

Office of the Inspector General

October 1, 2001 — March 31, 2002



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

April 30, 2002

*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 October 1, 2001 to March 31, 2002. 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

Table of Contents

<i>Message from the IG</i>	i
<i>Productivity Indicators</i>	iii
<i>Statutory and Regulatory Review</i>	1
<i>Audit Activities</i>	7
Health and Life Insurance Carrier Audits	7
Information Systems Audits	20
Other External Audits	23
OPM Internal Audits	25
<i>Investigative Activities</i>	35
Health Care-Related Fraud and Abuse	36
Retirement Fraud and Special Investigations	39
OIG Hotlines and Complaint Activity	41
<i>Index of Reporting Requirements</i>	43
<i>Appendix I:</i>	
Final Reports Issued With Questioned Costs	44
<i>Appendix II:</i>	
Final Reports Issued With Recommendations for Better Use of Funds	44
<i>Appendix III:</i>	
Insurance Audit Reports Issued (<i>Standard Audits</i>)	45
<i>Appendix IV:</i>	
Internal Audit Reports Issued	46
<i>Appendix V:</i>	
Information Systems Audit Reports Issued	46
<i>Appendix VI:</i>	
Combined Federal Campaign Audit Reports Issued	47
<i>Appendix VII:</i>	
Evaluation Reports Issued	47
<i>Investigations Tables</i>	
Table 1: Investigative Highlights	40
Table 2: Hotline Calls and Complaint Activity	41

Message from the IG

Our Office of Inspector General has embarked on an initiative to improve the efficiency and the effectiveness of our audits relating to the Federal Employees Health Benefits Program (FEHBP). The initiative combines the use of affordable computer technology with expert knowledge in the field of health benefit analysis. The goal is to develop a data warehouse, employ program-wide review strategies and, ultimately, implement sophisticated data analysis (*data mining*) techniques to thoroughly analyze FEHBP health benefit payments.

Because this is such a significant development in the way our OIG and our agency may more efficiently and effectively combat waste, fraud and abuse in a federal program worth billions of dollars, I wanted to address the most significant aspects of this auditing initiative and our future goals relating to data warehousing and data mining.

We have discussed components of this initiative for several years. However, only recently have the necessary resources become available to implement the project successfully. Advancements in affordable computer hardware and software, as well as the maturity of our information systems audit function, are the key factors in making our goals in this area achievable.

We have developed an implementing strategy that will have an immediate impact on our claims analysis capabilities, while offering future opportunities for our auditors to use their expertise to discover other types of improper claims payments. We envision that this data warehouse/data mining project will significantly increase our ability to highlight potential health care fraud in the FEHBP. The project will also provide our investigative staff with the ability to react quickly to investigative leads. For example, our investigators will be able to determine the potential program risks associated with an identified provider or subscriber fraud allegation, and take appropriate action in a matter of hours versus days or weeks.

Our current data warehouse plan centers around health benefit claims data from the FEHBP contract with the BlueCross BlueShield Association (BCBS Association). In 2001, the BCBS FEHBP contract was worth \$7 billion in FEHBP health benefit payments. BCBS enrollment represents approximately 50 percent of all subscribers in the FEHBP. Our ultimate goal is to include claims data from all carriers who determine premium rates using the same methodology as FEHBP-participating Blue Cross and Blue Shield plans.

To date, we have implemented a series of computer claims analysis applications that our auditors are using as part of our routine BCBS Association FEHBP audits. Prior to the development of these applications, the auditors were required to work through a single computer specialist. While we were very successful with this approach, it limited the number of audits that could be completed annually. Now, by applying these technical advancements in computer hardware and software with the skills of our staff (computer specialists, information systems audit staff and FEHBP program auditors), we have realized two important auditing goals. First, we have made our claims analysis process more comprehensive; secondly, we have significantly increased the number of health care audits we are able to complete each year.

These user-friendly, computer-assisted audit techniques have standardized the audit process, while allowing our auditors the necessary flexibility to adjust the applications to the specific requirements of their assignments. By empowering our auditors to complete more routine computer analyses, our computer specialists, in turn, are free to concentrate on more complex ones. These specialists also have time to work on the development of our OIG data warehouse and, ultimately, our data mining applications. A recent advancement also allows our OIG auditors to run these computer applications from remote locations throughout the country through a secure, virtual private network.

Our next challenge is to implement our claims analysis applications on a global rather than plan-by-plan basis. The data warehouse, once populated with multiple years of claims data for all BCBS plans participating in the FEHBP, will enable us to identify the global impact of claim payment issues that we currently can only review on a plan-by-plan basis. This approach offers us the opportunity to address significant issues one time only instead of multiple times per year and to recover overcharges to the program when appropriate.

One of the key components of this strategy is to work with OPM's Retirement and Insurance Service (RIS) and the appropriate carriers to identify and resolve the root causes of these claim payment issues. The goal is to work cooperatively to resolve issues once and for all. With routine data updates to the data warehouse, we will be able to monitor our joint efforts in resolving these global issues.

We also anticipate that other program offices within the agency will benefit from access to our data warehouse. Initial discussions with management representatives within RIS's contract office and actuarial staff have identified practical applications for their respective organizational units. Once operational, we plan to provide staff members within these organizations access to the data warehouse.

Finally, we plan to apply data mining techniques to our data warehouse to automate the process of discovering useful trends and unusual payment patterns. Our first step has been to form a data mining team. This team, made up of a senior FEHBP program auditor and a senior computer specialist, will have the unique challenge of employing data mining software to discover relationships and hidden patterns in FEHBP claims data. Using their combined technical skills, the team will use these relationships and patterns to identify potential health benefit payment errors and possible fraudulent payments. The data mining team is also supported by additional auditors with claims audit experience, as well as our OIG information systems audit unit. As we venture further into our data mining efforts, we plan to contact other federal programs that have practical experience in data warehousing and/or data mining applications.

The key to our ongoing success is to provide the audit and investigative staff—our experts—with powerful, yet easy-to-use, computer-assisted auditing tools that will increase our effectiveness and efficiency in combating fraud, waste and abuse in the Federal Employees Health Benefits Program. This initiative mixes affordable computer technology with our human capital expertise to maintain and enhance our audit and investigative capabilities in a rapidly changing technical environment.

Productivity Indicators

Financial Impact:

Audit Recommendations for Recovery of Funds	\$10,389,342
Recoveries Through Investigative Actions	\$4,019,851
Management Commitments to Recover Funds	\$43,211,226

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

Accomplishments:

Audit Reports Issued	27
Investigative Cases Closed	32
Indictments	14
Convictions	19
Hotline Contacts and Complaint Activity	429
Health Care Provider Debarments and Suspensions	1,664

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.

Oversight of legislative and regulatory issues affecting our office and the Inspector General (IG) community remained a high priority during this reporting period. While no bills specific to the IG community were introduced during the period, we have continued to assist Congress in reviewing possible remedies to problems facing us as Offices of Inspector General.

In particular, we have continued to discuss with Congress the need for permanent statutory law enforcement authority for IG special agent investigators. As we have explained in detail in several prior semiannual reports, we consider this need to be a particularly significant concern for the entire IG community. We are committed to bringing about the statutory changes necessary for the efficient operation of the law enforcement responsibilities of the OIGs.

One of the most important programs our agency administers is the Federal Employees Health Benefits Program (FEHBP). This program exists to provide affordable health insurance to federal employees, retirees, their spouses and dependents. As such, one of our agency's goals, and our OIG's, is to safeguard this program and its subscribers from unscrupulous and even incompetent health care providers.

The article which directly follows is devoted to a settlement agreement that underlines our agency's efforts to protect the integrity of the FEHBP and reduce costs whenever possible for its FEHBP enrollees.

A second article includes a detailed discussion of how our OIG has systematically improved the enforcement tools available to our agency to combat health-care provider fraud in all its many forms. That article appears on pages 3-5 of the FEHBP Administrative Sanctions section.

PacifiCare HMO Settling Lawsuit for Over \$87 Million

During the reporting period, our office, was heavily involved with the U.S. Department of Justice (DOJ) in negotiating a final settlement of a highly complex false claims case against PacifiCare Health Systems, Inc. (PacifiCare). While all practical aspects of the settlement were agreed to during March, final settlement did not occur until April 12.

Our office's interest in this case predates the lawsuit that was filed against PacifiCare over three years ago. Following multiple OIG audits and follow-up investigations linked to PacifiCare and its subsidiary health maintenance organizations (HMOs), our auditors and investigators were in a position to provide

valuable assistance to the U.S. Department of Justice in its efforts to substantiate allegations that a number of health maintenance organizations owned by PacifiCare and its predecessors had overcharged for health benefits provided under their FEHBP contracts. Also making significant contributions to the successful outcome of this case was our agency's Retirement and Insurance Service and Office of General Counsel.

The key allegation was that the HMOs in question, between contract years 1990 and 1997, failed to follow the applicable rules and regulations set forth by our agency in developing the premium rates charged for these benefits. As an example, although the regulations require that the FEHBP receive a premium discount equivalent to the largest discount given to other groups with a similar number of subscribers, our audits showed that the FEHBP frequently did not receive the required discount.

The settlement of this case, the largest false claims case in the history of the FEHBP, will result in the return of over \$87 million dollars to the federal government. The settlement amount is more than six times the annual budget of our OIG. More details regarding the settlement will appear in our next semiannual report.

Administrative Sanctions Activities

Virtually every federal program is protected by administrative sanctions authorities, which serve as a crucial tool in fighting fraud and other types of questionable activities carried out by individuals or business entities that directly or indirectly participate in government programs.

These sanctions authorities are of two general types. *Exclusion-based sanctions* deny individuals or businesses the right to participate in federal programs. *Financial sanctions* enable agencies to order a sanctioned party to pay damages, costs, fines and penalties for violations that have had some adverse financial impact on a federal program. Either type of sanctions authority may be based on regulation, statute, executive order or some combination thereof.

Under a delegation of authority from the OPM Director, our OIG has operated an FEHBP administrative sanctions program since 1993. The purpose of the program, which currently involves debarment and suspensions (exclusion-based sanctions) but not financial sanctions, is to prevent untrustworthy health care providers from participating in the Federal Employees Health Benefits Program.

The major difference between a debarment and a suspension is the immediacy of a suspension (usually for egregious violations) versus the longer process of debarment that requires prior notice to the offending provider. We have been using the authority granted to us under the government-wide Nonprocurement Suspension and Debarment Common Rule (common rule) that allows us to exclude health care providers that have previously been debarred or suspended from another federal health care program, such as Medicare.

During the reporting period, we debarred 1,664 health care providers. And, as a reflection of the broad impact of these sanctions, during the period, we responded to a collective total of 2,230 inquiries relating to debarments and suspensions from health care providers, health insurance carriers and federal agencies.

Settlement to Yield Payment of Over \$87 Million to Federal Government

While the common rule is an efficient basis for administrative action, it was designed as a standardized, government-wide sanctions authority capable of being applied by any agency to virtually any program other than procurement activities.

We have long recognized that the FEHBP reflects unique enforcement challenges for administrative sanctions, making a sanctions authority specifically tailored to a health care context highly desirable. Therefore, our office worked with OPM management over a period of several years to obtain statutory sanctions authority, culminating in the enactment of the Federal Employees Health Care Protection Act of 1998 (P.L. 105-266) in October 1998. Section 2 of this act contains 18 bases for exclusion-based sanctions and six bases for financial sanctions.

The following article describes some of the principal policy considerations underlying the statute, and discusses some of the issues that make sanctions enforcement within the FEHBP qualitatively more challenging than in other federal programs.

FEHBP Administrative Sanction Authorities Nearing Implementation

During the reporting period, the regulations that we developed to put in place the exclusion-based authorities of P.L. 105-266 went through a 60-day public comment period as a proposed rule. As of this writing, the final regulations are in OPM's final clearance process. When issued as a final rule in the *Federal Register*, they will immediately supplant the common rule as the authority for the FEHBP's exclusion-based provider sanctions.

P.L. 105-266 authorities were drawn specifically to supply a sanctions com-

ponent to OPM's overall efforts to combat fraud within the FEHBP and to protect the interests of both the FEHBP and its members. Thus, their effectiveness has a direct, tangible impact, not only on the integrity of the FEHBP, but also on the health care available to the 9 million persons who receive health insurance coverage through it.

Sanctions Are Proactive

Exclusion-based sanctions are intended to be proactively protective. The sanctions authorities under P.L. 105-266 draw a broad circle of protection around the FEHBP, with the purpose of preventing exposure of the program or its enrollees to health care providers whose prior conduct indicates that they may pose a risk to the integrity of the program or to the health care interests of enrollees.

In furtherance of this protective role, the bases for debarment and suspension permit—and in some cases require—exclusion of providers who have committed sanctionable violations, whether or not the violation involved the FEHBP itself. For example, the statute requires OPM to debar health care providers who:

- Have been sanctioned by other agencies for any reason, even if the reason was unrelated to health care.
- Have been convicted in federal or state court of crimes involving financial misconduct, patient abuse or neglect, controlled substances violations or obstruction of justice.

P.L. 105-266 establishes 13 other categories of noncriminal violations as permissive grounds for debarment, meaning that the debarring official can exercise discretion in deciding whether to debar in such cases. In addition, providers who have been indicted or for whom our OIG obtains credible evidence of violations may be suspended (i.e.,

Enhanced
Sanction
Authorities to
Better Protect
FEHBP &
Enrollees

excluded immediately and without prior notice) pending further investigation or prosecution.

Rather than being inefficient or ineffective, however, the wide reach of the sanctions authorities is an absolutely essential protective device that serves to forestall contact between the FEHBP and untrustworthy health care providers.

Enrollee Protection Provisions

FEHBP sanctions law specifically places responsibility on OPM and FEHBP-participating carriers to enforce debarments of health care providers by denying payment to them. However, the nature of health-care provider sanctions poses enforcement problems that are different from exclusion-based sanctions in other federal programs.

Typically, participation in a federal program requires some form of preapproval by or on behalf of the agency administering the program. For example, loans, loan guarantees, grants and contracts all involve applications which must be reviewed and approved by a federal official or a private-sector designee before any federal funds can be paid.

As a prerequisite for clearing such applications, Executive Order 12549 requires every agency to determine if the applicant appears on the official government-wide *List of Parties Excluded from Procurement and Nonprocurement Programs*, a comprehensive listing of every federal exclusion-based sanction, and which is maintained by the General Services Administration (GSA). It is commonly referred to as the “GSA List.” If the applicant is debarred or suspended by any agency, the individual or business must be disqualified from participating in any other federal program unless the agency administering the program specifically approves a waiver.

In contrast, FEHBP enrollees, by law, enjoy wide latitude to obtain health care from providers of their own choosing without preapproval by OPM. In these circumstances, FEHBP sanctions law protects the interests of enrollees by ensuring payment for items or services obtained from debarred or suspended providers even if the enrollee was unaware that the provider had been previously sanctioned.

In the case of fee-for-service plans—constituting approximately 70 percent of enrollees—the FEHBP has no way of knowing that an enrollee has used a sanctioned provider until after services have been provided and a claim for payment submitted. As this situation illustrates, the enforcement of sanctions orders prior to an individual receiving services from one of these excluded providers is impossible in the FEHBP context. Thus, a debarred or suspended provider becomes entitled to receive FEHBP payments—even though he or she is ineligible to participate in the FEHBP—simply by furnishing health care services and supplies covered by the FEHBP to a member who is not aware of the suspension or debarment.

Clearly, the FEHBP sanctions law conditions the enforceability of exclusion-based sanctions on the enrollee’s knowledge of a provider’s debarment. We received several comments on this issue during the regulatory public notice period. Two health insurance industry responses suggested that we require the excluded providers themselves to inform every FEHBP enrollee seeking services from them of their exclusion. Beyond questions of the reliability with which providers could be expected to carry out this responsibility and the difficulty of identifying FEHBP enrollees, we concluded that the FEHBP sanctions statute simply does not contain the

Key Regulation Requires Informing FEHBP Enrollees of Provider Debarments

authority for OPM to regulate the conduct of providers in this way. In fact, the law unambiguously designates notification as a carrier responsibility.

Ultimately, we decided to address this issue by balancing: (1) the need to enforce sanctions; (2) notification costs that would be incurred by carriers that would be charged back to the FEHBP through the carriers' contracts; and (3) the likelihood that an enrollee would deal with a sanctioned provider.

Our final regulations will require carriers to provide provider debarment notices to their enrollees who have obtained services or supplies within 12 months prior to a provider's debarment. We believe this approach affords the best combination of opportunities to reach the enrollees who are most likely to encounter excluded providers, while holding notification costs to a reasonable level. Once the enrollee is notified, no claims for items or services received from the excluded provider

after the effective date of the exclusion are payable.

In addition to the enhanced exclusion-based authorities for the FEHBP, regulations to implement the financial sanctions authorities of P.L. 105-266 are now in clearance within OPM to be issued as a proposed rule in the *Federal Register*.

In contrast to the proactive function of suspensions and debarments, financial sanctions—civil monetary penalties and financial assessments—specifically address violations that have actually been committed against the FEHBP. They are intended to provide an administrative method for recovering FEHBP funds paid wrongfully because of provider violations, and to serve as a deterrent to future misconduct by providers.

We will continue to report regularly on all of our administrative sanctions activities, including our progress in implementing these new FEHBP sanctions regulations.

FEHBP Financial Sanctions Authorities in Regulatory Pipeline

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 300 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 to nonrenewal of existing contracts or because of plan mergers and acquisitions. Annual premium payments are in excess of \$23.9 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-

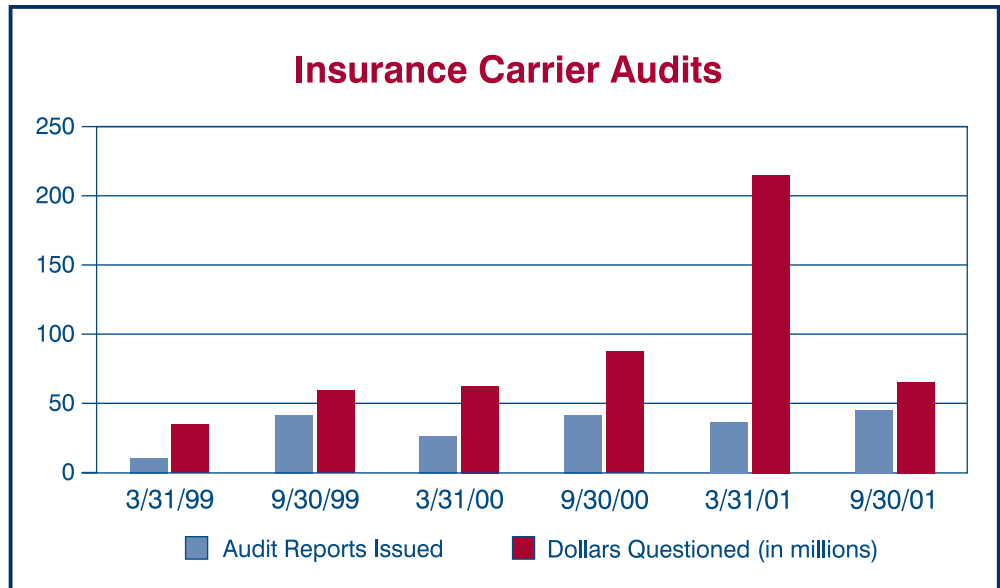
vice charges for administering a specific group's contract. With respect to the FEHBP, each experience-rated carrier must maintain a separate account for its federal contract, adjusting future premiums to reflect the FEHBP group enrollees' actual past use of benefits.

During the current reporting period, we issued 15 final reports on organizations participating in the FEHBP, 12 of which contain recommendations for monetary adjustment in the aggregate amount of \$10.4 million due the FEHBP.

Our OIG issued 203 reports and questioned \$523.4 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 and V on pages 45 and 46, respectively.

The sections that immediately follow provide additional details concerning the two categories of health plans described on this page, along with audit summaries of significant final reports



we issued within each category during the past six months.

Community-Rated Plans

Our community-rated HMO audit universe covers approximately 200 plan 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.

The rates health plans charge the FEHBP are derived predominantly from two 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 category includes fee-for-service plans as well as experience-rated HMOs.

The regulations governing the FEHBP require each carrier to 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. The rates charged are determined by the FEHBP-participating carrier, which is responsible for selecting the two appropriate groups. Should our auditors later determine that equivalent rates were not applied to the FEHBP, they declare a condition of defective pricing to exist. The FEHBP is entitled to a downward rate adjustment to compensate for any overcharges resulting from this practice.

We issued five 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 \$3 million to the FEHBP. A summary of the findings and recommendations for two of these audits follows.

Fallon Community Health Plan

in Worcester, Massachusetts

Report No. 1C-JV-00-01-05
January 15, 2002

Fallon Community Health Plan (Fallon) began its participation in the FEHBP as a community-rated comprehensive medical plan in 1982. This HMO provides primary health care services to its members in the central and eastern parts of Massachusetts. The audit of the plan's FEHBP activities covered contract years 1995 through 1999. During this five-year period, the plan received approximately \$69.4 million in FEHBP premiums.

In conducting the audit, we identified \$1,960,559 in questioned costs, including \$1,876,308 for improper health benefit charges and an additional \$84,251 for lost investment income. The lost investment income amount represents the interest the FEHBP would have earned on money the plan overcharged the FEHBP. Fallon disagrees with most of our findings and contends that the over-charges, including lost investment income, amount to less than \$200,000.

A primary objective of the audit was to determine if Fallon met its contractual obligation by offering the FEHBP the same premium rate discounts it offered the two other subscriber groups comparable in 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.

We also looked at whether the plan developed FEHBP rates in accordance with the laws and regulations governing the FEHBP. As discussed below, most of our findings concern overcharges for health benefit loadings.

Loadings

Because the FEHBP's universe of subscribers is so extensive and covers groups with special health care needs, our agency negotiates with health plans to include benefits that go beyond those stated in the basic benefits package. These additional benefits are called *loadings* within the health care industry. Each HMO contract with our agency requires a plan to set the charge for its basic rates and loadings at a fair and reasonable cost to the FEHBP and its subscribers.

In this audit, we uncovered numerous problems with the cost of loadings under the plan's FEHBP contract and one year in which the premiums for basic benefits were too high. These findings are summarized below:

Substance abuse loading. In 1995 and 1996, in setting the charge for the FEHBP's unlimited inpatient substance abuse loading, the plan calculated these additional benefit charges by applying an incorrect factor to determine the cost of the loading.

Inflated loadings. In 1999, Fallon overstated FEHBP's base rates, which, in turn, inflated the cost of two loadings: (1) the unlimited inpatient substance abuse loading; and (2) the mental health outpatient loading.

Children's loading. The FEHBP was overcharged a total of \$118,502 for its children's loading in contract years 1995 through 1999.

I mproper Health Benefits Charges Exceed \$1.8 Million

Overstated Medicare Loadings Result in \$1.2 Million Overcharge

This loading accounts for the difference between the plan's standard non-student dependent coverage to age 18/19 and the FEHBP's dependent coverage to age 22.

Medicare loading. The FEHBP's Medicare loading for individuals over 65 was overstated in 1995 through 1999 in the amount of \$1,203,504.

We found that the plan could not support the enrollment figures used in its Medicare loading calculations and/or data regarding distribution of Medicare members among those covered by Medicare Part A, Part B, or Parts A and B (see box below for Medicare Parts A and B coverage summary).

The Medicare program is administered by the Centers for Medicare and Medicaid Services (CMS), an agency within the Department of Health and Human Services.

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.

We also noted that the health benefit payments that CMS made on behalf of FEHBP Medicare participants were understated by Fallon when it calculated the Medicare loadings for contract years 1995 through 1998. Because the payment amount was understated, the FEHBP's Medicare loading was too high in each of these years.

In an effort to establish an accurate Medicare loading for each of the contract years in question, we obtained

enrollment and Medicare distribution figures from OPM and adjusted the amount of money that CMS paid for FEHBP Medicare participants. For each contract year covered by the audit, we compared the Medicare loading we developed to the loading amount that the Fallon plan charged the FEHBP. We then determined that the FEHBP was overcharged \$1,203,504 in total.

Contract undercharge. In contract year 1997, Fallon actually undercharged the FEHBP. Despite overstating the inpatient substance abuse loading again, overall, the plan undercharged the FEHBP \$98,620. This occurred because FEHBP's premium rates were not increased to account for a reduction in subscriber office visit copays.

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 \$84,251 from the plan for lost investment income through December 31, 2000, on the defective pricing overcharges identified in the report.

CIGNA HealthCare of Virginia, Inc.

in Raleigh, North Carolina

Report No. 1C-W2-00-01-014
January 28, 2002

CIGNA HealthCare of Virginia (CIGNA) began participating in the FEHBP in 1986. This plan provides comprehensive medical services to its members throughout the central and southeastern areas of Virginia.

Our audit was conducted at CIGNA HealthCare's regional offices in Raleigh, North Carolina, and covered the plan's FEHBP activities during contract years 1995 through 2000. During this period, the FEHBP paid the plan over \$68.5 million in premiums. CIGNA HealthCare of Virginia ceased participating in the FEHBP as of December 31, 2001.

Our audit revealed that the FEHBP was overcharged \$685,998 for defective pricing, as well as \$104,370 for an extension of coverage loading. As described in the previous audit narrative, a *loading* is an additional health care benefit added to a plan's basic benefits package that increases the overall cost of the FEHBP contract. In addition to the above overcharges, the FEHBP is due \$212,520 for lost investment income on the defective pricing findings.

In commenting on the report, the plan said that it does not totally agree with our defective pricing findings. CIGNA contends that the FEHBP is due substantially less for defective pricing and that lost investment income should be based on that lower amount. CIGNA agrees that it overcharged the FEHBP \$104,370 for the extension of coverage loading previously referenced.

Premium Rates

The primary objectives of this audit were to determine if:

- The plan offered the FEHBP market price rates.
- The loadings to the FEHBP were reasonable and equitable.
- The plan developed the premium rates in accordance with the laws and regulations governing the FEHBP.

Defective pricing. In 1995, the plan could not adequately support the rates it charged the two groups closest in enrollment size to the FEHBP. Because we

did not have sufficient information, we could not determine whether or not these groups received premium discounts. Since the FEHBP is entitled to the greatest discount granted to either of these two groups, and documentation was not provided, we applied a remedy that we believed was fair to the FEHBP and the plan.

Under the remedy, we looked at our prior audit of CIGNA, covering contract years 1988 through 1992, to determine if it gave discounts during the former period. We determined that eight of the groups reviewed during the previous audit were granted premium discounts. The average discount given to those groups amounted to 4.185 percent, and we considered it to be indicative of the discounts typically granted by the plan at that time. Therefore, we reduced the FEHBP's 1995 audited rates by this percentage, determining that the FEHBP was overcharged \$170,140 in 1995.

In 1996, the plan gave the two groups closest in size to the FEHBP substantial discounts, while the FEHBP received none. In applying the larger discount given to one of these two groups comparable in size to the FEHBP, we found that CIGNA overcharged the FEHBP \$253,448.

For contract year 1997, CIGNA could not support the average per-member per-month cost of certain medical and prescription drug claims it used in developing the FEHBP's rates. When we used the supporting documentation provided during our onsite visit, a lower per-member per-month cost for these claims resulted. After redeveloping the FEHBP rates using the lower cost, we compared those rates to the plan's reconciled rates and found an additional FEHBP overcharge of \$97,107 in 1997.

Our analysis of the 1999 rates showed that the FEHBP's rates should have been

Inappropriate Charges to FEHBP Total Over \$1 Million

Premium Discounts Not Given to FEHBP Exceed \$591,000

higher than what the plan charged. However, our auditors also determined that the two groups closest in size to the FEHBP received discounts in 1999 while the FEHBP did not. To remedy this inequity to the FEHBP, we applied the larger rate advantage to the higher FEHBP rates and determined that the FEHBP was overcharged \$168,303 in 1999.

Extension of coverage loading. This loading is designed to cover any FEHBP-participating plan's costs for providing benefits to individuals whose employment with the U.S. government has ended and who are no longer eligible to receive FEHBP benefits. Such coverage lasts 31 days beyond active employment.

As this pertains to CIGNA, the additional charge for the extension of coverage benefit occurred in contract years 1995, 1996 and 2000. We found, however, that a loading was not appropriate because CIGNA developed the rates using an adjusted community rating methodology. Under this claims-based methodology, the cost related to the extension of coverage was already accounted for in the FEHBP's per-member per-month charge. Consequently, the \$104,370 the plan charged the FEHBP for this loading was not appropriate.

Lost Investment Income

In accordance with the FEHBP contract with community-rated carriers and FEHBP regulations, the FEHBP is entitled to recover lost investment income on the defective pricing findings in 1995, 1996, 1997 and 1999. We determined that the FEHBP is due \$212,520 for lost investment income through December 31, 2001, on the overcharges we identified. Additional lost investment income is due for the period beginning January 1, 2002, until all questioned costs have been returned to the FEHBP.

Experience-Rated Plans

The Federal Employees Health Benefits Program offers a variety of experience-rated plans, including fee-for-service plans, the latter constituting 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 7 at the beginning of the Audits Activities section.

The universe of experience-rated plans currently consists of approximately 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 nine audit reports on experience-rated plans. These audits consisted of seven Blue Cross and Blue Shield plans, one experience-rated comprehensive medical plan and one employee organization plan. In these reports, our auditors recommended that OPM's contracting officer require the plans to return \$7.3 million in inappropriate charges and lost investment income to the FEHBP.

A description of the three types of experience-rated plans we audit can be found on the following pages, along with an audit summary from each plan category that illustrates typical findings associated with these audits.

FEHBP Due
\$212,520
for Lost
Investment
Income

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, the BCBS Association has established a Federal Employee Program (FEP) Director's Office in Washington, D.C., to provide centralized management for its federal BCBS plan.

The BCBS 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 as well as 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 \$6,422,158 in questionable contract costs charged to the FEHBP. Our auditors also noted an additional \$61,845 in lost investment income on these questioned costs, for a total of \$6,484,003 owed to the FEHBP. The BCBS Association agreed with substantially all the questioned costs in these reports.

The following audit narrative describes the major findings from one of these reports, as well as the questioned costs associated with those findings.

BlueCross BlueShield of Alabama

in Birmingham, Alabama

Report No. 1A-10-09-01-032
November 29, 2001

Our audit of the FEHBP operations at BlueCross BlueShield of Alabama (BCBS of Alabama) took place at the plan's offices in Birmingham, Alabama. We reviewed health benefit payments made by the plan from 1998 through 2000, as well as miscellaneous payments, administrative expenses and cash management covering contract years 1997 through 1999.

In performing this audit, we determined whether BCBS of Alabama charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of its contract. As a result of this audit, our auditors questioned \$1,716,921 in health benefit costs; \$361,252 in administrative expense charges; and \$43,018 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 \$2,121,191. The BCBS Association agreed with the questioned costs with few exceptions.

Blue Cross
Blue Shield
**Plan Owes
\$2,121,191
to the FEHBP**

Health Benefits

During the contract periods 1998 through 2000, BCBS of Alabama paid \$573 million in actual FEHBP claim payments. For purposes of this audit, we selected claims for examination at random, as well as in specific health benefit categories, principally those concerning coordination of benefits with Medicare and potential duplicate claim payments.

We also reviewed specific financial and accounting areas, such as refunds and other miscellaneous credits relating to FEHBP claim payments. Consequently, we determined that inappropriate health benefit charges to the FEHBP totaled \$1,716,921 during contract years 1998-2000.

Some of our significant findings included:

Coordination of benefits. For the period 1998-2000, our auditors identified 1,453 claim payments wherein the FEHBP paid as primary insurer when Medicare Part A or B was actually the primary insurer. As a result, we estimated that BCBS of Alabama overcharged the FEHBP \$1,528,646 for these coordination of benefit (COB) payment errors.

This type of inappropriate charge occurs when a plan fails to coordinate benefits properly with Medicare, a common administrative error. To assist its BCBS member plans with this and other claim reviews, the BlueCross BlueShield Association maintains a national claims system at its Federal Employee Program (FEP) operations center in the Washington, D.C. area, discussed on the preceding page.

For most of the claims questioned, we noted there was no information in the FEP national claims system 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 national claims system, BCBS

of Alabama did not review and/or adjust the patients' prior claims back to the Medicare effective dates. Therefore, these claim benefit costs remained charged to the FEHBP in their entirety, resulting in overcharges to the program.

The preceding claims involved Medicare Parts A and B. Similarly, when patients in the hospital had Medicare Part B only, BCBS of Alabama also failed to follow its procedures and properly coordinate inpatient claims. While Medicare Part A helps pay for care in hospitals, skilled nursing facilities, hospices and some home health care, Medicare Part B also covers some inpatient claims, such as ancillary items like medical supplies, diagnostic tests and clinical laboratory services (see Medicare coverage summary below).

The Medicare program is administered by the Centers for Medicare and Medicaid Services (CMS), an agency within the Department of Health and Human Services.

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 also helps pay for covered doctor services that are medically necessary.

We recommended to the OPM contracting officer that all the uncoordinated claim payments we identified during the audit be disallowed. We further recommended that the contracting officer instruct the plan to make a reasonable effort to recover the overpayments represented by these COB payment errors and credit any recovered amounts to the FEHBP.

Questioned
Health
Benefits Charges
Total \$1,716,921

Duplicate payments. Another type of payment error we noted involved duplicate payments. Of the approximately \$573 million in claims paid during this period, we identified 136 duplicate claim payments, resulting in overcharges of \$109,180 to the FEHBP. We concluded that this relatively small number of duplicate claim payments was evidence that the plan had effective controls in place to minimize such payments. Nevertheless, we recommended that the contracting officer disallow these duplicate payments and direct BCBS of Alabama to make a diligent effort to recover these payments and credit all amounts recovered to the FEHBP.

Payment errors from sampling. We selected multiple samples of claims for the purpose of determining if BCBS of Alabama had paid these claims properly over the contract periods covered by this audit. During our sample reviews, we identified 118 claim payment errors, resulting in overcharges of \$46,161 to the FEHBP. We recommended that OPM's contracting officer disallow these 118 claim overcharges and instruct the plan to be conscientious in attempting to collect these overcharges and credit all overpaid amounts recovered to the FEHBP.

Miscellaneous payments. In reviewing BCBS of Alabama's procedures, allocation methods, along with accounting records for refunds, uncashed health benefit checks and miscellaneous payment and credits, our auditors determined that the plan did not return uncashed checks to the FEHBP in a timely manner. For example, it took BCBS of Alabama from 18 to 48 months to return uncashed checks to the FEHBP once the plan had voided them.

The FEHBP contract specifically requires a carrier to void and return uncashed checks to the FEHBP within two years

of issuance. In addition, federal regulations require the carrier to credit the FEHBP for investment income lost on these funds. Consequently, we determined that BCBS of Alabama owed the FEHBP \$32,071 in lost investment income on the uncashed checks it had not returned timely to the FEHBP.

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

Administrative Expenses

During our review of administrative expenses for contract years 1997-1999, we noted that BCBS of Alabama charged the FEHBP for some expenses that did not qualify for reimbursement under its contract. These disallowed charges and costs totaled \$261,477.

We used the following criteria to make these determinations, based on federal regulations requiring a cost either to:

- Be incurred specifically for the FEHBP contract.
- Benefit both the FEHBP contract and other plan business.
- Be necessary to the overall operation of the plan's business.

We also noted that BCBS of Alabama charged the FEHBP \$99,775 twice for the same administrative cost. As a result, we recommended that the contracting officer direct the plan to credit the FEHBP \$361,252 for all disallowed administrative charges found, including this duplicate administrative charge.

Auditors
Question
**\$361,252 in
Administrative
Expenses**

Plan's FEHBP Letter of Credit Procedures Questioned

Cash Management

Since January 1, 1997, all BCBS plans have been required to use the “checks-presented method” to withdraw funds from their respective letter of credit (LOC) accounts to pay health benefit claims. The checks-presented method is a procedure whereby LOC withdrawals are delayed until checks issued for authorized FEHBP disbursements have been presented to the carrier’s financial institution for payment.

During our review of cash management for contract years 1997-1999, our auditors concluded that BCBS of Alabama did not withdraw funds from the LOC account using this method. For example, we reviewed the plan’s 1997-1999 LOC schedules and found that the plan’s daily LOC drawdowns did not equal the daily health benefit checks presented for payment, taking into account adjustments for miscellaneous credits and payments. Since BCBS of Alabama did not maintain documentation to support its LOC drawdown calculations, plan personnel could not explain how the LOC drawdowns were derived.

In our audit recommendations, we stated to the contracting officer that she direct BCBS of Alabama to withdraw funds from the LOC account using the checks-presented method. Our auditors also recommended that the contracting office instruct the plan to maintain documentation supporting these LOC drawdowns.

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 com-

puted lost investment income resulting from our audit findings in the amount of \$43,018 through June 30, 2001.

We have recommended to the contracting officer that this amount be returned to the FEHBP, as well as additional lost investment income due after that date until BCBS of Alabama has returned all questioned costs owed to the FEHBP.

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 7 of the Audit Activities section, the key difference 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 audit report. The following audit narrative describes the major findings from this report, as well as the questioned costs associated with those findings.

California Care in Woodland Hills, California

Report No. 1D-M5-00-01-046
February 27, 2002

California Care is a prepaid comprehensive medical plan, located in Woodland Hills California, providing health benefits to federal enrollees and their families throughout the state.

The purpose of this audit was to determine whether the plan 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 1998 through 2000, as well as miscellaneous payments and administrative expenses for contract years 1995 through 1999.

At the conclusion of this audit, our auditors questioned:

- \$341,521 in claim payments.
- \$23,873 in uncashed health benefit checks.
- \$36,204 in administrative expenses.

Of these amounts, California Care agreed with \$331,408 and disagreed with \$70,190. Lost investment income on these questioned costs totaled \$13,151. Final calculations by our auditors regarding amounts owed to the FEHBP totaled \$414,749.

Health Benefits

From 1998 through 2000, California Care paid \$142 million in actual FEHBP claim payments. For purposes of this audit, we selected claims for examination at random, as well as in specific

health benefit categories, principally those concerning coordination of benefits (COB) with Medicare and potential duplicate payments. We also reviewed FEHBP claim payment activities relating to refunds and uncashed health benefit checks.

Our findings relating to health benefit charges totaled \$365,394 and included the following summarized categories:

Coordination of benefits. During this review, our auditors identified 71 hospital claim payments and 102 physician claim payments wherein the FEHBP paid as primary insurer when Medicare Part A or B was actually the primary insurer. As discussed in the preceding audit narrative on the BCBS of Alabama plan, this type of inappropriate charge occurs when there is a failure to coordinate benefits properly with Medicare coverage. We estimated that the FEHBP was overcharged \$334,807 for these 173 claims.

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

Duplicate payments. Our auditors also determined that California Care inappropriately charged the FEHBP for duplicate claim payments. For the period 1998 through 2000, we identified 17 duplicate claim payments, resulting in overcharges of \$6,714 to the FEHBP.

Although this small number of duplicate claim payments indicated to our auditors that the plan had effective controls in place to minimize payments of this type, we still recommended that the contracting officer disallow them. We also recommended to her to instruct the plan to make a conscientious effort to collect

Auditors
Calculate
**\$414,749 Owed
to the FEHBP**

Plan's Failure to Coordinate Payments with Medicare Costly to FEHBP

these 17 duplicate payments and credit all amounts recovered to the FEHBP.

Uncashed FEHBP checks. In reviewing California Care's procedures for processing FEHBP refunds, uncashed checks and miscellaneous credits, we identified uncashed health benefit checks issued from 1992 through 1996 that had been voided by the plan but not credited to the FEHBP.

The FEHBP contract specifically requires a carrier to void and return uncashed checks to the FEHBP within two years of issuance. As a result, we determined that California Care owed the FEHBP \$23,873 for uncashed checks.

Administrative Expenses

Under the terms of its FEHBP contract, a plan is entitled to be reimbursed for certain administrative expenses it incurs in administering the contract, using specific criteria set forth in federal regulations and in the contract itself.

For contract years 1995-1999, California Care charged the FEHBP approximately \$12 million for administrative expenses. For audit purposes, we selected samples of these administrative expenses and determined if the charges were actual and met the government's criteria to permit reimbursement for these costs. During our sample reviews, we noted that the plan charged the FEHBP \$36,204 for sales incentive expenses that did not meet the criteria.

In this instance, the expenses in question provided no benefit to the FEHBP and, thus, could not be allowed as legitimate expenses under its FEHBP contract. As a result, we recommended that the contracting officer direct the plan to credit the FEHBP for the disallowed sales incentive charges.

Cash Management

Regarding cash management of FEHBP funds, our auditors noted that California Care did not use the "checks-presented method" to withdraw funds from its letter of credit account from 1997 through 1999 in conjunction with FEHBP health benefit claims and administrative expenses.

As discussed in the preceding audit narrative on the BCBS of Alabama plan, all plans are required to use the checks-presented method to withdraw funds from their respective LOC accounts. Since California Care personnel stated that the plan currently draws funds from the LOC account using this method, we recommended that the contracting officer review the plan's current procedures for withdrawing funds from the LOC account to substantiate compliance.

Employee Organization Plans

Employee organization plans also fall into the category of experience-rated, and may operate or sponsor participating health benefits programs. These plans operate on a fee-for-service basis, which allows members to obtain treatment through facilities or providers of their choice.

The 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.

During the reporting period, we issued one employee organization plan audit report relating to the Mail Handlers Benefit Plan (Mail Handlers). A summary of that report, including our audit findings, follows.

Claims Administration Corporation as Administrator for Mail Handlers Benefit Plan

in Rockville, Maryland

Report No. 1B-45-00-01-096
January 24, 2002

In September 2000, we completed an audit of the FEHBP operations at Mail Handlers Benefit Plan's administrator, Claims Administration Corporation (CAC), based in Rockville, Maryland. CAC processes FEHBP claims on behalf of Continental Assurance Company, which underwrites the Mail Handlers plan. During the audit, we identified one area, enrollment discrepancies, that required further review.

Consequently, we performed a supplemental audit. This audit covered health benefit payments with enrollment discrepancies from 1997 through 1999, and was conducted to determine whether CAC paid claims during gaps in subscriber coverage or after termination of subscriber coverage with the Mail Handlers plan.

As a result of this new audit, our auditors identified 3,159 claim payments

that CAC made during gaps in subscriber coverage, resulting in overcharges of \$384,931 to the FEHBP. We recommended that the contracting officer disallow these claim overcharges and instruct CAC to make a diligent effort to recover these payments and credit all amounts recovered to the FEHBP.

Our auditors also identified 24,940 claim lines that CAC may have paid after subscribers terminated coverage with Mail Handlers. Due to the significant number of claim lines, we established specific criteria for selecting those to review and subsequently reviewed 100 claim lines. As a result, we determined that CAC made overpayments on 85 of these claim lines, totaling \$10,712.

We recommended to OPM's contracting officer to:

- Direct CAC to make a reasonable effort to collect these 85 claim overpayments.
- Credit all amounts recovered to the FEHBP.
- Instruct CAC to review the remaining 24,840 claim lines.
- Initiate recovery efforts on all additional overpayments.

In total, we questioned \$395,643 in health benefit overcharges.

Auditors
Identify
\$395,643 in
Health Benefit
Overcharges

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.

The information systems and audits function is now well established in our OIG. We have built on our early success and are now able to provide a valuable service to our customers by auditing computer information systems of our agency and health insurance carriers participating in the Federal Employees Health Benefits Program (FEHBP).

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 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 security-related activities and agency computer systems development. In addition, our office audits 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 audit of Aetna U.S. Healthcare, a comprehensive medical organization that participates in the FEHBP. This audit covered Aetna's general information system controls environment and application controls over its HMO claims processing system. Aetna sponsors 31 HMO plans in the FEHBP.

Information System General and Application Controls at Aetna U.S. Healthcare

in Hartford, Connecticut

Report No. 1C-JN-00-01-007
November 1, 2001

Aetna U.S. Healthcare is a community-rated health maintenance organization (HMO) that provides health insurance coverage to subscribers nationwide. In conjunction with its FEHBP contract, we conducted an audit of its general information system and applications controls at its national claims processing center, located in Hartford, Connecticut.

Aetna's HMO claims system processes claims for the 31 Aetna HMO plans that participate in the FEHBP. During contract year 2000, the scope of this audit, these plans accounted for approximately \$784 million in health benefit premiums.

The goal of our audit was to obtain reasonable assurance that Aetna had implemented proper controls over the integrity, confidentiality and availability of computerized data associated with its FEHBP contracts. We evaluated Aetna's information system general control with guidance from the U.S. General Accounting Office's *Federal Information System Controls Audit Manual*, industry best practices, and pertinent federal law and regulations. We also audited the application controls in place to ensure that the HMO claims system was processing all transactions accurately and completely.


In reviewing the company's general controls, we examined how well the

company managed security policy and access controls, along with software changes related to its computer-based information systems. Our auditors also assessed whether there was an appropriate segregation of duties among Aetna employees involved in these information systems. Additionally, we looked at controls over the mainframe operating system and examined Aetna's plan for maintaining or quickly restoring all its computer-based systems in the event of a disaster.

With respect to Aetna's claims processing system, we performed a limited review to determine if Aetna had controls in place to ensure that transactions were valid, properly authorized and accurately processed in all respects. The objective of the review was to assess the reliability of the data that Aetna's actuarial and underwriting department used to set premium rates for its FEHBP HMO plans.

We found that Aetna had a number of controls in place that helped promote a secure computer environment. These included:

- A comprehensive, company-wide security policy that was developed after performing a risk assessment.
- A computer network protected from unauthorized access through the Internet.
- Correctly configured mainframe security software and controls over software changes that limited the possibility of these being compromised.
- A well-tested strategy for resuming business operations in the event of disaster.
- Adequate application controls for Aetna's HMO claims processing system.

 **Aetna
Agrees
with OIG
Recommendations
to Improve
Information
System Controls**

On the other hand, we noted several areas we believe Aetna management should strengthen:

- Aetna's computer security incident policy and controls for handling computer security issues when employees leave the company.
- Access controls and security for employees who use dial-up technology to gain remote access to the network.

Aetna management agreed to implement most of our recommendations. It was apparent that Aetna recognized the need for a formal policy and associated standards and procedures for responding to computer security incidents. In responding to our recommendations,

Aetna indicated it intended to revise its personnel manual to strengthen employee termination procedures. It also agreed to develop automated procedures for handling personnel actions. Aetna has also committed to taking steps to reduce the risks associated with dial-up access to its network.

We are confident that this OIG review, along with our specific recommendations, will enhance Aetna's information system general and application controls, and thereby safeguard the confidential medical records of its enrollees. Aetna's efforts will also ensure the reliability and continued availability of the company's critical automated information.

Other External Audits

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

Combined Federal Campaign

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

- Provide eligibility guidelines for national and local organizations and charities participating in the Combined Federal Campaign (CFC).
- Define the role of local CFCs.
- Identify the U.S. Office of Personnel Management's specific oversight responsibilities relating to the CFC.

An estimated 365 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.

When we conduct our CFC audits, each audit covers two consecutive campaign years of an individual CFC. Our auditors look closely at the eligibility of participating local charities, whether these local charities have complied with federal regulations and OPM guidelines, and if any irregularities appear in their financial records. In addition, all CFC organizations are required by regulation to have an independent public accounting firm (IPA) conduct an audit of their respective financial activities.

In addition, we audit national charitable federations that participate in the CFC. During these audits, we focus on the eligibility of federation member charities and how funds are distributed and expenses allocated to member charities.

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 calendar year 2001, we selected 11 campaigns and four federations for audit, based on a risk assessment that considers such factors as the size of the campaign and amount of time since the last audit. We issued three final CFC federation audit reports during the current reporting period, listed on page 47 in Appendix VI.

New CFC Campaign Oversight Procedures Needed

We have summarized the key results obtained through these CFC federation audits as follows:

- One federation failed to request its IPA to verify the federation had properly distributed funds to its member charities.
- One federation lacked internal controls over payments distributed by state-affiliated offices.
- One federation was unable to provide all of the audit documentation requested.

In addition, during this reporting period we made several recommendations to OPM's Office of Combined Federal Campaign Operations (OCFCO), intended to improve OPM's campaign oversight internal control procedures.

The key recommendations made were:

- Develop agreed-upon procedures to be used by IPAs in conducting all required CFC audits to more closely meet OCFCO's program oversight needs.
- Increase training for local federal coordinating committees (LFCC).
Note: An LFCC acts as the board of directors for each local campaign and is responsible for conducting the campaign. We routinely find the LFCCs not fully informed regarding CFC regulations.
- Disclose the full administrative costs for federations in the CFC brochure.

Regarding the last recommendation, we noted in some cases that national federations deduct administrative expenses from the donations, then forward them to their local affiliate. In turn, the local affiliate deducts an administrative fee before the remaining amount is finally sent to the charities. Currently, federal employees do not see this information when making their pledges.

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 issuing an audit relating to the agency's annual performance report to Congress, the latter a requirement of the Government and Performance Results Act of 1993 (GPRA).

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 and the internal controls governing these 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.

The following pages contain descriptions of our efforts in each of the primary areas that our internal audits cover:

- Agency performance audits.
- Agency consolidated financial statements audits.
- OPM's Federal Managers' Financial Integrity Act of 1982 (FMFIA) compliance reviews.

Agency Performance Audits

The performance audits described below are divided into two categories: program audits and economy and efficiency audits. We conducted two program audits and three economy and efficiency audits. The two program audits related to our agency's data prepared under the requirements of the Government Performance and Results Act of 1993 (GPRA). The three economy and efficiency audits were in relationship to the Federal Employees' Life Insurance program; OPM's compliance with Section 508 of the Rehabilitation Act of 1973, as amended; and OPM's compliance with elevator inspections.

Program audits. As defined by government auditing standards, a program audit is designed to determine: (1) the extent to which the desired results or benefits established by Congress or another federal authorizing body is being achieved; (2) the effectiveness of agency programs, activities or functions; and (3) agency compliance with laws and regulations pertaining to specific program areas.

Economy and efficiency audits. This type of audit is performed primarily to determine: (1) whether an in-house entity is acquiring, protecting and using its resources economically and efficiently, including areas such as personnel, property and space; (2) the causes of inefficiencies or uneconomical practices; and

(3) whether an entity has complied with laws and regulations on matters of economy and efficiency.

Government Performance and Results Audits

During this reporting period, we continued to allocate resources to auditing the agency's documents relating to the Government Performance and Results Act of 1993 (P.L. 103-92). This legislation was enacted to improve government performance and accountability through better planning and reporting of agency results government-wide.

GPRA, as it is more commonly called, 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.

Under the performance planning process, OPM program offices are responsible for developing indicators and goals for their program activities. Each program office submits performance information to OPM's strategic initiative coordinator. The strategic coordinator and OPM's budget office review the information and combine performance plan submissions from each program office into a single document that includes the agency's congressional budget justification and its annual performance plan.

OPM program offices are also responsible for measuring their performance in achieving the goals and indicators set forth in the annual performance plan.

In an October 1998 congressional request, the Inspector General 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 two audits below describe our activities and corresponding results.

Audit of OPM's FY 2003 Annual Performance Plan

Report No. 4A-OD-00-02-030
February 26, 2002

As referenced in the preceding GPRA-related audits introduction, agencies government-wide are required to provide an annual performance plan along with their respective budgetary submissions for each fiscal year. In that report, each agency must detail its achievements under its annual performance plan.

The objectives of our reviews were to determine if OPM's FY 2003 annual performance plan (APP):

- Integrated the APP with budgetary information.
- Addressed current management challenges and presidential initiatives.
- Included measurable goals and indicators.

We found the agency's FY 2003 performance plan improved from the previous year. OPM's FY 2003 annual performance plan continues to provide program goals that support OPM's general goals and objectives discussed in OPM's FY 2000-2005 strategic plan. Our audit focused on 12 out of 25 agency strategic objectives and related goals and indicators. The 12 strategic objectives included 27 goals from the following eight key program offices:

- Office of Executive Management Resources
- Employment Service
- Office of Merit Systems Oversight and Effectiveness

M measurable
Performance
Indicators Reach
82 Percent

- Retirement and Insurance Service
- Investigations Service
- Office of Workforce Relations
- Office of Chief Information Officer
- Workforce Compensation and Performance Service

Areas needing improvement include the references of goals or indicators that address each of the presidential initiatives and management challenges.

Eighty-two percent of the indicators we reviewed were measurable. OPM should improve its performance indicators by including definitions, target values, baseline data and other more detailed information. This additional information will more adequately show the progress toward achieving an indicator or goal and the government-wide impact of OPM's efforts.

OPM's FY 2001 Performance Results Internal Controls

Report No. 4A-CF-00-02-053
March 29, 2002

On the preceding page in the introductory material pertaining to GPRA-related audits, we mention that agencies government-wide are required to provide an annual performance report. In that report, each agency must detail its achievement of goals and indicators.

Using the above criteria, our objectives for this audit were to:

- Verify and validate performance data for selected FY 2001 GPRA performance indicators in OPM's performance report.

- Evaluate the effectiveness of controls over performance measurement data.

The U.S. General Accounting Office's report, *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.

Our agency submitted its second annual performance plan to Congress with its FY 2001 budget request. We focused on ten major program offices by selecting 33 program goals and 73 performance measures to verify and validate.

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

- Office of Executive Management Resources
- Employment Service
- Office of Merit Systems Oversight and Effectiveness
- Retirement and Insurance Service
- Office of the Chief Financial Officer
- Office of Human Resources and Equal Employment Opportunity
- Office of Communications
- Office of Contracting and Administration Services
- Office of Chief Information Officer
- Workforce Compensation and Performance Service

OIG Conducts OPM Performance Data Reviews

OPM Performance Reporting Controls Continue to Need Strengthening

Our reviews found that OPM needs to improve controls over the performance reporting process by:

- Establishing policies and procedures for obtaining and compiling performance data.
- Providing better oversight and monitoring of performance data by OPM managers.
- 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 cited in our audit recommendations.

OPM's Travel Card Program Internal Controls

Report No. 4A-CF-00-01-102
November 15, 2001

The Government Travel Charge Card Program was created by the General Services Administration as a government-wide travel payment and expense control system. Under the Travel and Transportation Reform Act of 1998, federal employees are required to use a government contractor-issued travel charge card for official travel expenses unless an exemption has been granted. Bank of America is currently under contract to provide travel charge card services to OPM and OPM employees.

Responsibility for OPM's travel card program resides with the Office of Chief Financial Officer (OCFO). OCFO is responsible for administering and manag-

ing the travel card program at OPM and serves as the intermediary between the cardholder, the bank and OPM program management. Program managers, in turn, have responsibility for monitoring employee travel card use within their respective program areas.

Our audit was designed to review what internal controls were in place regarding OPM's travel card program. The specific objectives of this audit were to understand and analyze specific controls over:

- Travel card uses on individually billed accounts.
- Travel card balance payments for individually billed accounts.

This audit covered the time frame between June 2000 and June 2001. We noted that the travel card program included over 1,467 individual OPM employee cardholders as of July 2001. We reviewed the travel transaction file maintained by the Office of the Chief Financial Officer and determined that during this period charge card activity reflected over 23,600 transactions, totaling over \$3.7 million.

Identified below are specific internal control issues affecting the travel card program that we recommended be addressed and improvements made by:

- Establishing written policies and procedures relating to the travel card program.
- Increasing the number of OCFO and program management travel card activity reviews.
- Improving system edits in the travel management system to prevent duplicate payments.

Additional comments concerning these three internal control issues appear below.

Travel Card Program Policies and Procedures

There are no policies and procedures for the OPM travel card program. Written policies and procedures are needed to provide guidance and to ensure consistency for the administration of the travel card program. We recommended that OCFO develop and implement written procedures to administer and monitor the travel card program at OPM. OPM concurred with the finding and recommendation.

Travel Card Program Management

Travel card cancellations. OPM does not maintain a current listing of cardholders as required by section 32 of the SmartPay Master Contract. This section was designed to ensure that travel cards issued to OPM employees who have since left the agency are cancelled timely.

During our audit, we noted 46 terminated employees who still had active cards. Two of the 46 employees had used their travel cards after the termination date. However, all charges were paid in full. We recommended that the CFO office deactivate the active card status of the 46 people we identified as terminated OPM employees.

To ensure that the travel cards for all employees separated from OPM will be cancelled more timely, we also recommended that OCFO promptly recover travel cards issued previously to OPM employees upon their separation from the agency, and periodically compare the active cardholder file to personnel files showing employees who have resigned or otherwise departed from the agency.

Charge card reports. OPM's travel card contractor, Bank of America, has a Web-based application program called EAGLS (Electronic Accounting Government Ledger System) set up to help manage

our agency's travel card activity. It is capable of producing numerous reports that could be beneficial in account analysis. However, we noted that OPM routinely only uses EAGLS to produce one report, a delinquency report.

As of June 17, 2001, 125 OPM cardholders had past due balances, totaling \$94,311. These particular accounts were past due, ranging from one to 180 days. In addition, on August 8, 2001, a delinquency amount of \$101,818, charged collectively by 48 cardholders, was written off as uncollectible.

Outside of a delinquency, we concluded that any individual who has been misusing the travel card could continue to do so and not be detected unless a delinquency problem arose. We, therefore, recommended that OPM's various program offices be given appropriate access to EAGLS, so that they can take advantage of the various reports that can be generated from EAGLS. This will permit these offices to monitor and perform periodic reviews of travel card use and more readily identify employee misuse or abuse of the travel card.

OPM's Compliance with Leave Without Pay Regulations

Report No. 4A-CF-00-02-051
March 27, 2001

We reviewed OPM's compliance with Leave Without Pay (LWOP) regulations contained in the U.S. Code of Federal Regulations, specifically 5 CFR 531, 870 and 890. In accordance with those regulations, we focused our review on payroll and personnel documentation for transactions occurring between

OPM
Travel Card
Program Will
Benefit From
Tighter Controls

January 1, 2000 and June 30, 2001, to determine if OPM had:

- Delayed within-grade increases for employees with LWOP status as required in Part 531.
- Cancelled life insurance coverage for employees in LWOP status for twelve consecutive months as required in Part 870.
- Cancelled health insurance coverage for employees in LWOP status for twelve consecutive months as required in Part 890.

Our audit resulted in the following findings:

- A part-time employee was charged in the payroll system with more LWOP time than he was scheduled to work.
 - Had this employee remained at OPM and the error not corrected, the long-term effect would have been a delay in the employee's within-grade increase for more pay periods than required by regulation.
- OPM did not cancel in a timely manner life insurance benefits for an employee who was in LWOP status for twelve consecutive months.
 - These life insurance benefits were retroactively cancelled three years after the effective date when the employee voluntarily retired.
- OPM did not cancel health insurance benefits for an employee in LWOP status for twelve consecutive months.
 - Based on payroll records, the employee was still covered by health benefits when she left the agency 24 weeks after the coverage should have been cancelled.

Based on our recommendations, our agency's Office of Human Resources and EEO (Equal Employment Opportunity) and Office of the Chief Financial Officer are developing a method to monitor the payroll system to ensure that situations described in the preceding bullets do not occur in the future.

OPM's Consolidated Financial Statements Audits

As we have described in previous semi-annual reports, our agency contracts with an independent public accounting (IPA) firm, KMPG LLP to perform OPM's consolidated financial statements audits annually under the requirements of the Chief Financial Officers' Act of 1990 (CFO Act).

The CFO Act was enacted as a result of a congressional finding that the agencies and departments of the federal government were in great need of fundamental reform in financial management requirements and practices. All evidence at the time pointed to financial management systems government-wide being obsolete, inefficient and unable to provide complete, consistent, reliable or timely information.

In performing these audits, KPMG, as our designated IPA, is responsible for providing audit reports that contain the following determinations:

- Fairness (the absence of material misstatements) of OPM's consolidated financial statements and their conformance with generally accepted accounting principles.
- OPM management's internal controls over financial reporting.
- OPM management's compliance with laws and regulations.

IG Recommends Improvements in LWOP Controls

Our office monitors KPMG's performance during these audits to ensure that all work is conducted in accordance with the contract and in compliance with government auditing standards and other authoritative references pertaining to OPM's financial statements. Specifically, we are involved in the planning, performance and reporting phases of the audit through participation in key meetings and review of KPMG's work papers and reports.

This particular audit covered OPM's retirement, health and life insurance benefits programs, and its revolving fund (RF) and salaries and expense (S&E) accounts for fiscal years 2001 and 2000. The RF programs provide a variety of human resource-related services to other federal agencies, such as pre-employment testing, security investigations and employee training. The S&E accounts are the resources provided to and used by OPM to cover the costs to administer the agency.

This is the second year that our agency has issued consolidated financial statements, and the first year that comparative financial statements have been presented. In prior years, OPM prepared separate financial statements for each benefits program, its revolving fund, and salaries and expense accounts.

Based on our monitoring efforts, we concurred with the IPA's reports on the consolidated financial statements, internal controls and compliance with laws and regulations. A summary relating to the audit report we issued on KPMG's work follows.

OPM's FY 2001 & FY 2000 Consolidated Financial Statements

Report No. 4A-CF-00-01-101
February 8, 2002

Under a contract monitored by our office, the international accounting firm of KPMG LLP (KPMG) performed audits of OPM's FY 2001 and FY 2000 consolidated financial statements. KPMG's audit covered the retirement, health and life insurance programs; revolving fund (RF); and salaries and expense (S&E) accounts.

As we have mentioned in previous semi-annual reports, the benefits programs are key to the flow of benefits to federal civilian employees, annuitants and their respective dependents, and operate under the following names:

- Civil Service Retirement System
- Federal Employees Retirement System
- Federal Employees Health Benefits Program (FEHBP)
- Federal Employees' Group Life Insurance program

These programs are administered by OPM's Retirement and Insurance Service (RIS).

Consolidated & Benefits Programs Financial Statements

KPMG determined that the consolidated fiscal years 2001 and 2000 financial statements and the individual statements of the three programs that govern the health, life, and retirement benefits of

No Material Weaknesses Reported for Second Consecutive Year

federal employees and retirees were presented fairly in all material respects and were prepared in conformance with generally accepted accounting principles.

KPMG noted six reportable conditions in the internal control environments of the benefits programs and the RF and S&E accounts during fiscal year 2001. Five of these conditions existed in the prior year and remain uncorrected. *Reportable conditions* are defined as items that if left uncorrected could jeopardize the agency's ability to record, process, summarize and report financial data accurately, although they would not result in material misstatements to the consolidated financial statements. If the items would result in material misstatements, then they are defined as *material weaknesses*.

Table 1 on the next page includes reportable conditions that KPMG identified during its audit work on the financial statements for FYs 2001 and 2000. This is the second time since the CFO Act was implemented that none of the reportable conditions was considered to be a material weakness in the agency's internal controls over financial reporting.

Specifically, KPMG reported the following conditions that needed improving:

- Controls over program administration for community-rated health carriers under the FEHBP.
- Quality control over annual financial statement preparation [Retirement and Insurance Service and Office of the Chief Financial Officer (OCFO)].
- Budgetary accounting structure of OCFO.*

*Note: Budgetary accounts are included in two financial statements: the statement of budgetary resources and statement of financing. Without

a set of general ledger accounts to summarize budgetary activity that requires debits and credits to balance, the risk of reporting inaccurate budgetary figures exists.

- Account analysis and other significant reconciliation procedures of OCFO.
- Implementing documented policies and procedures of OCFO.
- Electronic data processing (EDP) general control environment of OPM:
 - Service continuity relating to information resource protection and unplanned service interruption
 - Software development and change controls
 - Access controls
 - Entity-wide information security program
 - System software controls

KPMG reported no instances of non-compliance that are required to be reported under government auditing standards or Office of Management and Budget Bulletin No. 01-02, *Audit Requirements for Federal Financial Statements*, except for the following areas where OPM's financial management systems did not substantially comply with the requirements of the Federal Financial Managers' Improvement Act:

- Federal financial management system requirements.
- Standard general ledger at the transaction level (RF and S&E only).

The following table lists the internal control weaknesses reported for FYs 2001 and 2000 and the programs to which they apply.

Deficiencies Still Noted in OPM's Financial Reporting for FYs 2001 & 2000

Table 1: FYs 2001 & 2000 Internal Control Weaknesses

Issues	Retirement Program	Health Benefits Program	Life Insurance Program	Revolving Fund	Salaries & Expense Accounts
Controls Over Program Administration for the Community-Rated Health Carriers	N/A	RC	N/A	N/A	N/A
Quality Control Over Annual Financial Statement Preparation	RC	RC	RC	RC	RC
Budgetary Accounting Structure	NRC	NRC	NRC	RC	RC
Account Analysis and Other Significant Reconciliation Procedures of OCFO	NRC	NRC	NRC	RC	RC
EDP General Control Environment	RC	RC	RC	RC	RC
Implementation of Documented Policies and Procedures of the OCFO	NRC	NRC	NRC	RC ¹	RC ¹

RC = A reportable condition NRC = No reportable condition N/A = Not applicable to the program

¹This reportable condition applies to FY 2001 only.

OPM's FMFIA Compliance Efforts

As part of our office's auditing responsibilities, we reviewed OPM's Federal Managers' Financial Integrity Act of 1982 (FMFIA) reporting process for calendar year 2001. As required under this act, all agencies must evaluate their respective systems of internal accounting and administrative control and report their findings to the President.

In performing these audits, our office determines whether those systems provide reasonable assurance that:

- Obligations and costs are in compliance with applicable law.
- Funds, property and other assets are safeguarded against waste, loss, unauthorized use or misappropriation.

- Revenues and expenditures applicable to agency operations are properly recorded and accounted.

Note: This revenues and expenditures review is performed to ensure the reliability of the agency's financial and statistical reports and an accurate accounting of all assets.

The purpose of our most recent FMFIA review was to determine whether OPM's reported conclusion regarding the adequacy of its internal accounting and administrative controls was complete and accurate. In order to do this, we performed the following procedures:

- Examined documentation supporting the FMFIA reporting process.
- Analyzed management's summary of FMFIA internal control weaknesses and financial system non-conformances.

Financial Management Controls Remain Critical Issue for OPM

- Compared OPM's weaknesses and nonconformance summary in its calendar year 2001 FMFIA review to IPA's interim findings in OPM's FY 2001 consolidated financial statements.
- Compared these same weakness and nonconformance issues referenced in the FMFIA report to our other performance and program audit work.

OPM reported no material weaknesses and two material nonconformances as of December 31, 2001. A *nonconformance* is defined as a situation in which an agency's accounting system does not conform to the principles, standards and related requirements prescribed by the U.S. Comptroller General, U.S. General Accounting Office. OPM also reported that four weaknesses and one nonconformance included in the prior year's report were corrected, subject to audit validation.

In our opinion, the results of both our work and KPMG LLP's support the overall conclusion reached by OPM management. The change in material weaknesses reported from the prior calendar year FMFIA report to none for this year's report are due to improvements in agency internal controls as well as the continuing effectiveness of several compensating controls.

While we fully agreed with the noted conclusions in the FMFIA report, we want to emphasize that the correction of the prior year material weaknesses is still subject to audit validation. In some cases, the correction is based on temporary compensating controls in place until permanent controls can be implemented. These temporary controls allow the agency to achieve minimal levels of control until the necessary resources—people, money, technology—can be achieved under future agency funding priorities.

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 nine million current and retired civilian employees, including eligible family members, and disburse about \$69 billion annually. While we investigate employee misconduct and other wrongdoing brought to our attention, the majority of our OIG investigative efforts is spent examining potential fraud involving these trust funds.

As a result of this office's investigative activities, we realized a significant number of judicial and administrative successes during this reporting period, including monetary recoveries totaling \$4,019,851.

Overall, we opened 19 investigations and closed 32 during the reporting period, with 80 still in progress at the end of the period. Our investigations also led to 14 arrests and 19 convictions during the period. For a more complete statistical summary of our office's investigative activity in this reporting period, refer to Table 1 on page 40 of this section, along with the OIG's productivity indicators listed at the beginning of this report.

As mentioned in the shadow box above, most of our case work relates to the federal health, life and retirement trust fund programs our agency administers on behalf of millions of federal employees, retirees, their spouses and dependents. Our office aggressively pursues individuals and corporate entities seeking to defraud these trust funds upon which these federal employees, retirees, their spouses and dependents rely.

Over the years, our OIG has worked a number of annuity fraud cases involving the Civil Service Retirement and Disability trust fund. This trust fund covers all civilian federal employees who contributed to the Civil Service Retirement System (CSRS) and/or the newer Federal Employees Retirement System

(FERS). FERS was established by Congress in 1983. At that time, federal employees were given the opportunity to remain in CSRS or switch to the new program. All new federal government employees hired on or after January 1, 1984, were automatically placed in the FERS retirement program.

With CSRS being the older of the two systems, more people have retired under this system, creating more opportunity for annuity fraud under it than FERS. Our office long ago assumed a proactive stance in identifying individual cases upon which to base investigations of this nature.

We identify fraud in this area by routinely reviewing CSRS annuity records for anything that might present an irregularity of some type, including excessive age. We receive additional information from our agency's Retirement and Insurance Service (RIS) through the computer matches it performs using OPM's annuity rolls and the Social Security Administration's death records. These computer matches have proven very helpful to OPM, since many CSRS annuitants or those receiving CSRS's survivor benefits are also eligible for Social Security benefits. RIS also provides our office other annuity records data in support of our investigative activities.

Other useful tools to help our office in its efforts to uncover and expose fraud

and abuse within OPM-administered programs has been our health care fraud hotline and our retirement and special investigations hotline, along with mailed-in complaints. Formal complaints and calls we receive on these hotlines totaled 429 during this reporting period. Additional information, including specific activity breakdowns for each hotline, can be found on pages 41-42 in this section.

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.

In addition to our responsibility to detect and investigate fraud perpetrated against the trust funds, this office conducts investigations of serious criminal violations and misconduct by OPM employees. These cases may involve the theft or misuse of government funds and property.

On the following pages, we have provided narratives relating to health care and retirement fund fraud investigations we conducted or concluded during the reporting period. These illustrate not only the various types of fraud we encounter in our investigations, but what penalties and sanctions face those involved in wrongdoing affecting OPM programs.

Health Care-Related Fraud and Abuse

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 narratives describe five of the cases we concluded in the area of health care fraud during this reporting period.

Pharmacist Involved in Illegal Waiver of Copayments

In December of 2000, we received a referral from Mail Handlers Benefits Plan (Mail Handlers), a federal health insurance employee organization that participates in the FEHBP, reporting that a pharmacy in Wilkes-Barre, Pennsylvania, had been waiving the required copayment on the purchase of injectable pharmaceuticals being dispensed to one of the plan's enrollees.

After conducting our investigation, we determined that the owner of this pharmacy, who also was a pharmacist, was maximizing his profits by submitting hard copy claims to this plan to avoid using the Mail Handlers plan's online prescription service that automatically factored in copays to the pharmacy.

Following our consultations with the U.S. Attorney's office with jurisdiction over this area of Pennsylvania and with the plan, the pharmacy owner signed an agreement on February 12, 2002, to reimburse the FEHBP plan \$225,144 for the overpayment he received.

Settlement
Totaling
\$225,144
Agreed to by
Pennsylvania
Pharmacy Owner

Texas Physician Indicted for Health Care Fraud

In August 2001, our office, the FBI, the Texas Rangers, and the state of Texas Medicaid fraud control unit began an investigation of a Midland, Texas physician who was purportedly engaged in fraudulently billing federal and state health insurance programs as well as private insurance companies. Specifically, these programs included the Federal Employees Health Benefits Program, Medicare, and the federally funded but state-administered Medicaid program.

This investigation provided sufficient evidence to obtain search warrants for the physician's office, his residence, and places of business unrelated to his medical practice. These warrants were executed in early November 2001. While the primary reason for performing these searches was related to the alleged billing fraud, federal and state law enforcement officers discovered 5.7 grams of cocaine at his residence. Consequently, on November 5, 2001, he was arrested on one count of illegal possession of a controlled substance, and one count of distributing illegal controlled substances to a juvenile.

On December 19, 2001, this doctor was indicted for health care fraud by a federal grand jury in Midland, Texas, for: (1) billing these health care programs and insurance companies for medical services never rendered; and (2) changing treatment codes to reflect high-end services not performed. Both practices resulted in substantially larger reimbursements to this doctor from these various health insurance programs and private insurance companies than he otherwise should have received.

Potential loss to these health insurance programs and private insurance companies has been calculated at over one mil-

lion dollars. Of this amount, the loss to the Federal Employees Health Benefits Program, administered by our agency, was estimated to exceed \$240,000.

A trial date has been set for May 16, 2002. The outcome of the trial relating to the health care fraud will be reported in a future semiannual report.

Durable Medical Equipment Company Owner Guilty of Mail Fraud

Our office has been conducting an ongoing investigation involving another Midland, Texas case in cooperation with the state of Texas Medicaid fraud control unit, the FBI, and the Government Employees Hospital Association (GEHA). It came to our attention in June 1997 that the owner of a durable medical equipment (DME) company in Midland had been involved in health care fraud activities for an extended period of time.

This investigation was initiated based on a referral from GEHA, a fee-for-service plan based in Kansas City, Missouri, that participates in the FEHBP. We subsequently learned that the owner of this company created fraudulent documentation to support the sale and rental of expensive medical equipment rather than the less expensive equipment actually acquired by the DME company's customers. This resulted in a larger reimbursement to the company than it otherwise should have received.

After being interviewed by an investigator from our office and other law enforcement agents, he agreed to plead guilty to a mail fraud charge inasmuch as the fraudulent claims and the supporting documentation had been sent through the U.S. mail. He also agreed to make restitution in the amount of \$2.6 million to the federal and state health insurance

Federal-State Health Insurance Programs Fraud Losses May Exceed \$1 Million

FEHBP to Recover \$100,000 from \$2.6 Million Medical Equipment Scam

programs he had defrauded. Of this amount, \$100,000 was earmarked for the FEHBP trust fund for its losses.

APWU Cited in Improper Administrative Payments & Kickbacks

In October 1998, our OIG initiated an investigation involving the American Postal Workers Union Health Plan (APWU) and the National Health Services, Inc. (NHS) of Louisville, Kentucky, and United Payors & United Providers, Inc. (UP&UP) of Rockville, Maryland, after a false claim lawsuit was filed in U.S. District Court in Baltimore, Maryland.

The lawsuit alleged that, from 1993 through 1997, APWU, also located in Rockville, Maryland, contracted with the National Health Services, Inc., and United Payors & United Providers, Inc., to assist APWU in reducing claims expenses required under its Federal Employees Health Benefits Program (FEHBP) contract administered by our agency. It was further alleged that these cost containment contracts were inflated with kickbacks that NHS and UP&UP paid APWU.

Through the extensive work our OIG investigative and audit staffs performed during this investigation, and with the assistance of the U.S. Attorney’s office for the District of Maryland, we were able to substantiate these allegations. Our work resulted in a settlement agreement.

On February 12, 2002, our office received the final settlement agreement made between OPM, the Department of Justice, APWU, NHS and UP&UP. After the settlement, UP&UP and NHS were acquired in March 2000 by BCE Emergis, a Canadian corporation.

The final agreement called for APWU, NHS and UP&UP to reimburse the federal government \$2,193,000 to resolve allegations that they submitted false claims to the FEHBP. Under the terms of the settlement agreement, APWU will return \$1,243,000, with the remaining \$950,000 paid by NHS and UP&UP. The FEHBP trust fund will receive \$908,000 of the \$2,193,000 settlement amount.

Norfolk Chiropractor Obtains Illegal Reimbursements for Services

In November 1999, the FBI requested assistance in investigating allegations of health care fraud involving a chiropractor clinic in Chesapeake, Virginia, and its owner, Michael J. Concessi, a Norfolk, Virginia chiropractor.

In addition to the FBI, we were joined in our investigation by Trigon Blue Cross and Blue Shield (Trigon BCBS) and the U.S. Defense Criminal Investigative Service. Our investigation revealed that Dr. Concessi, who owned and operated the Healthwise Medical and Rehabilitation Center, had engaged in a fraudulent billing scheme over a period of several years.

Specifically, Mr. Concessi had been successful in getting a medical doctor and a doctor of osteopathy to submit medical claims for services as if they had performed them when, in fact, these services had been rendered by Mr. Concessi. As a chiropractor, Mr. Concessi was not entitled to receive reimbursement for these services. This scheme was used in billing Trigon BCBS, an FEHBP-participating BCBS insurance carrier, as well as TRICARE/CHAMPUS, the federal health insurance program that provides health benefits to our active and retired military personnel, their spouses and eligible dependents.

A **PWU Health Plan Agrees to \$2.2 Million Settlement**

On March 1, 2001, Mr. Concessi and the Healthwise Medical Rehabilitation Center were indicted by a federal grand jury in Norfolk, Virginia, on multiple counts of health care fraud and making false statements. Several months later, on August 24, 2001, both were convicted on 24 counts relating to the above charges. Sentencing took place on November 19, 2001.

Mr. Concessi received a term of 30 months imprisonment, a \$25,000 fine, three years of supervised release, and was ordered to pay full restitution to Trigon Blue Cross Blue Shield under its FEHBP contract in the amount of \$35,994.69 and \$51,384.53 to TRICARE/CHAMPUS. Healthwise Medical Rehabilitation Center was fined an additional \$158,000 and received three years' probation.

Based on these convictions, Mr. Concessi and Healthwise Medical and Rehabilitation Center, along with Concessi Chiropractic Center in Norfolk, were suspended and debarred from the Federal Employees Health Benefits Program under the FEHBP administrative sanctions program. This program is administered by our OIG through a delegation of authority from the OPM Director. For a more detailed discussion of the program, please refer to an article in our Statutory and Regulatory Review section on pages 3-5.

Retirement Fraud and Special Investigations

As previously stated, in accordance with our mission to prevent and detect fraud, OIG special agents routinely review CSRS annuity records for indications of unusual circumstances. For example, using excessive annuitant age as an indication of potential fraud, our investi-

gators attempt to contact the annuitants and determine if they are alive and still receiving their benefits. In addition, we receive inquiries from OPM program offices, other federal agencies and private citizens that prompt us to investigate cases of potential retirement fraud or alleged misconduct by OPM employees and contractors.

Below are the summaries of two cases we completed during this reporting period that illustrate the type of vigilance necessary to combat federal annuity fraud.

CSRS Annuitant's Daughter Involved in Annuity Fraud

Our office's involvement in a joint investigation with the U.S. Secret Service, the IRS Criminal Investigations Division, and the Office of Inspector General at the Social Security Administration has yielded a conviction and prison sentence for the daughter of a deceased Civil Service Retirement System (CSRS) annuitant found guilty last year on charges of mail and wire fraud and tax evasion by a jury in Pittsburgh, Pennsylvania. In addition, the court ordered the daughter to pay restitution to the federal government in connection with these charges for taking federal benefit payments totaling \$369,000 intended for her deceased mother.

In February 1999, OPM's Office of Retirement and Insurance Service referred this case to our office for investigation. Our investigation disclosed that, following her mother's death in 1983, the daughter Amaryllis E. Corbett, a resident of Allegheny County, Pennsylvania, misappropriated widow's insurance benefits from the Social Security Administration as well as CSRS retirement benefits from our agency.

Chiropractor Guilty of FEHBP Fraud Will Serve Prison Term, Pay Fines & Return \$137,379 to Government

P **rison Sentence & Restitution Imposed for CSRS Annuity Theft**

To compound this fraud, she failed to file federal income tax forms to avoid paying taxes on these benefits. The total sum received by the daughter over the years following her mother’s death was \$369,000. Ms. Corbett was successful in withdrawing this money from her mother’s bank account because she had access to her mother’s ATM card.

On August 10, 2001, in U.S. District Court, located in Pittsburgh, Pennsylvania, Ms. Corbett was convicted of mail and wire fraud as well as tax evasion. Four months later, on December 10, 2001, Ms. Corbett was sentenced to serve 30 months in prison, given three years’ supervised probation and ordered to pay back \$260,674 to the Civil Service Retirement System trust fund and another \$108,326 to the Social Security Administration for their respective monetary losses.

Retirement Fund Investigation Leads to Guilty Plea

The successful conclusion to one of our annuity fraud cases was a direct result

of the proactive investigative work we routinely perform in analyzing OPM’s retirement rolls and verifying that retirement payments are being received by eligible beneficiaries.

This case was unusual in that the son of a deceased CSRS annuitant, who fraudulently acquired \$410,620 in annuity payments intended for his mother, insisted that she was alive when, in fact, she had died in 1988.

The son, Douglas K. Smith, a resident of Everett, Pennsylvania, would not provide our office with any information as to the whereabouts of his mother. Extensive and persistent investigative work resulted in one of our special agents locating a gravesite in Silver Spring, Maryland, and subsequently obtaining a death certificate with the assistance of the Maryland State Funeral Directors Association.

On July 24, 2001, Mr. Smith was indicted for theft of government funds. Subsequent to that date, on December 7, 2001, in U.S. District Court, in Alexandria, Virginia, Mr. Smith pleaded guilty to

Table 1: Investigative Highlights

Judicial Actions:

Arrests	14
Indictments	14
Convictions	19

Administrative Actions¹: 0

Judicial Recoveries:

Fines, Penalties, Restitutions and Settlements.	\$3,690,880
---	-------------

Administrative Recoveries:

Settlements and Restitutions	\$328,971
--	-----------

Total Funds Recovered \$4,019,851

¹Includes suspensions, reprimands, demotions, resignations, removals, and reassignments.

one count of theft of government funds. He received a sentence to serve one year and one day in a federal penitentiary. He also was ordered to pay restitution in the amount of \$328,801 to the CSRS retirement trust fund.

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.

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 10 telephone calls, 70 letters, 7 agency referrals, 8 walk-ins, and 15 complaints initiated by the OIG, for a total of 110. Our administrative monetary recoveries resulting from retirement and special investigation complaints totaled \$1,236,742.

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.

Son Illegally Appropriates \$410,620 After Mother's Death

Table 2: Hotline Calls and Complaint Activity

Retirement and Special Investigations Hotline and Complaint Activity:	
Retained for Investigation	15
Referred to:	
OIG Office of Audits	2
OPM Groups and Offices	52
Other Federal Agencies	41
Total	110
Health Care Fraud Hotline and Complaint Activity:	
Retained for Investigation	134
Referred to:	
OPM Groups and Offices	83
Other Federal/State Agencies	54
Health Insurance Carriers or Providers	48
Total	319
Total Contacts	429

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 175 telephone calls and 144 letters, for a total of 319. During this period, the administrative monetary recoveries pertaining to health care fraud complaints totaled \$2,454,138.

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 65 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.

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

Inspector General Act of 1978
(as amended)

	Page
Section 4 (a) (2):	Review of legislation and regulations 1-5
Section 5 (a) (1):	Significant problems, abuses and deficiencies 27-34
Section 5 (a) (2):	Recommendations regarding significant problems, abuses and deficiencies. 22, 27-30, 32-34
Section 5 (a) (3):	Recommendations described in previous semiannual reports on which corrective action has not been completed 44
Section 5 (a) (4):	Matters referred to prosecutive authorities 1-2, 36-41
Section 5 (a) (5):	Summary of instances where information was refused during this reporting period No Activity
Section 5 (a) (6):	Listing of audit reports issued during this reporting period 45-47
Section 5 (a) (7):	Summary of particularly significant reports 9-19, 21-22, 26-33
Section 5 (a) (8):	Audit reports containing questioned costs 45-46
Section 5 (a) (9):	Audit reports containing recommendations for better use of funds No Activity
Section 5 (a) (10):	Summary of unresolved audit reports issued prior to the beginning of this reporting period 44
Section 5 (a) (11):	Significant revised management decisions during this reporting period No Activity
Section 5 (a) (12):	Significant management decisions with which OIG disagreed during this reporting period No Activity

Appendix I: Final Reports Issued With Questioned Costs October 1, 2001 to March 31, 2002

	Subject	Number of Reports	Questioned Costs ¹	Unsupported Costs ¹
A.	Reports for which no management decision had been made by the beginning of the reporting period	24	\$68,927,144	\$
B.	Reports issued during the reporting period with findings	12	10,389,342	
	Subtotals (A+B)	36	79,316,486	
C.	Reports for which a management decision was made during the reporting period:	24	62,090,432	
	1. Disallowed costs		43,211,226 ²	
	2. Costs not disallowed		18,879,206 ³	
D.	Reports for which no management decision has been made by the end of the reporting period	12	17,226,054	
	Reports for which no management decision has been made within 6 months of issuance	3	8,106,692 ⁴	

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

² Does not include \$758,259 in investment income assessed by the program office in excess of questioned costs.

³ Amount includes approximately \$10.7 million that would not have been questioned if the OIG had proper or adequate information prior to issuing the final report.

⁴ 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 October 1, 2001 to March 31, 2002

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

Appendix III: Insurance Audit Reports Issued October 1, 2001 to March 31, 2002

Report Number	Subject (<i>Standard Audits</i>)	Issue Date	Questioned Costs	Unsupported Costs
1C-UK-00-01-026	<i>Texas Health Choice. L. C. in Dallas, Texas</i>	October 4, 2001	\$	
1A-10-56-01-049	<i>Blue Cross and Blue Shield of Arizona in Phoenix, Arizona</i>	October 22, 2001	1,324,632	
1C-EC-00-01-003	<i>Prudential HealthCare HMO of Jacksonville in Alpharetta, Georgia</i>	November 6, 2001	131,500	
1A-10-79-01-094	<i>Blue Cross and Blue Shield of Central New York in Syracuse, New York</i>	November 20, 2001	35,602	
1A-10-09-01-032	<i>Blue Cross and Blue Shield of Alabama in Birmingham, Alabama</i>	November 29, 2001	2,121,191	
1A-10-58-01-079	<i>Regence Blue Cross and Blue Shield of Oregon in Portland, Oregon</i>	December 10, 2001	484,489	
1C-2N-00-01-099	<i>PacifiCare Health Plans of the Oklahoma Region in Tulsa, Oklahoma</i>	January 2, 2002		
1C-JV-00-01-005	<i>Fallon Community Health Plan in Worcester, Massachusetts</i>	January 15, 2002	1,960,559	
1B-45-00-01-096	<i>Claims Administration Corporation as Administrator for the Mail Handlers Benefit Plan in Rockville, Maryland</i>	January 24, 2002	395,643	
1C-W2-00-01-014	<i>CIGNA HealthCare of Virginia, Inc. in Glen Allen, Virginia</i>	January 28, 2002	1,002,888	
1A-10-10-01-098	<i>Blue Cross of Idaho in Boise, Idaho</i>	January 28, 2002	67,403	
1A-10-54-01-092	<i>Mountain State Blue Cross and Blue Shield in Parkersburg, West Virginia</i>	January 31, 2002	86,190	
1A-10-97-01-045	<i>Blue Cross of California in Woodland Hills, California</i>	February 12, 2002	2,364,496	
1D-M5-00-01-046	<i>California Care in Woodland Hills, California</i>	February 27, 2002	414,749	
TOTALS			\$10,389,342	\$

Appendix IV: Internal Audit Reports Issued October 1, 2001 to March 31, 2002

Report Number	Subject	Issue Date	Funds Put to Better Use	Questioned Costs
4A-CF-00-01-102	Office of Personnel Management's Travel Card Program Internal Controls	November 15, 2001	\$	\$
4A-CA-00-02-040	Elevator Inspections at the Office of Personnel Management	January 31, 2002		
1A-10-91-01-106	Blue Cross and Blue Shield Association Federal Employees Program Director's Office in Washington D.C.	February 4, 2002		
4A-OD-00-02-030	Office of Personnel Management's Fiscal Year 2003 Annual Performance Plan	February 26, 2002		
4A-CF-00-01-101	Office of Personnel Management's Fiscal Years 2001 and 2000 Consolidated Financial Statements	February 27, 2002		
4A-CF-00-02-051	Office of Personnel Management's Compliance with Leave Without Pay Regulations	March 27, 2002		
4A-CF-00-02-053	Office of Personnel Management's Fiscal Year 2001 Performance Results Internal Controls	March 29, 2002		
TOTALS			\$	\$

Appendix V: Information Systems Audit Reports Issued October 1, 2001 to March 31, 2002

Report Number	Subject	Issue Date	Funds Put to Better Use	Questioned Costs
1C-JN-00-01-007	Information System General and Application Controls at Aetna U.S. HealthCare in Hartford, Connecticut	November 1, 2001	\$	\$
TOTALS			\$	\$

Appendix VI: Combined Federal Campaign Audit Reports Issued October 1, 2001 to March 31, 2002

Report Number	Subject	Issue Date	Funds Put to Better Use	Questioned Costs
3A-CF-00-01-085	<i>The 1998 and 1999 Combined Federal Campaigns for the Community Health Charities Federation in Arlington, Virginia</i>	October 15, 2001	\$	\$
3A-CF-00-01-086	<i>The 1998 and 1999 Combined Federal Campaigns for the United Service Organization in Washington, D.C.</i>	October 18, 2001		
3A-CF-00-01-087	<i>The 1998 and 1999 Combined Federal Campaigns for the American Red Cross in Washington, D.C.</i>	October 22, 2001		
TOTALS			\$	\$

Appendix VII: Evaluation Reports Issued October 1, 2001 to March 31, 2002

Report Number	Subject	Issue Date	Funds Put to Better Use	Questioned Costs
4A-CA-00-01-105	<i>Assessment of Non-Personnel Administrative Authorities Delegated to Office of Personnel Management Field Components in Washington, D.C.</i>	March 5, 2002	\$	\$
4A-CF-00-02-035	<i>Office of Personnel Management's Internal Controls Over Closed Appropriation Accounts</i>	March 27, 2002		
TOTALS			\$	\$



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