

*Office of the Inspector General*

*April 1, 2001 — September 30, 2001*



# Semiannual Report

TO CONGRESS



*United States Office of Personnel Management*

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OFFICE OF  
THE INSPECTOR GENERAL

UNITED STATES  
OFFICE OF PERSONNEL MANAGEMENT  
WASHINGTON, D.C. 20415-0001

*October 31, 2001*

*Honorable Kay Coles James  
Director  
U.S. Office of Personnel Management  
Washington, D.C. 20415*

*Dear Mrs. James:*

*I respectfully submit the Office of the Inspector General's Semiannual Report to Congress for the period April 1, 2001 to September 30, 2001. This report describes our office's activities during the past six-month reporting period.*

*Should you have any questions about the report or any other matter of concern, please do not hesitate to call upon me for assistance.*

*Sincerely,*

  
*Patrick E. McFarland*  
Patrick E. McFarland  
Inspector General

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## Message from the IG

During this reporting period, the U.S. Office of Personnel Management (OPM) won an important victory in the courts that will have a significant impact on the Federal Employees Health Benefits Program (FEHBP) in the years to come. On September 24, 2001, the United States Court of Appeals for the Federal Circuit, in *Qualmed Plans for Health of New Mexico, Inc. v. United States*, supported the ability of my office to identify, and OPM's right to collect, interest the FEHBP loses when a health insurance carrier overcharges the program through its premium rates.

The Court of Appeals decision will allow OPM to continue collecting millions of dollars of interest due the FEHBP. Since the interest will be paid directly back to the FEHBP trust fund, this will help offset any future increases in FEHBP premium rates.

Specifically, this ruling by the U.S. Court of Appeals for the Federal Circuit reverses a U.S. Court of Federal Claims decision that took away our agency's right to collect lost investment income on certain defective pricing audit findings involving rate overcharges to the FEHBP in 1991 and 1992. Our auditors identified these overcharges after discovering that Qualmed, in developing the FEHBP's premium rates, had made a mistake in selecting the two subscriber groups used to determine if the FEHBP's rates were equitable and reasonable.

After selecting the appropriate groups and recalculating the FEHBP's rates, we found that Qualmed had overcharged the FEHBP. Qualmed did not deny the overcharge and reached agreement with OPM on the overcharge amount. The plan paid that amount within 30 days, notwithstanding the lost investment income still due. The issue over lost investment income owed to the FEHBP remained unresolved.

Qualmed contended that no interest was due and filed a complaint with the U.S. Court of Federal Claims. Qualmed argued that simply not selecting a subscriber group closest in subscriber size to the FEHBP did not represent defective pricing and, therefore, any interest on the overcharge was due only from the date that it was notified of the overcharge and then only if the amount was not paid within 30 days.

The U.S. Department of Justice, with the assistance of OPM's Office of General Counsel, argued that Qualmed had engaged in defective pricing and that the FEHBP contract and applicable regulations provide for interest from the date of the overcharge. With this decision, the court voiced strong disagreement with the

lower court's position, ruling that the selection of inappropriate groups did, in fact, represent defective pricing and that Qualmed must pay OPM interest from the date of the FEHBP overcharges.

If the court had ruled against OPM, the decision would have had a decidedly negative impact on the FEHBP. First, OPM would not have been able to collect interest amounting to more than \$28 million, owed not only by Qualmed but by numerous other plans which also had refused to pay any lost investment income while the court case was pending. Second, future overcharges resulting from the selection of improper subscriber groups would no longer be subject to lost investment income charges. The FEHBP would lose millions of dollars as a consequence, because my office would no longer be in a position to recommend an interest assessment on overcharges in these cases.

We cannot overstate how potentially critical this ruling is for the FEHBP since such a large portion of the overcharges we identify in our audits result from plans selecting inappropriate subscriber groups.

I believe it is entirely appropriate for plans to pay interest when they overcharge the FEHBP, particularly since the FEHBP is losing money by not having the funds available to it. Furthermore, the FEHBP and its subscribers are able to realize a specific benefit when lost investment income is returned to the FEHBP trust fund: the return of this money will have a positive impact on future premium rates. I am hopeful that the decision the court made in this case will end any question that plans may have concerning OPM's right to collect lost investment income in the future.

**I**would like to offer a special thanks to OPM's Retirement and Insurance Service and Office of General Counsel for their diligence and determination in bringing this case to a successful conclusion. Without their efforts to protect the FEHBP and its subscribers, the FEHBP would have continued to be financially harmed indefinitely by these insurance carriers' actions. Now, the government, our agency, and FEHBP subscribers alike will benefit for years to come.

## Productivity Indicators

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### Financial Impact:

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<b>Audit Recommendations for</b>	
Recovery of Funds .....	\$65,309,332
<b>Recoveries Through</b>	
Investigative Actions .....	\$1,483,547
<b>Management Commitments to</b>	
Recover Funds .....	\$174,242,861*

*\* Note: OPM management commitments for recovery of funds during this reporting period reflect amounts covering current and past reporting period audit recommendations.*

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### Accomplishments:

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<b>Audit Reports Issued .....</b>	<b>60</b>
<b>Investigative Cases Closed .....</b>	<b>17</b>
<b>Cases Accepted for Prosecution .....</b>	<b>17</b>
<b>Indictments .....</b>	<b>16</b>
<b>Convictions .....</b>	<b>12</b>
<b>Hotline Contacts and Complaint Activity .....</b>	<b>483</b>
<b>Health Care Provider Debarments and Suspensions .....</b>	<b>1,918</b>

## Statutory and Regulatory Review

*As is required under section 4 (a) (2) of the Inspector General Act of 1978, as amended, (IG Act) our office monitors and reviews legislative and regulatory proposals for their impact on the Office of the Inspector General (OIG) and the Office of Personnel Management (OPM) programs and operations. Specifically, we perform this activity to evaluate their potential for encouraging economy and efficiency and preventing fraud, waste and mismanagement. We also monitor legal issues that have a broad effect on the Inspector General community and present testimony and other communications to Congress as appropriate.*

Our oversight of legislative and regulatory issues affecting our office and the Inspector General community continued to be one of our highest operational priorities during this reporting period. One area of particular and long-standing concern is the need for permanent law enforcement authority for OIG investigators. As we indicated in detail in our last semiannual report, we are committed to bringing about the statutory changes necessary for the efficient operation of the law enforcement responsibilities of the OIGs.

Another concern that we have addressed frequently in our semiannual reports is providing an appropriate statutory basis for health care anti-fraud efforts within the Federal Employees Health Benefits Program (FEHBP). For some time, we believed that extending the FEHBP certain provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) would resolve the shortcomings in our legal authorities. However, a recent and careful reanalysis of this issue now leads us to believe that a more selective approach may be preferable.

The multiple terrorist attacks on America have caused us—as they have all parts of the federal government and, indeed, all Americans—to reconsider the ways that we can contribute to the overriding national priority of ensuring the safety of our democracy and all its citizens.

It is clear that the Inspector General community can serve an important role through its cooperative actions with other law enforcement agencies.

These issues, as well as our health care administrative sanctions activities, are discussed in the articles which follow in this section.

### Legislative and Regulatory Review

#### OIG Support for Terrorist Investigations

The FBI has always been one of the lead agencies in protecting Americans from terrorist acts. Beginning with the tragic events of September 11 and the subsequent bioterrorism episodes, this has become its number one priority.

As has been widely reported in the news media, the FBI has been conducting investigations to identify all those who may have been involved in these terrorists act, to unravel the complexities of their support structure, and to take all actions necessary to deter future acts that could undermine the integrity of our way of life.

The Federal Aviation Administration (FAA) is also contributing significantly



**I** **G Community Assists in Federal Anti-Terrorist Activities**

to revitalizing America’s sense of safety and security. Its federal sky marshal program protects airline employees and passengers by having armed federal law enforcement officers on many commercial flights.

Both the FBI and the FAA need additional trained law enforcement personnel to assist them in their tasks. The IG community, with over 2,600 well-trained special agents, has such personnel. Our OIG, as well as others, has already made many of its agents available to the FBI and FAA for roles directly related to America’s response to terrorism.

A number of IG community law enforcement personnel have been assigned on a rotating basis to assist in ongoing investigations and to act as sky marshals. IG auditors with financial expertise also have been made available to the FBI to help follow the terrorists’ various money trails.

As a direct result of these efforts, the IG community has become aware of statutory issues concerning the IG Act and appropriation law that limit our flexibility to make personnel available quickly to assist in emergency situations. As a consequence, we are considering statutory and regulatory options to allow the IG community to respond more readily when called upon in the future. We expect to discuss those options in more detail in a future semiannual report.

**Health Care Fraud Authority for OPM**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) substantially expanded the system of enforcement tools and sanctions authorities available for use against health care provider fraud in Medicare and other federal health programs. Specific statutory language in HIPAA excluded the FEHBP from coverage by these provisions.

For nearly five years after passage of HIPAA, we deemed legislation to remove this exclusion to be an urgent priority on the basis that OPM was seriously disadvantaged, vis-a-vis other agencies, in its anti-fraud activities. However, a thorough reexamination of recent cases has led us to question the premise that making HIPAA applicable to FEHBP would be advantageous, or even necessary, as a means to improve health care provider integrity.

Our belief that FEHBP must be included in the HIPAA provisions has changed because of the enactment of the Federal Employees Health Care Protection Act of 1998. We now have a better understanding of how the anti-kickback provisions of HIPAA may affect the FEHBP.

During the past two years, we have been drafting regulations to implement the Federal Employees Health Care Protection Act of 1998, which contains administrative sanctions provisions, including debarment, suspension and civil monetary penalties, designed specifically to safeguard the FEHBP and its enrollees from untrustworthy health care providers. We believe this statute as implemented by the proposed regulations will deter FEHBP health care fraud in a manner similar to many of the HIPAA provisions. *(A fuller discussion of the status of the proposed regulations can be found in the Administrative Sanctions Activities article which immediately follows.)*

In addition, it is possible that applying HIPAA’s anti-kickback provisions, which are tied to Medicare’s system of payment limitations, could adversely affect the FEHBP’s operation as a market-based provider of health coverage.

We plan to work closely with OPM’s Retirement and Insurance Service to develop proposals that may include a

**O** **IG & Agency Developing New Health Care Anti-Fraud Strategy**

mix of administrative, regulatory and legislative action to ensure that the FEHBP has the best possible protection against health care provider fraud.

## Administrative Sanctions Activities

*Common rule debarments.* Our OIG currently participates in a government-wide regulatory mechanism known as the nonprocurement debarment and suspension common rule (common rule) and which provides an efficient but limited debarment authority.

The common rule permits debarment actions taken by any federal agency to be applied within all other federal programs. We use the common rule to debar from participation in the Federal Employees Health Benefits Program those health care providers previously debarred by the Department of Health and Human Services from participating in the Medicare program.

A *debarment* is an administrative action that disqualifies a health care provider from receiving FEHBP funds. A *suspension* has the same effect as a debarment, but is taken on an immediate basis without prior procedures, because the provider represents either a risk to the health and safety of FEHBP enrollees or to the integrity of the FEHBP.

During this reporting period, our office issued 1,915 debarments and three suspensions of health care providers from the FEHBP. This total represents the second highest number of debarments by our OIG during any semiannual reporting period, exceeded only by the 2,031 issued during the previous six months. The full fiscal year total of 3,946 debarments is substantially larger than for any prior twelve-month period.

*Debarment-related inquiries.* The rapid growth of our OIG's debarment workload has generated a corresponding increase in inquiries associated with debarments from FEHBP carriers, debarred providers, and other federal agencies and departments.

These inquiries come mostly in the form of letters, telephone calls and Internet communications. We refer to these corollary activities as our *inquiry workload*. These inquiries demonstrate the broad impact of debarments within the FEHBP, as well as the efforts required by agencies issuing common rule debarments to help make them effective on a government-wide basis.

During the current reporting period, we responded to 1,181 debarment-related inquiries, divided in approximately equal numbers between FEHBP-related and government-wide sources as described below.

*FEHBP-related inquiries.* Within the FEHBP, the insurance carriers that contract with OPM to provide health coverage to federal enrollees, their spouses and dependents bear the immediate responsibility to enforce debarment orders issued through our office in accordance with guidelines we have furnished to them. The carriers contact us frequently regarding implementing these guidelines and for specific information concerning the procedural requirements for denying payment of FEHBP funds to debarred health care providers.

The debarred providers themselves also cause an equally active and complex inquiry workload, consisting of administrative appeals of debarments under the common rule and requests for stays of debarment and reinstatement into the FEHBP.

A further, although somewhat smaller, inquiry workload relates to FEHBP

**OIG  
Debarment-  
Related  
Workload  
Increases  
Dramatically**

**P**roposed  
Administrative  
Sanctions  
Regulations  
Resubmitted  
to OMB

enrollees who have previously received services from debarred providers and are seeking waivers to permit them to continue receiving treatment from those providers, notwithstanding the debarment.

*Government-wide inquiries.* The debarment common rule is designed to be truly government-wide in its applicability. Thus, the health care providers whom we debar may in turn be debarred from participating in any federal program, whether it is health care-related or not. For example, debarred providers may also be ineligible to receive federally sponsored or guaranteed mortgage or education loans, to contract with federal agencies or to serve as an employee of a federal contractor.

Implementing the government-wide aspect of common rule debarments necessarily involves extensive coordination among agencies. In fact, approximately half our inquiries workload stems collectively from other federal agencies and private-sector firms who contract with federal agencies to carry out federal program requirements. For example, the latter would include financial institutions processing applications for federally insured loans.

These debarment inquiries include: (1) seeking additional information on debarments that these agencies intend to apply to their own programs; and (2) verifying our debarments before disqualifying persons from participating in their respective programs.

*Debarment and suspension regulations.* Our proposed regulations to implement the debarment and suspension provisions of the Federal Employees Health Care Protection Act of 1998 were forwarded for clearance by the Office of Management and Budget (OMB) in August 2000. Under the blanket withdrawal of pending regulatory actions directed by the Bush administration, these regulations were returned to OPM for review and for a decision to resubmit them by the agency's new policy leadership.

The new OPM management team has indicated its strong and continuing support for these regulations to become part of the overall health care anti-fraud effort. The broad importance of these regulations, and of the underlying sanctions provisions of the Federal Employees Health Care Protection Act of 1998, are also noted in the preceding article regarding our office's overall health care fraud plans.

With the Senate confirmation of OPM Director Kay Coles James in July 2001, we have been able once again to initiate the formal agency clearance process. We are extremely appreciative that Director James approved the sanctions regulatory package in August 2001 and subsequently resubmitted it to OMB.

At this time, these proposed regulations are still pending OMB approval for publication in the *Federal Register*.

# Audit Activities

## Health and Life Insurance Carrier Audits

*The Office of Personnel Management (OPM) contracts with private-sector firms to underwrite and provide health and life insurance benefits to civilian federal employees, annuitants, and their dependents and survivors through the Federal Employees Health Benefits Program (FEHBP) and the Federal Employees' Group Life Insurance program (FEGLI). Our office is responsible for auditing these benefits program activities to ensure that these various insurance entities meet their contractual obligations with our agency.*

Our audit universe contains approximately 320 audit sites, consisting of health insurance carriers, sponsors, and underwriting organizations, as well as two life insurance carriers. The number of audit sites are subject to yearly fluctuations due primarily to contracts not being renewed or because of plan mergers and acquisitions. Annual premium payments are in excess of \$19 billion for this contract year.

The health insurance plans that our office is responsible for auditing are divided into two categories: *community-rated* and *experience-rated*. Within the first category are comprehensive medical plans, commonly referred to as health maintenance organizations (HMOs). The second category consists of mostly fee-for-service plans, with the most popular among these being the various Blue Cross and Blue Shield health plans.

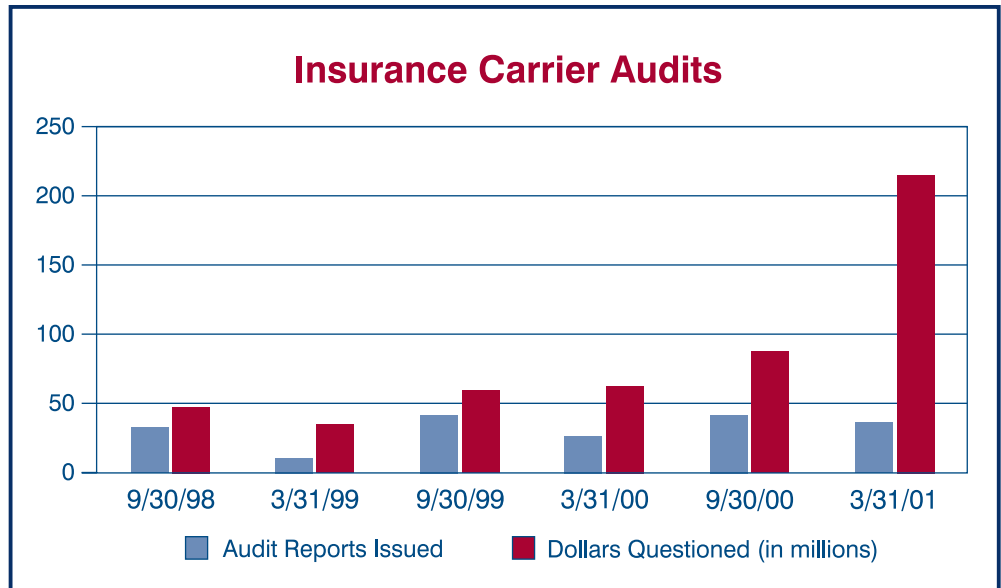
The critical difference between the categories stems from how premium rates are calculated for each. A community-rated carrier generally sets its subscription rates based on the average revenue needed to provide health benefits to each member of a group, whether that group is from the private or public sector. Rates established by an experience-rated plan reflect a given group's projected paid claims, administrative expenses and ser-

vice charges for administering a specific group's contract. With respect to the FEHBP, each experience-rated carrier must maintain a separate account for its federal contract, adjusting future premiums to reflect the FEHBP group enrollees' actual past use of benefits.

During the current reporting period, we issued 45 final reports on organizations participating in the FEHBP, 24 of which contain recommendations for monetary adjustment in the aggregate amount of \$65.3 million due the FEHBP. Of the 45 reports issued, 21 audits were HMO rate reconciliation audits (RRAs), with findings amounting to \$2.5 million. See pages 10-11 for a more in-depth discussion of RRAs.

The OIG issued 191 reports and questioned \$507.6 million in inappropriate charges to the FEHBP during the previous six semiannual reporting periods. We believe it is important to note the dollar significance resulting from our audits of FEHBP carriers and the monetary implications for the FEHBP trust fund. These audit results are reflected in the graph on the following page.

A complete listing of all health plan audit reports issued during this reporting period can be found in Appendices III-A and III-B on pages 42-45, and Appendix V on page 46.



The graph above is even more significant in view of the September 24, 2001 decision of the U.S. Court of Appeals for the Federal Circuit concerning monies due the FEHBP from certain HMOs for lost investment income we questioned.

Specifically, this decision validates our OIG’s audit findings concerning the collection of FEHBP lost investment income on certain HMO premium rate overcharges that have occurred since contract year 1991. Ultimately, this will ensure additional monetary recoveries in the millions from these and other HMOs in our audit universe. This court decision and its impact on the FEHBP are discussed in more detail in the *Message from the IG* appearing at the beginning of this report.

The sections that immediately follow provide additional details concerning the two categories of health plans described on the prior page, along with audit summaries of significant final reports we issued within each during the past six months.

### Community-Rated Plans

Our community-rated HMO audit universe includes approximately 220 rating areas. Audits of these plans are designed to ensure that the plans assess the appropriate premium rates in accordance with their respective FEHBP contracts and applicable federal regulations.

With few exceptions, these rates derive from two predominant rating methodologies. The key rating factors for the first methodology (*community rating by class*) are the age and sex distribution of a group’s enrollees. In contrast, the second methodology (*adjusted community rating*) is based on the projected use of benefits by a group using actual claims experience from a prior period of time adjusted for increases in medical cost. However, once a rate is set, it may not be adjusted to actual costs incurred.

The inability to adjust to actual costs, including administrative expenses, distinguishes community-rated plans from experience-rated plans. The latter in-

clude experience-rated HMOs and fee-for-service plans.

For the period 1991 through 1994, the applicable regulations for HMOs required that subscription rates charged to the FEHBP be equivalent to the rates charged the two subscriber groups closest in size (*actual number of enrollees*) to the FEHBP and whose respective contracts contained similar benefits.

In 1995, the provision requiring similar benefits was eliminated. Under these revised regulations, each carrier must certify that the FEHBP is being offered rates equivalent to the rates given to the two groups closest in enrollment size to the FEHBP. It does this by submitting to OPM a certificate of accurate pricing. These rates are determined by the FEHBP-participating carrier, which is responsible for selecting the appropriate groups. Should our auditors determine that equivalent rates were not applied to the FEHBP, a condition of defective pricing exists. The FEHBP is entitled to a downward rate adjustment to compensate for any overcharges resulting from this practice.

We issued 36 audit reports on community-rated plans during this reporting period. These reports contain recommendations for OPM's contracting officer to require the plans to return over \$61.4 million to the FEHBP. Fifteen of these reports resulted from traditional HMO audits, ten of which contained findings of \$58.9 million. The remaining 21 audits are HMO rate reconciliation audits (RRAs), with findings amounting to \$2.5 million. We have provided on the following pages a summary of two traditional HMO audits, along with a discussion of the results of our RRA audits.

## ***Kaiser Foundation Health Plan, Inc. (California Division)***

**in Pasadena, California**

Report No. 62-00-98-052  
May 8, 2001

Kaiser Foundation Health Plan, Inc. (California Division) has participated in the FEHBP as a community-rated comprehensive medical plan since 1960. This particular plan provides primary health care services to its members throughout the state of California. The audit covered contract years 1993 through 1998 for the Kaiser plan's Southern California region (Southern region) and 1998 for its Northern California region (Northern region). The Southern region received approximately \$1.4 billion in FEHBP premiums from 1993 through 1998. The Northern region received about \$262.5 million in 1998.

Through this audit, we identified \$30,755,852 in questioned costs, including \$23,212,726 for improper health benefit charges and \$7,543,126 for lost investment income. Improper health benefit charges amounted to \$15,961,891 for the Southern region and \$7,250,835 for the Northern region. The lost investment income amount represents the interest the FEHBP would have earned on money the plan overcharged the FEHBP.

### **Premium Rates**

A key objective of the audit was to determine if Kaiser had met its contract requirement to offer the FEHBP the same premium rate discounts it offered to

**I** nappropriate  
Costs to  
FEHBP Total  
Over \$23 Million

two other groups comparable in subscriber size to the FEHBP. Another was to determine if specific health benefit premium charges that were not part of the plan's basic benefits package were fair and reasonable to the FEHBP. These particular charges are known as *loadings*. We also looked at whether the rates were in compliance with the laws and regulations governing the FEHBP. The audit findings discussed in the report are summarized below.

*Southern region.* Our review of the 1993 rates for this region showed that the outpatient copayment amount increased for the FEHBP and for one of the two subscriber groups closest to it in size. Usually, when a copayment is increased, subscribers do not use their benefits as often, thereby lowering claims costs to their plans. In this case, the plan lowered the rates of the subscriber group closest in size to the FEHBP in recognition of the copayment increase, but not for the FEHBP. By federal regulation, the FEHBP must be rated consistently with its comparable subscriber group. To correct this inequity, we adjusted the FEHBP's rates to account for the copayment increase.

We also determined that the plan overstated its FEHBP Medicare loading, which, in turn, inflated the FEHBP's premium rates. A Medicare loading (a benefit cost increase) represents additional costs a plan incurs to cover individuals age 65 and older. To address this rating discrepancy, we lowered the FEHBP's Medicare benefit charge. Taking the above two adjustments into account, we determined that the FEHBP was overcharged \$3,554,782 in 1993.

In 1994, Kaiser inexplicably gave a benefit adjustment to one of the two groups closest in size to the FEHBP when there had been no benefit changes for that contract year. Since the rating documen-

tation contained no explanation for this adjustment, we assumed it reflected benefit changes for contract years 1992 to 1993. Consequently, we developed an adjustment factor for the FEHBP based on the change in benefits for contract years 1992 to 1993 and applied it to the FEHBP's rates for 1994. Kaiser also overstated the FEHBP Medicare loading.

After adjusting the FEHBP rates by applying the benefit adjustment factor and reducing the Medicare loading charge, the final corrective measure we took was to apply a discount that the plan gave to one of the groups closest in enrollment size to the FEHBP in 1994. Our calculations revealed that Kaiser overcharged the FEHBP \$5,958,812 for contract year 1994.

In 1995, Kaiser changed the way it calculated the additional contract costs associated with those FEHBP members age 65 and older. The plan opted to use a different methodology. Instead of adding a Medicare benefit charge to the premium rates, the plan opted to employ a per-member per-month revenue requirement for Medicare-eligible members.

In using this approach, Kaiser understated the amount of revenue it received from the Centers for Medicare and Medicaid Services (CMS), which is responsible for administering the Medicare program within the Department of Health and Human Services. Until earlier this year, this agency was known as the Health Care Financing Administration. By understating the revenue Kaiser received from CMS, additional costs were shifted unfairly to the FEHBP for those federal subscribers covered by Medicare and the FEHBP.

In addition to the Medicare issue, we found that one of the groups closest in subscriber size to the FEHBP received a discount not given the FEHBP. After ad-

## **K**aiser Plan Consistently Overcharged the FEHBP for Medicare- Related Costs

justing the age 65 and older revenue requirement and applying the discount, we found that the FEHBP rates were overstated by \$4,533,305.

The plan again overstated the FEHBP revenue requirement for age 65 and older members in 1996. One of the groups closest in size to the FEHBP received a discount in its rates not given to the FEHBP. Therefore, we recalculated the FEHBP rates by once again adjusting the revenue requirement and applying the discount. We determined that overcharges to the FEHBP totaled \$1,914,992.

*Northern region.* In 1998, we found that the FEHBP did not receive a discount that Kaiser gave one of the two groups closest in size to the FEHBP. The discount resulted from the plan's understating that group's Medicare loading and its failure to recoup the lost revenue from that group in the subsequent year. By applying the discount to the FEHBP rates, we determined that Kaiser overcharged the FEHBP \$7,250,835 in 1998.

#### **Lost Investment Income**

The FEHBP contract with community-rated carriers states that the FEHBP is entitled to recover lost investment income on defective pricing findings. We determined that the FEHBP is due \$7,543,126 from the plan for lost investment income through December 31, 2000, on the overcharges identified in the report. Beginning January 1, 2001, additional amounts of lost investment income will accrue until such time as all questioned costs have been returned to the FEHBP. The lost investment income totals are in addition to the \$23,212,726 in overcharges to the FEHBP resulting from improper rate development.

### ***Lovelace Health Plan*** **in Santa Ana, California**

Report No. 1C-Q1-00-00-071  
August 22, 2001

The Lovelace Health Plan (Lovelace), a wholly owned subsidiary of CIGNA Health Corporation, began participation in the FEHBP in 1981. The plan provides comprehensive medical services to its members throughout the state of New Mexico. The audit, conducted at CIGNA offices in Santa Ana, California, covered contract years 1995 through 2000. During this six-year period, the plan received over \$219 million in premiums from the FEHBP.

As a result of the audit, we identified \$16,468,134 in inappropriate health benefit charges to the FEHBP, representing inappropriate charges to the FEHBP for all contract years except 1996. In addition, the FEHBP is due \$2,670,214 for investment income lost as a result of the overcharges. The plan agrees with only \$8,942,748 of the inappropriate charges exclusive of lost investment income.

The primary objectives of the audit were to determine if the Lovelace plan offered market price rates to the FEHBP and if any additional health benefit charges (*loadings*) the FEHBP received were fair and reasonable. We also looked at whether the rates were in compliance with those laws and regulations governing the FEHBP.

*Discounted rates.* We found that the FEHBP did not receive a market price adjustment equivalent to the largest discount given to one of the two groups closest in subscriber size to the FEHBP

**A**uditors  
**Determine**  
**FEHBP Due**  
**\$19.1 Million**



in four of the six years reviewed. In 1995, Lovelace could not provide documentation to support the rates it had given one of these two groups. Consequently, we redeveloped the rates of this group by using the plan's 1994 community rates. After adjusting those rates based on additional rating information provided by Lovelace, we determined that this group had received a discount not afforded the FEHBP.

As a result of applying this discount to the FEHBP's rates, we also had to adjust two additional charges to the rates. The first charge, an *extension of coverage* loading, covers a plan's costs for providing benefits to federal employees whose employment with the U.S. government has ended and who are no longer eligible to receive FEHBP benefits. *Note: To assist these employees in their transition to retirement or other employment, they remain covered for the first 31 days after leaving federal service.*

The second charge is an *enrollment discrepancies* loading, which compensates a plan for unresolved discrepancies between its and OPM's enrollment figures. In the case of Lovelace, we corrected the loadings and determined that the plan owed the FEHBP \$2,867,888 in contract year 1995.

In 1997, the discount the plan gave the FEHBP was substantially lower than the largest discount given to one of the two groups closest in size to the FEHBP. During our review, we determined that the rates for this subscriber group had been frozen over an 18-month period, starting January 1, 1997. We determined that group's discount by calculating the revenue amount the plan needed from this group during the 18-month period and comparing it to the group's billed rates. After applying the discount to the FEHBP rates and making appropriate adjustments to the discrepancies in the

loadings described in the previous two paragraphs, we determined that Lovelace owed the FEHBP \$2,157,083 for 1997.

Our review of the 1998 and 1999 rates showed that in each of these years the plan gave significant discounts to one of the two groups closest in size to the FEHBP. The FEHBP did not receive discounts equal to that particular subscriber group in either year. Thus, when we adjusted the FEHBP discounts, we determined that Lovelace overstated the FEHBP's rates by \$2,764,652 in 1998 and \$6,795,972 in 1999.

*Rating factors.* Our review of the FEHBP rates for contract year 2000 identified problems with two rating factors. We found that: (1) the plan could not support the experience factor it used in developing the FEHBP's rates; and (2) it did not use updated community-wide age/sex data in developing the FEHBP age/sex factor. Consequently, in redeveloping the FEHBP's rates, we lowered both factors. Changes to these factors also necessitated adjustments to the extension of coverage and enrollment discrepancies loadings as described previously. Once we compared the redeveloped rates to the rates the plan actually charged the FEHBP, we determined the FEHBP should have been charged \$1,882,539 less in contract year 2000.

### Rate Reconciliation Audits

In addition to the standard community-rated audits, we also conduct rate reconciliation audits (RRA) of health maintenance organization plans. These audits are performed prior to the settlement of the FEHBP's final rates for any given contract year.

Since 1996, the first year our office conducted RRA audits, significant dollar savings have accrued to the FEHBP.

## **F**EHBP Rates Not Appropriately Discounted in 4 of 6 Contract Years

A total of 101 RRAs have been completed, with dollar savings to the FEHBP amounting to over \$61 million. In addition, the RRA process has increased carrier compliance with FEHBP rating requirements. For instance, in 1996, only about 20 percent of the plans we audited under the RRA process were in compliance. This year, 13 out of the 21 plans audited (62 percent) complied with the requirements. For the eight plans with audit findings, overcharges amounted to just over \$2.5 million dollars.

OPM requires each community-rated plan to submit its proposed premium rates by May 31 of each year, seven months before the rates take effect in January of the following year. Because of these early submissions, plans must estimate the FEHBP premium rates for the next contract year. The rate reconciliation process allows plans to adjust their estimated rates to the rates actually being charged for the current contract year.

The RRA process assists OPM contracting officials negotiate the best premium rates possible for FEHBP subscribers by ensuring that the agency is provided with current, complete and accurate information by the participating plans. RRAs are limited to the current year's rate reconciliation and are performed and completed from mid-May through early August, just prior to the time OPM's Office of Actuaries must finalize the rates.

In addition to achieving the best premium rates, RRA audits provide significant benefits to OPM and participating community-rated carriers as follows:

- Rating data is reviewed shortly after it is produced when both carrier records and staff who prepare the reconciliation are usually readily available to assist in the audit and the subsequent resolution of any audit issues that may arise.

- Representatives from OPM's Office of Actuaries and plan officials receive almost immediate feedback relating to our audit results.
- The audit resolution process begins immediately, thus benefiting both the plans and OPM through timely resolution of audit issues.
- RRAs result in more timely and frequent audit coverage of the HMOs participating in the FEHBP.
- The RRAs reduce carrier uncertainty regarding any future liabilities that could result from a post-award audit, including any potential interest accruals.

The RRA audit with the most significant findings was the 2001 rate reconciliation for Independent Health Association. This community-rated plan is located in Buffalo, New York.

Our audit showed that the plan's calculation of the Medicare benefit charge for our over-65 subscriber group included an amount to recoup a payment actually made to the Centers for Medicare and Medicaid Services, the agency under the Department of Health and Human Services that administers the Medicare program. Since under FEHBP regulations it was not appropriate to charge the FEHBP for such a payment, we did not include it in our recalculation of the Medicare loading.

In addition, we excluded a ten percent administrative charge the plan had added to the FEHBP rates. This charge was not permissible, because the plan's administrative costs are already accounted for in the base rates it charged the FEHBP. After lowering the Medicare loading and eliminating the administrative charge, we determined that the FEHBP's premium rates were overstated by approximately \$830,000.

## **R** RAs Show Improved Compliance with OPM Rating Requirements

## **R** RA Audit Reveals \$830,000 in Rate Overcharges

## Experience-Rated Plans

The Federal Employees Health Benefits Program offers a variety of experience-rated plans, including fee-for-service plans, the latter which constitute the majority of federal contracts in this category. Certain comprehensive medical plans qualify as experience-rated HMOs rather than community-rated plans. For an overview of these rating categories, refer to page 5 at the beginning of the Audits Activities section.

The universe of experience-rated plans currently consists of 100 audit sites. When auditing these plans, our auditors generally focus on three key areas:

- Allowability of contract charges and the recovery of appropriate credits, including refunds.
- Effectiveness of carriers' claims processing, financial and cost accounting systems.
- Adequacy of internal controls to ensure proper contract charges and benefit payments.

During this reporting period, we issued eight audit reports on experience-rated plans. These were audits of Blue Cross and Blue Shield plans, since we issued no final reports on either experience-rated HMOs or employee organization plans. In these reports, our auditors recommended that OPM's contracting officer require the plans to return \$3.9 million in inappropriate charges and lost investment income to the FEHBP.

The three types of experience-rated plans we audit are discussed below.

### *Government-Wide Service Benefit Plan*

This plan comes under the broad definition of a fee-for-service plan and is administered by the BlueCross BlueShield

Association (BCBS Association), which contracts with our agency on behalf of its numerous member plans. Participating Blue Cross and Blue Shield plans throughout the United States underwrite and process the health benefits claims of their respective federal subscribers under the BCBS Service Benefit Plan. Approximately 46 percent of all FEHBP subscribers are enrolled in Blue Cross and Blue Shield plans nationwide.

While its headquarters are in Chicago, Illinois, for administrative purposes, the BCBS Association has established a Federal Employee Program (FEP) Director's Office in Washington, D.C., to provide centralized management for the Service Benefit Plan. Recently, the FEP Director's Office was the subject of a special audit regarding its internal operations. Details relating to this audit can be found on pages 22-23.

The association also oversees a national FEP operations center, also located in the Washington, D.C. area, whose activities include verifying subscriber eligibility; approving or disapproving reimbursement of local plan FEHBP claims payments (using computerized system edits); and maintaining an FEHBP claims history file and an accounting of all FEHBP funds.

During this reporting period, we issued eight Blue Cross and Blue Shield experience-rated reports in which our auditors cited \$3,853,867 in costs charged to the FEHBP that were determined questionable under BCBS contracts. Our auditors also noted an additional \$44,262 in lost investment income on these questioned costs, for a total of \$3,898,129 owed to the FEHBP. The following audit narratives describe the major findings from two of these reports, as well as the questioned costs associated with them.

## **Anthem BlueCross BlueShield**

**in Denver, Colorado, and  
Reno, Nevada**

Report No. 1A-10-30-01-018  
August 27, 2001

Our audit of the FEHBP operations at Anthem BlueCross BlueShield (Anthem) took place at the plan's offices in Denver, Colorado, and Reno, Nevada. The plan's financial and administrative operations are located in Denver, while the claims operations are in Reno.

The purpose of this audit was to determine whether Anthem charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of its contract. Our auditors reviewed health benefit payments made by the plan from 1997 through 1999, as well as miscellaneous payments, administrative expenses, and cash management covering contract years 1997 through 1999.

As a result of this audit, our auditors questioned \$1,261,949 in health benefit costs; \$214,042 in administrative expense charges; \$3,181 in cash management; and \$36,726 in lost investment income. As discussed elsewhere in this report, lost investment income represents those monies the FEHBP would have earned on the questioned costs. Final calculations by our auditors regarding amounts owed to the FEHBP totaled \$1,515,898.

### **Health Benefits**

During the period 1997 through 1999, Anthem paid out \$180 million in connection with FEHBP health benefit claims. For purposes of this audit, we selected claims for examination at ran-

dom as well as in specific health benefit categories, principally those concerning coordination of benefits with Medicare and potential duplicate payments. We also reviewed specific financial and accounting areas, such as refunds and other miscellaneous credits relating to FEHBP claim payments. Our findings relating to inappropriate health benefit charges to the FEHBP totaled \$1,261,949.

Some of our significant findings included the following issues:

*Claim payment errors.* For the period January 1, 1999 through December 31, 1999, we selected 100 claims for the purpose of determining if Anthem paid these claims properly. As a result of this review, our auditors identified 25 claim payment errors, resulting in overcharges of \$422,196 to the FEHBP. We also identified four additional claim payment errors during our review of claims where amounts paid by the plan were greater than amounts covered. This resulted in overcharges of \$181,275 to the FEHBP. We recommended that OPM's contracting officer disallow these 29 claim overpayments, totaling \$603,471, and instruct Anthem to make a diligent effort to collect these payments and credit all amounts recovered to the FEHBP.

*Coordination of benefits.* For the period 1997-1999, our auditors identified 154 hospital claims, totaling \$933,898, and 447 physician claims, totaling \$82,458, wherein the FEHBP paid as the primary insurer when Medicare Part A or B was the primary insurer. This type of inappropriate charge occurs when there is a failure to coordinate benefits properly with a patient's Medicare coverage when Medicare is the primary insurer. As a result, we estimated that the FEHBP was overcharged \$440,735 for these 601 claims that represent payments to hospitals and physicians from the FEHBP trust fund.

**A**uditors  
**Determine**  
**\$1,515,898 Owed**  
**to the FEHBP**

**A**uditors  
**Question**  
**\$1,261,949 in**  
**Health Benefit**  
**Charges**

We recommended that the contracting officer disallow these uncoordinated claim payments and instruct Anthem to make a concerted effort to collect these payments and credit all overpaid amounts to the FEHBP should the plan be successful in its recoveries.

*Medicare Part A helps pay for care in hospitals, skilled nursing facilities, hospices, and some home health care.*

*Medicare Part B helps pay for doctors, outpatient hospital care, and some other medical services that Part A does not cover, such as services of physical and occupational therapists and some home health services. Part B helps pay for covered doctor services that are medically necessary.*

*Duplicate payments.* Our auditors also determined that Anthem charged the FEHBP inappropriately for duplicate claim payments. During the period 1997-1999, we identified 237 duplicate claim payments, resulting in overcharges of \$154,205 to the FEHBP. This relatively small number of duplicate claim payments indicated to our auditors that the plan had effective controls in place to minimize payments of this type. Nevertheless, we recommended that the contracting officer disallow the duplicate payments we identified, and instruct Anthem to be conscientious in attempting to collect these payments and credit all amounts recovered to the FEHBP.

*Inpatient hospital precertification.* Precertification is the process that allows a plan to evaluate the medical necessity of any patient’s proposed stay and the number of days required to treat a condition.

For the contract periods 1997 through 1999, we identified 94 claims where the patient failed to obtain precertification from Anthem prior to admission. This

should have resulted in the plan reducing the benefits payable to the provider by \$500 in accordance with the BCBS Service Benefit Plan brochure. Since the plan did not reduce these claim benefits to reflect this oversight, overcharges to the FEHBP totaled \$47,000. We recommended that the contracting officer disallow these claim overcharges and direct the plan to credit these overcharges to the FEHBP.

*Miscellaneous payments.* In reviewing Anthem’s procedures for processing refunds, uncashed health benefit checks and miscellaneous credits, we identified one instance where the plan could not provide documentation to substantiate that uncashed checks totaling \$16,538 were returned to the FEHBP. The FEHBP contract requires the carrier to retain and make available all records applicable to a contract year that support the annual statement of operations. As a result, we recommended that the contracting officer ensure that the plan returns these uncashed checks to the FEHBP.

*Note: Under its FEHBP contract, a plan should be able to demonstrate that claim overpayments cited in our audit report were made in good faith. It should also be able to show that it had made a reasonable effort to collect these funds. OPM’s contracting officer then can consider all uncollected amounts (questioned costs by our auditors) to be allowable charges to the FEHBP. This applies to all FEHBP experience-rated plan contracts.*

**Administrative Expenses**

During our review of administrative expenses from 1997-1999, we noted that Anthem overcharged the FEHBP for costs totaling \$214,042, the majority of which related to pension costs. Under the terms of the FEHBP contract, Anthem can charge personnel expenses, including salary and pension costs, as

**A**uditors  
Identify  
**\$214,042 in  
Administrative  
Expense  
Overcharges**

administrative expenses for work associated with the contract.

*Pension costs.* The FEHBP is charged a certain percentage to cover pension costs for plan employees who work on FEHBP activities. When a plan reduces its workforce and therefore its overall pension costs, it should make a corresponding reduction to the FEHBP's allocation for pension costs.

Although the plan reduced its workforce, it did not adjust the pension costs charged to the FEHBP in contract years 1998 and 1999. Therefore, our auditors calculated that the plan overcharged the FEHBP \$149,644 for pension costs in those years. We recommended that the contracting officer instruct the plan to credit the FEHBP for these pension cost overcharges.

#### **Cash Management**

Regarding cash management of FEHBP funds, our auditors concluded that Anthem had handled these funds from 1997 through 1999 in accordance with applicable laws and regulations with one exception. The exception occurred during December 1997 when the plan did not credit the FEHBP \$3,181 for investment income.

#### **Lost Investment Income**

Federal regulations require a carrier to invest and reinvest all excess FEHBP funds on hand and to credit all investment income earned on those funds. We computed lost investment income resulting from our audit findings in the amount of \$36,726 through June 30, 2001. We have recommended to the contracting officer that lost investment income of \$36,726 be returned to the FEHBP, as well as additional lost investment income due after that date until Anthem has returned all questioned costs owed to the FEHBP.

## **BlueCross BlueShield of New Mexico**

### **in Albuquerque, New Mexico**

Report No. 1A-10-03-01-027

July 25, 2001

Our audit of the FEHBP operations at BlueCross BlueShield of New Mexico (BCBS of New Mexico) took place at the plan's headquarters in Albuquerque, New Mexico. We reviewed health benefit payments made by the plan from 1997 through 1999, as well as miscellaneous payments and administrative expenses for contract years 1995 through 1999.

In performing this audit, we determined whether the plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of its contract. At the conclusion of this audit, our auditors determined that the plan improperly charged the FEHBP \$816,101 in claim payments and never credited the FEHBP \$2,428 for a refund. Lost investment income on these questioned amounts totaled \$328. Final calculations by our auditors regarding all inappropriate charges and lost investment income to the FEHBP totaled \$818,857. The BCBS Association agreed with all the questioned amounts.

#### **Health Benefits**

From 1997 through 1999, BCBS of New Mexico paid \$109 million in actual FEHBP claim payments. We selected claims to examine at random and in specific health benefit categories. Principally, these concerned coordinating benefits with Medicare and potential duplicate payments. We also reviewed specific financial and accounting areas, such as refunds and other miscellaneous

**A**uditors  
**Calculate**  
**\$818,857 Owed**  
**to the FEHBP**

credits relating to FEHBP claim payments. Our findings related only to health benefit charges and totaled \$818,857. Some of our findings in this area were:

*Coordination of benefits.* During this review, we identified 949 claim payments where the FEHBP paid as primary insurer when Medicare Part A or B was actually the primary insurer. As a result, we estimated that the plan overcharged the FEHBP \$732,237 for these coordination of benefit payment errors.

As discussed in the preceding audit narrative on the Anthem BCBS plan, this type of inappropriate charge occurs when there is a failure to coordinate benefits properly with Medicare coverage. To assist its BCBS member plans with this and other claim reviews, the BlueCross BlueShield Association maintains a national claims system database at its Federal Employee Program (FEP) operations center in the Washington, D.C. area.

For most of the claim lines questioned, there was no information in the BCBS Association national database to make the plan aware that Medicare benefits coordination was necessary at the time these claims were paid. However, when this Medicare information was later added to the FEP claims system, BCBS of New Mexico did not review and adjust its members' prior claim lines back to the Medicare effective dates. Therefore, the claim benefit costs remained charged to the FEHBP in their entirety, which resulted in overcharges of \$732,237 to the FEHBP.

These claims involved Medicare Parts A and B. Similarly, BCBS of New Mexico did not follow its procedures and coordinate inpatient claims when patients had Medicare Part B only. We recommended that OPM's contracting officer disallow all of these uncoordinated claim payments and instruct the plan to make every reasonable effort to recover

these overpayments and credit all amounts recovered to the FEHBP.

*Duplicate claim payments.* BCBS of New Mexico inappropriately charged the FEHBP for duplicate claim payments during contract years 1997 through 1999. Of the approximately \$109 million in claims paid during this period, our auditors identified 159 duplicate claim payments, totaling \$83,864. Having noted that this was a small number of duplicate claim payments, we concluded that the plan had effective controls in place to minimize such payments.

*Refunds.* In one instance, BCBS of New Mexico did not credit the FEHBP for a refund of \$2,428 it received in 1999. Federal regulations require the carrier to credit refunds relating to health benefit payments to the FEHBP, along with investment income lost on these funds. Consequently, our auditors determined that BCBS of New Mexico owed the FEHBP \$328 in lost investment income on this refund. As a result, we recommended that the contracting officer ensure that the plan credits the FEHBP \$2,756 representing the refund and associated lost investment income.

#### **Administrative Expenses**

For contract years 1995 through 1999, BCBS of New Mexico charged the FEHBP \$16.3 million in administrative expenses. Our auditors determined that the administrative expenses incurred and charged to the FEHBP were actual, necessary, and reasonable expenses incurred in accordance with the terms of the contract and applicable regulations.

#### **Experience-Rated Comprehensive Medical Plans**

Comprehensive medical plans (HMOs) fall into one of two categories: community-rated or experience-rated. As was previously explained in more detail on page 5 of this section, the critical differ-

**U**ncoordinated  
**Medicare**  
**Payments Cost**  
**FEHBP \$732,237**

ence between the two categories stems from how premium rates are calculated for each.

Like other health insurance plans participating in the FEHBP, experience-rated HMOs offer what is termed a “point of service” product. Under this option, members have the choice of using a designated network of providers or using non-network providers.

In selecting one health provider over another, a member’s choice has specific monetary and medical implications. For example, if a member chooses a non-network provider, the member will pay a substantial portion of the charges and the benefits available may be less comprehensive.

During this reporting period, we issued one experience-rated comprehensive medical plan draft audit report but no final reports.

### *Employee Organization Plans*

Employee organization plans also fall into the category of experience-rated, and may operate or sponsor participating health benefits programs.

The two largest types of employee organizations are federal employee unions and associations. Some examples are the American Postal Workers Union, the National Association of Letter Carriers, the Government Employees Hospital Association and the Special Agents Mutual Benefit Association. These plans operate on a fee-for-service basis, which allows members to obtain treatment through facilities or providers of their choice.

We did not issue any final reports for employee organization plans during the reporting period.



## Information Systems Audits

*In accordance with the Inspector General Act of 1978, as amended, we conduct and supervise independent and objective audits of agency programs and operations to prevent and detect fraud, waste and abuse. To assist in fulfilling this mission, we perform information systems audits of health and life insurance carriers that participate in the Federal Employees Health Benefits Program (FEHBP) and the Federal Employees' Group Life Insurance program (FEGLI). We also audit the agency's computer systems development and management activities.*

Information systems audits are a relatively new audit activity for our OIG. We are pleased with our early success in auditing computer information systems of health insurance carriers participating in the Federal Employees Health Benefits Program (FEHBP). We have had similar results in detecting control weaknesses in reviewing OPM's internal information systems control environment.

The inherent need for this type of oversight lies in the federal government's heavy reliance on information systems to administer federal programs, manage federal resources, and accurately report costs and benefits. Any breakdown in federal computer systems, including systems of federal contractors, can compromise the government's efficiency and effectiveness, increase the costs of federal projects and programs, and threaten the safety of United States citizens.

Ever increasing malicious attacks on both public and private computer systems underscore the importance of this issue. These threats include outbreaks of destructive computer viruses, web site defacements, sabotage, and theft of valuable or sensitive information in computer databases.

To minimize information system security risks, our office audits various agency

computer systems development and security-related activities. In addition, our office conducts audits pertaining to general and applications controls at health carriers under contract with OPM to provide health benefits under the FEHBP.

*General controls* are defined as the policies and procedures that apply to an entity's overall computing environment. *Application controls* are those directly related to individual computer applications, such as a carrier's payroll system or benefits payment system. General controls provide a secure setting in which computer systems can operate, while application controls ensure that the systems completely and accurately process transactions.

During this reporting period, we completed an evaluation of OPM's security programs and practices in accordance with Title X, Subtitle G ("Government Information Security Reform") contained in P.L. 106-398, the FY 2001 Defense Authorization Act. We also completed an audit of an FEHBP carrier's information systems general controls and a review of OPM's Internet privacy practices. A summary of our audit findings and recommendations are described on the following pages.

## **Review of OPM's Compliance With the Government Information Security Reform Act**

Report No. 4A-CI-00-01-088  
August 31, 2001

On October 30, 2000, former President Clinton signed into law the FY 2001 Defense Authorization Act that included an important amendment to the Paperwork Reduction Act of 1995 pertaining to information security.

This subchapter of the FY 2001 Defense Authorization Act is commonly referred to as the Security Act. It focuses on program management, implementation and evaluation of security for unclassified and national security computer systems, and seeks to ensure proper management and security for the information resources supporting federal operations and assets.

### **General Overview**

Pursuant to the Security Act, we performed an independent evaluation of OPM's computer security program and practices. We evaluated OPM's entity-wide security controls and the security environment of the mainframe computer operation. This computer operation supports most of OPM's essential systems, including critical applications for the agency's Retirement and Insurance Service, Investigations Service, and Office of the Chief Financial Officer.

In addition, we reviewed OPM's general compliance efforts for specific areas defined in the U.S. Office of Management and Budget's (OMB) Security Act implementation guidance and corresponding reporting instructions.

While we concluded that OPM is committed to improving its computer security, we identified several areas where progress is still needed. However, nothing came to our attention that would cause us to believe that there are material weaknesses in OPM's information security controls. The specifics of our review are summarized below.

### **Security Program Performance**

*Program office compliance.* OPM maintains a security plan for the mainframe operation and assets under its control. Also, security personnel have appropriately configured the security software to maintain an audit trail of system activity and ensure that security violations are reported to management and subsequently investigated. However, we determined that OPM's mainframe systems administrator does not have a formal methodology to assess the risks associated with the operations and assets under the administrator's control.

*OCIO security responsibilities.* OPM has not yet implemented an agency-wide security program. However, a draft information technology security policy has been developed by OPM's Office of the Chief Information Officer (OCIO).

*Security training.* OCIO has not implemented a security training program to ensure that employees are sufficiently trained in their security responsibilities. While several key staff members have received some technical training, most have not. However, OCIO has sponsored security awareness training for all agency employees and contractors the last two years. This fall, OCIO is planning a comprehensive, online security awareness program.

**OPM  
Committed  
to Improving  
Computer  
Security**

## Weaknesses Noted in OPM's Computer Security Program

*Incident reporting.* OPM does not have a documented, formally established computer incident response team. The absence of this team could cause existing or potential vulnerabilities to escape detection.

*Capital planning.* OPM has not adequately integrated security requirements or cost estimates into its capital planning and investment control process.

*Critical assets planning strategies.* OPM has implemented controls to identify, prioritize, and protect critical assets within its enterprise architecture. The strategies used by OPM include developing and testing a draft disaster recovery plan for its mainframe operation and implementing an agency-wide continuity of operations plan.

*Security life cycle.* Although OPM has not completed the development of an agency-wide systems development life cycle (SDLC) methodology, it has made significant progress toward that goal. OPM has established an SDLC framework and has started to implement pieces of it. Implementing this strategy will ensure that information technology security will be included as an important aspect of future system development efforts at OPM.

*Critical infrastructure protection.* OPM is not in compliance with directives on critical infrastructure protection. This issue was discussed in detail in our April 2001 semiannual report to Congress.

*Contractor services security.* Contractors employed by OPM are supervised in accordance with OPM regulations. Contractors have unique user identifications for accountability, reporting and monitoring purposes. However, we found that OPM does not have adequate controls for deleting system access for contractors when they leave the agency.

### OPM Specific Security Act Responsibilities

We determined that OPM was not in compliance with two of the three government-wide training responsibilities identified in the Security Act.

Specifically, OPM has not reviewed or updated regulations concerning computer security training for federal civilian employees. OPM also has not assisted the Department of Commerce in updating and maintaining guidelines for training in computer security awareness and computer security best practices. However, OPM has worked with the National Science Foundation to develop and implement a Scholarship for Service (SFS) program to promote the development of information technology skills within the federal government. This program provides scholarships to undergraduate and graduate students who are pursuing a degree in the information assurance and computer security fields. It is set to begin this fall.

### OPM Internet Privacy Review

Report No. 4A-CI-00-01-038  
May 9, 2001

Last year, Congress passed the Treasury and General Government Appropriations Act of 2001, Public Law 106-544. Contained in section 646 of this act is a directive to the Inspector General of each department or agency to submit to Congress a report that discloses any agency activity related to the collection or review of personally identifiable information from individuals who access the agency's Internet sites.

It also requires the disclosure of any agreements with third parties to collect, review or obtain personally identifiable information relating to an individual's access or viewing habits for governmental and non-governmental Internet sites.

In accordance with PL. 106-544, we conducted a review to determine whether OPM, or any third parties under agreement with OPM, are obtaining personally identifiable information relating to any individual's access or viewing habits without appropriate authorization.

We determined that OPM is not collecting personally identifiable information on OPM Internet users' access or viewing habits through its web sites or through third-party agreements. However, we did identify several areas where the agency could improve its Internet web site practices.

We have recommended that the Office of the Chief Information Officer, who maintains responsibility for OPM's Internet activities, do the following:

- Implement steps to ensure that all major entry points into OPM's web sites and any OPM web pages, where substantial amounts of personal information is collected, have a direct link to OPM's privacy policy.
- Continue to work with program offices to ensure that OPM web sites do not use persistent cookies to collect personally identifiable information, as directed in OPM's privacy policy. *Persistent cookies* are small bits of software placed on a web user's hard drive that can be used to track web browsing behavior.

- Review and update the agency's policies and procedures relating to Internet web site activity.

Regarding the last bulleted recommendation, our office has suggested that these improvements include the following:

- Adding a section to its policies and procedures related to agency and program office Internet privacy responsibilities.
- Updating a web page approval process.
- Implementing formal change control policies and procedures related to web site development and maintenance.
- Adding a section that addresses agreements with third parties for web site activities.
- Requiring all OPM web sites with non-OPM hyperlinks to notify the user when they are about to leave an OPM web site.

The Chief Information Officer stated that her office concurs with our findings, conclusions and recommendations. OCIO has concluded through its own review and a concurrent internal review that the agency needs to adopt a more formal and rigorous process related to Internet web site activities.

As an initial step, they have already obtained agency-wide management approval to reengineer how they will accomplish this work. OCIO also plans to incorporate our recommendations into the development and implementation of its updated Internet web site policies and procedures.

## **Auditors Recommend Improvements in OPM's Web Site Practices**

## **OPM Management Agrees with Web Site Security Recommendations**

***Audit of Information System General Controls at the BlueCross BlueShield Association FEP Operations Center in Washington, D.C.***

Report No. 1A-10-92-00-028  
July 30, 2001

The BlueCross and BlueShield Association (BCBS Association) contracts with our agency on behalf of its numerous member plans. Participating Blue Cross and Blue Shield plans throughout the United States underwrite and process the health benefits claims of their respective federal subscribers under the government-wide BCBS Service Benefit Plan. Approximately 46 percent of all FEHBP subscribers are enrolled in Blue Cross and Blue Shield plans nationwide.

Because of the sheer number of federal subscribers served by BCBS member plans, we considered this audit of the association's Federal Employee Program (FEP) operations center particularly important. During FEHBP contract year 2000, which was the scope of our audit, the operations center processed \$6.3 billion in FEHBP claims.

The FEP operations center is the central processing location for all medical claims processed by the various Blue Cross and Blue Shield plans. Currently, the BCBS Association contracts with CareFirst BlueCross BlueShield to host and maintain the operations center at its Columbia, Maryland data center in suburban Washington, D.C.

The goal of our audit was to obtain reasonable assurance that the operations center had implemented proper controls over the integrity, confidentiality and availability of computerized data associated with its FEHBP contracts. We evaluated the plan's information system general controls using guidance contained in the General Accounting Office's *Federal Information System Controls Audit Manual*, industry best practices, along with pertinent federal law and regulations.

This review included examining how well CareFirst was managing security policy and access controls, along with software changes related to CareFirst's information systems. Our auditors also assessed whether there was an appropriate segregation of duties among employees who were involved in the FEP operations center's information systems. Additionally, we looked at controls over the mainframe operating system and examined the operations center's plan for maintaining or quickly restoring all its computer systems functions in the event of a disaster.

Our audit revealed that the FEP operations center managers should take steps to strengthen and formally implement a corporate security plan. We also found that there were opportunities for improvement in other general controls that had been implemented at the operations center to safeguard its assets and data. As a result, our auditors made a number of recommendations intended to improve those controls.

In response, FEP operations center management agreed to implementing many of our recommendations, beginning with updating, revising and consolidating its security policies and procedures.

**Computer Operations at BCBS Central Processing Center Benefit from Audit Recommendations**

In other general controls areas, the operations center has accepted our recommendations to improve policies and procedures related to application software development, application change control, and system software. For example, the operations center managers have assigned a team to improve and implement procedures to control changes to application software. In addition, operations center management is developing formal written procedures to initiate,

approve and review changes to critical operating system data sets.

We believe that our review, and particularly our specific recommendations, will enhance the BCBS Association FEP operations center's information system general controls, thereby safeguarding the confidential medical records of the association's FEHBP enrollees, as well as ensuring the reliability and continued availability of the operations center's critical automated information.

## Other External Audits

*When requested by Office of Personnel Management (OPM) procurement officials, our office conducts pre- and post-award contract audits relating to the acquisition of goods and services by agency program offices. We also conduct audits of the local organizations of the Combined Federal Campaign (CFC), the only authorized fundraising drive conducted in federal installations throughout the world.*

## Combined Federal Campaign

The U.S. Civil Service Commission (the precursor of OPM) was given the responsibility of arranging for national voluntary health and welfare agencies to solicit funds from federal employees and members of the armed services at their place of employment by Executive Order 10927, issued on March 18, 1961. Since then, additional executive orders and new federal regulations (5 CFR 950) have been issued as well as one public law (P.L. 100-202) that:

- Make national and local organizations and charities eligible to participate in the Combined Federal Campaign (CFC).
- Define the role of local CFC organizations.
- Cite OPM's oversight responsibilities regarding the Combined Federal Campaign.

An estimated 366 local campaigns participated in the 2000 Combined Federal Campaign, the most recent year for which statistical data is available. These CFCs are usually organized within large urban areas to maximize the territory covered where federal employees work and live. Federal employee contributions reached \$224 million for the 2000 CFC, while administrative expenses totaled \$19.4 million.

Combined Federal Campaign audits will not ordinarily identify savings to the government, because the funds involved are charitable donations made by federal employees, not federal entities. While infrequent, our audit efforts can result in an internal referral to our OIG investigators for potential fraudulent activity.

During the current reporting period, we issued 11 final CFC reports, a listing of which is on page 47 in Appendix VI.

As described in previous semiannual reports, our CFC audits have focused on the eligibility of local charities participating in local campaigns, on local campaign compliance with CFC regulations, and testing the various local campaigns' financial records. This year's audits covered campaign years 1998 and 1999.

### CFC Audit Findings

Generally speaking, the local CFC administrators we audited were in compliance with federal regulations and guidelines. However, we found some key noncompliances. These noncompliances described below were taken from two of our CFC audits to illustrate those areas in which the CFC administrators needed to improve when conducting future campaigns.

These CFC administrators failed to:

- Follow proper application procedures.
- Notify charities of their eligibility status within established time frames.

## Auditors Note Areas of Noncompliance with CFC Regulations & Guidelines

- Adhere to regulations regarding administrative expense reimbursements.
- Accurately identify a charity in a local campaign brochure.
- Distribute donations within required time limits.
- Provide timely responses to OIG auditor requests.

### Agency Contract Audits

Our office conducts two types of agency contract audits. We perform pre-award contract audits to: (1) ensure that a bidding contractor is capable of meeting contractual requirements; (2) assess whether estimated costs are realistic and reasonable; and (3) determine if the

contract complies with all applicable federal regulations. We also conduct post-award contract audits to ensure that costs claimed to have been incurred under the terms of an existing contract are accurate and in accordance with provisions of federal contract regulations.

These audits provide OPM procurement officials with the best information available for use in contract negotiations and oversight. In the case of post-award contract audits, for example, the verification of actual costs and performance charges may be useful in negotiating future contract modifications pertaining to cost-savings and efficiency.

During this reporting period, we did not issue any audit reports on agency contracts.



## OPM Internal Audits

*Our office is responsible for conducting audits, as well as evaluations and inspections, of the Office of Personnel Management's (OPM) programs and administrative operations. This includes audits of OPM's consolidated financial statements required under the Chief Financial Officers Act (CFO Act of 1990) and performance reviews, particularly those pertaining to the human resource management role OPM fulfills for the federal government.*

Our internal audits staff consists of auditors and program evaluators working together to provide recommendations for improving the economy and efficiency of our agency operations. We use a risk-based methodology to assess OPM's activities and establish annual work agendas. The objective is to identify high impact areas where the OIG can provide the best possible benefit to the agency.

To ensure that we achieve our goals, we carefully plan and conduct our activities involving audits or evaluations and inspections in accordance with government standards. We conscientiously include OPM program managers in every step of the audit process to ensure that we have met their needs, addressed concerns and obtained feedback on how we can improve the value of our services. We believe this cooperative spirit ensures that all parties involved with our activities will obtain the maximum benefit and that we will continually improve our level of services.

During this reporting period, we: (1) completed one internal audit of OPM's FY 2000 annual performance report; (2) addressed one congressional inquiry relating to OPM's 12 most significant performance measures (indicators) and another concerning improper payments made from the retirement, health and life insurance trust funds administered by the agency; and (3) continued our

assistance to the Office of the Chief Financial Officer (OCFO). We also issued a report on OMB Bulletin 01-02 concerning OPM's benefit withholdings and contributions payroll procedures.

The following pages contain descriptions of our efforts in each of these areas and an update on OPM management's top ten challenges as identified by our OIG.

## Performance Audits

During this reporting period, we continued to concentrate our performance audit efforts on agency program audits. As defined by Government Auditing Standards, a *program audit* can determine three things:

- The extent to which the desired results or benefits established by the U.S. Congress or another authorizing body are being achieved.
- The effectiveness of programs, activities or functions.
- Agency compliance with significant laws and regulations.

Specifically, we reviewed documentation relating to our agency's data prepared under the requirements of the Government Performance and Results Act of 1993. This act, most frequently referenced by its acronym GPRA, was designed to produce improvements in government performance and account-

ability in federal programs. GPRA also includes directives for federal agencies and departments to follow regarding strategic planning and performance management processes that emphasize goal-setting, customer satisfaction and results measurements.

In an October 1998 congressional request, the IG community was asked to include in future semiannual reports to Congress a summary of reportable actions under GPRA resulting from OIG audit activities. Accordingly, the following paragraphs describe these activities and corresponding results.

### ***Audit of Internal Controls of OPM's FY 2000 Performance Results***

Report No. 4A-OP-00-01-023  
June 19, 2001

*Verification and validation reviews.* The Government Performance and Results Act of 1993 requires agencies to prepare an annual performance plan covering each program activity. GPRA also instructs agencies to include a description of the means to be used to verify and validate measured values. The U.S. General Accounting Office's (GAO) report, titled *Selected Approaches for Verification and Validation of Agency Performance Information* (GAO/GGD-99-139), defines verification and validation as follows:

- *Verification* is the assessment of data completeness, accuracy, consistency, timeliness and related quality control practices.
- *Validation* is the assessment of whether data are appropriate for the performance measure.

Although not required under GPRA, we decided to perform our own verification and validation reviews to assess independently OPM's performance required under GPRA. Our decision was based on the high level of interest afforded GPRA by Congress and the GAO.

The objectives of our reviews were to:

- Verify and validate performance data for selected FY 2000 GPRA performance indicators in OPM's performance report.
- Evaluate the effectiveness of controls over performance measurement data.

Our agency submitted its second annual performance plan to Congress with its FY 2000 budget request. The performance plan established five general agency goals, 117 program goals and 458 performance indicators (measures). Out of those goals and measures, we focused on eight major program offices by selecting 42 program goals and 117 performance measures to verify and validate.

Specifically, we selected goals and performance measures from the following OPM program offices:

- Office of Executive and Management Development
- Investigations Service
- Employment Service
- Office of Merit Systems Oversight and Effectiveness
- Retirement and Insurance Service
- Office of the Chief Financial Officer
- Office of Workforce Relations
- Workforce Compensation and Performance Service

## **OIG Conducts Reviews of OPM Performance Data**

## Controls Over Agency Performance Reporting Need Strengthening

Included in our selection were many of the goals that relate to the top management issues we reported to members of the House and Senate in letters dated December 1, 2000 (see table on page 31), and referenced in our last two OIG semi-annual reports.

At the completion of our reviews, we found that OPM specifically needed to improve controls over the performance reporting process. We noted the following areas within OPM program operations that needed to be addressed and improved:

- Establishing policies and procedures for obtaining and compiling performance data.
- Providing better oversight and monitoring of performance data by OPM managers.
- Improving documentation supporting performance data.
- Using specific time frames (cutoff controls) to coincide with performance data.
- Correlating results to pertinent measures.

Our office is encouraged that OPM management has been responsive to our findings and has begun taking steps to implement improvements.

To put our findings in their proper context, we recognize that performance reporting is still a new process for all federal departments and agencies. We also realize that additional guidance will be forthcoming from Congress and the Office of Management and Budget through our agency's budget review process. In the interim, we can report with confidence that OPM remains committed to presenting accurate and consistent data in meeting GPRA requirements.

While not all other OPM program offices had the same issues described in the preceding bullets, all of these deficiencies point to the need for OPM's performance results to be as accurate and reliable as possible. We will continue our oversight of our agency's performance measurement reporting through our OIG's annual verification and validation reviews.

## OIG Responds to Congressional Leadership Inquiries

As with all OIGs, we receive many requests from Congress, particularly from the Senate and House leadership and from those committees having jurisdiction over our respective agency programs. A number of these inquiries have fallen under the purview of our internal audit activities that we believe are noteworthy.

In the immediate paragraphs that follow, we describe three inquiries received during the current reporting period we consider of particular importance. One relates to OPM's performance and accountability report and another to improper payments made from the three federal benefits programs (retirement, health and life) administered by our agency. In the third inquiry, we were asked to provide updates on the status of OPM's top management challenges our OIG had identified in a previous reporting period.

The critical aspects of our response to these inquiries are highlighted below.

### OPM's FY 2000 Performance & Accountability Report

On April 5, 2001, the Honorable Dan Burton, in his capacity as chairman of the House Committee on Government Reform, asked our office to review

## OPM Management Committed to Improving Performance Reporting

OPM's performance and accountability report for FY 2000. At Chairman Burton's specific request, we examined the following:

- OPM's most significant measures.
- Why these measures are, or are not, useful indicators of performance.
- The steps taken to verify the validity of the results of the measures.
- The extent to which the results are valid and accurate.

*OPM's most significant measures.* As described on page 27, OPM's performance and accountability report established five general agency goals, 117 program goals, along with 458 performance measures. OPM's report further defined some of the performance measures as critical to the mission of our agency. From these measures, we concluded that the following 12 measures were OPM's most significant:

- Human resource management policy and policy leadership (*includes 5 of the 12 measures*).
- Workforce planning.
- Merit systems principles oversight.
- Trust fund financial management.
- Annuitant customer satisfaction.
- Information technology solutions for retirement and human resource data (*includes 2 of the 12 measures*).
- Information security.

*Usefulness of performance measures.* We reported on OPM's new measurement framework, designed to provide a clearer picture of agency achievement at the strategic goal level. Specifically, this framework will permit OPM to begin aligning program goals and measures to the strategic goal level in its FY 2001 performance plan.

The impact of this new framework will be more evident in the FY 2003 plan and beyond. But, specifically regarding the FY 2000 report we reviewed for Chairman Burton, we reported that seven of the 12 measures we identified could be improved by making them outcome-oriented.

*Verification and validation process.* We also reported that we had verified the validity of the performance measures by conducting verification and validation audits and testing internal controls over OPM's FY 2000 performance data. These audits are discussed in more detail on pages 27-28.

Our verification and validation audits covered six of the 12 most significant measures on our list. Two of those 12 significant measures were verified and validated by an independent public accountant (IPA) during its audit of OPM's FY 2000 consolidated financial statements audit. The IPA's results of this audit were contained in our semi-annual report issued this past spring. The remaining four of the 12 significant measures were not subject to verification and validation by us or the IPA. Regarding the latter, we will consider examining these four measures during next year's audit of performance data.

*Verification and Validation process findings.* We determined that seven of the eight measures subject to verification and validation by us and the IPA were valid and accurate, while one was not.

#### **Improper Payments**

In a letter dated June 26, 2001, Senators Joseph I. Lieberman and Fred Thompson, Chairman and Ranking Member of the Committee on Governmental Affairs, respectively, requested the 24 major departments and agencies, including OPM, to review a U.S. General Accounting Office (GAO) report on *Strategies to*

**OIG  
Identifies  
12 Key Agency  
Performance  
Measures**

## Need for Improved FEHBP Payment Controls Cited

*Managing improper payments.* They also asked agencies to evaluate the adequacy of their respective internal controls and to consider implementing any GAO strategies that were appropriate for each agency.

In a separate letter to OPM Inspector General Patrick McFarland, Chairman Lieberman and Senator Thompson requested our office to assess OPM's efforts in response to the June 26 letter they had also sent to OPM.

As a result of this request to Inspector General McFarland, we examined OPM's internal controls and overall strategies to manage improper payments made in association with the retirement, life and health insurance programs administered by our agency.

These programs are formally identified as the Civil Service Retirement System and the Federal Employees' Retirement System, the Federal Employees Health Benefits Program (FEHBP) and the Federal Employees' Government Life Insurance program. These programs account for approximately 99.7 percent of OPM's program costs.

OPM responded to Chairman Lieberman and Senator Thompson by providing them with the status of the four items relating to improper payments involving the benefits programs, which they specifically requested in their June 26, 2001 letter to the agency. These items are as follows:

- Adequacy of OPM's control environment over improper payments.
- OPM's risk assessment of improper payments.
- Monitoring improper payments.
- Actions taken regarding improper payments.

Based on our audit work over the past few years, and that of KPMG, LLP, the independent public accounting firm that audits OPM's financial statements, we agreed with OPM's response with one exception.

The exception concerned the FEHBP, wherein we reported to Chairman Lieberman and Senator Thompson that OPM's program managers in the FEHBP did not consider in their risk assessments and systematic controls the entire transaction cycle. These controls only extended to the insurance carrier and did not address the service providers (physicians, hospitals and labs) at the end of the health benefit payment cycle.

### OPM's Top Management Challenges

Inspector General McFarland received an October 12, 2000 letter from several House and Senate leaders, including the chairman and ranking minority member of the committees having jurisdiction over OPM program operations. In it, our OIG was asked to provide an assessment of the most serious management challenges facing OPM. In our response to that letter last fall, we identified six challenges. These were discussed in our semiannual report issued last spring.

OPM continues to work towards meeting these challenges. While we believe that with sufficient time and resources agency management will be successful in addressing them, these challenges remain serious operational issues for our agency.

The table on the following page provides an update regarding six management challenges, as well as OPM's efforts to resolve them, that we identified in our semiannual report released last April.

## OPM Is Addressing Top Management Challenges

## Summary of OPM's Top Management Challenges

Issue Reported	Agency Actions
OPM's Financial Management Oversight of the FEHBP (CRC enrollment reconciliations)	OPM is developing a centralized enrollment system.
Reconciliation of OPM's Fund Balance with U.S. Treasury Account	OCFO has improved reconciliation procedures, but is still resolving large differences between cash balances. OPM has contracted for assistance in reconciling balances with the independent accounting firm KPMG, LLP.
Data Reconciliation and Control	OCFO has developed detailed general ledger reports, increased contractor support, implemented several critical transaction codes, and assigned responsibility for all transaction code work to a senior-level manager to aide in better data reconciliation controls.
Revolving Fund and Salaries & Expense Accounts Financial Statement Preparation	OCFO has contracted for development of needed transaction codes and improved the audit trail for year-end adjusting entries. OPM prepared a Statement of Financing, including RF and S&E accounts, in its FY 2000 consolidated financial statements.
Retirement Systems Modernization (RSM)	OPM has put in place an RSM project team for reengineering business processes related to the federal civilian retirement program.
OPM's GPRA Implementation	OPM plans to strengthen its data validation and verification procedures to clarify the link between each performance measure and overall strategic goals and explain how continuing goals and objectives address the agency's management challenges.
Human Resources Management	OPM has designed a workforce planning model for use by the federal government and will perform oversight reviews in federal agencies.
Health Care Fraud and Abuse in the Federal Employees Health Benefits Program	OPM management has submitted to OMB proposed regulations implementing the FEHBP Protection Act of 1998. OPM management and the OIG also are working together to strengthen FEHBP statutory provisions to provide additional tools to fight FEHBP health care provider fraud and abuse.

### OPM Implements New Financial Systems

We have continued to work with the Office of the Chief Financial Officer (OCFO) to enhance their operations. During this reporting period, we focused on OCFO's financial system implementation efforts. These efforts and our assistance are summarized below.

*Financial accounting and reporting.* OCFO is implementing a new financial accounting and reporting system to replace the old accounting and reporting system. The old system became outdated and could not provide sufficient information to support auditable financial statements.

OCFO has contracted with an outside entity to install this system to meet its

## **OIG Participates in OPM's Financial System Implementation**

financial, accounting and reporting needs. Meanwhile, OPM program offices and the OIG are participating in the planning, setup and implementation of the new system. Our participation includes:

- Communicating OIG financial, accounting and reporting needs to ensure a system that will meet our requirements.
- Communicating our auditing needs to ensure that adequate audit trails are available for us to perform our duties under the Inspector General Act of 1978, as amended.
- Ensuring that adequate system planning, development and implementation controls are being used by OCFO and its contractor.

*Payroll outsourcing.* As we described in our last semiannual report, OPM has entered into a contract with the U.S. General Services Administration (GSA) to administer our agency's payroll activities. This type of federal interagency support is known as *cross-servicing*. Our role in this process is to ensure that controls are in place to maximize the accuracy of OPM's payroll activities and GSA information transfers to OPM financial systems.

We will continue monitoring this program and the agency's financial accounting and reporting system, reporting on their status through our office's audits of OPM's consolidated financial statements audits.

## Investigative Activities

*The Office of Personnel Management (OPM) administers benefits from its trust funds for all federal civilian employees and annuitants participating in the federal government's retirement, health and life insurance programs. These trust fund programs cover approximately 9.5 million current and retired civilian employees, their spouses and dependents (coverage for these latter two categories is limited by law) and disburse about \$61 billion annually. This agency also oversees the federal government's only federal fundraising activity, the Combined Federal Campaign (CFC). Investigating potential fraud involving these trust funds, the CFC, OPM employee misconduct and other wrongdoing occupies the majority of our OIG investigative efforts.*

The majority of our case work during the current reporting period involved fraud committed by individuals and corporate entities against the three trust fund programs described in the shadow box above.

We continued to pursue aggressively criminal and civil prosecutions against all persons and businesses we identified as having engaged in some form of trust fund fraud. Our efforts resulted in 17 arrests and 12 convictions, along with \$1,483,547 in judicial and administrative monetary recoveries. We opened 39 investigations, closed 17, and 91 were still in progress at the end of the period. For additional information on investigative activity during this reporting period, refer to Table 1 on page 36 of this section as well as the OIG's productivity information at the beginning of this report.

We received a total of 483 hotline calls and complaints during this reporting period. These calls and complaints included such areas as health care fraud, retirement fraud, employee misconduct or other suspected wrongdoing by individuals. Information we obtain through these hotline calls, as well as written complaints received in the office, continue to be extremely helpful to us in our investigative efforts to protect the programs under the jurisdiction of our

agency. Please consult page 37 in this section for additional statistical data relating to our OIG hotline and complaint activity.

### Health Care-Related Fraud and Abuse

In keeping with the emphasis that Congress and various departments and agencies in the executive branch place on combating health care fraud, we coordinate our investigations with the Department of Justice (DOJ), the FBI, and other federal, state and local law enforcement agencies.

At the national level, we are participating members of DOJ's health-care fraud working groups. We work actively with the various U.S. Attorney's offices in their efforts to further consolidate and increase the focus of investigative resources in those regions that have been particularly vulnerable to fraudulent schemes and practices engaged in by unscrupulous health care providers. Additionally, our office maintains a close liaison with other federal law enforcement agencies participating in health care fraud investigations throughout the country. As a consequence, we participate in many health-care fraud working groups that simultaneously



represent governmental interests at the federal, state and local levels.

Our OIG special agents also work closely with the various health insurance carriers participating in the Federal Employees Health Benefits Program (FEHBP). This cooperative effort provides an effective means for reporting instances of possible fraud by FEHBP health care providers and subscribers. Our investigators, of course, continue to have a close working relationship with our OIG auditors on fraud issues that may arise during the course of FEHBP health carrier audits.

The following case summaries represent three typical, but significant, health care fraud activities carried out against the FEHBP, culminating in federal prosecution, guilty pleas or settlements during this reporting period.

### Physician Commits Major Medical Fraud

On June 22, 2001, in U.S. District Court in Jacksonville, Florida, Dr. Sammir Najjar of Orange Park, Florida, pleaded guilty to making false claims for payment of medical services. These claims were paid by insurance carriers participating in the Federal Health Employees Benefit Program and the federal Medicare program and which also provided health insurance coverage to private citizens, businesses, and state employees in the state of Florida where Dr. Najjar practiced medicine.

Dr. Najjar’s plea and sentencing were the culmination of a three-year investigation conducted by the Florida Division of Insurance Fraud, the FBI, our office and that of the Office of Inspector General at the Department of Health and Human Services (HHS). HHS is responsible for overseeing and administering the Medicare program on behalf of the federal government.

The investigation disclosed that Dr. Najjar submitted over \$5 million in false claims for services he never performed. These services all related to women purportedly having silicone breast implant-related problems. While there was no evidence that Dr. Najjar gave a false diagnosis to any of his patients, the claims for treatment were all fraudulent.

Following his plea, Dr. Najjar was sentenced to a three-year prison term and ordered to pay \$5 million in restitution, \$85,790 of which was to be returned to the FEHBP.

### Diagnostic Services Firm Agrees to Settlement

The Department of Justice and UroCor, Inc. (UroCor), an Oklahoma City-based corporation providing medical diagnostic services, signed a settlement agreement on June 11 of this year in which UroCor agreed to pay the federal government \$9 million for billing fraud involving federal health insurance programs, including the FEHBP.

The fraud included billing for laboratory tests and pathology services that:

- Were medically unnecessary.
- Were never performed.
- Had never been ordered.
- Contained falsified billing codes that led to a higher rate of reimbursement.

This settlement followed a four-year investigation initiated as a result of a referral to the Department of Justice by the affected federal parties whose health care programs had been defrauded. Specifically, this included the Department of Defense, the Department of Health and Human Services and OPM. Consequently, our respective OIGs conducted this investigation.

**F**EHBP  
**Receives**  
**\$252,200 in**  
**Settlement**  
**Agreement**

By agreeing to pay the federal government the sum of \$9 million, UroCor will have resolved its federal liability for the alleged submission of false and fraudulent claims for services it provided to the various victimized federal health insurance programs involved. UroCor is to pay \$252,200 to our agency, which represents the amount UroCor owes the FEHBP trust fund.

### Physicians Group Agrees to Settle Fraud Charges

A continuing five-year investigation being conducted by our office in conjunction with the Department of Justice, has culminated in a civil settlement with a corporation representing emergency room physicians.

Emergency Physicians Medical Group, PC (EPMG), of Michigan, Pennsylvania and Ohio, agreed to pay the federal government \$1.9 million. This payment represents EPMG's liability for its alleged involvement in a billing scheme to defraud federal and state health insurance programs. Under the agreement, the FEHBP is to receive \$176,955, representing its portion of the settlement.

We initiated this investigation based on a referral by a Blue Cross Blue Shield plan that had alleged that an emergency room physicians' billing service (Emergency Physicians Billing Service), routinely charged for high-end services involving emergency room physicians when, in reality, lower-priced basic services had actually been provided. This activity inflated costs charged to the FEHBP and to other federal and state health insurance programs.

We learned through this investigation how the billing service initially succeeded in its fraudulent billing practices. When billing these federal health insurance

programs for medical services, the billing service deliberately changed specific treatment codes to indicate higher-priced service. This type of billing fraud is known in the insurance industry as "upcoding." EPMG was a customer of the billing service and willingly participated in this fraud.

Inasmuch as this is an ongoing investigation of the billing service, we expect to realize additional recoveries from other corporate entities involved in the scheme. These, of course, will be reported in future semiannual reports.

### Retirement Fraud and Special Investigations

In addition to health care fraud, our office works closely with other federal, state and local law enforcement officials to uncover fraud involving OPM's retirement and life insurance program trust funds.

Our office's proactive efforts to identify fraud against OPM's retirement fund takes two forms: (1) we routinely review Civil Service Retirement System (CSRS) annuity records for indications of unusual circumstances, and (2) we maintain contact with the federal annuitant population, including telephone calls and on-site visits to the homes of annuitants listed in OPM's retirement records. While our fraud recoveries in this area are, for the most part, smaller than in the health care fraud area, criminal prosecutions and sentences tend to be more significant.

In addition, this office conducts special investigations in other areas having to do with serious criminal violations and misconduct by OPM employees. These cases primarily involve the theft of government funds and property.

**E**xposed  
Billing  
Scheme Results  
in \$176,955  
FEHBP Recovery

**G**uilty Plea Results in Confinement and \$71,156 Recovery for CSRS

The three case narratives that follow illustrate the various types of retirement fraud our OIG can expect to encounter. These investigations were closed during this reporting period.

**CSRS Annuity Overpayment Linked to Former Spouse**

The investigation, pursued jointly with the FBI, disclosed that James T. Bond of Fort Walton Beach, Florida, misappropriated his former spouse’s CSRS annuity funds following her death in 1996. Mr. Bond gained access to the funds, located in the deceased annuitant’s checking account, by using her ATM card.

Our office entered into this investigation after receiving a referral from the FBI office in Jacksonville, Florida. After being interviewed by federal authorities, Mr. Bond admitted to illegally taking money out of his former spouse’s checking account, including her government annuity funds. Loss to the government was \$82,780.

After pleading guilty to theft of government funds, Mr. Bond appeared in U.S. District Court in Jacksonville, Florida, on April 26, 2001, for sentencing. Mr. Bond received a sentence of eight months in prison, followed by three years’ supervised probation. He also was ordered to make restitution to our agency in the amount of \$59,055, which represented a major portion of his former wife’s federal annuity he had accessed illegally. Our OIG also recovered another \$12,101 that had remained in the checking account after Mr. Bond’s arrest.

**Annuitant’s Son Admits to Retirement Fraud**

On July 27, 2001, in U.S. District Court, in Pensacola, Florida, Michael S. Hurst, a resident of the city, was sentenced to eight months’ imprisonment, five years of supervised probation and ordered to make restitution in the amount of \$32,262 to the federal government for theft of government funds.

**Table 1: Investigative Highlights**

<b>Judicial Actions:</b>	
Arrests . . . . .	17
Indictments . . . . .	16
Convictions . . . . .	12
<b>Administrative Actions<sup>1</sup>:</b>	1
<b>Judicial Recoveries:</b>	
Fines, Penalties, Restitutions and Settlements . . . . .	\$955,426
<b>Administrative Recoveries:</b>	
Settlements and Restitutions . . . . .	\$528,121
<b>Total Funds Recovered . . . . .</b>	<b>\$1,483,547</b>

<sup>1</sup>Includes suspensions, reprimands, demotions, resignations, removals, and reassignments.

Mr. Hurst’s plea and sentencing were the results of an OIG investigation that disclosed that he had misappropriated CSRS retirement funds intended for his mother after her death in 1995. When questioned by OIG investigators, the son admitted to the theft, which he accomplished by forging his mother’s signature on checks and cashing them in a local bar and package store.

**Daughter Guilty of CSRS Annuity Theft**

Mary Ann Gerson of Laurel, Maryland, entered into a settlement agreement with OPM, approved by the Department of Justice, on July 27, 2001, whereby Ms. Gerson agreed to reimburse the CSRS trust fund the sum of \$146,994. These funds represented part of \$253,265 in payments intended for her father, a deceased CSRS annuitant.

The settlement agreement and recovery of funds were the results of an investigation initiated by our office that disclosed that Ms. Gerson had successfully

accessed the annuity payments intended for her father over an 11-year period following his death in 1987. During the investigation, Ms. Gerson admitted to investigators that she had converted the funds to her own use.

**OIG Hotlines and Complaint Activity**

The information we receive on our OIG hotlines is generally concerned with FEHBP health care fraud, retirement fraud and other complaints that may warrant special investigations. Our office receives inquiries from the general public, OPM employees, contractors and others interested in reporting waste, fraud and abuse within the agency.

In addition to hotline callers, we receive information from individuals who choose to write letters or who appear in our office. Those who report information can do so openly, anonymously or confidentially without fear of reprisal.

**S**ettlement Results in **\$146,994** Recovery to CSRS

**Table 2: Hotline Calls and Complaint Activity**

**Retirement and Special Investigations Hotline and Complaint Activity:**

Retained for Investigation . . . . .	100
Referred to: OIG Office of Audits . . . . .	0
OPM Groups and Offices . . . . .	54
Other Federal Agencies . . . . .	48
<b>Total . . . . .</b>	<b>202</b>

**Health Care Fraud Hotline and Complaint Activity:**

Retained for Investigation . . . . .	140
Referred to: OPM Groups and Offices . . . . .	54
Other Federal/State Agencies . . . . .	36
Health Insurance Carriers or Providers . . . . .	51
<b>Total . . . . .</b>	<b>281</b>
<b>Total Contacts . . . . .</b>	<b>483</b>

## **OIG Proactive Efforts Play Key Role in Retirement Fraud Cases**

### **Retirement Fraud and Special Investigations**

The Retirement and Special Investigations hotline provides the same assistance as traditional OIG hotlines in that it is used for reporting waste, fraud and abuse within the agency and its programs.

The Retirement and Special Investigations hotline and complaint activity for this reporting period included 93 telephone calls, 55 letters, 4 agency referrals, 2 walk-ins, and 48 complaints initiated by the OIG, for a total of 202. Our administrative monetary recoveries resulting from retirement and special investigation complaints totaled \$219,387.

### **Health Care Fraud**

The primary reason for establishing an OIG hotline was to handle complaints from subscribers in the Federal Employees Health Benefits Program administered by OPM. The hotline number is listed in the brochures for all the health insurance plans associated with the FEHBP.

While the hotline was designed to provide an avenue to report fraud committed by subscribers, health care providers or FEHBP carriers, frequently callers have requested assistance with disputed claims and services disallowed by the carriers. Each caller receives a follow-up call or letter from either the OIG hotline coordinator, the insurance carrier or another OPM office as appropriate.

The Health Care Fraud hotline and complaint activity for this reporting period involved 164 telephone calls and 117 letters, for a total of 281. During this period, the administrative monetary recoveries pertaining to health care fraud complaints totaled \$308,734.

### **OIG-Initiated Complaints**

As illustrated earlier in this section, we respond to complaints reported to our office by individuals, government entities at the federal, state and local levels, as well as FEHBP health care insurance carriers and their subscribers. We also initiate our own inquiries as a means to respond effectively to allegations involving fraud, abuse, integrity, and occasionally malfeasance. Our office will initiate an investigation if complaints and inquiries can be substantiated.

An example of a specific type of complaint that our office will initiate involves retirement fraud. This might occur when our agency has already received information indicating an overpayment to an annuitant has been made. At that point, our review would determine whether there were sufficient grounds to justify our involvement due to the potential for fraud. There were 22 such complaints associated with agency inquiries during this reporting period.

Another example of an OIG-initiated complaint occurs when we review the agency's automated annuity records system for certain items that may indicate a potential for fraud. If we uncover some of these indicators, we initiate personal contact with the annuitant to determine if further investigation is warranted. This investigative activity resulted in 26 instances where our office initiated personal contacts to verify the status of an annuitant.

We believe that these OIG initiatives complement our hotline and outside complaint sources to ensure that our office can continue to be effective in its role to guard against and identify instances of fraud, waste and abuse.

# Index of Reporting Requirements

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(as amended)

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**Appendix I: Final Reports Issued With Questioned Costs  
April 1, 2001 to September 30, 2001**

	Subject	Number of Reports	Questioned Costs <sup>1</sup>	Unsupported Costs <sup>1</sup>
A.	Reports for which no management decision had been made by the beginning of the reporting period	31	\$217,565,835	\$872,806
B.	Reports issued during the reporting period with findings	24	65,309,332	0
	Subtotals (A+B)	55	282,875,167	872,806
C.	Reports for which a management decision was made during the reporting period:	31	213,948,023	872,806
	1. Disallowed costs <sup>2</sup>		174,242,861	872,806
	2. Costs not disallowed		39,705,162	0
D.	Reports for which no management decision has been made by the end of the reporting period	24	68,927,144	0
	Reports for which no management decision has been made within 6 months of issuance	3	8,106,692 <sup>3</sup>	0

<sup>1</sup> Questioned costs represent recommendations for recovery of funds resulting from OIG audits. Unsupported costs are included in questioned costs.

<sup>2</sup> Does not include \$6,493,113 in investment income assessed and coordination of benefits disallowed by the program office in excess of questioned costs.

<sup>3</sup> Resolution of this item has been postponed at the request of the OIG.

**Appendix II: Final Reports Issued With Recommendations for Better Use of Funds  
April 1, 2001 to September 30, 2001**

	Subject	Number of Reports	Dollar Value
	No activity during this reporting period	0	\$ 0

### Appendix III-A: Insurance Audit Reports Issued April 1, 2001 to September 30, 2001

Report Number	Subject ( <i>Standard Audits</i> )	Issue Date	Questioned Costs	Unsupported Costs
1C-V2-00-00-021	NYLCare Health Plans of the Southwest, Inc., in Dallas, Texas	April 2, 2001	\$ 2,214,292	\$
1C-L4-00-01-016	HMO Health of Ohio in Cleveland, Ohio	April 13, 2001		
1A-10-47-01-006	Blue Cross and Blue Shield United of Wisconsin in Milwaukee, Wisconsin	April 26, 2001	380,015	
1A-10-88-01-021	Blue Cross of Northeastern Pennsylvania in Wilkes-Barre, Pennsylvania	May 7, 2001	545,677	
62-00-98-052	Kaiser Foundation Health Plan, Inc., California Division in Pasadena, California	May 8, 2001	30,755,852	
1C-17-00-01-004	Rush Prudential HMO in Chicago, Illinois	May 11, 2001	1,024,070	
1A-10-59-01-022	Anthem Blue Cross and Blue Shield of Maine in South Portland, Maine	May 14, 2001	225,725	
1C-SG-00-01-048	Capital District Physicians' Health Plan, Inc., in Albany, New York	June 15, 2001		
1A-10-24-01-031	Blue Cross and Blue Shield of South Carolina in Columbia, South Carolina	June 21, 2001	411,957	
1C-GV-00-01-042	Preferred Care in Rochester, New York	June 28, 2001		
1C-VC-00-01-008	United HealthCare of Ohio, Inc., in Minneapolis, Minnesota	July 10, 2001	1,032,988	
1A-10-03-01-027	Blue Cross Blue Shield of New Mexico in Albuquerque, New Mexico	July 25, 2001	818,857	
1C-3U-00-01-012	United HealthCare of Ohio, Inc., in Minneapolis, Minnesota	July 26, 2001	1,845,035	
1C-K6-00-01-033	SelectCare in Troy, Michigan	August 16, 2001		
1C-VR-00-00-072	Group Health Cooperative of Puget Sound (formerly Group Health Northwest) in Spokane, Washington	August 16, 2001		
1C-JH-00-01-017	Humana Medical Plan of the Tampa Area in Louisville, Kentucky	August 20, 2001	890,695	
1C-Q1-00-00-071	Lovelace Health Plan in Santa Ana, California	August 22, 2001	19,138,348	



**Appendix III-A: Insurance Audit Reports Issued  
April 1, 2001 to September 30, 2001**

Report Number	Subject ( <i>Standard Audits</i> )	Issue Date	Questioned Costs	Unsupported Costs
1A-10-64-01-093	<i>Blue Cross and Blue Shield of the Rochester Area in Rochester, New York</i>	<i>August 22, 2001</i>		
1A-10-30-01-018	<i>Anthem Blue Cross and Blue Shield in Denver, Colorado</i>	<i>August 27, 2001</i>	1,515,898	
1C-C8-00-01-028	<i>First Priority Health in Wilkes-Barre, Pennsylvania</i>	<i>August 31, 2001</i>	713,741	
1A-10-43-01-089	<i>Regence Blue Shield of Idaho in Lewiston, Idaho</i>	<i>September 19, 2001</i>		
1C-IN-00-01-013	<i>The M Plan in Indianapolis, Indiana</i>	<i>September 19, 2001</i>	803,596	
1C-DF-00-01-015	<i>Health Partners of Alabama in Birmingham, Alabama</i>	<i>September 19, 2001</i>	480,494	
<b>TOTALS</b>			<b>\$62,797,240</b>	<b>\$</b>

### Appendix III-B: Insurance Audit Reports Issued April 1, 2001 to September 30, 2001

Report Number	Subject ( <i>Rate Reconciliation Audits</i> )	Issue Date	Questioned Costs	Unsupported Costs
1C-EM-00-01-051	AvMed Health Plan of South Florida Proposed Rate Reconciliation	June 11, 2001	\$	\$
1C-VR-00-01-065	Group Health Cooperative of Puget Sound Proposed Rate Reconciliation	June 25, 2001		
1C-A7-00-01-063	Intergroup of Arizona Proposed Rate Reconciliation	July 3, 2001		
1C-UB-00-01-055	Prudential HealthCare HMO of Tennessee Proposed Rate Reconciliation	July 3, 2001		
1C-PX-00-01-056	Cimarron Health Plan of New Mexico Proposed Rate Reconciliation	July 3, 2001		
1C-KF-00-01-061	BlueCare Network of West Michigan Proposed Rate Reconciliation	July 10, 2001	155,865	
1C-KA-00-01-083	OmniCare Health Plan of Michigan Proposed Rate Reconciliation	July 10, 2001		
1C-GA-00-01-066	MVP Health Plan of New York Proposed Rate Reconciliation	July 17, 2001		
1C-LX-00-01-084	BlueCare Network of Michigan Proposed Rate Reconciliation	July 19, 2001		
1C-W3-00-01-069	CIGNA HealthCare of Richmond, Virginia Proposed Rate Reconciliation	July 30, 2001	352,284	
1C-7Z-00-01-073	PacifiCare of Oregon Proposed Rate Reconciliation	July 30, 2001		
1C-Q8-00-01-058	Univera HealthCare of New York of Western New York Proposed Rate Reconciliation	July 30, 2001	66,277	
1C-K9-00-01-072	PacifiCare of Nevada Proposed Rate Reconciliation	July 30, 2001	267,505	
1C-D2-00-01-057	Humana Health Plan of Kentucky Proposed Rate Reconciliation	July 30, 2001		
1C-MM-00-01-071	Group Health Plan of Missouri Proposed Rate Reconciliation	July 31, 2001		

**Appendix III-B: Insurance Audit Reports Issued  
April 1, 2001 to September 30, 2001**

Report Number	Subject ( <i>Rate Reconciliation Audits</i> )	Issue Date	Questioned Costs	Unsupported Costs
1C-S4-00-01-067	Keystone Health Plan Central of Central Pennsylvania Proposed Rate Reconciliation	July 31, 2001	117,821	
1C-W2-00-01-070	CIGNA HealthCare of Hampton Roads, Virginia Proposed Rate Reconciliation	July 31, 2001	545,426	
1C-QA-00-01-059	Independent Health Association of New York Proposed Rate Reconciliation	July 31, 2001	830,538	
1C-64-00-01-064	Kaiser Foundation Health Plan of Ohio Proposed Rate Reconciliation	August 3, 2001	176,376	
1C-E3-00-01-062	Kaiser Foundation Health Plan of the Mid-Atlantic States Proposed Rate Reconciliation	August 9, 2001		
1C-JN-00-01-090	Aetna U.S. HealthCare of the Capital Region Proposed Rate Reconciliation	August 13, 2001		
<b>TOTALS</b>			<b>\$2,512,092</b>	<b>\$</b>

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**Appendix IV: Internal Audit Reports Issued**  
**April 1, 2001 to September 30, 2001**

Report Number	Subject	Issue Date	Funds Put to Better Use	Questioned Costs
4A-OP-00-01-023	<i>Internal Controls of the Office of Personnel Management's FY 2000 Performance Results</i>	<i>June 19, 2001</i>	\$	\$
4A-CF-00-01-104	<i>OMB Bulletin 01-02: Agreed-Upon Benefit Withholdings and Contributions Payroll Procedures</i>	<i>September 21, 2001</i>		
<b>TOTALS</b>			\$	\$

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**Appendix V: Information Systems Audit Reports Issued**  
**April 1, 2001 to September 30, 2001**

Report Number	Subject	Issue Date	Funds Put to Better Use	Questioned Costs
4A-CI-00-01-038	<i>OPM Internet Privacy Review</i>	<i>May 9, 2001</i>	\$	\$
1A-10-92-00-028	<i>Information System General Controls at the BlueCross BlueShield Association Federal Employee Program Operations Center</i>	<i>July 30, 2001</i>		
4A-CI-00-01-088	<i>Government Information Security Reform Act Review for FY 2001</i>	<i>August 31, 2001</i>		
<b>TOTALS</b>			\$	\$

## Appendix VI: Combined Federal Campaign Audit Reports Issued April 1, 2001 to September 30, 2001

Report Number	Subject	Issue Date	Funds Put to Better Use	Questioned Costs
3A-CF-00-01-034	<i>The 1998 and 1999 Combined Federal Campaigns of the Philadelphia Area in Philadelphia, Pennsylvania</i>	<i>April 4, 2001</i>	\$	\$
3A-CF-00-01-040	<i>The 1998 and 1999 Combined Federal Campaigns of Tarrant, Denton and Johnson Counties in Fort Worth, Texas</i>	<i>May 7, 2001</i>		
3A-CF-00-01-039	<i>The 1998 and 1999 Combined Federal Campaigns of Metropolitan Dallas in Dallas, Texas</i>	<i>May 29, 2001</i>		
3A-CF-00-01-041	<i>The 1998 and 1999 Combined Federal Campaigns of Greater Fort Hood in Killeen, Texas</i>	<i>May 31, 2001</i>		
3A-CF-00-01-036	<i>The 1998 and 1999 Combined Federal Campaigns for the National Black United Federation of Charities in Newark, New Jersey</i>	<i>July 25, 2001</i>		
3A-CF-00-01-037	<i>The 1998 and 1999 Combined Federal Campaigns of Long Island, New York in Deer Park, New York</i>	<i>July 26, 2001</i>		
3A-CF-00-01-081	<i>The 1998 and 1999 Combined Federal Campaigns of Los Angeles in Los Angeles, California</i>	<i>August 8, 2001</i>		
3A-CF-00-01-054	<i>The 1998 and 1999 Combined Federal Campaigns of Central New Mexico in Albuquerque, New Mexico</i>	<i>August 16, 2001</i>		
3A-CF-00-01-053	<i>The 1998 and 1999 Combined Federal Campaigns of Tucson and Southern Arizona in Tucson, Arizona</i>	<i>August 16, 2001</i>		
3A-CF-00-01-082	<i>The 1998 and 1999 Combined Federal Campaigns of the Bay Area in San Francisco, California</i>	<i>August 31, 2001</i>		
3A-CF-00-01-052	<i>The 1998 and 1999 Combined Federal Campaigns of El Paso County in El Paso, Texas</i>	<i>September 24, 2001</i>		
<b>TOTALS</b>			\$	\$



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