

Office of the Inspector General

**SEMIANNUAL
REPORT
TO CONGRESS**

October 1, 1998 - March 31, 1999

U.S. Office of Personnel Management

OIG-SAR-20
April 1999

April 30, 1999

*Honorable Janice R. Lachance
Director
U.S. Office of Personnel Management
Washington, D.C. 20415*

Dear Ms. Lachance:

I respectfully submit the Office of the Inspector General's Semiannual Report to Congress for the period October 1, 1998 to March 31, 1999. 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
Inspector General*

Table of Contents

Message From the IG	I
Productivity Indicators	iii
Statutory and Regulatory Review	1
Audit Activities	3
<i>Health and Life Insurance Carrier Audits</i>	3
<i>Other External Audits</i>	13
<i>OPM Internal Activities Audits</i>	14
Investigative Activities	25
<i>Health Care-Related Fraud and Abuse</i>	26
<i>Employee Integrity Investigations</i>	27
<i>Retirement Fraud and Special Investigations</i>	28
<i>OIG Hotlines</i>	29
Evaluation and Inspections Activities	33
Index of Reporting Requirements	37
Appendix I: <i>Audit Reports Issued With Questioned Costs</i>	39
Appendix II: <i>Final Reports Issued With Recommendations for Better Use of Funds</i>	40
Appendix III: <i>Insurance Audit Reports Issued (Standard Audits)</i>	41
Appendix IV: <i>Internal Audit Reports Issued</i>	42
Appendix V: <i>Combined Federal Campaign Reports Issued</i>	43
Investigations Tables	
Table 1: <i>Investigative Highlights</i>	31
Table 2: <i>Hotline Calls and Complaint Activity</i>	31

Message From the IG

During the current reporting period, our Office of Inspector General (OIG) has seen incremental progress in all areas of our work as we continue to focus on innovative ways to fulfill our mandate under the Inspector General Act of 1978. The basic principles of good government contained in the Act--to identify and ferret out waste, fraud and abuse and to promote integrity, effectiveness and efficiency within government--apply, of course, equally to our own activities, our agency's program offices and to all who have a business relationship with our agency and the federal government generally. Due to the commitment demonstrated by Congress and the Office of the President during this decade to improving how the federal government does business and the fact that it parallels so closely the mission of all OIGs covered by the IG Act, we have intensified our proactive approach in reaching these goals.

I am especially pleased to report the success we have achieved in the financial statement audits of the life, health and retirement programs during this reporting period. Our achievement here illustrates what we consider to be creative problem-solving in fulfilling our OIG mission goals. This process has spanned a seven-year period. During the past three years, the financial statement audits of these programs were performed by an independent public accountant and monitored by us. As a result of our FY 1998 financial statements audits, all three programs received an unqualified audit opinion--the first time this has occurred during the same audit period. This was a major milestone that grew out of earlier OIG audit recommendations. Collaborative efforts between OIG auditors, OPM's Retirement and Insurance Service, and our independent public accounting firm made this success possible. The financial statement audits relating to these benefits programs and a related article are discussed on pages 18-20 and 23, respectively.

We also are beginning to see the results of our efforts to address an ongoing OIG concern involving the long-term effectiveness of our oversight capability dealing with the reliability and security of specific computer-based information systems affecting our agency programs.

In this regard, we realized that it was incumbent upon our organization to develop an audit capability to ensure that the integrity of these particular computer-based systems and the data maintained there affecting major OPM programs, such as the Federal Employees Benefits Program (FEHBP) and OPM's financial systems operations, could not be impugned. Consequently, we now have in place a new audit unit whose purpose is to work with insurance carriers and OPM's program offices to identify weaknesses and offer recommendations to strengthen the reliability and security of the data maintained in and generated from these information systems. See page 12 for a discussion of an audit we performed based on this initiative.

We would also like to call attention to selective program reorganization in our office

that we believe will be most beneficial in meeting some of the problems associated with staffing needs directly affecting our OIG mission. For example, having sufficient audit resources to respond adequately to the sheer number and range of audit subjects within our audit universe has remained a long-term challenge for our OIG. For sometime, we have been analyzing ways to meet this challenge. In particular, we have been faced with the necessity of freeing up our auditors to concentrate on areas where their skills are the most needed to overcome a material weakness associated with the FEHBP that we have reported previously under the Federal Managers' Financial Integrity Act.

In responding to this issue, OIG management decided that we could shift our office's oversight responsibility for the Combined Federal Campaign and its local campaign organizations from our audit function and place it under our evaluation and inspection function. We are confident that this decision will permit us to increase our ability to conduct more FEHBP audits yet in no way sacrifice the integrity of the CFC reviews. In fact, we are in the process of devising an improved plan to allow even greater annual coverage of the CFCs while minimizing the human resources needed to carry out the work.

Another area where we feel internal program reorganization will have an impact is through cross-training our investigators so that they will have the necessary expertise to handle cases dealing with such diverse issues as health care and annuity fraud and employee fraud and misconduct within the agency. This has been taking place over the past few months.

And, finally, as announced in our last semiannual report, we moved our health care administrative sanctions program associated with the FEHBP to operate under the auspices of our OIG special counsel. With the enactment of the 1998 FEHB Act amendments in October 1998, giving our agency broader authority to operate our sanctions program, we immediately began work drafting regulations to administer our sanctions program under this new authority.

Once these regulations are implemented, they will significantly strengthen our ability to fight health care provider fraud within the FEHBP. At that point, all that will remain to maximize our enforcement capabilities in saving the federal government and the American taxpayer health care fraud dollars running into the millions will be the FEHBP's full inclusion under the provisions of the Health Insurance Portability and Accountability Act of 1996.

In reflecting on the accomplishments of my office during the reporting period, I would like to commend my staff not only for their work ethic and constant dedication to the concept of better government, but for being an inspiration through their achievement and innovative thinking. With that said, however, I remain mindful that true and steady progress in realizing our OIG goals is measured every day in how focused we remain and the amount of resolve we show in the face of current problems and those that inevitably will confront us in the days ahead.

Productivity Indicators

FINANCIAL IMPACT:

Audit Recommendations for	
Recovery of Funds	\$35,097,704
Recoveries Through	
Investigative Actions	\$1,010,440
Management Commitments to	
Recover Funds	\$16,815,156

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	17
Investigative Cases Closed.	26
Cases Accepted for Prosecution	5
Indictments	10
Convictions	5
Hotline Contacts and Complaint Activity	939
Health Care Provider Debarments	
and Suspensions	1,475

Evaluation and Inspections Reports Issued 1

Statutory and Regulatory Review

As is required under section 4 (a)(2) of the Inspector General Act of 1978 (IG Act), as amended, our office monitors and reviews legislative and regulatory proposals for their impact on the Office of the Inspector General 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.

During the current reporting period, we continued to exercise our oversight responsibilities regarding regulatory and legislative issues. An ongoing area of legislative interest and concern during the period was congressional reconsideration of the exclusion of the Federal Employees Health Benefits Program (FEHBP) the civil enforcement and anti-kickback provisions of the Health Insurance Portability and Accountability Act of 1996. We discussed this legislation and its importance to our work at length in our last semi-annual report.

While this was the only significant statutory or regulatory measure we reviewed during the reporting period, we did continue to make progress in another area of importance to this agency, that of administrative sanctions. Through this program, we are able to remove from participation those health care providers previously sanctioned under other federal health care programs, including Medicare. Our sanctions activities for the period are described below.

Administrative Sanctions Update

As we noted briefly in our last semiannual report, on October 19, 1998, President Clinton signed P.L. 105-266, the Federal Employees Health Care Protection Act of 1998. Section 2 of this statute provides for a thorough revision of the FEHBP administrative sanctions law. Passage of these provisions had been a high priority over several years for both OPM and our office, because serious flaws in the existing sanctions provisions previously have deprived the administrative decision-making process of any meaningful finality and invited prolonged litigation--precisely the consequences that administrative sanctions are intended to avoid.

The new statute applies current standards of administrative practice to replace the former deficiencies, giving OPM an effective enforcement device against provider fraud. It also provides our agency with an efficient means of addressing not only the integrity interests of the FEHBP and the financial interests of the taxpayers who share in the costs of the program, but also the rights of beneficiaries to participate in a health insurance program that actively seeks to protect their health and safety. We are committed to exercising the newly

enacted authorities in coordination with other federal sanctions programs as required by law and regulation in order to maximize their overall impact.

As we proceed with implementing the new statutory provisions, we have continued to work closely with, and to receive extensive assistance from, the Office of the Inspector General at the Department of Health and Human Services, the office that conducts the Medicare provider sanctions program. And, until we are in a position to take advantage of all aspects of our new authorities, we will operate, as in the past, under the more limited debarment program available to us under the authority of the government-wide debarment and suspension common rule. Under that authority, we debarred 1,475 providers during the reporting period.

New FEHB Law Provides Improved Sanctions Authorities

Audit Activities

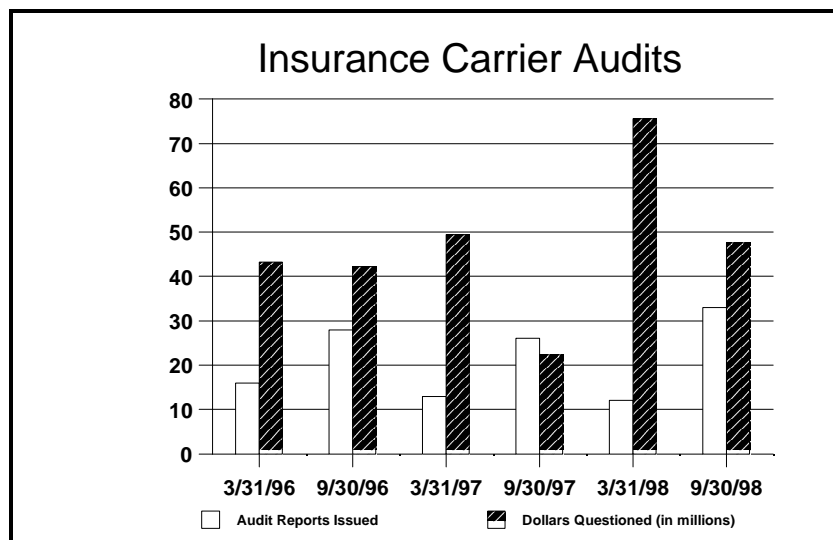
Health and Life Insurance Carrier Audits

The Office of Personnel Management (OPM) contracts with private sector firms to underwrite and provide health and life insurance benefits to federal employees, annuitants, and their dependents and survivors through the Federal Employees Health Benefits Program (FEHBP) and the Federal Employees' Group Life Insurance (FEGLI) program. Our Office of Inspector General (OIG) is responsible for auditing their activities.

Our audit universe contains approximately 500 audit sites, consisting of health insurance carriers, sponsors, and underwriting organizations, as well as two life insurance carriers, all of which share in annual premium payments in excess of \$17.7 billion.

During the current reporting period, we issued 11 final reports on organizations participating in the FEHBP, nine of which contain recommendations for monetary adjustment in the aggregate amount of \$35.1 million due the FEHBP. A complete listing of all these reports is provided in Appendix III on page 41 of this report.

We believe it is important to illustrate the dollar significance resulting from our audits of FEHBP carriers and what this means to the FEHBP trust fund. For instance, during the past six semiannual reporting periods, the OIG issued 128 reports and questioned \$280.3 million in inappropriate FEHBP charges as the graph below illustrates.



The sections that immediately follow explain the differences among the types of Federal Employees Health Benefits Program (FEHBP) carriers and provide audit summaries of significant final reports we issued during the past six months.

Community-Rated Plans

Within the community-rated, comprehensive medical plans, also known as health maintenance organizations (HMOs), we audit approximately 405 rating areas. A community-rated carrier generally sets the subscription rates for benefits on the basis of an average revenue requirement for each member. Under current statutes for HMOs, subscription rates can vary from group to group as the result of adjustments for factors such as the age and sex distribution of a group's enrollees (community rating by class) or its projected utilization of benefits (adjusted community rating). However, once a rate is set, it may not be adjusted to actual costs incurred or actual utilization. The inability to adjust to actual costs or utilization distinguishes community-rated plans from experience-rated HMOs, indemnity, or service benefit plans.

For the period 1991 through 1994, regulations required that subscription rates charged to the FEHBP be equivalent to the rates charged those two subscriber groups closest in size to the FEHBP and whose respective contracts contain similar benefits. In 1995, the provision requiring similar benefits was eliminated. These similarly sized subscriber groups are called SSSGs. Under these regulations, each carrier must certify that the FEHBP is being offered equivalent SSSG rates by submitting to the Office of Personnel Management (OPM) a certificate of accurate pricing. These rates are determined by the FEHBP-participating carrier, which has the responsibility of selecting the two groups that qualify as SSSGs. During an audit, should our auditors determine that equivalent rates were not applied to the FEHBP or that the appropriate SSSGs were not selected, then a condition of defective pricing (DP) exists. The FEHBP is entitled to a downward rate adjustment to compensate for any overcharges resulting from DP.

During this reporting period, we issued eight audit reports on community-rated plans. The following summaries of two of these HMO audits issued during the current period illustrate a number of problems encountered in applying and enforcing community-rating principles within the FEHBP.

MD-Individual Practice Association, Inc. In Rockville, Maryland

**Report No. JP-00-98-003
February 19, 1999**

MD-Individual Practice Association, Inc. (MD-IPA) is a community-rated comprehensive medical plan based in Rockville, Maryland, that provides primary health care services to its members throughout Washington, D.C. and surrounding suburbs in Maryland and Virginia as well as other portions of both states, Roanoke, Richmond, and the Virginia Tidewater areas in particular. Our audit of MD-IPA covered contract years 1992 through 1997. During this audit period, the FEHBP paid MD-IPA over \$387 million in premiums.

As the result of a previous audit, we determined that the plan used a rating methodology that adversely affected the FEHBP's rates for contract years 1988-1991, resulting in the plan having to return \$4.6 million to the FEHBP. During this audit, we identified an additional \$17,109,231 in questioned costs, including \$12,656,068 for defective pricing and \$4,453,163 for lost investment income. While MD-IPA agrees with \$12,199,348 of this amount, it has also taken the position that it undercharged the FEHBP by \$5,375,331 in 1996 and 1997 and that this amount should be offset against the finding amount. We have stated in our report that we do not agree with the plan regarding this issue. Some of our specific findings from this audit are highlighted below.

Premium Rates

In conducting this audit, our primary objectives were to verify that MD-IPA had offered market price rates to the FEHBP that were reasonable and equitable and that it was in compliance with the laws and regulations governing the FEHBP.

Discounted market rates. We found that the FEHBP did not receive the highest discount given to an SSSG in 1992 through 1994. The discounts amounted to 6.87 percent in 1992, 5.33 percent in 1993, and 7.3 percent in 1994. In applying these discounts to the FEHBP rates, we found that the FEHBP was overcharged a total of \$12,656,068 (\$4,274,981 in 1992; \$3,775,066 in 1993; and \$4,606,021 in 1994) during this three-year period.

Auditors Determine FEHBP is Due \$17.1 Million

MD-IPA agrees with the overcharges we identified in 1992 and 1993. However, it maintains that the overcharge to the FEHBP in 1994 should have been \$4,149,301, \$456,720 less than the amount we identified. According to MD-IPA, our finding amount should be reduced because it undercharged the FEHBP for the prescription drug rider in 1994. We disagreed. In developing the finding amount, we used the same rider that MD-IPA included in its state-filed rates and in the 1994 FEHBP reconciliation (final rate settlement negotiated between the plan and OPM program managers). The same state filing was also used to develop the SSSG rates. The information MD-IPA provided to support its position contained no indication that the rider it used in developing its overcharge amount was part of the state-filed rates.

Although we found no problems with the rates charged to the FEHBP in 1995 through 1997, MD-IPA has stated there was an undercharge favorable to the FEHBP totaling \$5,375,331 in 1996 and 1997. According to the plan, this amount should be deducted from the overcharges we identified in 1992-1994. MD-IPA contends that the undercharge occurred because the discounts the SSSGs actually received were not as large as it calculated for the FEHBP. We again disagreed. Our position is that MD-IPA knew or should have known the actual rate advantages applied to the SSSG rates at the time of the FEHBP reconciliation and could have adjusted the FEHBP rates accordingly. In addition, the FEHBP is not prohibited from receiving a rate advantage that is larger than that given to an SSSG.

Lost Investment Income

In accordance with the FEHBP contract with community-rated carriers, the FEHBP is entitled to recovery of lost investment income on defective pricing findings. We found that the FEHBP is due \$4,453,163 in lost investment income through December 31, 1998. An additional amount is due for the period beginning January 1, 1999, until all funds have been returned to the FEHBP. In commenting on the report, MD-IPA said that OPM does not have the authority under its contract to claim interest on defective pricing amounts and wants to defer resolution of the interest issue until a final decision is made by a federal appeals court regarding OPM's authority to charge interest. Because we continue to disagree with the plan on this issue, we have recommended that OPM's contracting officer require the plan to return all amounts due the FEHBP as identified in our report.

Plan Disagrees With OIG Over Total Amounts Due the FEHBP

FHP-New Mexico in Albuquerque, New Mexico

**Report No. P2-00-97-049
March 2, 1999**

FHP-New Mexico (FHP-NM) entered the Federal Employees Health Benefits Program (FEHBP) in 1988 as a federally qualified, community-rated comprehensive medical plan. FHP merged with PacifiCare Health Systems in 1997, but by November of that year PacifiCare completed the sale of FHP-NM to Presbyterian Network, Inc. However, PacifiCare retained responsibility for any liability arising from this audit. FHP-NM provides health care services to its members throughout the Albuquerque, Farmington, Las Cruces, and Santa Fe areas of New Mexico, and El Paso and Hudspeth counties in Texas. Our audit covered contract years 1992 through 1997. During this period, the plan charged the FEHBP approximately \$44 million in premiums.

As a result of this audit, we questioned a net amount of \$4,797,429. This amount also includes a credit of \$343,117 due FHP-NM for Medicare loadings that were applicable, although not included, in the cost of the FEHBP basic benefits package premium rate. A loading, in this instance, would have resulted in an upward adjustment to the cost of the basic benefits package. Also included in the net amount was \$1,184,933, representing lost investment income due the FEHBP because of defective pricing.

Premium Rates

Redeveloping FEHBP rates. We found that the rates FHP-NM charged the FEHBP in 1992 through 1997 exceeded the market price rates. The FEHBP audited rates were determined by redeveloping the rates in a manner consistent with the SSSG rates. A comparison of the FEHBP's audited rates with FHP-NM reconciled rates showed the FEHBP was overcharged \$1,198,085 in 1992; \$562,727 in 1993; \$671,086 in 1994;

\$629,793 in 1995; \$828,271 in 1996; and \$65,651 in 1997.

Credits & premium discount issues The most significant issue we found related to the age/sex factors used in developing FEHBP rates. From 1992-1996, FHP-NM included federal annuitants over age 65 in the calculation of these factors for the FEHBP. Since such annuitants were not included in the development of the SSSGs' age/sex adjustment factors, it was inappropriate to use federal annuitants in the development of the FEHBP's factors. Therefore, we redeveloped the FEHBP factors by removing federal annuitants over age 65. In addition to this adjustment, we identified a number of other problems related to the development of the FEHBP rates, including among others:

- A charge for a heart transplant benefit loading in 1993-1996 even though heart transplants were covered by FHP-NM's basic benefit package.
- No credit given the FEHBP for state premium taxes in 1992.
- No credit applied to remove the family security benefit coverage in 1993.
- Insufficient abortion credit applied to the FEHBP's rates in 1996 and no abortion credit applied in 1997.
- FEHBP not granted a discount reduction equivalent to the largest reduction granted an SSSG in either 1992 or 1997.

Medicare loadings. In conjunction with the redevelopment of the FEHBP's age/sex factors to remove federal annuitants over age 65, FHP-NM was entitled to Medicare loadings in 1992 through 1996. Application of the lower age/sex factors resulted in lower rates for the FEHBP. However, the costs associated with members over age 65 with and without Medicare coverage could have been higher than costs for active employees. Using the formula for determining the Medicare loading provided by OPM's Office of Actuaries, we found that FHP-NM was due an additional \$343,117 for years 1992-1996.

PacifiCare agreed with the redevelopment of the FEHBP's age/sex factors but not that the FEHBP should receive a credit for the exclusion of the abortion benefit, the removal of the heart transplant loadings or that the methodology used to calculate the Medicare loadings was correct.

Lost Investment Income

In accordance with the FEHBP contract with community-rated carriers, the FEHBP is entitled to recovery of lost investment income on defective pricing findings. We found that the FEHBP is due \$1,184,933 in lost investment income through December 31, 1998. An additional amount is due for the period beginning January 1, 1999, until all funds have been returned to the FEHBP. PacifiCare did not comment on our recommendation in the report to have these monies returned to the FEHBP.

Inappropriate Health Benefits Charges Total \$4.8 Million

Experienced-Rated Plans

In addition to community-rated plans, the Federal Employees Health Benefits Program (FEHBP) offers a variety of experience-rated plans, including the Government-wide Service Benefit Plan, those plans sponsored by employee organizations, and comprehensive medical plans (experience-rated HMOs). An experience rate is a rate that reflects a given group's projected paid claims, administrative expenses and retentions. Each carrier maintains separate accounts for its federal contract, and future premiums are adjusted to reflect the federal enrollees' actual past use of benefits.

Audits of these plans generally focus on the allowability of contract charges and the recovery of appropriate credits, the effectiveness of carriers' claims adjudication systems, and the adequacy of internal controls to ensure proper contract charges and benefit payments.

With regard to internal controls in particular, we recognize that our agency and its contractors have become increasingly dependent on computerized information systems to carry out operations and to process, maintain and report essential information. As a result, we have been concerned with the reliability and security of computerized data and the systems that process, maintain and report this data. To address this concern, we recently established an information systems audit unit within our OIG.

This audit unit is responsible for conducting information systems audits of either FEHBP insurance carriers or OPM and assisting other OIG audit groups when computerized data is required from the mainframe computers of carriers and OPM. This unit will also be responsible for developing and maintaining computer-assisted audit techniques. We hope that, in creating this new audit unit, our office can help reduce the risks of loss due to errors, fraud and other illegal acts, as well as technological disasters or other incidents that are related to inadequate or unavailable systems controls.

OIG Establishes Information Systems Audit Unit

Government-Wide Service Benefit Plan

This plan is administered by the Blue Cross and Blue Shield (BCBS) Association on behalf of its member plans. The association, headquartered in Chicago, Illinois, delegates authority to participating local Blue Cross and Blue Shield plans throughout the United States to underwrite and process the health benefits claims of its federal subscribers in the Service Benefit Plan. For administrative purposes, the association has established a Federal Employee Program (FEP) Director's Office in Washington, D.C., that provides centralized management for the Service Benefit Plan, including a claims control center known as the FEP Operations Center. The operations center verifies, among other things, subscribers eligibility; approves or disapproves the reimbursement of local plan payments of FEHBP

claims (using computerized system edits); and maintains both a history file of all FEHBP claims and an accounting of all program funds.

The BCBS federal employee program currently consists of approximately 55 audit sites throughout the United States. Approximately 40 percent of all FEHBP subscribers are enrolled in Blue Cross and Blue Shield plans nationwide.

During this reporting period, we issued two BCBS reports. The following audit narrative describes the major findings from one of these reports, along with questioned costs associated with those findings.

Blue Cross and Blue Shield of Missouri in St. Louis, Missouri

Report No. 10-76-97-010

December 24, 1998

Our audit of the FEHBP operations at Blue Cross and Blue Shield of Missouri (BCBS of Missouri) took place at the plan's headquarters in St. Louis. We examined health benefits payments made by the plan from January 1, 1993 through June 30, 1996, as well as administrative expenses and supplementary and miscellaneous payments covering the five-year period 1991-1995.

In performing this audit, we were to determine whether the plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of its contract. As a result, our auditors questioned \$154,304 for inappropriately charged FEHBP claim payments, \$155,756 for refunds and uncashed checks not credited to the FEHBP, \$147,048 in unallowable administrative expense charges, \$572,453 for losses due to improper cash management practices, and an additional \$271,001 representing lost investment income on FEHBP funds erroneously held by the plan for the period covered by our audit. Final calculations by our auditors regarding all inappropriate charges to the FEHBP totaled \$1,300,562.

Auditors Calculate \$1,300,562 in Inappropriate FEHBP Charges

Insufficiently defined internal control processes pertaining to financial and accounting procedures and policies played a major part in many of the adverse findings we noted during this audit.

Health Benefits

During this period, the plan paid over 2.9 million claim lines, representing \$236.9 million in actual claims payments. We selected claims at random as well as in specific health benefits categories, principally those concerning coordination of benefits and duplicate payments.

Other areas of concern covered by our audit were financial and accounting problems affecting refunds and uncashed checks relating to the FEHBP. Some of these findings are highlighted below.

Coordination of benefits. For the period July 18, 1995 through June 30, 1996, we identified 15 claims totaling \$60,995 that the FEHBP paid in full when Medicare was the primary carrier. This type of inappropriate charge occurs when there is a failure to coordinate benefits properly with the Medicare coverage. We recommended that OPM's contracting officer direct BCBS of Missouri to credit the FEHBP the full amount it erroneously paid for these claims.

Duplicate payments. Our auditors also determined that the plan charged the FEHBP inappropriately for duplicate claims payments. During the review period of January 1, 1993 through June 30, 1996, there were 61 duplicate payment errors, totaling \$54,595. The BCBS Association has agreed to credit the FEHBP for any duplicate payment recoveries it receives.

We also reviewed another category of duplicate payments, specifically inter-plan duplicate payments. Between January 1, 1993 and June 30, 1996, BCBS of Missouri charged the FEHBP for 70 duplicate health benefit payments that previously had been paid by two other BCBS plans. We further noted that the FEP operations of the BCBS Association was a contributing factor, since the FEP Operations Center claim edits did not properly identify and reject these claims. These 70 duplicate payments resulted in an additional \$20,488 in inappropriate health benefits charges to the FEHBP.

Miscellaneous payments. Our auditors also reviewed other issues concerning monies due the FEHBP involving various types of health benefit payment refunds, claims correction adjustments, and uncashed health benefit checks, totaling \$155,756.

Under our refunds finding, for example, we examined 278 FEP refunds, totaling \$1,335,875, and determined that all but \$74,475 had been returned to the FEHBP. However, to date, BCBS of Missouri has furnished no data to show that the latter amount was ever credited to the FEHBP. The same is true for an additional \$1,993, representing part of another refund. Consequently, we have requested that \$76,468 be returned to the FEHBP or that BCBS of Missouri demonstrate that the refunds have been returned to the FEHBP.

Inappropriate FEHBP Claims Charges Total \$310,060

Administrative Expenses

During our review of administrative expenses from 1991-1995, we noted that BCBS of Missouri overcharged the FEHBP for such items as the FEHBP's portion of the plan's building rent, depreciation on a building exchange, the plan's national BCBS Association dues, and certain costs associated with publication of BCBS of Missouri's preferred provider organizations directory. These inappropriate charges to the FEHBP totaled \$147,048.

In addition to these items, we determined that BCBS of Missouri's cost accounting practices were inadequate. In particular, we found there were no written policies and procedures in place regarding the plan's cost accounting system to ensure its fairness or

accuracy. For example, not having adequate control procedures in place exposed the plan to accounting errors affecting the FEHBP. BCBS of Missouri basically relied on manual procedures instead of system edits to identify and remove nonchargeable costs from FEHBP cost filings. The plan acknowledged the need to document and incorporate new cost accounting policies and procedures into its accounting manual. Accordingly, BCBS of Missouri began making corrections to its cost allocation procedures in January 1997.

Cash Management

BCBS of Missouri did not comply with federal regulations nor contract terms concerning drawdowns from the letter of credit (LOC) account. It is a legal requirement that FEHBP monies be made available for payment to a participating plan using the LOC arrangement *only after* checks are presented and paid by a bank. Under this checks-presented requirement, the drawdown on the letter of credit must be delayed until the checks issued for FEHBP disbursements are presented to the carrier's financial institution for payment.

For the period January 1993 through June 1996, we analyzed three different categories of claims (subscriber, facility and physician claims) and determined that the plan had prematurely received payment from its LOC, holding excess FEHBP funds on average 37.17, 4.55, and 11.92 days, respectively, during the period reviewed. Also in violation of its contract, BCBS of Missouri commingled FEHBP funds with other funds, making investment income earned on these excess funds difficult to identify. However, our auditors estimated that the amount due the FEHBP for the latter was \$572,453. We recommended in our report that this amount be returned to the FEHBP.

[Editor's note: A global settlement with all BCBS plans was reached on this audit issue in March 1999. As a result of the negotiated settlement, the BCBS Association agreed to return \$26.5 million to the FEHBP.]

Auditors Cite Cash Management Deficiencies

Employee Organization Plans

These plans also fall in the category of experience-rated and may operate or sponsor participating health benefits programs. Employee organization plans operate on an indemnity and fee-for-service basis. Members are free to obtain treatment through facilities or providers of their choice for which claims are submitted to the carrier for adjudication and payment.

During the reporting period, we issued one employee organization plan audit report,

which is summarized below.

**Audit of the General Controls Related to
Postmasters Benefit Plan's Computer-Based Information Systems
in Alexandria, Virginia**

Report No. 36-00-98-021

March 31, 1999

The Postmasters Benefit Plan (Postmasters) is headquartered in Alexandria, Virginia, and sponsored by the National League of Postmasters. This organization provides FEHBP coverage to postal workers and other federal employees who pay dues to it.

Our audit goal was to verify whether or not Postmasters had implemented proper computer-related controls over the integrity, confidentiality and availability of computerized data associated with the processing of FEHBP health benefits claims and the accurate reporting of costs to OPM. We examined the general controls environment surrounding Postmasters' computer-based systems, such as the structure, policies, and procedures that applied to its overall computer operations. If the controls are weak, they severely diminish the reliability of controls associated with individual application systems, increasing the risk of erroneous claim payments being made or reported to OPM on behalf of the FEHBP subscribers enrolled in the plan.

This audit was designed from procedures contained in the General Accounting Office's (GAO) *Federal Information System Controls Audit Manual*. The GAO audit manual outlines six major categories of general controls that should be considered during such an audit. The six major categories include: (1) entity-wide security program, (2) access controls, (3) application software development and change controls, (4) segregation of duties, (5) system software controls, and (6) service continuity controls.

Our audit of Postmasters information system general controls identified several areas of concern, including the lack of a comprehensive security plan, weak logical and physical access controls, inadequate controls over software development and changes, and inadequate separation of duties. However, we found that Postmasters does have appropriate disaster recovery plans tested and in place.

During a subsequent site visit, we noted that Postmasters had made significant improvements in internal controls in some areas. We were able to verify that they had implemented several of our recommendations, including increasing the frequency of its off-site data storage, documenting the results of contingency plan tests, installing a cipher lock on the computer room door, requiring a longer password length that would include at least one numerical character, encrypting the password file, and creating standard forms for use in requesting services from the information systems department.

Auditors Identify Need to Improve Information System Controls

There are, however, several important areas remaining where Postmasters should strengthen

its controls. These include the development of an overall security plan, system rules and ownership, security training, and improved personnel controls. Postmasters also should continue to address areas related to software library management, system software access, and overall adherence to recently implemented policies and procedures.

Other External Audits

Pre-award and post-award contracts. As requested by OPM procurement officials, our OIG conducts pre- and post-award contract audits relating to the acquisition of goods and services by agency program offices. During this reporting period, no pre- or post-award audits were requested.

Combined Federal Campaign (CFC). Our office has oversight responsibility over the operations of local organizations of the Combined Federal Campaign, the solely authorized fund-raising drive conducted in federal installations throughout the world.

Since 1961, the CFC has netted over \$3.6 billion in charitable contributions. Approximately 395 local campaigns participated in the 1997 CFC, the most recent year for which statistical data was available. Federal employee contributions reached \$197.1 million, for the 1997 CFC, while expenses totaled \$16.8 million.

During this reporting period, we issued one CFC report, which is identified on page 43 in Appendix V of this report. It should also be noted that the oversight function of the CFCs was reassigned within our office during the current period. Future reporting on this subject will be contained under the section of our report involving evaluations and inspection activities.

OPM INTERNAL ACTIVITIES AUDITS

Our office also has responsibility for conducting a wide range of audit activity covering the Office of Personnel Management (OPM) programs and administrative operations. This activity includes such diverse areas as financial statement audits required by the Chief Financial Officers Act (CFO Act); President's Council on Integrity and Efficiency government-wide audits; audits of agency compliance with laws and regulations, such as the Prompt Payment Act, the Federal Managers' Financial Integrity Act (FMFIA), the Federal Financial Management Improvement Act (FFMIA); and performance audits of OPM programs that involve the range of the agency's responsibilities for retirement, employee development, and personnel management activities.

As we mentioned in several of our past semiannual reports, resource limitations have made it necessary for us to limit the scope of our internal audits workload. Consequently, our primary focus during this reporting period was on OPM's financial statements and certain other internal audit work deemed critical to our agency. The latter included reviews of the Office of Federal Employees' Group Life Insurance's (OFEGLI) compliance with laws and regulations related to its accounts receivable collection procedures at Metropolitan Life's corporate headquarters and the status of OPM's Year 2000 (Y2K) compliance project.

We completed eight internal audits during the reporting period, five relating to OPM's financial statements audits. The following pages contain selected audit narratives pertaining to both performance audits and the agency's financial statement audits, along with an article on health carrier financial accountability.

Agency Performance Audits

It is important to point out the significance of our inability to conduct a full range of independent performance audits, an ongoing issue for the past several years. This audit scope limitation diminishes our ability to monitor or improve the efficiency and effectiveness of OPM's key program offices. Through our CFO Act financial statement audits, we identify material control weaknesses and noncompliance with laws and regulations that relate to the financial statements for all OPM program offices. While these CFO Act audits focus on laws and regulations material to the financial statements, they do not cover all performance-related controls. Therefore, there is an increased risk that nonfinancial management control weaknesses and other noncompliance with laws and regulations could go undetected. Inasmuch as performance audits would improve our ability to minimize fraud, waste and abuse in OPM programs, we reported in our October 1998 FMFIA report that this lack of performance audits was a material weakness. Since that time, however, we have reconsidered and now believe this issue to be only a reportable condition, based on the audit coverage provided by the CFO Act financial statement

audits.

As we reflect on this issue, we realize the increasing importance of our evaluation and inspections function as it pertains to examining our agency's program activities. Through this function, we look at agency program operations and perform evaluations of agency program and administrative activities to assist OPM's various program offices become more efficient. As a corollary benefit of these program reviews, we often uncover areas vulnerable to waste, fraud and abuse and discover noncompliance with laws and regulations not covered by our OPM financial statement audits. As a result, we believe we are compensating in part for the absence of these performance audits. The Evaluation and Inspections Activities section of this report can be found on pages 33-36.

OPM's Audit of OFEGLI Overpayment Recovery Procedures in New York City, New York

**Report No. 2F-00-98-100
February 5, 1999**

OPM contracts with Metropolitan Life Insurance Company (MetLife) to provide life insurance benefits to federal employees and annuitants enrolled in the Federal Employees' Group Life Insurance (FEGLI) program. Its Office of Federal Employees' Group Life Insurance is located at MetLife's headquarters in New York City.

At the request of our agency, our office conducted a performance audit of OFEGLI's compliance with laws and regulations, in particular the Life Insurance Federal Acquisition Regulations (LIFAR) and the OFEGLI overpayment recovery guidelines. It should be noted that OFEGLI significantly revised its procedures for receivables as a result of these guidelines, implemented over a nine-month period, following their approval by OPM in July 1997. Accordingly, the period we reviewed (October 1, 1996 through July 31, 1998), contained accounts that were subject to various collection procedures, including these guidelines.

Specifically, we audited OFEGLI's compliance with overpayment procedures, debt collection, bad debt expense and related allowances for bad debt procedures. As a result, our auditors determined that OFEGLI had:

- Complied with LIFAR 2146.270 (FEGLI program quality assurance requirements) as they apply to overpayment receivables.
- Complied with LIFAR 2131.205-3 except for supporting amounts charged against the contract as bad debt expense. (*Note:* While OFEGLI has documented its good faith efforts to collect overpayments, there was one instance, representing five percent of our sample, in which OFEGLI lost a case file that was eventually written off as a bad debt expense.)
- Complied with OPM-approved guidelines except for meeting timeliness requirements and not involving a collection agency to assist in overpayment collection.

- Made reasonable adjustments to overpayment receivable balances in the general ledger.
- Implemented effective controls over recoveries to ensure that amounts were recorded and refunded to OPM.
- Not put in place detection controls and had only limited overpayment prevention controls to safeguard against overpayment errors, relying mainly on OPM and beneficiaries to detect overpayment errors. (*Note:* This control environment increases the likelihood of overpayment errors and that the errors will not be found by OFEGLI.)

We noted that OFEGLI did not maintain complete cost information on collection procedures. As a result, there was insufficient data available to analyze OFEGLI's efficiency and effectiveness during this audit. We did, however, recommend that OPM incorporate an overpayment analysis into its annual monitoring procedures, with an emphasis placed on cost information analysis to determine the efficiency and effectiveness of debt collection procedures. We noted that this process could be used as a baseline for future comparative analysis that management could use to make informed decisions. We also determined that OFEGLI's collection procedures were overly burdensome and we made several suggestions for improving the process.

Auditors Make Recommendations to Maximize OFEGLI Recoveries

Status of OPM's Year 2000 Compliance Project

Report No. 99-00-98-048

March 23, 1999

During this reporting period, we continued to review the progress made by our agency in minimizing the risk associated with a potential agency-wide Y2K-related computer failure. As indicated in our last semiannual report to Congress, we are using procedures contained in the U.S. General Accounting Office's *Year 2000 Computing Crisis: An Assessment Guide* as the basis for designing our review. The GAO guide outlines a five-phase approach in planning, managing and evaluating an agency's Y2K compliance efforts. As also cited in our previous semiannual report, the five phases are: awareness, assessment, renovation, validation and implementation. Our most recent review was conducted from August through November 1998.

We recognize that our agency is heavily engaged in Y2K activities and that it continues to work to ensure full compliance. The audit work outlined in this report was completed during the fall of 1998. We have been advised by OPM that significant progress related to its Y2K efforts has occurred during the ensuing four months since we completed the work outlined in this report. Beginning in April 1999, we will commence the next phase of our review during which, among other things, we will be following up on the recommendations made in this report. We further recognize that the Y2K effort is a moving target and believe the agency continues to make good progress in achieving full Year 2000 compliance.

Due to the inherent nature of OPM's Year 2000 compliance project, our review continues to be completed in stages that coincide with the completion time line established by GAO. Therefore, during this stage of our review, we concentrated on the renovation, validation, and implementation stages, as appropriate, of a sample of OPM's mission-critical systems.

Specifically, we reviewed a judgmental sample of 18 of OPM's 39 non-Retirement and Insurance Service (RIS) mission-critical systems. In addition, we reviewed documentation supporting OPM's November 13, 1998 report to the Office of Management and Budget (OMB) with the exception of Section VIII. Section VIII of the OMB report deals with actual and estimated costs necessary to complete the Year 2000 compliance project. Finally, we reviewed the status of OPM's efforts to implement our prior reports' audit recommendations. At this stage in our Y2K compliance review, we have not reviewed the 70 missioncritical systems associated with RIS. To date, we have relied on the Y2K work completed by the international accounting firm of KPMG Peat Marwick LLP in conjunction with its annual audit of OPM's trust fund activity.

Overall, OPM continues to make good progress in achieving Year 2000 compliance for its non-RIS mission-critical systems. However, we identified several areas where OPM's compliance status should be clarified or where improvements in the compliance process could be made, such as system-configuration management and overall supporting documentation.

Audit Confirms Agency's Progress in Achieving Y2K Compliance

The non-RIS systems we reviewed had been classified as "implemented" without being tested in a simulated Y2K environment. In fact, for most of the systems we reviewed, a comprehensive Y2K test plan had not been developed. OPM and GAO Y2K compliance guidelines include the development of a Y2K test plan and the completion of Year 2000 testing as critical elements in ultimately classifying a system as implemented, the latter being GAO's final Y2K compliance phase.

It is important to note that OPM has actually implemented a six-phase Y2K compliance strategy instead of the five-phase approach suggested by GAO. OPM's strategy employs a "compliance verification" phase after the implementation phase. The purpose of this phase is to verify each system's compliance in a Year 2000-compliant environment. We agree that adding this additional phase should assist in minimizing the risk of an agency-wide Y2K-related system failure. However, the classification of these systems as fully implemented (under GAO's five-phase Y2K compliance strategy) in OPM's November 1998 report to OMB could lead to some confusion or misunderstanding of OPM's compliance status. Thus, we have recommended that OPM's report to OMB clearly identify non-RIS mission-critical systems identified as implemented but which have yet to go through OPM's compliance verification phase--a key component of OPM's overall compliance strategy.

We have also recommended that OPM's Office of Chief Information Officer (OCIO) develop and issue guidance regarding the development of Year 2000 test plans to assist the various organizations in completing comprehensive test plans. We made other recommen-

dations related to improvements in the overall documentation supporting the individual system Y2K compliance efforts and the implementation of a formal configuration management process to ensure that subsequent changes to the system, if any, are monitored and do not adversely affect the Y2K compliance status.

In addition to reviewing select mission-critical systems, we reviewed other Year 2000 status information detailed in OPM's November 1998 submission to OMB. Our review showed that, except for the mission-critical systems concerns described above, OPM's report to OMB fairly reflects the status of OPM's Year 2000 compliance efforts as of November 13, 1998.

Finally, we followed up on the status of the recommendations from our prior audits (, contained in Report No. 2F-00-98-101 and Report No. 99-00-98-022, issued on July 17, 1998 and October 21, 1998, respectively, and determined that OPM has adequately addressed our concerns and recommendations. However, we identified one area where improvements still can be made. OPM's OCIO should develop and implement controls to ensure that proper documentation is maintained in support of OPM's Year 2000 program plan, including documentation to support the quarterly submissions to OMB and all other Year 2000 compliance activity.

As we indicated in our semiannual report issued last fall, OPM has dedicated significant efforts to reducing the risks associated with a potential agency-wide Y2K system failure. We believe that our ongoing oversight contributes to OPM's overall Y2K compliance efforts, and we will continue providing reports on this ongoing review activity in the coming months.

OIG Makes Recommendations to Assist Agency With Y2K Compliance Goals

OPM's Financial Statements Audits

The FY 1998 CFO Act audits of OPM's benefits programs financial statements were performed under contract by an independent public accounting (IPA) firm, KPMG Peat Marwick LLP (KPMG). These audits covered financial statements related to OPM's retirement, health and life insurance benefits programs. Our office monitored these financial statement audits to ensure that the IPA performed all work in accordance with the contract and in compliance with government auditing standards and other authoritative references pertaining to OPM's financial statements. Our oversight of the IPA's work and review of the work papers and reports provided sufficient evidence for us to concur with the IPA's opinions. Summaries of the reports issued by the IPA appear in this section.

Additionally, OIG auditors attempted to perform audits of OPM's revolving fund (RF) and salaries and expenses accounts (S&E) FY 1998 financial statements. However, due to

limitations on our scope of work resulting from significant internal control weaknesses and incomplete agency record keeping, we concluded that we would be unable to express an opinion on the fairness of the financial statements. We have provided a narrative summarizing our report on this work as well.

OPM's Fiscal Year 1998 Benefits Programs Financial Statements

Report No. 2F-00-98-103
March 1, 1999

Under provisions of the CFO Act, our office is required to audit and report on the financial statements of OPM's reporting entities or select an independent accounting firm to do so. Under a contract monitored by our office, the international accounting firm of KPMG Peat Marwick LLP performed audits of OPM's FY 1998 benefits programs financial statements.

As mentioned previously, the benefits programs financial statements reviewed during this audit covered the retirement, health and life insurance programs. These benefit programs are key to the uninterrupted flow of benefits to federal civilian employees, annuitants and their respective dependents, and operate under the following names: the Civil Service Retirement System, the Federal Employees' Retirement System, the Federal Employees Health Benefits Program, and the Federal Employees' Group Life Insurance program. These programs are administered by OPM's Retirement and Insurance Service.

KPMG's fiscal year 1998 audit report includes opinions on the benefits programs financial statements, as well as reports on internal controls and the agency's compliance with laws and regulations pertaining to these programs. Table 1 on page 20 includes reportable conditions that KPMG identified during their audit work on the financial statements and reportable conditions they considered to be material weaknesses in the internal controls. A summary of KPMG's audit work is reflected below.

Benefits Programs Financial Statements

KPMG issued unqualified opinions on the financial statements of each of the benefits programs: the federal employees retirement program (RP), health benefits program (FEHBP), and life insurance program (LP). Their reports on internal controls noted improvements in the control environments of all three benefit programs during fiscal year 1998 through the reduction of several material weaknesses to reportable conditions. Reportable conditions KPMG identified and reported for all three benefit programs included the following areas:

- Cash management-investments.
- Electronic data processing (EDP) general control environment:
 - Entity-wide security program
 - Access control

- ⊆ Application change control/systems development
- ⊆ Service continuity

- Annual financial reporting, policies and procedures.

In addition, KPMG reported that the benefits programs were not in substantial compliance with federal system requirements and the U.S. Standard General Ledger (SGL), both of which have been incorporated in the Federal Financial Management Improvement Act.

Retirement Benefits Program

In addition to the items cited for the three benefits programs, KPMG cited two reportable conditions to the RP. Specifically, these were controls over both benefit payments and annuity overpayments made to annuitants.

Health Benefits Program

As previously mentioned, KPMG issued an unqualified opinion on the financial statements pertaining to the FEHBP. This was the first time that the health benefits programs financial statements had received an unqualified opinion. In the prior year, KPMG disclaimed an opinion because OPM did not have an adequate control system over carrier-reported activities nor was adequate evidential matter available to support transactions and balances related to insurance premiums and the activity of all experience-rated carriers (ERC). OPM corrected these weaknesses in FY 1998 by issuing the *FEHBP Experience-Rated Carrier and Service Organization Audit Guide* which requires experience-rated carriers to obtain audits of their FEHBP data that is included in OPM's financial statements (see related article on carrier financial accountability on page 23).

Items affecting the health benefits program other than those common to the three benefits programs included one material weakness and two reportable conditions. These were as follows:

- Financial reporting control environment (*material weakness*).
- Reconciliation of inter-program transactions (*reportable condition*).
- Controls over program administration by the health carriers (*reportable condition*).

Life Insurance Benefits Program

In addition to the items referenced previously pertaining to the three benefits programs, KPMG reported one reportable condition for the LP pertaining to the reconciliation of inter-program transactions.

Table 1.

<i>FY 1998 Internal Control Weaknesses</i>			
<i>Issues</i>	<i>Retirement Program</i>	<i>Health Insurance Program</i>	<i>Life Insurance Program</i>
Cash Management - Investments	RC	RC	RC
EDP General Control Environment	RC	RC	RC
Annual Financial Reporting, Policies and Procedures	RC	RC	RC
Controls Over Benefit Payments Made to Annuitants	RC	N/A	N/A
Controls Over Annuity Overpayments Made to Annuitants	RC	N/A	N/A
Financial Reporting Control Environment	N/A	M	N/A
Reconciliation of Inter-Program Transactions	N/A	RC	RC
Controls Over Program Administration by Health Carriers	N/A	RC	N/A

M = A reportable internal control weakness considered to be a material weakness

RC = A reportable condition

N/A = Not applicable

Report on OPM's FY 1998 Revolving Fund and Salaries & Expenses Accounts Financial Statements

Report No. 2F-00-98-102

March 1, 1999

During this reporting period, we made our third attempt at full-scope audits of the revolving fund (RF) and salaries and expenses accounts (S&E) financial statements. Due to continuing significant limitations on the scope of our work, we were unable to express an opinion on the FY 1998 financial statements. These scope limitations were due mainly to the absence of standard accounting records for substantially all of the material accounts and line items represented in the statements.

Section 5(b) of the FFMIA requires Inspectors General to report information to Congress related to the agency's compliance with this Act. Our report of disclaimer on the FY 1998 RF and S&E financial statements details our conclusions regarding the agency's compliance with the FFMIA. In summary, we reported instances where the RF and S&E financial management systems did not substantially comply with federal financial management system requirements, applicable accounting standards or the SGL.

Revolving Fund and Salaries & Expenses Accounts Financial Statements

We identified several material internal control weaknesses and reportable conditions during our audits of the RF and S&E financial statements that were common to both entities. Material weaknesses were found in:

- Operating policies and procedures.
- Financial statement preparation.
- Systems administration.
- Fund balance with U.S. Treasury reconciliation.
- Accounts receivable and accounts payable.
- Controls over recorded transactions.

There was one reportable condition pertaining to controls relating to application software development and change.

In addition to the instances referred to above where the RF and S&E did not substantially comply with the requirements encompassed under the FFMIA, we identified and reported other issues in the RF and S&E related to compliance with certain laws and regulations. We reported for both entities that during fiscal year 1998, neither was in full compliance with the objectives of FMFIA nor with Office of Management and Budget (OMB) Bulletin 97-01 (Form and Content of Agency Financial Statements).

Revolving Fund Financial Statements

We also identified one material internal control weakness and one material nonconformance with federal financial system requirements. These were, respectively:

- Investigations Service (IS) transactions and balances (*material weakness*).
- Training Management Assistance Project Tracking System (*material nonconformance* with OMB Circular A-127).

Salaries & Expenses Accounts Financial Statements

We did not identify any material weaknesses or nonconformances relating to federal financial system requirements.

***OIG Issues Disclaimers of Opinion on FY 1998 RF & S&E Financial
Statements***

Table 2 below provides a complete list of the areas in which we identified material weaknesses and reportable conditions for the RF and S&E Accounts during FY 1998.

Table 2.

<i>Fiscal Year 1998 Internal Control Weaknesses</i>		
<i>Issues</i>	<i>Revolving Fund</i>	<i>Salaries & Expenses Accounts</i>
Operating Policies and Procedures	M	M
Financial Statement Preparation	M	M
Systems Administration	M	M
Fund Balances With U.S. Treasury	M	M
Accounts Receivable	M	M
Accounts Payable	M	M
IS Transactions and Balances	M	N/A
Controls Over Recorded Transactions	M	M
Application Software Development and Change Control	RC	RC

M = A reportable internal control weakness considered to be a material weakness

RC = A reportable condition

N/A = Not applicable

As a result of our audits of the FY 1998 RF and S&E financial statements, we made several recommendations to address the key material weaknesses noted that resulted in our disclaimers of opinion. These recommendations were for the OCFO to:

- Maintain complete and accurate subledgers or other detailed support for general ledger balances, and to perform periodic reconciliations between them.
- Establish procedures for supervisory review and approval of all material transactions.
- Implement periodic analytical reviews of general ledger balances.
- Continue the development and documentation of operating policies and procedures for all accounting and control activities.

Health Insurance Carrier Financial Accountability

In our last semiannual report, we reported on the issuance and implementation in FY 1998 of the *FEHBP Experience-Rated Carrier and Service Organization Audit Guide*. As we mentioned at that time, the audit guide was a collaboration between our office and OPM's

Retirement and Insurance Service (RIS) to bring about better financial accountability and increased oversight to the FEHBP. This audit guide, referenced in our audit summary on page 20, describes expanded reporting requirements for experience-rated insurance carriers who participate in the FEHBP, as well as audit procedures to be conducted on these carriers' FEHBP operations by their IPAs. The procedures were designed to ensure that these insurance carriers met federal financial reporting and audit requirements. In the past, the lack of adequate oversight and control over ERC-reported amounts and balances used for financial statement reporting was a material weakness that contributed to a disclaimer of opinion on the FEHBP's FY 1996 and FY 1997 financial statements.

We believe that proof of the success of our efforts to improve carrier financial accountability is exhibited in the fact that the financial statements audit of the FEHBP resulted in an unqualified opinion for the first time. And it was specifically the ability of the auditors to access complete and accurate information that allowed them to express this unqualified opinion. Without having these audit guide procedures in place, this would not have been possible. The work of the OIG and RIS quality improvement team that developed this audit guide deserves a great deal of credit for this achievement. As an ongoing effort to ensure the integrity of this data, we will be conducting quality assurance reviews of the carriers' IPA work and participate in future revisions of the audit guide.

Joint OIG & Agency Efforts Result in Improved Carrier Accountability

Investigative Activities

The Office of Personnel Management administers benefits from its trust funds for all federal civilian employees and annuitants participating in the federal government's retirement, health and life insurance programs. These trust fund programs cover approximately 9.5 million current and retired federal civilian employees, including their family members, and disburse about \$60 billion annually. The investigation of fraud involving OPM's trust funds occupies the majority of our OIG investigative efforts.

During this reporting period, we have continued to aggressively pursue criminal and civil sanctions against both individuals and corporate entities. These efforts have produced 13 arrests and five convictions. More importantly, however, they have resulted in judicial and administrative monetary recoveries to the OPM-administered trust funds totaling \$1,010,440. Other investigative efforts resulted in the detection of ongoing frauds in the Civil Service Retirement System, with a projected savings of \$452,340 to the Civil Service Retirement and Disability trust fund over the next five years. Overall, we opened 15 investigations and closed 26 during this reporting period, with 79 still in progress at the end of the period. (See Table 1 for investigative activity highlights on page 31 of this section.)

Calls received on our health care fraud hotline and our retirement and special investigations hotline, along with complaints mailed in, totaled 939. Additional information, including specific activity breakdowns for each hotline, can be found on pages 29-30 in this section.

In keeping with the emphasis that Congress and various departments and agencies in the executive branch have placed on combating health care fraud, we coordinate our investigations with the Department of Justice (DOJ) and other federal, state and local law enforcement agencies. At the national level, we are participating members of DOJ's health-care fraud working group. We actively work 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 the retirement area, we have continued our proactive efforts to identify fraud by routinely reviewing CSRS annuity records for indications of unusual circumstances, as well as maintaining contact with the federal annuitant population. While our recoveries in this area are, for the most part, smaller than in the health care fraud area, criminal prosecutions and sentences tend to be more significant.

In addition 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 of government funds and property, bribery involving federal officials and financial conflicts of interest.

On the following pages, we have provided narratives relating to health care and retirement fund fraud and employee misconduct investigations we conducted during the reporting period.

Health Care-Related Fraud and Abuse

Our OIG special agents are in regular contact with the numerous insurance carriers participating in the FEHBP to provide an effective means for reporting instances of possible fraud by health care providers and FEHBP subscribers. Our office also maintains liaison with federal law enforcement agencies involved in health care fraud investigations and participates in several health care fraud working groups on both national and local levels. Additionally, we work closely with our own Office of Audits when fraud issues arise during the course of health carrier audits.

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

Weight-Loss Treatments Disguised As Covered Services

A physician pleaded guilty in U.S. District Court in Alexandria, Virginia, to conspiracy to commit mail and wire fraud in connection with his operation of a medical center located in Vienna, Virginia. He previously had been indicted, along with his wife, by a federal grand jury on multiple charges of conspiracy, mail and wire fraud. .

The physician's clinic specialized in preventive medicine, specifically weight-loss treatment. During the period 1990-1996, he submitted bills through his clinic to private insurance companies as well as federal health care insurance programs, masking and concealing the nature of his practice. To be compensated for noncovered weight-loss treatment of patients, he billed the insurance plans for covered services not actually performed.

Estimated losses resulting from this fraudulent billing totaled between \$800,000 and \$1.5 million. Sentencing is set for June 1999, at which time the physician faces up to five years' incarceration, fines of \$250,000, in addition to making full restitution, including to the FEHBP trust fund.

Northern VA Physician Convicted for Fraudulent Billing

Retail Pharmacy Chain Exposed in RX Fraud Scheme

A referral from the Department of Justice in May 1997 resulted in our initiating an investigation of a national pharmacy chain for overcharging FEHBP subscribers and other customers for prescription drugs. The referral alleged that this company shortchanged customers on prescriptions by providing a smaller quantity than actually ordered by the customers' physicians, yet charging full price based on the actual prescribed amount.

Our office conducted this investigation jointly with several other federal and state investigative agencies under the auspices of DOJ's commercial litigation branch. As a

result, the company agreed to return \$7.6 million, of which \$273,000 represented restitution due the FEHBP.

FEHBP to Receive \$273,000 in RX Chain Settlement

Clinic With Resort & Health Spa Ties Involved in Medical Claims Fraud

A four-year investigation conducted by our office in conjunction with the Department of Justice culminated in a civil settlement involving a West Virginia-based clinic. The clinic, operated in conjunction with a resort hotel and health spa, specialized in providing high-priced physical examinations for resort customers.

Our investigation revealed that the clinic billed FEHBP insurance carriers multiple times, falsifying diagnostic codes for each patient seen when, in fact, the patients only were given routine physical examinations. The codes in question indicated higher priced services than those rendered. This type of billing fraud is known as “upcoding.” The clinic agreed to return \$100,000 to the FEHBP and sign a corporate integrity agreement that also contained a compliance plan.

Investigators Uncover Billing Scheme Resulting in \$100,000 Civil Settlement

Employee Integrity Investigations

One of the primary missions of IG offices is ensuring that the federal workforce maintains the highest standards of integrity in the performance of its duties. In order to maintain those standards within our agency, our OIG conducts investigations of employee misconduct that may result in criminal, civil or administrative action.

The following narratives describe two of the cases we concluded in the area of employee misconduct and fraud during this reporting period.

OPM Employee Submits Fraudulent Vouchers

Based on a referral from an agency supervisor, we conducted an investigation concerning an OPM employee with responsibility for timekeeping and processing travel vouchers and training certifications.

The investigation revealed that the employee falsified certificates for training involving training sessions the employee never attended. In addition, the employee submitted

fraudulent vouchers and was reimbursed for parking and transportation expenses not incurred. Following an administrative hearing on the matter, the employee was permitted to resign in lieu of termination.

Fraud Results in Employee Resignation From Agency

Unauthorized Use of Government Travel Card

As a result of a referral from the credit card vendor authorized to issue the government travel cards used by OPM employees in conducting official business, we initiated an investigation of alleged misuse of a card by an employee. The specific issue was whether the employee used the travel card for personal purchases in violation of federal regulations.

Our investigation revealed that the employee, while absent without leave, purchased airline tickets, rented vehicles and made cash withdrawals from automated teller machines using the government-issued travel card. In addition, the employee failed to make any payments to the vendor for these purchases. Following the agency's receipt of our report, the employee was terminated from federal service.

Employee Terminated From Government Service After Travel Card Misuse

Retirement Fraud and Special Investigations

In accordance with our mission to prevent and detect fraud, OIG special agents routinely review CSRS annuity records for indications of unusual circumstances. Using excessive annuitant age as an indication of potential fraud, our investigators 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.

Cited below are narratives related to two of the cases in these areas that we completed during this reporting period.

Deceased Annuitant's Son Involved in Check Forgery

After receiving information from OPM's Office of Insurance Programs, our office conducted an investigation involving CSRS benefits paid to an annuitant who died in 1986 in Augusta, Georgia. Because the death had not been reported to OPM, annuity payments totaling \$81,327 were erroneously dispersed after the annuitant's death.

During the course of our investigation, we were able to determine that the annuitant's son had forged the signature of his deceased mother on these U.S. Treasury checks in

order to convert the funds to his own use. On January 21, 1999, in the U.S. District Court for Northern Georgia in Atlanta, the subject pleaded guilty to theft of government funds.

A sentencing date has not yet been set subject to a report from the U.S. Probation Office. We will provide a sentencing update in a later semiannual report.

Annuity Fraud Results in \$81,327 Loss to CSRS Retirement Fund

Anonymous Tip Results in Retirement Fund Investigation

Upon receipt of information from an anonymous source, our office performed an investigation involving the theft of U.S. Treasury checks intended for a U.S. Civil Service retiree who had died in May 1994.

Our investigation revealed that a friend misappropriated \$74,700 in CSRS benefit checks made out to this deceased Greenbelt, Maryland resident. He was able to convert the funds to his use by forging her signature on U.S. Treasury checks sent to her home and which he later deposited to his account.

The individual was indicted by a federal grand jury in the District of Columbia on December 15, 1998, for theft of government funds. On January 27, 1999, the individual pleaded guilty and was sentenced to six months' imprisonment and ordered to make full restitution to the CSRS retirement trust fund.

Six Months' Prison Sentence Imposed for Retirement Fund Theft

OIG Hotlines

The OIG maintains two hotlines, the Retirement and Special Investigations hotline and the Health Care Fraud hotline.

Retirement and Special Investigations Hotline

The Retirement and Special Investigations hotline provides the same assistance as traditional OIG hotlines. For example, we receive inquiries from OPM employees, contractors and others interested in reporting waste, fraud and abuse within the agency. Callers, or those who choose to write letters, can report information openly, anonymously or confidentially without fear of reprisal.

The Retirement and Special Investigations hotline and complaint activity for this reporting period included 52 telephone calls, 48 letters, 7 agency referrals, 1 walk-in, and 75 complaints initiated by the OIG, for a total of 183. Our administrative monetary recoveries resulting from retirement and special investigation complaints totaled \$381,527.

OIG-initiated complaints Complaints initiated by our office can be one of two types. The first occurs when the agency has already received information indicating an overpayment to an annuitant has been made, and our review leads us to determine there are sufficient grounds to justify our involvement due to the potential for fraud. There were 15 such complaints associated with agency inquiries during this reporting period.

The second type of OIG-initiated complaint occurs when we review the agency's automated annuity records system for certain items that may indicate a potential for fraud. At that point, we initiate personal contact with the annuitant to determine if further investigation is warranted. This investigative activity resulted in 59 instances where our office initiated personal contacts to verify the status of the annuitant.

Health Care Fraud Hotline

The Health Care Fraud hotline was established 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 plans associated with the FEHBP.

While the hotline is designed to provide an avenue to report fraud 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 the reporting period involved 520 telephone calls and 233 letters, for a total of 753. During this period, the administrative monetary recoveries pertaining to health care fraud complaints totaled \$25,386.

Investigative Activity Tables

TABLE 1: Investigative Highlights

Judicial Actions:	
Arrests	12
Indictments	10
Convictions	5
Administrative Actions: ¹	1
Judicial Recoveries:	
Fines, Penalties, Restitutions and Settlements	\$593,527
Administrative Recoveries:	
Settlements and Restitutions	\$406,913
Total Funds Recovered	\$ 1,000,440

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

TABLE 2: Hotline Calls and Complaint Activity

Retirement and Special Investigations Hotline and Complaint Activity:	
Retained for Investigation	128
Referred to:	
OIG Office of Audits	0
OPM Groups and Offices	33
Other Federal Agencies	25
Total	186
Health Care Fraud Hotline and Complaint Activity:	
Retained for Investigation	205
Referred to:	
OPM Groups and Offices	202
Other Federal/State Agencies	96
Health Insurance Carriers or Providers	250
Total	753
Total Contacts	939

Evaluation and Inspections Activities

Section 4(a)(3) of the Inspector General Act provides a broad mandate to IGs to assist their respective departments and agencies in promoting economy and efficiency and in preventing and detecting fraud and abuse with respect to their programs and operations. It calls for IGs to be proactive in their activities beyond those specifically prescribed under its audit and investigation responsibilities to make sure the intent and purposes of the Act are met.

Within this context, evaluation and inspections activities have become a core function within our OIG. Through these activities, we are providing assistance to agency program managers in an effort to determine the feasibility of new initiatives and the effectiveness and efficiency of existing operational methodologies. We conduct independent analytical reviews that often serve as the cornerstone for strategies to improve the delivery of services throughout the agency.

The Office of Personnel Management (OPM) has been in the forefront of the Administration's efforts to improve the quality of its services and reduce the size of government. The agency's program offices have experienced reorganizations, staff reductions and new program mandates during the last few years, with the intended goal of becoming a "model agency" for the twenty-first century. Our office provides this agency with a unique tool to address a variety of the pressing issues associated with today's government reorganizing. The evaluative process we employ, whether requested by our agency's program offices or initiated from within the OIG, focuses on current issues, such as reduced funding, increased workloads, decreasing staffing levels, inefficient or ineffective services, private or public-sector inquiries concerning delivery of services, and the absence of objective evaluative data to use in determining the impact of programs.

During this reporting period, the oversight function of the Combined Federal Campaign was reassigned to the evaluations and inspection activity. While no new CFC reviews have been completed, one is currently underway. In addition, we have begun an evaluation of OPM's CFC operations function.

Another ongoing area of review is the agency's compliance with the Government Performance and Results Act of 1993 (GPRA). Signed by President Clinton on August 3, 1993, the Act was designed to produce improvements in government performance and accountability in federal programs. GPRA, more recently referred to as the Results Act, 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. The Act requires all executive branch departments and agencies to submit five-year strategic plans and annual performance plans (APP) linked to their respective budgets. Prior to their submission to Congress, these APPs must be reviewed by OMB along with each agency's and department's traditional budget request.

In response to a request from Congress, we have prepared a plan that will be used by the OIG in our efforts to review OPM activities under the Results Act. Specifically, we have been asked to provide a review in two areas. We are to examine:

- Agency efforts to develop and use performance measures for determining progress toward achieving the performance goals and program outcomes described in the agency's annual performance plans and performance reports under the Results Act.
- Verification and validation of selected data sources and information collection and accounting systems that support the agency's Results Act strategic and performance plans and its performance reports.

The OIG plan is to emphasize performance measures associated with agency programs and activities that are at high risk of waste, fraud or mismanagement; and secondly, as determined by the IG, require a review to assess the adequacy of agency controls for ensuring that underlying performance data is accurate and reliable.

The review plan as envisioned by this office will entail efforts involving both the evaluation and inspections activity as well as its audit activity. The following section summarizes that plan.

OIG Formulates Results Act Review Plan At Request of Congress

Results Act Review Plan

Our OIG has begun a series of evaluations covering OPM's implementation of the Results Act. The first of these evaluations focused on OPM's FY 2000 annual performance plan, and the results of that review are presented in the next article. While this review was of early drafts of the APP, future reviews are planned to occur later in the process when the agency's APP is much closer to a final version. The reviews will continue to assess the following:

- Agency compliance with Results Act requirements, including consistency with the agency's strategic plan and complicity of external stakeholders.
- OPM's overall progress toward establishing a system of strategic and annual performance planning to set goals for program performance and measure results.

Both evaluators and auditors will independently perform reviews to verify and validate performance data. Initially, these reviews will focus on specific data sources and information collection and accounting systems that support the agency strategic and annual performance plans and performance reports. The verification and validation process will also include a review of the quality, completeness, accuracy, consistency and timeliness of data, along with the extent to which the data provides valid measures of performance.

Subsequent to the review of the FY 2000 annual performance plan, the OIG will focus its evaluative efforts on OPM's ability to generate reliable and timely performance data. Specifically, we will assess the adequacy of selected data sources and information collection systems for measuring the agency's progress toward achieving its annual and strategic goals. We will select specific agency goals and measures for review based upon a risk assessment. Such a review will be triggered by one or more of the following: (1) when a high risk for waste, fraud or mismanagement exists; (2) when data integrity is subject to challenge; and (3) where potential problems were noted in prior audit/evaluation reports.

Additionally, methodology for all future evaluations will include steps for the verification and validation of performance information. Also, as performance data becomes available in the future, evaluations will include an assessment of how OPM is using performance results to improve its programs.

OIG auditors will review performance measures contained in OPM's financial statements for compliance with OMB Bulletin 97-01 (Form and Content of Agency Financial Statements) and in accordance with OMB Bulletin 98-08 (Audit Requirement for Federal Financial Statements). Planned procedures include examining and comparing the performance measures for consistency of performance data with OPM's GPRA implementation efforts. Further, OIG auditors will assess control risk for the assertions relevant to the performance measures reported in the overview of the financial statements.

Our auditors will also obtain an understanding of internal controls relating to the existence and completeness assertions for high-risk performance measures included in the financial statements and determine whether controls have been placed in operation. Other tests will be performed to verify and validate the following: (1) data sources, (2) the methods of data collection, and (3) accounting systems that produce selected performance measures reported in the financial statements. Our objective is to obtain reasonable assurance that transactions are properly recorded, processed and summarized to permit the accurate and complete presentation of performance information.

Evaluators & Auditors Both at Work on Results Act Review Plan

OIG Oversight of OPM's FY 2000 Performance Plan

As mentioned in our semiannual report issued a year ago, OPM submits a single document to OMB that contains both traditional budget information and the agency's APP. As also previously stated, the latter is an aggregate of individual plans regarding performance goals and measures prepared by OPM's various organizational components, including the OIG.

On September 30, 1997, OPM completed its initial five-year strategic plan, and, in the fall of 1998, its first APP, covering fiscal year 1999. The OIG participated in an advisory

capacity in the development of both of these plans by providing review, commentary and recommendations for improvement. In June 1998, OPM began work on its FY 2000 annual performance plan, the second such plan prepared by OPM. As for the FY 1999 plan, we continued our advisory role by reviewing the FY 2000 plan during its draft stages.

Due to time constraints and resource limitations, it was not feasible to review the plans of all organizational components. Consequently, we focused our assessment on the plans of seven organizations performing functions critical to OPM's core mission.

The primary objective of our assessment was to assess the strengths and weaknesses of OPM's annual performance plan in meeting the requirements of GPRA and addressing the concerns expressed by both Congress and the U.S. General Accounting Office. We did not attempt to determine whether organizations had selected the most appropriate goals and measures for their plans.

While we noted many improvements over the FY 1999 plan, we generally found that OPM's goals are still not results-oriented or measurable, and remain output rather than outcome-oriented. In addition, many goals and measures lack numerical target levels or other measurable values that would facilitate the future assessment of performance.

We also found that the plan still needs improvement in its discussion of how specific processes, technologies and resources will be used to achieve OPM's goals. And, while there is more discussion of verification and validation in this plan than last year's plan, it does not adequately address many of the problems OPM will face in this area and the data and systems limitations that may affect the validity of performance measures.

In our report, we presented numerous ways OPM could improve its FY 2000 APP submission. However, given the limited amount of time OPM staff had to consider and incorporate any improvement stemming from our review and the fact that the document was still a work in progress, it is not evident how our comments affected the final APP that was issued by OPM on February 6, 1999. Nevertheless, we believe our findings will have further utility to the agency as they may relate to future annual plans.

Index of Reporting Requirements (Inspector General Act of 1978, As Amended)

	Page
Section 4 (a) (2):	Review of legislation and regulations 1-2
Section 5 (a) (1):	Significant problems, abuses, and deficiencies 21-23
Section 5 (a) (2):	Recommendations regarding significant problems, abuses, and deficiencies 23
Section 5 (a) (3):	Recommendations described in previous semiannual reports on which corrective action has not been completed 39
Section 5 (a) (4):	Matters referred to prosecutive authorities 26-29
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 41-43
Section 5 (a) (7):	Summary of particularly significant reports 3-12, 15-22
Section 5 (a) (8):	Audit reports containing questioned costs 41
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 39
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, 1998 to March 31, 1999

	Number of Reports	Questioned Costs	Unsupported Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	8 ¹	\$ 28,252,890	\$
B. Reports issued during the reporting period with findings	9	35,097,704	
Subtotals (A+B)	17	63,350,594	
C. Reports for which a management decision was made during the reporting period:	7	25,997,905	
1. Disallowed costs		16,815,156	
2. Costs not disallowed		9,182,749	
D. Reports for which no management decision has been made by the end of the reporting period	10	37,352,689	
Reports for which no management decision has been made within 6 months of issuance	2	4,429,030 ²	

¹ Adjustment made to correct previous report.

² Resolution of these items has been postponed at the request of the OIG.

APPENDIX II
Final Reports Issued With Recommendations
For Better Use of Funds
October 1, 1998 to March 31, 1999

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

APPENDIX III
Insurance Audit Reports Issued
October 1, 1998 to March 31, 1999

Subject (Standard Audits)	Report Number	Issue Date	Questioned Costs	Unsupported Costs
Harvard Community Health Plan, Inc. in Brookline, Massachusetts	68-00-95-017	December 11, 1998	\$ 4,605,946	\$
FHP of California (formerly TakeCare of California) in Fountain Valley, California	CY-00-97-051	December 17, 1998	1,206,364	
U.S. Healthcare of Massachusetts in Blue Bell, Pennsylvania	NE-00-96-012	December 17, 1998	1,592,202	
Blue Cross Blue Shield of Missouri in St. Louis, Missouri	10-76-97-010	December 24, 1998	1,300,562	
Keystone Health Plan West, Inc. in Pittsburgh, Pennsylvania	EF-00-97-016	January 11, 1999	1,939,820	
MD-Individual Practice Association, Inc. in Rockville, Maryland	JP-00-98-003	February 19, 1999	17,109,231	
FHP - New Mexico in Albuquerque, New Mexico	P2-00-97-049	March 2, 1999	4,797,429	
Humana Group Health Plan, Inc. in Washington, D.C.	50-00-98-014	March 15, 1999	0	
OmniCare Health Plan in Detroit, Michigan	KA-00-93-057	March 17, 1999	2,492,269	
Blue Cross Blue Shield of Montana in Helena, Montana	10-37-97-039	March 18, 1999	53,881	
General Controls Related to Postmasters Benefit Plan's Computer-Based Information Systems in Alexandria, Virginia	36-00-98-021	March 31, 1999	0	
TOTALS			\$ 35,097,704	\$

Appendix IV
Internal Audit Reports Issued
October 1, 1998 to March 31, 1999

Subject	Report Number	Issue Date	Funds Put to Better Use	Questioned Costs
U.S. Office of Personnel Management's Year 2000 Compliance Status Review, Office of the Chief Financial Officer: Awareness and Assessment Phases	2F-00-98-101	October 21, 1998	\$	\$
U.S. Office of Personnel Management's Audit of OFEGLI Overpayment Procedures, Metropolitan Life Insurance Company in New York, New York	2F-00-98-100	February 5, 1999		
U.S. Office of Personnel Management's Fiscal Year 1998 Revolving Fund and Salaries and Expenses Accounts Financial Statements	2F-00-98-102	March 1, 1999		
U.S. Office of Personnel Management's Benefits Programs Fiscal Year 1998 Financial Statements	2F-00-98-103	March 1, 1999		
Status of U.S. Office of Personnel Management's Year 2000 Compliance Project	99-00-98-048	March 23, 1999		
TOTALS			\$	\$

Appendix V
Combined Federal Campaign
Audit Reports Issued
October 1, 1998 to March 31, 1999

Subject	Report Number	Issue Date	Funds Put to Better Use	Questioned Costs
The 1995 and 1996 Combined Federal Campaigns of Southern Nevada, Las Vegas, Nevada	2A-CF-98-037	March 3, 1999	\$	\$
TOTALS			\$	\$