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

Final Audit Report

Audit of
Blue Cross Blue Shield of North Carolina
Durham, North Carolina

Report Number 2023-ERAG-005
February 26, 2024

EXECUTIVE SUMMARY

Audit of Blue Cross Blue Shield of North Carolina

Report No. 2023-ERAG-005 **February 26, 2024**

Why did we conduct the audit?

We conducted this limited scope audit to obtain reasonable assurance that Blue Cross Blue Shield of North Carolina (Plan), plan codes 310/810, 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 2018 through September 30, 2022, as well as administrative expense charges and statutory reserve payments for contract years 2017 through 2021, as reported in the Annual Accounting Statements. We also reviewed the Plan's cash management activities and practices related to FEHBP funds for contract year 2018 through September 30, 2022, and the Plan's Fraud and Abuse Program activities from January 1, 2022, through September 30, 2022.

Michael R. Esser
Assistant Inspector General for Audits

What did we find?

We questioned $954,142 in health benefit charges, administrative expense overcharges, cash management activities, and lost investment income (LII), and identified a procedural finding regarding the Plan's Fraud and Abuse Program. The Blue Cross Blue Shield Association (Association) and/or Plan agreed with all of the questioned amounts as well as the procedural finding for the Plan's Fraud and Abuse Program. As part of our review, we verified that the Plan subsequently returned $311,563 of these questioned amounts to the FEHBP because of the audit.

Our audit results are summarized as follows:

- Miscellaneous Health Benefit Payments and Credits – Due to the Plan's lack of due diligence with recovery efforts, we questioned $642,579 for provider offsets where the Plan had not recovered and/or returned funds to the FEHBP for 163 FEP claim overpayments.
- Administrative Expenses – We questioned $308,096 in administrative expense overcharges and LII, consisting of $258,550 in overcharges for non-recurring project costs, $21,794 in overcharges for Association dues, and $27,752 for applicable LII on these questioned charges.
- Statutory Reserve Payments – The Plan charged statutory reserve payments to the FEHBP in accordance with Contract CS 1039 and applicable laws and regulations.
- Cash Management – We questioned $3,467 for excess funds that were held by the Plan in the dedicated Federal Employee Program investment account as of September 30, 2022. Except for these questioned excess funds, we determined that the Plan handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations concerning cash management in the FEHBP.
- Fraud and Abuse Program – In one instance, the Association and Plan were not in compliance with the communication and reporting requirements for fraud and abuse cases set forth in FEHBP Carrier Letter 2017-13.

ABBREVIATIONS

Association	**Blue Cross Blue Shield Association**
BCBS	**Blue Cross and/or Blue Shield**
BCBSA	**Blue Cross Blue Shield Association**
CFR	**Code of Federal Regulations**
FEHB	**Federal Employees Health Benefits**
FEHBAR	**Federal Employees Health Benefits Acquisition Regulations**
FEHBP	**Federal Employees Health Benefits Program**
FEP	**Federal Employee Program**
FEPDO	**Federal Employee Program Director's Office**
FSTS	**FEP Special Investigations Unit Tracking System**
FWA	**Fraud, Waste, and Abuse**
LII	**Lost Investment Income**
LOCA	**Letter of Credit Account**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**Blue Cross Blue Shield of North Carolina**
SIU	**Special Investigations Unit**
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 Blue Shield of North Carolina (Plan). The Plan is located in Durham, North Carolina.

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 dependents. OPM's Healthcare and Insurance Office has overall responsibility for the administration of the FEHBP. The provisions of the FEHB Act are implemented by OPM through Federal 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 Government-wide 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 in Washington, D.C. to provide centralized management for the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the Association, member BCBS plans, and OPM.

The Association has also established an FEP Operations Center. The activities of the FEP Operations Center are performed by the Service Benefit Plan Administrative Services Corporation, an affiliate of CareFirst BCBS, 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 previous audit of the Plan (Report No. 1A-10-33-18-001, dated August 28, 2018), covering contract year 2012 through March 31, 2017, have been satisfactorily resolved.

The results of this audit were provided to the Plan in written audit inquiries; were discussed with Plan and/or Association officials throughout the audit and at an exit conference on September 27, 2023; and were presented in detail in a draft report, dated October 19, 2023. The Association's and Plan's comments offered in response to the draft report were considered in preparing our final report and are included as an Appendix to this report. Also, additional documentation provided by the Plan on January 2, 2024, was considered in preparing our final report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

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

Miscellaneous Health Benefit Payments and Credits

- To determine whether miscellaneous payments charged to the FEHBP were in compliance with the terms of the contract.
- To determine whether credits and miscellaneous income relating to FEHBP benefit payments were returned 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.

Statutory Reserve Payments

- To determine whether the Plan charged statutory reserve payments to the FEHBP in accordance with 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.

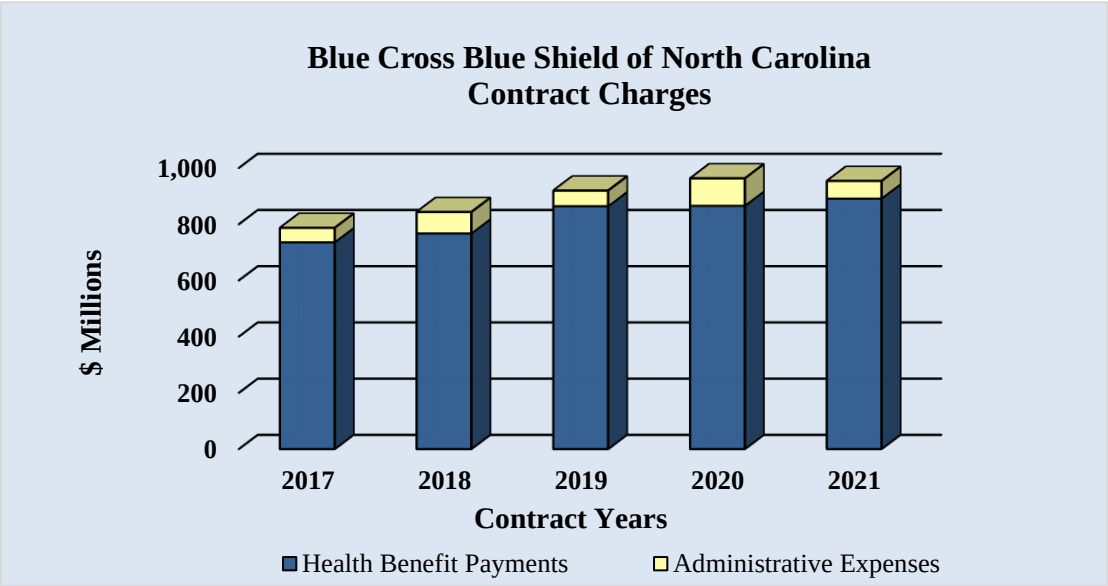
Fraud and Abuse Program

- 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 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 plan codes 310 and 810 for contract years 2017 through 2021. During this five-year period, the Plan paid approximately $4.1 billion in FEHBP health benefit payments and charged the FEHBP approximately $344 million in administrative expenses (see chart on the next page). The Plan also charged the FEHBP approximately $13 million in statutory reserve payments.



Specifically, we reviewed miscellaneous health benefit payments and credits, such as cash receipt and health care provider (provider) offset refunds, for contract year 2018 through September 30, 2022, as well as administrative expense charges and statutory reserve payments for contract years 2017 through 2021, as reported in the Annual Accounting Statements. We also reviewed the Plan's cash management activities and practices related to FEHBP funds for contract year 2018 through September 30, 2022, and the Plan's Fraud and Abuse Program activities from January 1, 2022, through September 30, 2022.

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 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 mostly performed remotely as a desk audit in our Jacksonville, Florida; Cranberry Township, Pennsylvania; and Washington, D.C. offices from April 17, 2023, through September 27, 2023, except for two site visits to the Plan's offices in Durham, North Carolina from May 9 through May 11, 2023, and July 17 through July 20, 2023. 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 2018 through September 30, 2022, we judgmentally selected and reviewed the following items:

Health Benefit Refunds[2]

- A high dollar sample of 150 FEP cash receipt health benefit refunds, totaling $11,931,736 (from a universe of 41,121 FEP cash receipt refunds, totaling $38,475,279 for the audit scope). Our sample consisted of the 30 highest dollar cash receipt refunds from each year of the audit scope, which included refunds from $24,030 to $1,370,980.

- A high dollar sample of 50 FEP health benefit refunds returned via provider offsets, totaling $7,175,151 (from a universe of 36,418 FEP refunds returned via provider offsets, totaling $40,259,913 for the audit scope). Our sample consisted of the 10 highest dollar provider offsets from each year of the audit scope, which included offsets from $33,819 to $1,748,837.

Other Health Benefit Payments, Credits, and Recoveries

- A judgmental sample of 31 uncollected FEP claim overpayments, totaling $605,280 (from a universe of 1,026 uncollected FEP claim overpayments, totaling $1,253,976 for the audit scope). Our sample included uncollected claim overpayments of $10,000 or more from the audit scope. We reviewed these uncollected claim overpayments to determine if the Plan made diligent efforts to recover the applicable funds.

[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), subrogation recoveries, provider audit recoveries, and/or fraud recoveries.

- A judgmental sample of 5 unidentified cash receipt refunds, totaling $55,379 (from a universe of 51 unidentified cash receipt refunds, totaling $95,923 for the audit scope). Our sample consisted of the five highest dollar unidentified cash receipt refunds from the audit scope.

- A judgmental sample of 30 special plan invoices (SPI) for miscellaneous health benefit payments and credits, totaling $1,008,789 in net FEP payments (from a universe of 305 SPIs, totaling $2,047,283 in net FEP payments for the audit scope). We judgmentally selected these SPIs based on our nomenclature review of high dollar invoice amounts. Specifically, we selected three SPIs with the highest dollar payment amounts and three SPIs with the highest dollar credit amounts from each year of the audit scope. SPIs are used by the Plan to process items such as miscellaneous health benefit payment and credit transactions that require manual adjustments and do not include primary claim payments.

We reviewed these samples to determine if health benefit refunds and recoveries 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 2017 through 2021. Specifically, we reviewed administrative expenses relating to cost centers; natural accounts; account payable transactions; allocations; pensions; post-retirement benefits; employee compensation limits; subcontracts; non-recurring items/projects; gains and losses; return on investment; sale-leasebacks; Association dues; lobbying; and Patient Protection and Affordable Care Act fees.[3] We used the FEHBP contract, the Federal Acquisition Regulations, 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 if the Plan handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations. Specifically, we reviewed letter of credit account (LOCA) drawdowns, working capital calculations, adjustments and/or balances, United States Department of the Treasury offsets, and interest income transactions for contract year 2018 through September 30, 2022, as well as the Plan's dedicated FEP investment account activity during the scope and balance as of September 30, 2022. As part of our testing, we selected and reviewed a judgmental sample of 57

[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 2017 through 2021, the Plan allocated administrative expenses of $267,272,599 (before adjustments) to the FEHBP, from 388 cost centers that contained 316 natural accounts. From this universe, we selected a judgmental sample of 73 cost centers to review, which totaled $177,164,229 in expenses allocated to the FEHBP. We also selected a judgmental sample of 75 natural accounts to review, which totaled $129,617,480 in expenses allocated to the FEHBP through the cost centers. For contract year 2021, we additionally reviewed a sample of 60 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.

LOCA drawdowns, totaling $401,174,088 (from a universe of 1,166 LOCA drawdowns, totaling $4,036,617,810 for contract year 2018 through September 30, 2022), for the purpose of determining if the Plan's drawdowns were appropriate and adequately supported. Our sample included the highest dollar LOCA drawdown from each month in the audit scope. The sample results were not projected to the universe of LOCA drawdowns, since we did not use statistical sampling.

We also interviewed the Plan's Special Investigations Unit regarding the compliance of the Fraud and Abuse Program, as well as reviewed the Plan's communication and reporting of fraud and abuse cases to test compliance with Contract CS 1039 and FEHBP Carrier Letter 2017-13.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

1. Health Benefit Refunds – Provider Offsets $642,579

Because of the Plan's lack of due diligence with recovery efforts, the Plan had not recovered and/or returned funds to the FEHBP for 163 FEP claim overpayments. As part of the Plan's recovery efforts, these claim overpayments were set up as provider offsets, where the Plan would reduce future benefit payments to the providers for the purpose of recovering the refunds related to these overpayments. However, these provider offsets have been outstanding from 157 days to 4 years as of September 30, 2022. Although the Plan mailed some refund request letters and set up provider offsets, we determined overall that the Plan was not prompt and diligent with the recovery efforts for these 163 claim overpayments. As a result, the Plan had not recovered and/or returned $642,579 to the FEHBP for these claim overpayments. Based on Contract CS 1039, the Plan must make prompt and diligent efforts to recover erroneous benefit payments until the debt is paid in full or determined to be uncollectible. Accordingly, the Plan should continue to pursue and recover these claim overpayments from the applicable health care providers.

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."

Contract CS 1039, Part II, Section 2.3(g) states, "If the Carrier [or OPM] determines that a Member's claim has been paid in error for any reason . . . the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider." Section 2.3(g) also states, "Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall –

(1) Send a written notice of erroneous payment to the member or provider . . .

(2) After confirming that the debt does exist . . . send follow-up notices . . . at 30, 60 and 90 day intervals, if the debt remains unpaid and undisputed;

(3) The Carrier may offset future Benefits payable . . . to a provider on behalf of the Member to satisfy a debt due under the FEHBP if the debt remains unpaid and undisputed for 120 days after the first notice . . .

(4) After applying the first three steps, refer cases when it is cost effective to do so to a collection attorney or a collection agency if the debt is not recovered; . . .

(5) Make prompt and diligent efforts to recover erroneous payments until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to pursue further collection efforts or it would be against equity and good conscience to continue collection efforts;

(6) Additional prompt and diligent effort is required for significant claim overpayments that exceed $10,000 per each claim. Examples of such efforts include copies of dated notices, offset attempt(s) made, certified letter communication(s), and third-party collection efforts to the extent required under (g)(4) above. The Carrier should maintain and provide to OPM upon request, documentation of those efforts."

The Plan had not recovered and/or returned $642,579 to the FEHBP for 163 FEP claim overpayments.

For contract year 2018 through September 30, 2022, there were 36,418 health benefit refunds, totaling $40,259,913, that potentially were returned to the FEHBP via the Plan's provider offset process (based on the Plan's universe file of provider offset refunds). From this universe, we selected and reviewed a judgmental sample of 50 provider offset refunds, totaling $7,175,151, to determine if the Plan timely returned these refunds to the FEHBP. Our sample consisted of the 10 highest dollar provider offset refunds from each year in the audit scope, which included offset refunds from $33,819 to $1,748,837. Provider offsets occur when the Plan reduces payments to participating providers or members for the purpose of recovering refunds related to previous claim overpayments. Due to exceptions identified during our initial review that were related to providers with terminated temporary identification numbers, we expanded our testing and selected an additional 202 provider offsets, totaling $342,027, to review. Our expanded review consisted of all claim overpayments where the provider offset refund requests were created against terminated temporary provider identification numbers.

Based on our review, we determined that the Plan did not perform adequate due diligence to recover and return 163 claim overpayments, totaling $642,579, to the FEHBP even though these overpayments were set up as provider offsets. Specifically, we determined the following:

- The Plan set up 160 provider offsets, totaling $354,972, to recover FEP claim overpayments from providers with terminated temporary identification numbers. We noted that these providers now have new active provider numbers for submitting claims. During our fieldwork phase, we asked if the Plan could move these provider offsets over to the new active provider identification numbers. After checking with the Plan's legal department, the Plan communicated to us that the provider offsets set up for these 160 claim overpayments could be moved to the new active provider numbers. As a result, we are questioning $354,972 because all prompt and diligent efforts were not previously made by the Plan to recover these 160 claim overpayments from the providers with terminated temporary provider identification numbers.

- For three claim overpayments, totaling $287,607, the Plan set up provider offsets but was not completely diligent with recovery efforts for these overpayments. These provider offsets have been outstanding for over three years, but the Plan did not refer these claim overpayments to a collection attorney or agency. For two of these provider offsets, the Plan could not provide support to demonstrate if follow-up refund request letters were mailed to the providers at 30-, 60- and 90-day

intervals as required by the contract. Since all of these provider offsets were over $10,000, the Plan should also have referred these claim overpayments to a collection attorney or agency if cost effective to do so, as well as mailed additional letters to the providers. Our understanding is that the Plan should take all reasonable steps to increase the chances of recovering FEP claim overpayments, especially significant overpayments of $10,000 or more.

In total, we determined that the Plan was not diligent in its efforts to recover 163 FEP claim overpayments, totaling $642,579 ($354,972 plus $287,607), to the FEHBP. Since these claim overpayments were over $10,000, the contract also requires additional prompt and diligent recovery efforts by the Plan. Although we recognize that the Plan set up provider offsets to recover these claim overpayments as well as supported that some refund request letters were mailed to the providers, we conclude that the Plan had not taken all required prompt and diligent efforts to recover these funds.

Recommendation 1

We recommend that the contracting officer require the Plan to recover and return $642,579 to the FEHBP for the questioned claim overpayments (currently set up as provider offsets). If these overpayments are determined to be uncollectible, then the contracting officer should require the Plan to provide adequate documentation demonstrating that all prompt and diligent efforts were made to recover these funds before writing them off, as required by the FEHBP contract.

Recommendation 2

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 claim overpayments are adequately pursued, monitored, recovered, and returned to the FEHBP, as required by Section 2.3(g) of Contract CS 1039. If the option is available and cost effective, the Plan should also refer cases to a collection attorney or agency if the debt is not recovered.

Association/Plan Response:

The Association and/or Plan agree with the recommendations. For the procedural recommendation, the Association will work with the Plan to provide documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that provider offsets are recovered and timely returned to the FEHBP. The Association will provide the supporting documentation for the corrective actions when responding to the final report.

The Association states, "The Plan would also like to address the following comments that the OIG included in the [draft] report:

In total, we determined that the Plan was not diligent in its efforts to recover 163 FEP claim overpayments, totaling $642,579 ($354,972 plus $287,607). Since these claim overpayments were over $10,000, the contract also requires additional prompt

and diligent efforts by the Plan. We do recognize that the Plan set up provider offsets to recover these claim overpayments as well as supported that some refund request letters were sent to the providers; however, we still conclude that overall, the Plan did not make a diligent effort to recover these funds.

The Plan does not agree with the above comments. The identified overpayments must be divided into components to fully address the OIG comments.

The first portion is $176,900 related to one overpayment to an active FEHBP member. The Plan disagrees with this portion of the finding. The Plan provided due diligence letters and support for setting this overpayment up for offset. The Plan will return any funds collected on this overpayment.

The second portion is related to $110,707 for two provider offsets. Provider offset 1 for $93,000 was completed when the Plan's process was to bill the Provider and set the overpayment up for offset in 45 days if the funds were not returned. At the time the Plan believed going directly to provider offsets satisfied the collection efforts mandated by FEP. The Plan continues to follow this process but also sends out letters to meet the current letter process for FEP. The Plan continues to disagree with this portion of the recommendation. For Provider offset 2 in the amount of $17,707 the Plan provided support for the due diligence letters but was unable to provide the actual letter. This overpayment was set up on auto recoupment. Plan also disagrees with this portion of the recommendation. Each of these Provider overpayments continue to be actively pursued using the auto recoupment process. Any funds recovered will be returned to the Program.

The last portion of the recommendation in the amount of $354,972 related to Providers originally paid under a temporary provider number. The due diligence process was documented for these overpayments and providers were set up for auto recoupment under the temporary provider number. For Providers which received a permanent provider number, the original overpayment has now been moved to this permanent number."

OIG Comments:

For the 160 provider offsets originally set up against terminated temporary identification numbers, the Plan should have made additional diligent efforts to recover these claim overpayments by setting up the provider offsets using the new active provider identification numbers. Since the Plan did not set up the provider offsets using the new active provider identification numbers during the audit scope, which would have resulted in a timelier provider offset process and thus significantly increased the chances of recovery for these claim overpayments, we can only conclude that the Plan had not made all prompt and diligent efforts to recover these 160 claim overpayments. For the remaining three provider offsets, Contract CS 1039, Part II, Section 2.3(g)(6) states that additional prompt and diligent efforts are required for significant claim overpayments that exceed $10,000. Since these three provider offsets were each more than $10,000 and the Plan did not make additional efforts to recover these claim overpayments, such as

referring these overpayments to a collection attorney or agency and/or mailing additional refund request letters, we can only conclude that the Plan had not made all prompt and diligent efforts to recover these three claim overpayments.

After we received the Association's draft report response, the FEP Director's Office confirmed on December 20, 2023, that the Association and Plan agree with the recommendations and questioned amounts for this audit finding. The Plan also provided a status update on January 2, 2024, stating that $50,015 of these questioned claim overpayments to date have been subsequently recovered and returned to the FEHBP.

B. ADMINISTRATIVE EXPENSES

1. Non-Recurring Costs $285,723

Our audit determined that the Plan overcharged the FEHBP $258,550 for non-recurring costs in contract year 2018 related to the CareFirst FEP Bridge project. As a result of this audit finding, the Plan subsequently returned $285,723 to the FEHBP, consisting of $258,550 for non-recurring project costs that were overcharged to the FEHBP and $27,173 for applicable lost investment income (LII) on these overcharges.

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."

FAR 52.232-17(a) states, "all amounts that become payable by the Contractor . . . shall bear simple interest from the date due . . . The interest rate shall be the interest rate established by the Secretary of the Treasury . . . 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., administrative expense overcharges . . . were already processed and returned to the FEHBP) prior to audit notification."

For contract year 2018, the Plan overcharged the FEHBP $258,550 for non-recurring project costs.

During our review of non-recurring costs, we noted that the Plan overcharged the FEHBP $258,550 for costs that were related to the CareFirst FEP Bridge project in contract year 2018. The Plan charged the FEHBP $8,773,737 for these CareFirst FEP Bridge project costs in contract year 2018. These costs were mostly related to migrating the Plan's local claims processing system to the CareFirst FEP Bridge. According to the Association's FEP Director's Office, the CareFirst FEP Bridge is a pre-processing claims system that prepares the claims for final adjudication in the FEP Operations Center.

Based on our review of the CareFirst FEP Bridge project costs, we determined that the Plan did not perform a manual adjustment for contract year 2018 to true-up the budgeted project costs charged to the FEHBP to the actual costs. Specifically, the Plan received monthly invoices that were based on budgeted amounts and then allocated and charged these costs to the FEHBP. The Plan subsequently received a final cost summary that was based on actual costs but did not perform the necessary true-up adjustment. This oversight by the Plan, as well as an allocation adjustment, resulted in overcharges of $258,550 to the FEHBP for the non-recurring CareFirst FEP Bridge project costs in contract year 2018. The Plan also self-disclosed these exceptions during our fieldwork phase after we requested an itemization of costs applicable to the CareFirst FEP Bridge project. For contract years 2017 and 2019 through 2021 in our audit scope, we verified that the Plan made the necessary true-up adjustments to charge the FEHBP for only actual costs.

In total, we are questioning $285,723 for this audit finding, consisting of $258,550 for non-recurring project costs that were overcharged to the FEHBP in contract year 2018 and $27,173 for applicable LII on these overcharges (as calculated by the Plan). We reviewed and accepted the Plan's LII calculation.

Recommendation 3

We recommend that the contracting officer disallow $258,550 for the non-recurring project costs that were overcharged to the FEHBP in contract year 2018. However, since we verified that the Plan subsequently returned $258,550 to the FEHBP for these questioned overcharges, no further action is required for this amount.

Recommendation 4

We recommend that the contracting officer require the Plan to return $27,173 to the FEHBP for the questioned LII calculated on the non-recurring project costs that were overcharged to the FEHBP. However, since we verified that the Plan subsequently returned $27,173 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. Blue Cross Blue Shield Association Dues $22,373

Our audit determined that the Plan overcharged the FEHBP $22,373 for Association dues in contract year 2021. Specifically, the Plan did not use the directly charged initiative factor to calculate the chargeable dues base before allocating costs to the FEP. As a result of this audit finding, the Plan subsequently returned $22,373 to the FEHBP, consisting of $21,794 for Association dues that were overcharged to the FEHBP and $579 for applicable LII on these 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.

FEP Memorandum Number 22-057 FYI, titled BCBSA Regular Member Plan Dues and Other Assessments: 2017 – 2022 (dated March 15, 2022) provides guidance to the BCBS plans with respect to charging the FEHBP for Association dues. This memorandum includes specific guidance related to the chargeability of Association initiatives to the FEHBP. Specifically, the memorandum states that most of these initiatives are not chargeable to the FEHBP and starting in contract year 2021, the BCBS plans are required to remove these costs by using a directly charged initiative factor (provided by the Association) to calculate the chargeable dues base before allocating costs to the FEP.

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."

To determine the reasonableness, allowability and allocability of the amounts charged to the FEHBP, we reviewed each year within the audit scope and recalculated the FEP's share of the Association dues. We used the Association dues invoices, the Plan's allocation support, the FEHBP contract, the Federal regulations, and the above cited memorandum to determine the amounts of Association dues that were chargeable to the FEHBP.

For contract year 2021, the Plan overcharged the FEHBP $21,794 for Association dues.

Based on our review, we determined that the Plan overcharged the FEHBP $21,794 for Association dues in contract year 2021. This exception occurred because the Plan inadvertently did not use the directly charged initiative factor to calculate the chargeable dues base before allocating costs to the FEP for contract year 2021. The Plan also disclosed this exception when responding to our Standard Information Request during the pre-audit phase.

In total, we are questioning $22,373 for this audit finding, consisting of $21,794 for Association dues that were overcharged to the FEHBP in contract year 2021 and $579 for applicable LII on these overcharges (as calculated by the Plan). We reviewed and accepted the Plan's LII calculation.

Recommendation 5

We recommend that the contracting officer disallow $21,794 for the Association dues that were overcharged to the FEHBP in contract year 2021. However, since we verified that the Plan subsequently returned $21,794 to the FEHBP for these questioned overcharges, no further action is required for this amount.

Recommendation 6

We recommend that the contracting officer require the Plan to return $579 to the FEHBP for the questioned LII calculated on the Association dues that were overcharged to the FEHBP. However, since we verified that the Plan subsequently returned $579 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.

C. STATUTORY RESERVE PAYMENTS

The audit disclosed no findings pertaining to statutory reserve payments. We concluded that the Plan calculated and charged statutory reserve payments to the FEHBP in accordance with Contract CS 1039 and applicable laws and regulations.

D. 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, except as noted in the audit finding for "Excess Funds in the Investment Account."

1. Excess Funds in the Investment Account $3,467

Our audit determined that the Plan held excess FEHBP funds of $3,467 in the dedicated FEP investment account as of September 30, 2022. As a result of this audit finding, the Plan subsequently returned $3,467 to the FEHBP for these questioned excess FEHBP funds. Since these questioned excess funds were maintained in the Plan's dedicated FEP investment account, LII is not applicable for this audit finding.

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."

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 within 60 days after receipt by the Carrier."

The Plan's dedicated FEP investment account generally includes FEP working capital funds, approved LOCA reimbursements, health benefit refunds and recoveries from providers and subscribers, interest income earned, and other cash identified as due to the FEP. Based on Contract CS 1039, all funds deposited into the FEP investment account, such as health benefit refunds and recoveries, interest income and excess working capital, should be returned to the FEHBP by adjusting the LOCA within 60 days after receipt by

the BCBS plan. In addition, approved reimbursements from the LOCA that are deposited into the Plan's FEP investment account should be timely transferred from the FEP investment account to the Plan's corporate account.

The Plan held excess FEHBP funds of $3,467 in the dedicated FEP investment account as of September 30, 2022.

In our Standard Information Request (dated October 3, 2022), we requested the Plan to provide a reconciliation and detailed itemization of the funds in the Plan's dedicated FEP investment account as of September 30, 2022. When reviewing the Plan's FEP investment account reconciliation and supporting documentation, we noted an exception. Specifically, we determined that the Plan held excess FEHBP funds of $3,467 in the Plan's FEP investment account as of September 30, 2022. The Plan should have held a balance of $2,500,936 in the FEP investment account; however, the Plan's actual account balance totaled $2,504,403. According to the Plan, these excess funds were caused by previous banking changes that occurred in contract year 2021. As a result, we are questioning $3,467 in excess FEHBP funds that were held in the Plan's dedicated FEP investment account as of September 30, 2022. Because these excess funds were held in the Plan's dedicated FEP investment account, LII is not applicable on these questioned excess funds.

Recommendation 7

We recommend that the contracting officer require the Plan to return $3,467 to the FEHBP for the questioned excess FEHBP funds that were held in the Plan's dedicated FEP investment account as of September 30, 2022. However, since we verified that the Plan subsequently returned $3,467 to the FEHBP for these questioned excess funds, no further action is required for this amount.

Association/Plan Response:

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

E. FRAUD AND ABUSE PROGRAM

1. Special Investigations Unit — Procedural

In one instance, the Association and Plan did not timely report a fraud and abuse case to the OPM OIG.

In one instance, the Association 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 Association and Plan did not timely report a fraud and abuse case to the OPM OIG. Without awareness of existing potential fraud and abuse issues, the OPM OIG cannot timely investigate the broader impact of these potential issues on the FEHBP as a whole.

FEHBP Carrier Letter 2017-13 (OPM Federal Employees Health Benefits 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 Association's FEP Director's Office (FEPDO) is primarily responsible for timely reporting fraud and abuse cases to the OPM OIG (i.e., within 30 working days of becoming aware of a fraud, waste, or abuse issue). In order to comply with the timeliness requirement, the FEPDO requires the BCBS plans to enter fraud and abuse cases into the Association's FEP Special Investigations Unit Tracking System (FSTS).[4] The FEPDO is responsible for the maintenance and oversight of this system as well as reporting to the OPM 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 cases are timely reported to the OPM OIG.

From January 1, 2022, through September 30, 2022, the Plan opened 77 fraud and abuse cases with potential FEP exposure. From this universe, we selected and reviewed all of these cases and determined if the Plan timely entered these fraud and abuse cases into the Association's FSTS and if the FEPDO and Plan timely reported these cases to the OPM OIG. We noted that only three of these cases had affirmative step dates that required the 30-day reporting to the OPM OIG. Based on our review, we identified no exceptions with the Plan timely entering fraud and abuse cases into the Association's FSTS; however, we noted that the FEPDO and Plan did not timely report one of the three cases with an affirmative step date to the OPM OIG.

Ultimately, the FEPDO and Plan's untimely reporting of this potential FEHBP case to the OPM OIG has resulted in non-compliance with the communication and reporting requirements that are set forth in Carrier Letter 2017-13. The lack of notification by the FEPDO and Plan did not allow the OPM OIG to timely investigate if other FEHBP health care Carriers were exposed to the identified fraudulent activity. As a result, this lack of OPM OIG notification by the FEPDO and Plan may result in additional improper payments being made by other FEHBP health care Carriers. This also does not allow the OPM OIG's Administrative Sanctions Group to be notified in a timely manner.

[4] 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.

Recommendation 8

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 the communication and reporting requirements of fraud and abuse cases that are contained in FEHBP Carrier Letter 2017-13.

Association/Plan Response:

The Association and/or Plan agree with the finding and recommendation. The Association states, "The Plan's process has been updated to ensure that once a case is identified as Fraud and it has FEP dollars at risk, the Plan will update FSTS within 20 dates [days] of that date. This will give the Association FEP SIU 10 days to make its referral to the OPM SIU within the 30 days allotted."

IV. SCHEDULE A – QUESTIONED CHARGES

BLUE CROSS BLUE SHIELD OF NORTH CAROLINA
DURHAM, NORTH CAROLINA

QUESTIONED CHARGES

AUDIT FINDINGS	2017	2018	2019	2020	2021	2022	2023	TOTAL
A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS								
1. Health Benefit Refunds - Provider Offsets	$0	$93,000	$194,607	$21,037	$288,260	$45,676	$0	$642,579
TOTAL MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS	$0	$93,000	$194,607	$21,037	$288,260	$45,676	$0	$642,579
B. ADMINISTRATIVE EXPENSES								
1. Non-Recurring Costs*	$0	$258,550	$8,069	$4,206	$2,588	$7,297	$5,013	$285,723
2. Blue Cross Blue Shield Association Dues*	0	0	0	0	21,794	579	0	22,373
TOTAL ADMINISTRATIVE EXPENSES	$0	$258,550	$8,069	$4,206	$24,382	$7,876	$5,013	$308,096
C. STATUTORY RESERVE PAYMENTS								
TOTAL STATUTORY RESERVE PAYMENTS	$0	$0	$0	$0	$0	$0	$0	$0
D. CASH MANAGEMENT								
1. Excess Funds in the Investment Account	$0	$0	$0	$0	$0	$3,467	$0	$3,467
TOTAL CASH MANAGEMENT	$0	$0	$0	$0	$0	$3,467	$0	$3,467
E. FRAUD AND ABUSE PROGRAM								
1. Special Investigations Unit	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL FRAUD AND ABUSE PROGRAM	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL QUESTIONED CHARGES	$0	$351,550	$202,676	$25,243	$312,642	$57,019	$5,013	$954,142

* We included lost investment income (LII) within audit findings B1 ($27,173) and B2 ($579). Therefore, no additional LII is applicable.

APPENDIX

BlueCross BlueShield
Federal Employee Program

750 9th St. NW.
Washington, D.C.
20001
www.BCBS.com

November 30, 2023

John A. Hirschmann
Group Chief, Experience Rated Audits Group
Office of the Inspector General
U.S. Office of Personnel Management
1900 E. Street, Room 6400
Washington, DC 20415-11000

Reference: OPM Draft AUDIT REPORT
Blue Cross Blue Shield of North Carolina
Audit Report Number 2023-ERAG-005

Dear Mr. Hirschmann:

This is the Blue Cross Blue Shield of North Carolina's response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Federal Employees Health Benefits Program (FEHBP). Our comments concerning the findings in the report are as follow:

A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

1. Health Benefit Refunds – Provider Offsets $642,579

Recommendation 1

We recommend that the contracting officer require the Plan to recover and return $642,579 to the FEHBP for the Questioned Claim overpayments (currently set up as provider offsets). If these overpayments are determined to be uncollectible, then the contracting office should require the Plan to provide adequate documentation demonstrating that prompt and diligent efforts were made to recover these funds before writing them off, as required by the FEHBP contract.

Plan Response

The Plan agreed with this recommendation and will return any funds received to the Program or provide documentation to support due diligence if the claims are determined to be uncollectible once the Final Report is issued.

The Plan would also like to address the following comments that the OIG included in the report:

In total, we determined that the Plan was not diligent in its efforts to recover 163 FEP claim overpayments, totaling $642,579 ($354,972 plus $287,607). Since these claim overpayments were over $10,000, the contract also requires additional prompt and diligent efforts by the Plan. We do recognize that the Plan set up provider offsets to recover these claim overpayments as well as supported that some refund request letters were sent to the providers; however, we still conclude that overall, the Plan did not make a diligent effort to recover these funds.

The Plan does not agree with the above comments. The identified overpayments must be divided into components to fully address the OIG comments.

The first portion is $176,900 related to one overpayment to an active FEHBP member. The Plan disagrees with this portion of the finding. The Plan provided due diligence letters and support for setting this overpayment up for offset. The Plan will return any funds collected on this overpayment.

The second portion is related to $110,707 for two provider offsets. Provider offset 1 for $93,000 was completed when the Plan's process was to bill the Provider and set the overpayment up for offset in 45 days if the funds were not returned. At the time the Plan believed going directly to provider offsets satisfied the collection efforts mandated by FEP. The Plan continues to follow this process but also sends out letters to meet the current letter process for FEP. The Plan continues to disagree with this portion of the recommendation. For Provider offset 2 in the amount of $17,707 the Plan provided support for the due diligence letters but was unable to provide the actual letter. This overpayment was set up on auto recoupment. Plan also disagrees with this portion of the recommendation. Each of these Provider overpayments continue to be actively pursued using the auto recoupment process. Any funds recovered will be returned to the Program.

The last portion of the recommendation in the amount of $354,972 related to Providers originally paid under a temporary provider number. The due diligence process was documented for these overpayments and providers were set up for auto recoupment under the temporary provider number. For Providers which received a permanent provider number, the original overpayment has now been moved to this permanent number.

Recommendation 2

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 claim overpayments are adequately pursued, monitored, recovered, and returned to the FEHBP, as required by Section 2.3(g) of Contract CS 1039. If the option is available and cost effective, the Plan should also refer cases to a collection agency if the debt is not recovered.

Plan Response

The Plan agreed to this recommendation.

Association Response

The Association will work with the Plan to provide evidence and supporting documentation to demonstrate that the Plan has implemented the necessary corrective actions to ensure Provider offsets are recovered and returned to the FEHBP timely. BCBSA will provide the supporting documentation with the response to the Final Report.

B. ADMINISTRATIVE EXPENSES

1. Non-Recurring Costs $285,723

Recommendation 3

We recommend that the contracting officer disallow $258,550 for the non-recurring project costs that were overcharged to the FEHBP in contract year 2018. However, since we verified that the Plan subsequently returned $258,550 to the FEHBP for these questioned overcharges, no further action is required for this amount.

Plan Response

The Plan agreed with this recommendation and as stated, no additional action is necessary.

Recommendation 4

We recommend that the contracting officer require the Plan to return $27,173 to the FEHBP for the questioned LII calculated on the non-recurring project costs that were overcharged to the FEHBP in contract year 2018. However, since we verified that the Plan subsequently returned $27,173 to the FEHBP for the questioned LII, no further action is required for this LII amount.

Plan Response

The Plan agreed with this recommendation and as stated, no additional action is necessary.

2. Blue Cross Blue Shield Association Dues $22,373

Recommendation 5

We recommend that the contracting officer disallow $21,794 for the Association dues that were overcharged to the FEHBP in contract year 2021. However, since we verified that the Plan subsequently returned $21,794 to the FEHBP for these questioned overcharges, no further action is required for this amount.

Plan Response

The Plan agreed with this recommendation and as stated, no additional action is necessary.

Recommendation 6

We recommend that the contracting officer require the Plan to return $579 to the FEHBP for the questioned LII calculated on the Association dues that were overcharged to the FEHBP in contract year 2021. However, since we verified that the Plan subsequently returned $579 to the FEHBP for the questioned LII, no further action is required for this LII amount.

Plan Response

The Plan agreed with this recommendation and as stated, no additional action is necessary.

C. CASH MANAGEMENT

1. Excess Funds in the FEP Investment Account $3,467

Recommendation 7

We recommend that the contracting officer require the Plan to return $3,467 to the FEHBP for the questioned excess FEHBP funds that were held in the Plan's dedicated FEP investment account as of September 30, 2022. However, since we verified that the Plan returned $3,467 to the FEHBP for these questioned excess FEHBP funds, no further action is required for this amount.

Plan Response

The Plan agreed with this recommendation and as stated, no additional action is necessary.

D. FRAUD AND ABUSE PROGRAM

1. Special Investigations Unit Procedural

Recommendation 8

We recommend that the contracting officer require the Association to provide evidence or supporting documentation demonstrating that the Plan implemented the necessary corrective actions to meet the communication and reporting requirements of fraud and abuse cases contained in FEHBP Carrier Letter 2017-13.

Plan Response

The Plan agreed with this recommendation. The Plan's process has been updated to ensure that once a case is identified as Fraud and it has FEP dollars at risk, the Plan will update FSTS within 20 dates of that date. This will give the Association FEP SIU 10 days to make its referral to the OPM SIU within the 30 days allotted.

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,

[redacted]
Managing Director, FEP Program Assurance

cc:

[redacted], Director, Program Assurance
[redacted], Manager, Program Assurance

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