ERAG-005

Dear Mr. Hirschmann:

This is the Blue Cross and Blue Shield of Alabama, response to the above referenced U.S. Office of Personnel Management OPM) Draft Audit Report covering the Federal Employees Program Claims Processing and Payment Operations. Our comments concerning the findings in the report are as follows:

A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

Recommendation 1

We recommend that the contracting officer require the Plan to return $175,726 to the FEHBP for the two questioned fraud recoveries. However, since we verified that the Plan subsequently returned $175,726 to the FEHBP in April 2025 for these questioned fraud recoveries, no further action is required for this amount.

Plan Response:

Blue Cross and Blue Shield of Alabama agreed with this recommendation and returned the funds to the Program. As stated in the recommendation, no further action is required.

Recommendation 2

We recommend that the contracting officer require the Plan to return $8,808 to the FEHBP for LII calculated on the questioned fraud recoveries that were returned untimely to the FEHBP.

However, since we verified that the Plan subsequently returned $8,808 to the FEHBP in May 2025 for the questioned LII, no further action is required for this LII amount.

Plan Response:

Blue Cross and Blue Shield of Alabama agreed with this recommendation and returned the funds to the Program. As stated in the recommendation, no further action is required.

Recommendation 3

We recommend that the contracting officer require the Association to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that fraud recoveries are returned timely to the FEHBP. The Association should also provide a certification that these corrective actions have been implemented by the Plan.

Association Response:

BSBCA agreed with this recommendation and will provide documentation to OPM ARC to close this recommendation once the final report is issued.

Recommendation 4

We recommend that the contracting officer require the Plan to return $22,562 to the FEHBP for the questioned medical drug rebate amount. However, since we verified that the Plan subsequently returned $22,562 to the FEHBP in May 2024 for the questioned medical drug rebate amount, no further action is required for this amount.

Plan Response:

Blue Cross and Blue Shield of Alabama agreed with this recommendation and returned the funds to the Program. As stated in the recommendation, no further action is required.

Recommendation 5

We recommend that the contracting officer require the Plan to return $2,071 to the FEHBP for LII calculated on the questioned medical drug rebate amount that was returned untimely to the FEHBP. However, since we verified that the Plan subsequently returned $2,071 to the FEHBP in June 2024 for the questioned LII, no further action is required for this LII amount.

Plan Response:

Blue Cross and Blue Shield of Alabama agreed with this recommendation and returned the funds to the Program. As stated in the recommendation, no further action is required.

Recommendation 6

We recommend that the contracting officer require the Plan to return $2,141 to the FEHBP for the questioned LII calculated on the SPI amounts that were returned untimely to the FEHBP during the audit scope. However, since we verified the Plan subsequently returned $2,141 to the FEHBP in April 2025 for the questioned LII, no further action is required for this LII amount.

Plan Response:

Blue Cross and Blue Shield of Alabama agreed with this recommendation and returned the funds to the Program. As stated in the recommendation, no further action is required.

B. ADMINISTRATIVE EXPENSES

Recommendation 7

We recommend that the contracting officer require the Plan to return $304,244 to the FEHBP for the questioned unallowable and/or unallocable cost center expenses that were charged to the FEHBP. However, since we verified that the Plan subsequently returned $304,244 to the FEHBP from March 2025 through May 2025 for these questioned cost center charges, no further action is required for this amount.

Plan Response:

Blue Cross and Blue Shield of Alabama agreed with this recommendation and returned the funds to the Program. As stated in the recommendation, no further action is required.

Recommendation 8

We recommend that the contracting officer require the Plan to return $40,787 to the FEHBP for the questioned LII calculated on the unallowable and/or unallocable cost center charges. However, since we verified that the Plan subsequently returned $40,787 to the FEHBP from March 2025 through May 2025 for the questioned LII, no further action is required for this LII amount.

Plan Response:

Blue Cross and Blue Shield of Alabama agreed with this recommendation and returned the funds to the Program. As stated in the recommendation, no further action is required.

Recommendation 9

We recommend that the contracting officer require the Plan to return $21,798 to the FEHBP for the questioned PCORI fees that were overcharged to the FEHBP for contract years 2019 through 2023. However, since we verified that the Plan subsequently returned $21,798 to the FEHBP in May 2025 for these questioned overcharges, no further action is required for this amount.

Plan Response:

Blue Cross and Blue Shield of Alabama agreed with this recommendation and returned the funds to the Program. As stated in the recommendation, no further action is required.

Recommendation 10

We recommend that the contracting officer require the Plan to return $2,657 to the FEHBP for the questioned LII calculated on the PCORI fees that were overcharged to the FEHBP. However, since we verified that the Plan subsequently returned $2,657 to the FEHBP in May 2025 for the questioned LII, no further action is required for this LII amount.

Plan Response:

Blue Cross and Blue Shield of Alabama agreed with this recommendation and returned the funds to the Program. As stated in the recommendation, no further action is required.

Recommendation 11

We recommend that the Plan calculate the PCORI fees using the average number of FEP lives that is available in the Association's membership enrollment totals.

Plan Response:

Blue Cross and Blue Shield of Alabama agreed with this recommendation and will change the cost report process to compute PCORI fees using the average number of FEP lives that is available in the Association's membership enrollment totals.

D. FRAUD AND ABUSE PROGRAM

Recommendation 12

We recommend that the Association provide evidence or supporting documentation demonstrating that the Association and Plan have implemented the necessary corrective actions to meet all communication and reporting requirements of fraud and abuse cases (including properly notifying the OPM OIG of potential settlements) that are contained in FEHBP Carrier Letter 2017-13.

Association Response:

BSBCA agreed with this recommendation and will provide documentation to OPM ARC to close this recommendation once the final report is issued.

We appreciate the opportunity to provide our response to this Draft Audit Report and request that our comments be included in their entirety as an amendment to the Final Audit Report.

Sincerely,

cc:

Report Fraud, Waste, and Mismanagement

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