

April 30, 2000

*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, 1999 to March 31, 2000. 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*

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Message from the IG

Customarily, my message would exclude references to issues relating to the activities of the President's Council on Integrity and Efficiency (PCIE), the organization in which all statutorily appointed Inspectors General automatically hold membership. However, an issue has been raised that is of such importance to the work of my office and that of other members of the IG community that I felt it imperative to address it.

In January 2000, the five-member Commission on the Advancement of Federal Law Enforcement, chaired by Judge William H. Webster, the former Director of both the Central Intelligence Agency and the Federal Bureau of Investigations (FBI), issued its final report, entitled *Law Enforcement in a New Century and a Changing World*. This lengthy document contains sweeping recommendations to restructure and refocus the federal law enforcement community to meet those challenges considered most likely to arise in the future. Examples include the globalization of crime, terrorism, and the federalization of crime (crimes that formerly were within the exclusive jurisdiction of the states that now have also been elevated to the federal level).

This commission was broadly critical of Offices of Inspector General (OIGs), questioning the appropriateness and validity of their continued role in the federal law enforcement community. The report suggested that a "proliferation" of small, specialized federal law enforcement entities, including most notably the OIGs, had hampered coordination of the overall federal law enforcement effort and placed its ability to maintain high professional standards at risk. It recommended that inspectors general should function solely as "auditors general," with their current law enforcement functions subsumed by the traditional law enforcement agencies, such as the FBI.

While not apparent on the face of the report, in fact, the commission's recommendations had been formulated without research into the background of the IG community and with virtually no consultation of sources knowledgeable about OIG operations. As a result, the report reflected a profound misunderstanding of the authority, structure and role of the OIGs.

Both the PCIE, as the government-wide coordinating body for presidentially appointed inspectors general and related offices, and the Executive Council on Integrity and Efficiency (ECIE), its counterpart for agency-appointed inspectors general, immediately recognized that such inaccurate and misleading commentary simply could not remain unchallenged. Our office took the lead in preparing a response that vigorously rebutted the commission's recommendations. Every member of the PCIE and the ECIE had the opportunity to contribute to this document. It was transmitted over the joint signatures of the vice chairs of the PCIE and ECIE to the House Committee on Government Reform and Oversight and the Subcommittee on Criminal Justice Oversight of the Senate Committee on the Judiciary on March 2, 2000. It was made part of the official record of that subcommittee's proceedings on the commission's report.

The PCIE/ECIE response explained the evolution of the IG's independent criminal investigative authority, emphasizing that placing criminal investigators together with

auditors, analysts and attorneys in the overall OIG structure generates a synergistic environment that has been highly effective in addressing program-related violations in federal agencies. It pointed out that the commission's recommendations were directly at odds with the premises of the Inspector General Act of 1978 (IG Act) and with the demonstrated record of the OIGs in producing results that benefit their respective agency programs and the American taxpayer.

In contrast, the commission's recommendations would reverse the clock to the situation existing before passage of the IG Act. At that time, most agencies had no authority to conduct criminal investigations of violations in their own programs. Instead, they relied on the "traditional" law enforcement agencies for those services. As was made abundantly clear in congressional hearings on the IG legislation, this situation was utterly unsatisfactory from the standpoint of effective program management. The objectives and priorities of the law enforcement agencies differed from the agencies in whose programs the violations were occurring. Thus, their investigations were uncoordinated with the needs of the agencies. Information about violations did not flow to the responsible agency program officials, nor were agency auditors or other oversight officials regularly involved. Inevitably, the impact of investigations was limited to securing convictions, and was not applied to such broader purposes as improving program integrity and administration nor recovering or saving funds.

The IG Act was precisely designed to coordinate auditing and investigative activities in a way that enhanced program effectiveness and oversight. It put auditors and criminal investigators together in an organizational setting that allowed each of them to contribute to the work of the other. All of an OIG's work focuses on improving the effectiveness and integrity of its agency's programs; there are no other priorities or objectives to detract from this mission. The placement of an OIG as part of each agency permits an effective exchange of information between the IG and agency program staffs. The reporting requirements of the IG Act assure that there is a continuing flow of information to Congress as well. If this structure were changed, and law enforcement authority were to revert solely to the "traditional" agencies, the benefits of the current IG system would be lost, and the problems solved by the IG Act would recur immediately.

Our response further demonstrated that the IG system, within the current structure, is highly productive. The IG community's investigative activities have collectively generated truly significant results in the form of financial impact, arrests, convictions, administrative sanctions and personnel actions. It also noted that the PCIE and ECIE members have taken aggressive measures to foster high levels of professionalism in their investigative operations through collaborative initiatives on training, work quality and work standards. The IG law enforcement workforce consists of approximately 2,900 criminal investigators, who are involved in criminal and related civil cases nationwide. All of the PCIE-member OIGs hold law enforcement authority, either by statute or blanket deputation from the Department of Justice, to whom they are as fully accountable for the exercise of their authorities as are the "traditional" law enforcement agencies.

Perhaps, most significantly, the PCIE/ECIE response underscored yet again the tenet that an OIG's statutory independence is the primary factor underlying its effectiveness. The lack of an independent law enforcement authority in the pre-IG Act era meant that

fraud, waste and abuse in agency programs were not vigorously investigated with the objective of improving those programs. Today, the existence of independent OIGs means that those objectives are pursued zealously and objectively. Further, this independence makes possible for the IG community to respond fully and freely to the commission's report and to correct the inaccurate portrayal of its contributions to federal law enforcement.

Exclusion of FEHBP from HIPAA Health-Care Fraud Enforcement Provisions Continues

In practically every semiannual report since 1996, we have reported on the detrimental effect that exclusion of the Federal Employees Health Benefits Program (FEHBP) from most anti-fraud provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) has had on our prosecution of abuses of this program.

The expressed purpose of HIPAA is to make vigorous enforcement measures available to federal health care programs. It is unconscionable to deny the largest employer-sponsored health insurance program in the United States and third largest federal health program the same fraud-fighting tools available to other federal health care programs.

In addition to limiting my office's effectiveness in fighting health care fraud, the exclusion has made it more difficult for federal prosecutors to handle even strong criminal cases involving the FEHBP, because the available legal authorities and standards, particularly with regard to anti-kickback provisions, may differ from those now being applied to all other federal health programs. If the FEHBP were included under HIPAA, then these previously described limitations would be effectively removed. It also would enable us to increase significantly administrative penalties that, in addition to deterring fraud, would allow us to make larger contributions to the health care fraud and abuse control account created by this Act to finance anti-fraud activity.

Although several bills have been introduced to correct this inequity, no further action has been taken by Congress. We will continue to work to enable this agency to become a player on equal footing with other federal agencies in fighting fraud for the American taxpayer.

Productivity Indicators

FINANCIAL IMPACT:

Audit Recommendations for	
Recovery of Funds	\$62,842,859*
Recoveries Through	
Investigative Actions	\$8,270,770*
Management Commitments to	
Recover Funds	\$49,345,197

**Note 1: Each of these amounts includes \$6 million, representing a joint recovery shared by our Office of Audits and Office of Investigations.*

Note 2: 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	31
Investigative Cases Closed.	19
Cases Accepted for Prosecution	7
Indictments	7
Convictions	7
Hotline Contacts and Complaint Activity	798
Health Care Provider Debarments and Suspensions	1,151
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, as amended, our office monitors and reviews legislative and regulatory proposals for their impact on the Office of the Inspector General (OIG) and the Office of Personnel Management (OPM) programs and operations. Specifically, we perform this activity to evaluate their potential for encouraging economy and efficiency and preventing fraud, waste and mismanagement. We also monitor legal issues that have a broad effect on the Inspector General community and present testimony and other communications to Congress as appropriate.

During the current reporting period, we continued to exercise our oversight responsibilities regarding regulatory and legislative issues. In areas relating to the Federal Employees Health Benefits Program (FEHBP), we recently completed drafting regulations to implement the administrative sanctions process authorized by the Federal Employees Health Care Protection Act of 1998, P.L. 105-266. We are now preparing to submit these draft regulations for agency review prior to publication in the *Federal Register* later this year. For a fuller discussion of the administrative sanctions authority contained in P.L. 105-266, please refer to our semiannual report to Congress issued last fall.

Other legislation we have been following closely is H.R. 1827, the Government Waste Corrections Act of 1999, also discussed in our last semiannual report and which we address further in this section.

During this reporting period, we also reviewed and presented formal comments on the Department of Health and Human Service's (HHS) proposed medical records privacy regulations as they appeared in the *Federal Register* this past November. Our comments on this proposal follow.

Regulatory Review

During the current reporting period, we carefully reviewed and commented on an important HHS proposed regulation, "Standards for Privacy of Individually Identifiable Health Information." This regulation, published in the *Federal Register* on November 3, 1999 (64 F.R. 59917-59966), contains proposed standards to protect the privacy of individuals whose health information is maintained or transmitted in connection with certain administrative and financial transactions. There is also a provision in the regulation to implement the privacy requirements of the administrative simplification subtitle of the Health Insurance Portability and Accountability Act of 1996. These rules would apply to health plans, health care clearinghouses and certain health care providers. Also contained in this regulation are specific standards that take into account the rights individuals should have as the subject of this information, procedures for the exercise of those rights, and the authorized and required uses and disclosures of this information.

We discussed portions of the draft regulation with the Department of Health and Human Services prior to its publication and also submitted public comments objecting to its adverse impact on our ability to combat health care fraud in the Federal Employees Health Benefits Program because of its overly restrictive nature. A member of our staff has been working on an HHS task force to review the public comments submitted following the draft regulation's publication in the *Federal Register* and to draft policy option papers for HHS Secretary Donna Shalala or her successor in the event this process exceeds the Secretary's tenure. These option papers contain revisions to various portions of the draft regulation to reflect public comment and internal HHS concerns. Revisions to the proposed regulation will be based solely upon the Secretary's decision after she has reviewed the option papers.

OIG Reviews Medical Records Privacy Regulations

Legislative Review

As noted in our prior report, this office spent considerable time and effort working with the House Committee on Government Reform staff on H.R. 1827, the Government Waste Corrections Act of 1999. This bill would require agency heads to conduct recovery audits for payment activities (*i.e., disbursements for goods and services*) that exceed \$500 million in the aggregate. A recovery audit is used as a financial management technique to identify overpayments made by executive agencies and departments with respect to vendors and other entities. Examples of activities that could lead to overpayments include duplicate payments, pricing errors, the failure to provide discounts, rebates or other allowances and inadvertent errors.

The committee reported H.R. 1827 on November 10, 1999, with amendments that addressed some of our earlier concerns with regard to the role OIGs would play in this process and how recovery audits would differ from those conducted in the traditional OIG auditing process. It then passed the House with minor changes on March 8, 2000.

Specifically, the amended bill defines recovery audits in a manner ensuring that they will not overlap or interfere with OIG auditing authorities. For instance, prior to authorizing a recovery audit, agency heads are required under the amended bill to consult with an agency's OIG and chief financial officer. Further, recovery auditors, usually private contractors, would be required to report to the agency head and the OIG patterns of overpayments, overpayments identified outside the recovery audit contract scope, and any incidents of fraud or other criminal activity identified during the review. This legislation also contains a provision to limit the records a recovery auditor can review almost exclusively to those in the possession of the agency. Under no circumstances can recovery auditors visit the offices of vendors to retrieve or review records. These particular restrictions are designed to reduce what we deem an unnecessary burden on federal contractors.

OIG Works with Committee on Recovery Audits Legislation

Audit Activities

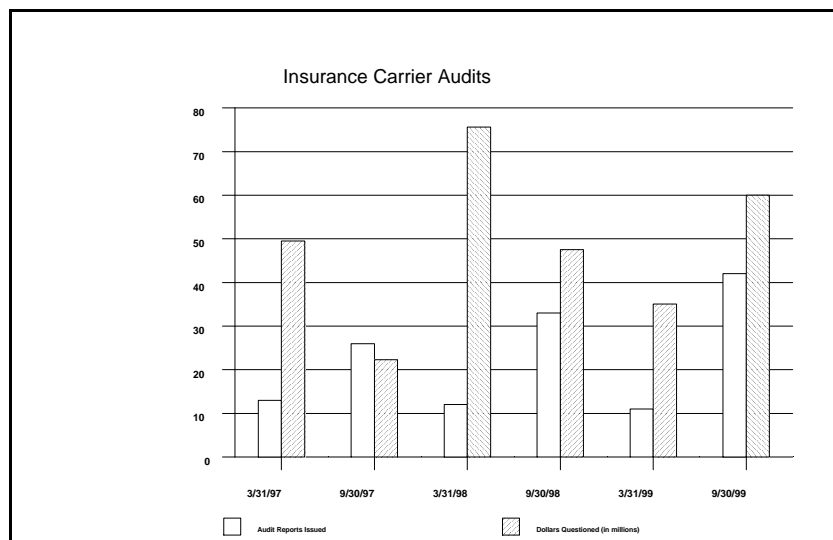
Health and Life Insurance Carrier Audits

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 program (FEGLI). Our office is responsible for auditing these benefits program activities.

Our audit universe contains approximately 435 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 \$19.4 billion.

During the current reporting period, we issued 27 final reports on organizations participating in the FEHBP, 21 of which contain recommendations for monetary adjustment in the aggregate amount of \$62.8 million due the FEHBP. A complete listing of all these reports is provided in Appendix III on pages 47-48 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 137 reports and questioned \$290 million in inappropriate FEHBP charges as the graph below illustrates.



The sections that immediately follow explain the differences among the types of 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), our OIG is responsible for auditing approximately 335 rating areas. A community-rated carrier generally sets the subscription rates based on the average revenue it will need to provide health benefits to each member of a group, i.e., private companies, state or county entities, the FEHBP, etc. Under current statutes for HMOs, subscription rates can vary from group to group. These rates derive from two predominant rating methodologies. The key rating factors for the first methodology (*community rating by class*) are the age and sex distribution of a group's enrollees. In contrast, the second rating methodology (*adjusted community rating*) is based on the projected use of benefits by a group using actual claims experience from a prior period of time and adjusted for increases in medical cost. However, once a rate is set, it may not be adjusted to actual costs incurred. The inability to adjust to actual costs, including administrative expenses, distinguishes community-rated plans from experience-rated HMOs, indemnity plans 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 the two subscriber groups closest in size to the FEHBP and whose respective contracts contain similar benefits. These similarly sized subscriber groups are called SSSGs. In 1995, the provision requiring similar benefits was eliminated. Under the regulations, each carrier must certify that the FEHBP is being offered equivalent SSSG rates by submitting to OPM a certificate of accurate pricing. These rates are determined by the FEHBP-participating carrier, which is responsible for selecting the appropriate SSSGs. Should our auditors determine that equivalent rates were not applied to the FEHBP, 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 14 audit reports on community-rated plans. The following are summaries of two of these reports, illustrating the types of problems we encounter in conducting HMO audits.

BlueCHOICE in St. Louis, Missouri

**Report No. M4-00-95-003
January 21, 2000**

BlueCHOICE is a wholly-owned subsidiary of Alliance Blue Cross Blue Shield located in St. Louis, Missouri. The plan provides primary health care services to its members in the St. Louis area. BlueCHOICE began participating in the FEHBP as a community-

rated carrier in 1989. Our audit of the plan covered contract years 1989 through 1994. As of March 1994, the FEHBP made up about 18 percent of the plan's total membership. During the period audited, the FEHBP paid the plan over \$73 million in premiums.

The audit identified \$8,574,771 in inappropriate charges to the FEHBP, including \$6,517,068 for defective pricing and \$2,057,703 for lost investment income. In 1995, we were routinely forwarding copies of draft audits to the Department of Justice (DOJ) because of an increase in questionable rating practices by FEHBP-participating health insurance carriers that raised the question of fraud. In this instance, OIG auditors and investigators worked together to assist DOJ develop this case, which was not completed until a negotiated settlement was reached on January 7, 2000. Under the conditions of this settlement BlueCHOICE agreed to return \$6 million to the FEHBP.

\$8.6 Million in Questioned Costs Identified

Premium Rates

The primary objectives of the audit were to determine if BlueCHOICE offered market price rates to the FEHBP, if loadings (*contract charges* and *credits*, also known as *riders*, that are not part of the basic benefit package) to the rates were reasonable and equitable and whether the rates were in compliance with the laws and regulations governing the FEHBP. The most significant findings of our audit are discussed below.

Defective pricing. Prior to 1991, FEHBP regulations defined a community rate as a rate equivalent to that charged on the effective date to all groups for the same contract period for the same level of benefits. For 1989, we found that the plan violated these regulations by giving one of its subscriber groups a 11 percent discount that it did not give the FEHBP. As a result, the FEHBP was overcharged \$318,676.

In 1993, the plan violated its certificate of accurate pricing by not developing the FEHBP rates in a manner consistent with how it developed the rates for one of its SSSGs. Under the methodology the plan used to arrive at the SSSG rates, it developed a per-member per-month rate (*capitated rate*) based on the group's actual claims experience for a previous, but specific, time period. The claims then were adjusted for medical inflation so that the rates would be appropriate for the 1993 contract period. However, our audit showed that the plan adjusted the FEHBP's claims differently than those for that SSSG by using, among other things, a different set of cost factors.

In addition, we found that the plan inappropriately charged the FEHBP for reinsurance in 1993. A reinsurance charge relates to the fee a plan charges to pay for the cost of catastrophic medical claims. Such a charge is appropriate only when an adjustment to remove catastrophic claims is made to a group's rates. There was no evidence to support that the reinsurance charge met this criteria. As a result of this and other inconsistencies previously described, we determined that the FEHBP's 1993 premium rates were overstated by \$2,217,146.

BlueCHOICE also did not develop the FEHBP and SSSG rates appropriately in contract year 1994. We found that the plan deviated from its adjusted community rating methodology in rating one of the SSSGs, resulting in a 13.3 percent rate advantage not provided to the FEHBP. By regulation, the FEHBP is entitled to this same rate reduction (*discount*). In applying the discount to the FEHBP audited rates, we calculated the FEHBP overcharge at \$1,945,187.

As noted earlier for contract year 1993, in 1994, the plan again was not consistent in how it adjusted the claims from the experience period to arrive at the FEHBP and SSSG rates. Likewise, the FEHBP was again inappropriately charged for reinsurance costs. Although the plan properly calculated the reinsurance cost charged to the FEHBP, we found that the SSSG with the highest discount was not charged this same cost. Consequently, we removed the reinsurance cost from the FEHBP rates and determined that the FEHBP was overcharged by \$1,622,144.

Dental benefit overcharges. In 1991, the FEHBP purchased the plan's basic benefits package that included preventive dental services for children through age 11. The FEHBP also purchased additional preventive dental services covering all members regardless of age. We found, however, that the cost of the additional services was not reduced to account for the overlapping coverage for children through age 11. As a result, the FEHBP was overcharged \$376,371 for its dental benefits in 1991.

Flawed Rating Methodology Costs FEHBP Millions

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 \$2,057,703 in lost investment income on the overcharges identified for 1989, 1993 and 1994.

Settlement

As mentioned earlier, questions concerning BlueCHOICE's rating practices that we identified during the audit caused us to request our Office of Investigations to conduct an investigation of these practices for evidence of fraud. We also had forwarded a copy of the draft audit report to the Department of Justice for its review, which was part of our normal practice at that time. DOJ shared our concerns and, together with our office, spent several years pursuing a resolution of the audit issues discussed in the report. On January 7, 2000, the plan signed a negotiated settlement, agreeing to return \$6 million to the FEHBP. At DOJ's request, we did not release our final audit report until these negotiations were completed.

Settlement Yields \$6 Million Return to the FEHBP

**CareFirst
in Owings Mills, Maryland**

**Report No. JQ-00-97-006
October 7, 1999**

CareFirst is a community-rated comprehensive medical plan providing primary health care services to its members throughout Maryland and the District of Columbia. The plan is a wholly owned subsidiary of Blue Cross Blue Shield of Maryland, Inc., and has participated in the FEHBP since January 1, 1986. Our audit of the plan covered contract years 1991 through 1996. During this period, the FEHBP paid the plan almost \$140 million in premiums.

As a result of the audit, we questioned a net amount of \$3,928,573 for inappropriate health benefit charges to the FEHBP covering 1991 through 1995. This amount takes into account \$3,359,332 for defective pricing, \$885,384 for lost investment income, and \$316,143 due CareFirst because it miscalculated the mental health/substance abuse loading in 1994. As mentioned elsewhere in this report, a loading is a contract charge or credit, also known as a rider, that is not part of the basic benefit package. In commenting on our audit findings, CareFirst agreed only that the FEHBP may have been overcharged \$395,525 in contract year 1993. We did not agree with the plan's position.

\$3.4 Million in Defective Pricing Identified

Premium Rates

We found that the FEHBP was overcharged \$1,258,791 for contract years 1991 through 1993. Specifically, we found that the FEHBP was overcharged \$209,669 in 1991; \$340,792 in 1992; and \$708,330 in 1993.

These overcharges related to the mental health and substance abuse benefits for those years and to a discount given to a subscriber group of approximately the same size and with similar benefits to the FEHBP and to a discount given to an SSSG in 1993. By regulation and for audit purposes, this group is defined as an SSSG.

For contract years 1991-1993, the FEHBP benefits provided for 30 days of inpatient hospitalization for either mental health or substance abuse. The FEHBP did not purchase a separate benefit for either of these treatment categories. CareFirst, however, developed the FEHBP's rates with separate charges for both inpatient mental health and substance abuse, resulting in an overcharge. The plan charged the FEHBP an additional amount for outpatient mental health benefits. This particular charge was inappropriate because the inpatient mental health and substance abuse per member-per month charge also included an amount for outpatient mental health.

Another example of defective pricing in contract year 1993 was the fact that the plan granted a 1.61 percent rate advantage to an SSSG, but not to the FEHBP. Since the FEHBP was entitled to the same discount, we applied the 1.61 percent discount to the FEHBP audited rates to determine the 1993 overcharge amount.

In 1994, instead of an overcharge finding, our audit revealed that CareFirst had actually undercharged the FEHBP \$316,143. This undercharge resulted from an error the plan made in rating the mental health and substance abuse loading for that contract year.

Our review of the plan's 1995 rate development showed that the SSSG premium rates were determined through a methodology that used group-specific hospital claims experience in the development of their rates. In contrast, the FEHBP's premium rates were established through a rating methodology that used community-wide hospital claims data rather than data specific to the FEHBP. Since one of the SSSGs renewed its contract in January 1995, as did the FEHBP, the FEHBP should have been rated using the same methodology as the SSSG. We redeveloped the FEHBP's rates using the latter methodology and determined that the FEHBP was overcharged \$2,100,541 for that contract year.

Lost Investment Income

Consistent with the FEHBP contract with community-rated carriers, the FEHBP is entitled to lost investment income on all defective pricing findings. We determined that the FEHBP was due \$885,384 in lost investment income covering the years 1991 through 1998. In addition to this amount, we recommended that OPM's contracting officer assess the plan lost investment income on amounts due for the period beginning January 1, 1999, until all funds have been returned to the FEHBP.

Lost Investment Income Exceeds \$885,000

Experienced-Rated Plans

In addition to community-rated plans, the Federal Employees Health Benefits Program 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 service charges for administering the FEHBP contract (*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. The universe of experience-rated plans consists of approximately 100 audit sites.

Audits of these plans generally focus on the allowability of contract charges and the recovery of appropriate credits, including refunds; the effectiveness of carriers' claims adjudication systems; and the adequacy of internal controls to ensure proper contract charges and benefit payments. During this reporting period, we issued 13 audit reports on experience-rated plans.

Government-Wide Service Benefit Plan

This plan is administered by the Blue Cross and Blue Shield Association (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. Approximately 46 percent of all FEHBP subscribers are enrolled in Blue Cross and Blue Shield plans nationwide.

For administrative purposes, the BCBS 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.

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

Blue Cross and Blue Shield of Indiana/Kentucky in Indianapolis, Indiana and Cincinnati, Ohio

Report No. 10-39-98-012
January 6, 2000

Blue Cross and Blue Shield of Indiana (BCBS of Indiana) and Blue Cross and Blue Shield of Kentucky (BCBS of Kentucky) merged in 1993 to form BCBS of Indiana/Kentucky. In 1995, Community Mutual Blue Cross and Blue Shield in Ohio then merged with BCBS of Indiana/Kentucky, renaming itself Anthem Blue Cross and Blue Shield. As the parent company, Anthem provides health insurance services to subscribers in Kentucky, Ohio, Indiana and several other states outside the Midwest.

Our audit was conducted to review the FEHBP operations of BCBS of Indiana/Kentucky only. The claims office is located in Indianapolis, Indiana, while the administrative operations facilities are in Cincinnati, Ohio. We examined health benefit payments made by each plan from 1995 through 1997, as well as miscellaneous payments and administrative expenses covering contract years 1992-1996 for BCBS of Kentucky and contract years 1993-1996 for BCBS of Indiana. Since almost all of the findings of this audit pertain to the plan after the original merger, all references to the plan will correspond to BCBS of Indiana/Kentucky unless otherwise noted.

The purpose of our audit was to determine whether the plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of its contract. As a result, our auditors questioned \$1,521,501 in claim payments, \$189,201 representing uncashed claim payment checks or refunds resulting from erroneous claim payments, and

\$1,123,825 in unallowable administrative expense charges. Of these amounts, the BCBS Association agreed with \$1,781,330, disagreed with \$1,006,855, and is still reviewing \$46,342. Lost investment income on these questioned costs totaled \$267,667. Final calculations by our auditors regarding all inappropriate charges to the FEHBP totaled \$3,102,194.

Auditors Calculate \$3,102,194 Owed to the FEHBP

Health Benefits

From 1995 through 1997, BCBS of Indiana/Kentucky paid \$433 million in actual FEHBP claim payments. We selected claims at random as well as in specific health benefit categories, principally those concerning coordination of benefits and duplicate payments. We also looked at financial and accounting problems affecting refunds and uncashed checks relating to FEHBP claim payments as described above. Some of our primary findings in these areas were as follows:

Coordination of benefits. For the period July 18, 1995 through 1997, we identified 144 claims, totaling \$1,020,873, that the FEHBP paid in full when Medicare was the primary insurer. This type of inappropriate charge occurs when there is a failure to coordinate benefits properly with Medicare coverage. We recommended that OPM's contracting officer disallow these uncoordinated claim payments and direct BCBS of Indiana/Kentucky to credit all overpaid amounts to the FEHBP should the plan be successful in its recoveries.

Duplicate claim payments. BCBS of Indiana/Kentucky improperly charged the FEHBP duplicate claim payments. During the contract period of 1995 through 1997, there were 712 duplicate payment errors totaling \$383,884. We recommended that OPM's contracting officer disallow these duplicate payments and direct the plan to make a diligent effort to collect this amount and credit all those monies recovered to the FEHBP.

Claim payment errors. We also noted overpayment and underpayment errors in relation to 14 claims, resulting in a net overcharge of \$116,744 to the FEHBP. We concluded that the errors were due to human error, such as entering an incorrect amount into the computer claim system. We recommended that OPM's contracting officer disallow the erroneous claim payments. We also recommended that OPM's contracting officer direct BCBS of Indiana/Kentucky to credit all amounts recovered to the FEHBP should it be successful in its collection efforts.

Note: Under its FEHBP contract, if this plan can demonstrate that all forms of claims overpayments cited in our audit report were made in good faith and can show further that it has made a diligent effort to collect these funds, then OPM's contracting officer can consider all uncollected amounts (i.e. questioned costs by our auditors) to be allowable charges to the FEHBP. This applies to all FEHBP Blue Cross Blue Shield plan contracts.

Miscellaneous payments. As previously mentioned, we reviewed other issues concerning monies due the FEHBP, such as health benefits refunds and uncashed claim payment checks. For example, under the refunds finding, we identified 678 refunds, totaling \$142,859, that were outstanding for more than 60 days and not credited to the FEHBP. (*Note: Based on industry practices, the plan should have credited all refunds to the FEHBP within 60 days after receipt.*)

Inappropriate Health Benefits Charges Total \$1,710,702

Administrative Expenses

During our review of administrative expenses from 1992-1996, we noted that BCBS of Indiana/Kentucky overcharged the FEHBP for unallowable, unallocable, and unsupported costs totaling \$1,123,825. The most significant finding in this category pertains to unallowable merger-related costs.

Merger-related costs. The plan charged the FEHBP for unallowable costs of \$905,027 related to the merger of the Indiana and Kentucky BCBS plans. In 1994, BCBS of Indiana/Kentucky charged the FEHBP start-up costs of \$450,463 and non-recurring project costs of \$370,304 related to the merger. In 1995, the plan charged the FEHBP additional non-recurring project costs of \$84,260 for merging the plans' computer systems. Federal regulations specifically state that merger costs, including directly associated costs, are unallowable. These start-up costs and non-recurring project costs were incurred by BCBS of Indiana/Kentucky as a direct result of the merger of the Indiana and Kentucky plans.

Cash Management

BCBS of Indiana/Kentucky did not properly manage FEHBP funds. Specifically, the plan did not comply with federal regulations or its contract terms concerning withdrawals (*drawdowns*) from the letter of credit (LOC) account. It is a legal requirement that FEHBP monies from the LOC account be made available for payment to a participating plan *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. Our analysis of 1995 and 1996 claim payments found that the plan received FEHBP funds before the benefit checks were presented to the plan's financial institution for payment. For instance, we found that withdrawals by BCBS of Indiana and BCBS of Kentucky in 1996 were occurring on average 11.7 days and 5.5 days, respectively, for physician claim payments prior to the time frame stipulated under the FEHBP contract and federal regulations. Our auditors noted a pattern of early withdrawals from the LOC with respect to subscriber and hospital payments as well.

Because of the plan's reimbursement arrangements for FEHBP claims, it not only maintained FEHBP funds on hand longer than it should, but it did not hold them in separate FEHBP income-producing accounts. This also prevented crediting the FEHBP with the interest that it should have earned on the excess funds. This issue has been

resolved as part of a global settlement reached in March 1999 with the BCBS Association and referenced in our past two semiannual reports.

Cash Management Deficiencies Cited

Lost Investment Income

Federal regulations require a carrier to invest and reinvest all excess FEHBP funds on hand and to credit all investment income earned on those funds. We computed lost investment income resulting from our audit findings in the amount of \$267,667 through December 1998. We have recommended to the contracting officer that this amount be returned to the FEHBP as well as additional lost investment income due after that date until BCBS of Indiana/Kentucky has returned all monies owed to the FEHBP.

Letter of Credit System at Blue Cross and Blue Shield Plans

Report No. 10-85-98-043
February 23, 2000

In 1989, in order to enhance the financial management of the FEHBP, OPM implemented a program of transferring health benefits premiums to experience-rated carriers under a letter of credit (LOC) arrangement. Under this LOC arrangement, carriers could withdraw funds from their individual LOC accounts at a level sufficient to pay current claims. Until 1997, the carriers could request funds using the so-called “delay of drawdown method” or “checks-presented method” or both. The “delay of drawdown method” is a procedure whereby the withdrawal from the LOC account is delayed until the checks issued for authorized disbursements have been forwarded to the payees. The “checks-presented method” is a procedure whereby LOC withdrawals are delayed until checks issued for authorized disbursements have been presented to the carrier’s financial institution for payment.

Since January 1, 1997, all Blue Cross Blue Shield (BCBS) plans have been required to use the “checks-presented method” to withdraw funds from their respective LOC accounts as described in the paragraph above. This change was instituted because plans were not waiting for the benefit checks they issued to be presented to their financial institutions for payment prior to reimbursing themselves with FEHBP funds.

Our audit covered LOC operations at 13 local Blue Cross Blue Shield plans for a 12-month period (January 1, 1997 through December 31, 1997). These BCBS plans paid \$2.83 billion in health benefits charges in 1997. They are as follows: CareFirst BCBS of Washington, D.C.; BCBS of Florida; BCBS of Texas; Trigon BCBS; BCBS of Georgia; CareFirst BCBS of Maryland; BCBS of Alabama; BCBS of Illinois; Blue Cross of California; BCBS of Massachusetts; Blue Shield of California; BCBS of Oklahoma; and Horizon BCBS of New Jersey.

In performing this audit, we determined whether the 13 local BCBS plans implemented the checks-presented method to withdraw funds from the LOC account and if the procedures implemented by these plans were in accordance with the terms of the contract and applicable laws and regulations. As a result, our auditors questioned \$21,565,704 for inappropriate management of their LOC accounts. The BCBS Association agreed with \$20,656,243 and disagreed with only \$909,461. The most significant findings are referenced in detail below.

Auditors Determine \$21,565,704 Due FEHBP for LOC Mismanagement

Excessive drawdowns. Our auditors determined that three BCBS plans (BCBS of Alabama, Blue Shield of California, and CareFirst BCBS of Maryland) withdrew funds from the LOC account that exceeded the amounts needed to cover health benefit checks presented for payment. As a result, the FEHBP is owed \$14,838,231 for excessive LOC drawdowns, including \$132,208 for interest income.

Health benefit refunds. Our auditors also determined that seven BCBS plans (BCBS of Texas; Horizon BCBS of New Jersey; Blue Cross of California; BCBS of Massachusetts; CareFirst BCBS of Washington, D.C.; BCBS of Oklahoma; and Blue Shield of California) did not credit health benefit refunds to the FEHBP. Also, we found that these seven BCBS plans did not have adequate procedures in place to ensure that all health benefit refunds were promptly credited to the FEHBP through the daily drawdown process as required under the checks-presented method. Consequently, the FEHBP is owed \$5,453,058 in health benefit refunds.

Employee Organization Plans

The employee organization 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 three employee organization plan audit reports, one of which is summarized below to illustrate the types of findings typically associated with a plan of this kind.

**Pan American Life Insurance Company
as Underwriter for Panama Canal Area Benefit Plan
in New Orleans, Louisiana**

**Report No. 43-00-97-019
December 28, 1999**

Pan American Life Insurance Company (Pan American Life) has been the underwriter for the Panama Canal Area Benefit Plan (Panama Canal Plan) since January 1, 1990. While Pan American Life's headquarters are located in New Orleans, Louisiana, its claims processing unit (Inversiones Guardian) is located in Panama.

As authorized under the Federal Employees Health Benefits Act of 1959, on July 1, 1960, the Group Insurance Board (GIB) entered into a contract with OPM's precursor, the U.S. Civil Service Commission, to provide a health benefits plan to serve civilian employees whose work presence was associated with the Panama Canal Zone. Since that time, GIB's role has continued as the sponsoring employee organization of the Panama Canal Plan. Enrollment is open to all active members and annuitants of the GIB who are eligible for coverage under the FEHBP. This was our first audit of the Pan American Life as underwriter for the Panama Canal Plan.

The purpose of this audit was to determine whether Pan American Life charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of its contract. Our audit covered health benefit payments made by Pan American Life from 1994 through 1996, as well as miscellaneous adjustments, administrative expenses, premium taxes and cash management covering the five-year contract period of 1991-1995.

Our auditors questioned \$76,610 for inappropriately charged claim payments, \$10,458 for refunds not credited to the FEHBP, \$1,655,284 in unallowable administrative expense charges, \$2,460,506 in unallowable premium taxes, and \$1,534,172 in lost investment income. Final calculations by our auditors regarding amounts owed the FEHBP totaled \$5,737,030.

Auditors Determine \$5,737,030 Owed to the FEHBP

Health Benefits

Claim payments. In reviewing claim payments, we noted coordination of benefits and duplicate payment problems. For the period 1994-1996, our auditors identified numerous claim payments, totaling \$61,448, that the FEHBP paid in full when Medicare was the primary insurer. For the same period, we also identified numerous duplicate claim payments, resulting in overcharges of \$15,162 to the FEHBP.

Miscellaneous adjustments. Our review of Pan American Life's refund and letter of credit withdrawal records identified five instances where Pan America Life did not credit refunds to the FEHBP. We determined the resultant cost to the FEHBP at \$10,458.

Administrative Expenses

During our review of administrative expenses from 1991-1995, we noted that Pan American Life overcharged the FEHBP for such costs as occupancy, overhead, international operations, computerized systems development, fringe benefits, cafeteria operations, internal department service rates, mail, supplies and printing. In addition, we noted that Pan American Life charged the FEHBP for unsupported miscellaneous expenses incurred by Inversiones Guardian, the claims unit in Panama, including public relations and advertising costs, as well as various unsupported costs incurred by Pan American Life's home office in Louisiana. In total, our auditors identified \$1,655,284 in unallowable administrative expense charges.

Occupancy cost overcharges. In the case of the occupancy cost overcharges, Pan American Life charged the FEHBP occupancy costs in excess of the normal cost of ownership. During the contract period 1991-1995, Pan American Life charged the FEHBP for rent expense and cost of capital on the home office and warehouse buildings located in New Orleans, Louisiana, that were owned by Pan American Life. After examining the total rent expense and cost of capital, we determined that they exceeded the normal cost of ownership. Since federal regulations do not allow this, we calculated that \$467,508 in excess occupancy expenses were owed the FEHBP.

Inflated FTR percentages. Regarding the costs for international operations, fringe benefits, cafeteria operations, internal department service rates, mail, supply and printing, Pan American Life used incorrect functional time report (FTR) percentages to allocate these costs to the FEHBP. The FTR is a tool used by Pan American Life to record the amount of time each employee works on various lines of business. Pan American Life used the FTR to develop cost-allocation percentages. These percentages were applied to certain costs allocated to the FEHBP. However, for the five-year period of our audit (1991-1995), Pan American Life personnel made several clerical errors in calculating the FEHBP's FTR percentages. Consequently, Pan American Life used inflated FTR percentages to allocate these costs to the FEHBP, resulting in overcharges of \$439,088.

Auditors Identify \$1,655,284 in Unallowable Administrative Expenses

Premium Taxes

Pan American Life charged the FEHBP \$2,460,506 for premium taxes from 1991 through 1995. Federal regulations and the FEHBP contract state that premium taxes are unallowable charges. While our auditors noted that Pan American Life had excluded the 75 percent government-paid premium portion, they did not exclude the remaining 25 percent enrollee's premium portions from its premium tax calculation.

It is our position that the employees' premium contributions lose their identity and become the property of the government once they are deposited in the Employees Health Benefit Fund held by the U. S. Treasury. Therefore, since the premiums collected by OPM and paid to Pan American Life are the property of the government, they are not subject to Panama premium taxes.

Auditors Question \$2,460,506 in Premium Tax Charges

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.

Approximately 385 local campaigns participated in the 1998 Combined Federal Campaign, the most recent year for which statistical data was available. Federal employee contributions reached \$206 million for the 1998 Combined Federal Campaign, while expenses totaled \$17 million.

During this reporting period, we issued one CFC report, which is identified on page 50 in Appendix V of this report.

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 of 1990 (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.

We have commented in several of our past semiannual reports about the fact that resource limitations have made it necessary to restrict the scope of our internal audits workload, which, in turn, made it imperative that we direct our focus on OPM's financial statements and certain other internal agency audit work deemed critical to our agency.

During this reporting period, we completed six internal audits, five of which are described in two audit reports relating to OPM's FY 1999 financial statements audits. The other audit concerned our final review of the agency's Y2K compliance efforts. The following pages are devoted primarily to a discussion of the agency's financial statement audits and a related issue. We have also included an article about our office's plans to conduct performance audits in the immediate future to address a reportable condition contained in our October 1999 Federal Managers' Financial Integrity Act report.

OPM's Financial Statements Audits

To meet the requirements of the Chief Financial Officers Act of 1990, our agency contracted with an independent public accounting (IPA) firm, KPMG LLP (KPMG), to perform OPM's FY 1999 benefits programs financial statements audits. These CFO Act audits relate 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. We were active in overseeing the IPA's work and reviewing the IPA's work papers and reports. As a result, we believe there is sufficient evidence for us to concur with the IPA's "unqualified opinions." In audit terms, issuing an unqualified opinion means that the financial statements were presented fairly in all material aspects and conformed to generally accepted accounting principles. Summaries relating to the two audit reports issued by KPMG appear in this section.

In addition, our OIG auditors attempted to perform audits of OPM's revolving fund (RF) and salaries and expenses accounts (S&E) FY 1999 financial statements. OPM

provides customer agencies an ongoing cycle of services, on a reimbursable basis, through its revolving fund. These services include: testing potential military inductees for the Department of Defense; providing employment information, automated staffing and related human resource management services to federal agencies nationwide; conducting employee background investigations; providing training management assistance; and training and development for federal managers and executives.

As was the case a year ago, we were limited in the scope of our work due to significant internal control weaknesses and incomplete agency record keeping, leaving us unable to express an opinion on the fairness of the RF and S&E financial statements. We have included a narrative summarizing our report on this work as well.

OPM's Fiscal Year 1999 Benefits Programs Financial Statements

Report No. 2F-00-99-106
February 25, 2000

Our office is required under provisions of the CFO Act 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 performed audits of OPM's FY 1999 benefits programs financial statements.

The benefits programs financial statements KPMG reviewed during this audit covered the retirement, health and life insurance programs. As we have mentioned in previous semiannual reports, these benefit programs are key to the 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 (RIS).

The audit report submitted by KPMG includes unqualified opinions (this term is described in detail on the preceding page) on the benefits programs fiscal year 1999 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 its audit work on the financial statements. KPMG did not consider any of the reportable conditions to be material weaknesses in the internal controls. The term "reportable condition" is a matter coming to the auditor's attention that could adversely affect the agency's ability to record, process, summarize and report financial data. Material weaknesses are reportable conditions in which the design or operation of one or more internal control components does not reduce to a relatively low level the risk that misstatements in material amounts would go undetected for a significant period of time by employees in the normal course of performing their assigned functions. A summary of KPMG's audit work is reflected in the following paragraphs.

No Material Weaknesses Cited in Benefits Programs for FY 1999

Benefits Programs Financial Statements

As previously mentioned, KPMG issued unqualified opinions on the financial statements of each of the benefits programs: the federal employees retirement program (RP), the federal employees health benefits program (FEHBP) and life insurance benefits program (LP). In its reports on internal controls, KPMG noted improvements in the control environments of all three benefits programs during fiscal year 1999. Reportable conditions KPMG identified and reported for all three benefit programs included the following:

- Electronic data processing (EDP) general control environment:
 - Entity-wide security program
 - Access control
 - Application change control/systems development
 - Service continuity (as it pertains to information resource protection and unplanned service interruption)
- Budgetary accounting structure *

**Note: Budgetary accounts are included in two financial statements: the statement of budgetary resources and statement of financing. Without a set of self-balancing accounts to summarize budgetary activity, the risk of reporting inaccurate budgetary figures exists.*

KPMG also reported that the benefits programs were not in substantial conformance with federal system requirements, federal accounting standards and the U.S. Standard General Ledger, all of which have been incorporated in the Federal Financial Management Improvement Act. The nonconformance is due to the lack of support for the budget execution function and system security.

Retirement Benefits Program

KPMG cited, in addition to the items cited for the three benefits programs, one other reportable condition to the RP pertaining to controls over actuarial census data affecting one specific segment of the federal annuitant population (U.S. Post Office retirees). This data is used by OPM in the calculation of actuarial liability estimates. While KPMG auditors noted that this data was not updated to reflect salary increases as of September 30, 1999, they also reported that the increase was not large enough to materially affect the estimate of the actuarial liability for the fiscal year ending that date. KPMG did note, however, that similar timing differences, should they continue to occur, may affect future years' estimations.

FEHB Program

OPM corrected the one FEHBP material weakness from FY 1998 by implementing a new financial management system and re-engineering the process of recording experience-rated carrier activity. Items affecting the health benefits program other than those common to the three benefits programs included two reportable conditions to the FEHBP. Specifically,

these were controls over the reconciliation of FEHBP and RP transactions and program administration for the community-rated health carriers.

Life Insurance Benefits Program

In addition to the items referenced previously pertaining to the three benefits programs, KPMG cited two reportable conditions for the life insurance benefits program. These were controls pertaining to the reconciliation of LP and RP transactions and actuarial census data.

OIG Monitors IPA Benefits Programs Audits

Table 1.

<i>FY 1999 Internal Control Weaknesses</i>			
<i>Issues</i>	<i>Retirement Program</i>	<i>Health Benefits Program</i>	<i>Life Insurance Program</i>
EDP General Control Environment	RC	RC	RC
Budgetary Accounting Structure	RC	RC	RC
Controls Over Actuarial Census Data	RC	NRC	RC
Reconciliation of Inter-Program Transactions	NRC	RC	RC
Controls Over Program Administration for the Community-Rated Health Carriers	N/A	RC	N/A

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

Report on OPM's FY 1999 Revolving Fund and Salaries & Expenses Accounts Financial Statements

**Report No. 2F-00-99-105
 March 3, 2000**

Unlike the benefits programs financial statement audits, OPM did not contract the financial statement audits of OPM's revolving fund (RF) and salaries and expenses accounts (S&E).

We made our fourth attempt at full-scope audits of the RF and S&E financial statements during this reporting period. Due to continuing significant limitations on the scope of our work, we were unable to express an opinion on whether the fiscal year 1999 financial statements were presented fairly in all material aspects. These 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 Federal Financial Management Improvement Act (FFMIA) requires inspectors general to report information to Congress related to their respective agencies' compliance with this Act. Our audit report on the FY 1999 RF and S&E financial statements details our conclusions regarding OPM'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 U.S. Standard General Ledger (SGL).

The FFMIA Act, under section 803(c), provides for agencies to prepare a remediation plan with specific intermediate target dates designed to bring the financial systems into substantial compliance when such noncompliance as discussed in the preceding paragraph. Also, under section 804(b) of the FFMIA, OIGs are required to report to Congress instances and reasons when their respective agencies have not met the intermediate target dates established in the remediation plan.

The Office of the Chief Financial Officer (OCFO) is the internal OPM organization responsible for correcting this noncompliance for the RF and S&E. OCFO has detailed its remediation plan for resolving material management deficiencies in quarterly letters to the Office of Management and Budget (OMB). The September 30, 1999 remediation plan listed 25 items, all to be completed by September 2000. As of March 2000, 12 of these items had not been completed. One new item has been added to the remediation plan. The main reasons cited by OCFO for items not being completed are limited programmer support due to Y2K compliance testing and other computer-related work.

Material Weaknesses Cited Again in FY 1999 RF and S&E Financial Statements

We made several recommendations to address the key material weaknesses and reportable conditions we noted during these audits of the FY 1999 RF and S&E financial statements that resulted in our inability to issue an opinion. We specifically concluded that the RF and S&E financial management systems did not substantially comply with the requirements included in the FFMIA, leading us to make the following recommendations to OCFO:

- Implement monthly reconciliation processes of general ledger control accounts to subledgers or other detailed support.
- 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.

- Revise, finalize and implement the draft OPM integrated entity-wide security program.

FFMIA Noncompliance Noted in FY 1999 RF and S&E Accounts

RF and S&E Accounts Financial Statements

Several material internal control weaknesses and reportable conditions were identified during our audits of the RF and S&E financial statements that were common to both entities. Material weaknesses, cited last year and again this year, are as follows:

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

Reportable conditions were found in the electronic data processing (EDP) general control environment and included the following areas:

- Application software development and change control
- Access control
- Inappropriate access permissions
- Updates of access control lists
- Multiple virtual storage (MVA) operating system issues
- Separation of duties issues
- Service continuity
- Entity-wide security program

We identified and reported other issues in the RF and S&E related to compliance with certain laws and regulations in addition to the material weaknesses and the reportable conditions related to OPM'S entity-wide security program bulleted above where the RF and S&E did not substantially comply with the requirements encompassed under the FFMIA. We reported for both entities that, during fiscal year 1999, neither was in full compliance with the objectives of FFMIA nor with OMB Bulletin 97-01 (*Form and Content of Agency Financial Statements*).

Revolving Fund Financial Statements

In addition to the items common to the RF and S&E, there was one material weakness unique to the RF pertaining to controls over OPM's Investigations Service transactions and balances. This issue also was reported in last year's audit report.

Salaries & Expenses Accounts Financial Statements

Again, as we reported last year, we did not identify any other material weaknesses other than those common to the RF and S&E.

OIG Unable to Issue Opinion on RF and 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 1999.

Table 2.

<i>Fiscal Year 1999 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
Controls Over Recorded Transactions	M	M
Investigations Service Transactions and Balances	M	N/A
Fund Balances with U.S. Treasury	M	M
Accounts Receivable	M	M
Accounts Payable	M	M
Electronic Data Processing (EDP) Control Environment	RC	RC

M = A reportable internal control weakness considered to be a material weakness
RC = A reportable condition
N/A = Not applicable

OPM FACTS Transmissions Procedures

We commented on FACTS (federal agencies centralized trial balance system) procedures in our previous semiannual report, emphasizing their importance in preparing the government-wide consolidated financial statements (CFS) and notes that are issued March 31 of each year. The notes are a vital component, reflecting both key accounting policies and procedures and other accounting data that assist the reader in interpreting the CFS.

The Department of the Treasury (Treasury) requires each agency’s Office of the Chief Financial Officer (OCFO) to transmit electronically a list of all standard general ledger accounts with preclosing balances prepared at year’s end and the notes.

As required by all agencies, our agency submits FACTS transmissions, including those pertaining to its salaries and expenses accounts, revolving fund and federal benefits programs entities. After we transmit FACTS amounts, Treasury compiles and summarizes the FACTS data at the department level.

Treasury requires OCFO and the Office of Inspector General (OIG) of selected agencies, including OPM, to compare and identify any differences between the FACTS data summarized by Treasury and agency consolidated financial statements submitted to the Office of Management and Budget. Treasury outlines specific procedures for OCFOs and OIGs to perform for this verification process. What appears to be a simple procedure of transmitting and verifying data is complicated by the many transmissions and parties involved.

For the FY 1999 verification, as well as last year's, difficulties arose from insufficient planning and control over this process by our agency. OPM did not produce consolidated agency financial statements, and we did not receive all of the required documentation necessary to perform the verification procedures required by Treasury. Consequently, we could not perform the procedures. The OIG and the independent accounting firm (KPMG) responsible for auditing OPM's benefits programs financial statements performed other procedures against the data OPM sent to Treasury and the summary data OPM received from Treasury. They were performed to assist Treasury in evaluating the comparison of the summarized FACTS data to related information in the agency's financial statements. Our procedures consisted of:

- Preparing a spreadsheet combining all of OPM's FACTS transmissions for each of the 17 OPM funds that make up the five reporting entities for which financial statements were prepared and comparing the total to FACTS data compiled and summarized by Treasury.
- Comparing OPM's FACTS transmissions for each of OPM's funds to OPM's financial statements. We identified differences, cited causes for some of the differences, and made recommendations for corrections.
- Comparing the FACTS notes report summarized by Treasury to data in the agency's financial statements. As with the FACTS transmissions, we identified differences and the causes for some of the differences, along with making recommendations for corrections.
- Reviewing proposed corrections and adjustments that OCFO submitted to Treasury.

Through these efforts, we facilitated the FACTS process for all parties involved, thus ensuring that a verification process was completed. We believe these efforts reduced the risk that OPM could be a reason for a delay in the preparation and audit of the government-wide consolidated financial statements and accompanying notes.

OIG Facilitates FACTS Verification Process

Agency Performance Audits

Our inability to conduct a full range of independent performance audits has been an ongoing issue for the past several years. This auditing limitation has diminished our ability to provide recommendations to improve the efficiency and effectiveness of specific OPM program offices or to minimize fraud, waste and abuse in those programs. The financial statement audits we perform afford us the opportunity to identify material control weaknesses and noncompliance with laws and regulations that relate to the financial statements for all OPM program offices. And, while these CFO Act audits include reviews of laws and regulations material to the financial statements, they do not cover all performance-related controls.

Due to the importance of this issue, our office cited in our October 1999 Federal Managers' Financial Integrity Act report that the lack of performance audits was a reportable condition needing correction.

To address this reportable condition, we are expanding our current audit functions to include performance audits, beginning in the next reporting period. As partial compensation for the absence of these performance audits in the past, we have been using our evaluation and inspections function to look at agency program operations and perform evaluations of agency program and administrative activities. For a report on this function, refer to pages 37-41 of this report.

OIG Expands Audit Functions to Include Performance Audits

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 \$61 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 eight arrests and seven convictions. More importantly, however, they have resulted in judicial and administrative monetary recoveries to the OPM-administered trust funds totaling \$8,270,770. Other investigative efforts resulted in the detection of five ongoing frauds involving funds from the Civil Service Retirement System (CSRS), with a projected savings of \$185,940 to the Civil Service Retirement and Disability trust fund over the next five years. Overall, we opened 10 investigations and closed 19 during this reporting period, with 78 still in progress at the end of the period. (For additional information on investigative activity during this reporting period, refer to Table 1 on page 35 of this section.)

Calls received on our health care fraud hotline and our retirement and special investigations hotline, along with complaints mailed in, totaled 798. Additional information, including specific activity breakdowns for each hotline, can be found on pages 33-34 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 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 primarily involve the theft of government funds and property. However, we also examine instances of bribery involving federal officials or financial conflicts of interest.

On the following pages, we have provided narratives relating to health care fraud, employee integrity and retirement fund fraud investigations we completed 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, our investigators work closely with OIG auditors when fraud issues arise during the course of health carrier audits.

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

Insurance Carrier Involved in Defective Rating Practices

During a routine audit of BlueCHOICE, a managed health care plan based in St. Louis Missouri, our auditors determined that the premium rates established for FEHBP subscribers during the contract periods reviewed were highly questionable and warranted additional scrutiny by our Office of Investigations.

Specifically, the audit disclosed that BlueCHOICE had engaged in pricing practices that failed to provide the FEHBP with premium rates that conformed to those charged other groups either similar in size or that were considered in the same community group of subscribers having equal benefits. Both conditions violated its FEHBP contract.

Our investigation confirmed that the plan's rating practices were, in fact, defective, and, as a result, cost the FEHBP over \$6 million in higher premiums during the specific contract years in question. This joint effort by OIG auditors and investigators resulted in a referral of our findings to the Department of Justice for possible criminal and civil prosecution. On January 7, 2000, BlueCHOICE agreed to a settlement arranged through the DOJ to return \$6 million to the FEHBP trust fund. See pages 4-6 of our Audit Activities section for a more detailed discussion of this case.

Joint Audit-Investigative Efforts Result in \$6 million FEHBP Settlement

Emergency Room Billing Fraud Exposed

As referenced in our semiannual report published last fall, this office has been engaged in a continuing five-year investigation with the Department of Justice to look at evidence of billing fraud involving a national emergency room billing service serving hospital and clinic emergency rooms nationwide.

Specifically, we have been investigating allegations by an FEHBP-participating health care plan that an emergency room billing service has been routinely charging the federal

government for high-end services involving emergency room physicians when lower-priced basic services were actually performed. Changing treatment codes in this manner to gain greater reimbursement from insurance plans, including those that participate in the FEHBP, is known as “up coding.”

This particular investigation concluded with the billing service agreeing on November 29, 1999, to a monetary settlement with the federal government amounting to \$950,140, all of which was to be returned to the FEHBP.

As this billing scheme investigation continues, we expect other corporate entities to be implicated, culminating in additional recoveries to the U.S. government.

Billing Service Agrees to \$950,140 Settlement

Joint Federal-State Project Results in Two Arrests

A five-month investigation completed during this reporting period involving our office, the State of Florida and several FEHBP health insurance plans ended with the arrest of two individuals from the Fort Lauderdale-Miami area for insurance fraud and grand theft.

Our involvement came at the request of the Florida Division of Insurance Fraud, which, in 1997, began working with several federal entities, including our office, the Defense Criminal Investigative Service, the Federal Bureau of Investigation, and the U.S. Postal Inspection Service, along with local Florida law enforcement agencies, to combat health care fraud. This group was designated as the South Florida Task Force and is devoted solely to this type of fraud.

In this particular case, the scheme these men devised involved using commercial and U.S. postal mail boxes to receive payments from insurance plans for health care services that, in fact, were never provided. Once payment was made to them, they would then switch mail box locations to avoid discovery and/or tracking by law enforcement agencies. By conducting surveillance and being successful in tracing these funds, law enforcement officials were able to make an arrest of these two men on March 13, 2000.

An update on this case will appear in a future semiannual report. We anticipate that our participation in the South Florida Task Force unit--and resulting arrests, convictions and monetary recoveries--will continue for the foreseeable future.

Health-Care Fraud Investigations Yielding Success in South Florida

Federal Employee Engages in Health Care Fraud

Based on a request from the OIG at the Department State, our office initiated an investigation of a U.S. Information Agency employee, living in Miami, Florida, who was alleged to have fraudulently enrolled his girlfriend under his membership in an FEHBP health insurance plan.

We examined the plan's payment history to health care providers on behalf of this employee during the enrollment period in question. As a result, we were able to determine that he was reimbursed for medical treatment provided to his girlfriend and her children totaling \$15,259, including payments covering a two-week hospital stay.

After an interview with our investigators and those with the State Department OIG, the employee admitted submitting paperwork to his agency to enroll his girlfriend in the FEHBP and knowing that this was illegal. No charges were filed, but he agreed to make full restitution to the FEHBP trust fund. The employee also has been administratively disciplined by his agency.

Girlfriend & Family Fraudulently Enrolled in FEHBP

Employee Integrity Investigations

One of the primary missions of IG offices is ensuring that the federal work force 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 OPM employee misconduct that may result in criminal, civil or administrative action.

The following narrative describes a significant case we concluded in the area of employee misconduct and fraud during this reporting period.

OPM Employees Misuse Government Vehicles

Based on an anonymous complaint originally lodged with the FBI, our office conducted an investigation regarding agency employees at an OPM testing center using official government vehicles for personal use, such as commuting, shopping and other personal errands. The complaint also alleged that the manager and the first-line supervisor of the center not only encouraged this activity, but engaged in it themselves.

Our investigators reviewed employee work assignments, vehicle mileage logs and fuel use and performed surveillance. As a result, they were able to confirm the widespread misuse of the government vehicles assigned to the center by OPM employees, their supervisor and the OPM center's manager. This misuse included using these official vehicles for commuting to and from home, personal errands on weekends, and personal travel. Our investigators further determined that these employees made excessive fuel purchases and other purchases apparently unrelated to government business using government-issued fuel credit cards. Following the agency's receipt of our report, five employees assigned to the testing center,

including the manager and supervisor, were issued suspensions ranging from 14 to 45 days. The agency also agreed to implement internal controls to guard against any future misuse of official government vehicles at agency facilities.

OPM Employees' Misconduct Ends in Suspensions

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 three narratives related to cases in this area that we completed during this reporting period.

CSRS Annuitant's Daughter Guilty of Annuity Fraud

After receiving information from the OIG at the Social Security Administration (SSA), our office agreed to participate in an investigation of the daughter of a deceased CSRS annuitant. The subject of the investigation, living in McLean, Virginia, was alleged to have received Social Security and Civil Service retirement benefits intended for her mother, beginning with her mother's death in 1988.

Our investigation revealed that the deceased annuitant's daughter failed to notify OPM when her mother died and subsequently misappropriated \$134,000 in CSRS funds over the course of ten years. The annuity checks were deposited electronically to the deceased annuitant's bank account, and the daughter was able to access the account because her name was also on the account.

Our investigators, together with agents from the OIG at SSA, interviewed the daughter, at which time she admitted to the theft of the funds. She was tried in U.S. District Court in Alexandria, Virginia, and convicted of the theft of government funds. At sentencing, she was ordered to serve five months in prison with three years' supervised probation. She also was instructed to make full restitution to the U.S. government.

Daughter to Pay \$134,000 in Restitution to CSRS Fund

Retirement Fund Fraud Ends in Arrest

Based upon information furnished through an interagency computer matching project, we undertook an investigation in November 1998 in conjunction with the OIG at the Social Security Administration, the U.S. Secret Service and the New York Office of Public Assistance's Bureau of Fraud Investigations concerning possible misappropriation of government funds totaling over \$197,000.

The computer match revealed that a CSRS annuitant, residing in New York City, had died in 1983 but that CSRS benefits had continued to be deposited electronically into a bank account jointly held by the deceased and his daughter. Not only had the annuitant's daughter failed to notify OPM of the death of her father, but the investigation further revealed that she had misappropriated \$122,262 in CSRS funds, along with another \$64,371 from the SSA Supplement Income Program, and an additional \$10,500 in New York State public assistance funds.

On February 9, 2000, she surrendered to federal authorities in New York City, based on a warrant issued for her arrest for theft of government funds. She was placed on a personal recognizance bond pending trial. Final resolution of this case will appear in a future semi-annual report.

Deceased Annuitant's Daughter Charged with \$122,262 CSRS Annuity Fraud

Annuitant's Daughter Involved in Retirement Fund Fraud

In yet another case involving the daughter of a deceased Civil Service Retirement System annuitant, we pursued an investigation resulting from a referral from OPM's Retirement and Insurance Service regarding retirement benefits distributed through 1999 to an annuitant whose death occurred in 1987.

RIS's Office of Insurance Programs reported to us in June 1999 that it had just been made aware of the 1987 death of the annuitant, who lived in Pompano Beach, Florida, and received her annuity checks through electronic deposit to her bank account. At the time OPM was able to stop further payments to this account in March 1998, the loss in U.S. government funds totaled \$180,972.

We issued a subpoena to the Florida bank for financial records associated with the account. After reviewing these records, our investigators learned that the daughter's name was also on the account, making her legally entitled to withdraw any funds in it. During our interview with her, the daughter admitted to failing to notify OPM of her mother's death and that she had taken the CSRS funds for her own use. She also indicated her willingness to make full restitution to the Civil Service retirement fund.

Due to the daughter's poor health, as well as her willingness to repay the entire amount

owed to the federal government, the Department of Justice declined to prosecute in favor of the administrative recovery by OPM.

OIG Investigators Instrumental in CSRS Trust Fund Recovery of \$180,972

OIG Hotlines and Complaint Activity

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 18 telephone calls, 51 letters, 61 agency referrals, 2 walk-in, and 30 complaints initiated by the OIG, for a total of 162. Our administrative monetary recoveries resulting from retirement and special investigation complaints totaled \$513,976.

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 this reporting period involved 375 telephone calls and 212 letters, for a total of 587. During this period, the administrative monetary recoveries pertaining to health care fraud complaints totaled \$39,511.

OIG-Initiated Complaints

As illustrated earlier in this section, we respond to complaints reported to our office by individuals; other federal, state and local entities; health care insurance carriers; etc., and also initiate our own inquiries as a means to respond effectively to situations involving fraud, abuse, integrity issues and occasionally malfeasance.

Our office will initiate an investigation if complaints and inquiries can be substantiated. As these pertain to those initiated by our office, they can be one of two types. The first occurs when our 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 61 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 162 instances where our office initiated personal contacts to verify the status of the annuitant.

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

Investigative Activity Tables

TABLE 1: Investigative Highlights

Judicial Actions:

Arrests	8
Indictments	7
Convictions	7

Administrative Actions:¹ 6

Judicial Recoveries:

Fines, Penalties, Restitutions and Settlements ²	\$7,717,283
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Administrative Recoveries:

Settlements and Restitutions	\$553,487
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Total Funds Recovered \$8,270,770

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

²*\$6 million of this amount was the result of the joint efforts of our OIG investigators and auditors. See also "Questioned Costs" in Appendix I, page 45, of this report.*

TABLE 2: Hotline Calls and Complaint Activity

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

Retained for Investigation	130
Referred to:	
OIG Office of Audits	0
OPM Groups and Offices	48
Other Federal Agencies	33
Total	211

Health Care Fraud Hotline and Complaint Activity:

Retained for Investigation	174
Referred to:	
OPM Groups and Offices	130
Other Federal/State Agencies	71
Health Insurance Carriers or Providers	212
Total	587

Total Contacts 798

Evaluation and Inspections Activities

Section 4(a)(3) of the Inspector General Act provides a broad mandate to all Offices of Inspector General 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 them 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.

To accomplish the goals stated above, this office's evaluation and inspections activities have been designed to target areas within OPM programs and operations that are relevant to current issues or controversy. For instance, we give advice and assistance to agency program managers in an effort to increase the effectiveness and efficiency of existing and emerging operations. In addition, our independent analytical reviews provide a perspective to agency operations that is sometimes lost in the immediacy of day-to-day priorities.

During this reporting period, our OIG staff that performs evaluations and inspections conducted a review of the agency's training management assistance (TMA) function. The mission of the TMA program is to provide contract management services on a reimbursable basis to federal agency customers who need highly specialized instructional materials and assistance in human resources and development. A summary of the outcome of that review is contained on pages 39-41.

An ongoing area of review is the agency's compliance with the Government Performance and Results Act of 1993 (GPRA). This 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. In addition, the Results Act requires all executive branch departments and agencies to submit five-year strategic plans and annual performance plans. Prior to their submission to Congress, these plans must be reviewed by OMB along with each agency's and department's traditional budget request.

Below is a more detailed discussion of our OIG's efforts to carry out its responsibilities under the Results Act. Specifically, we prepared a plan that will be used in our efforts to review OPM activities under the Results Act. This plan was detailed in our last semiannual report.

Results Act Review Plan

Background. In response to a request from Congress in October 1998, we prepared a plan to review OPM activities under the Results Act. Specifically, we were asked to provide a review of the following areas:

- 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 congressional request stipulated that the respective OIGs include in their semiannual reports to Congress, a summary of reportable actions falling under their individual plans. In the following paragraphs, we have summarized this office's accomplishments toward our OIG plan for last year. Information relating to that plan can be found in our semiannual report published in the spring of 1999. We have also included here our revised plan for the remainder of FY 2000.

Accomplishments. To be meaningful, any assessment of agency efficiency and effectiveness must consider the extent to which individual programs have incorporated the mandates of the Results Act and whether the outcomes reported support the stated goals and plans. Therefore, the review we conducted of the TMA program included an examination of how this program was represented in the FY 2000 annual performance plan. As a result, we recommended that the current customer satisfaction survey be modified to allow for the inclusion of in-person interviews at formal meetings to take place after project completion, and include OPM's TMA staff, the customer agency and the contractor.

Also, during the last six months, auditors completed OPM's fiscal year 1999 revolving fund and salaries and expense financial statement audits, which included a review of controls over selected performance measures in the overview to the financial statements. This information was useful to us as we pursued our review of performance measures.

Through interviews and supporting documentation, we gained an understanding of internal controls as they related to the existence and completeness assertions for selected performance measures in the overview of OPM's revolving fund and salaries and expenses financial statements. For example, we determined whether certain controls relating to existence and completeness assertions, including those for supervisory review and supporting documentation, were in place as required by OMB Circular 98-08 (*Audit Requirements for Federal Financial Statements*). We were able to confirm that the controls relating to the existence and completeness assertions documentation for selected performance measures in the overview were in place.

OIG Revised Results Act Plan at Request of Congress

Revised annual review plan. As we continue to oversee the agency's compliance with the Results Act, our evaluators and auditors will provide oversight and assistance to the agency in the preparation of strategic plans as well as annual performance plans and reports. This office will review selected performance measures that are reported for

consistency with the goals in OPM's five-year strategic plan and annual performance plan. For instance, one objective is to identify goals in the annual performance plan that are not specific and measurable.

We intend to select specific agency goals and measures for review based upon an assessment of one or more of the following conditions:

- When high risk for waste, fraud or mismanagement exists.
- When an element is mission-critical to the agency and the public.
- Where potential problems were noted in prior audit or other reports.

Our methodology for all future performance audits will include steps for the verification and validation of performance information, including an assessment of how OPM is using performance results to improve its programs. This verification and validation process will focus on evaluating whether the design of controls that cover reported items existed at a given date or occurred during a given period and whether all items reported are presented in the performance measures. We will also consider the data sources and information collection systems used by the agency to report its progress in meeting program goals in the annual performance report.

Evaluators & Auditors Will Work on Results Act Review Plan

OPM's Training Management Assistance Program

Our office conducted an evaluation of OPM's training management assistance (TMA) program over a six-month period, completing it during this reporting period. Located in the Office of Workforce Relations (OWR), TMA is one of several OPM programs financed through the agency's revolving fund and is thus self-supporting. A more detailed discussion of OPM's revolving fund can be found in the Audit Activities section of this report, beginning on page xx. The TMA program's fundamental mission is to provide contract management services on a reimbursable basis to federal agency customers who need highly specialized instructional materials and assistance.

Every five years, OWR staff who administer the TMA program, in concert with the OPM procurement contracting officer, conduct a formal solicitation process to maintain an inventory of private-sector contractors. Once selected, the private firm or individual remains under contract for five years. After selection, these contractors then undergo another proposal process to match their expertise in human resources and development to the needs of individual customer agencies that come to OPM seeking assistance. To ensure the success of this matching process, the TMA program staff works closely with client agencies to:

- Determine the scope of a potential project to ensure meeting selection criteria.
- Prepare task orders based on customer requirements.

- Select three or four contractors from the inventory to compete for each task order.
- Review the selected contractor's plans for fulfilling project task requirements once the selection process is over.
- Monitor contractor performance.
- Scrutinize the quality of task products or services delivered.
- Administer the channeling of funds from project onset to completion.

Prior to our evaluation of the TMA program, our OIG had conducted a formal audit of this program in 1989 and again in 1991. The focus of those audits was on financial and procedural integrity issues in program operations. Our auditors determined that significant deficiencies existed in the TMA program pertaining to financial records reconciliation, the inability of its information system data to be integrated with the agency's computerized financial system, and the absence of formalized operating procedures program-wide.

Just prior to our office's 1991 audit, OPM put in place new TMA management from within OWR to re-engineer and improve operating systems of the organization. Within that context, the objectives of our evaluation included determining the extent to which the conclusions and recommendations of the 1991 audit had been implemented and were relevant to program expectations and results. After the evaluation, our OIG staff concluded that challenges remain in the areas of financial management and systems. However, we also noted substantial progress has been made since 1991 to improve TMA operations regarding segregating task responsibilities and formalizing some of the program's operating procedures.

Noticeable Strides Taken to Correct Past Deficiencies

Present TMA management initiatives include providing training opportunities for staff to refine skills directly related to program operations, restructuring management levels to reduce the manager-to-line employee ratio, updating the TMA information system pertaining to funding and project data, and surveying client agencies more frequently to anticipate vendor needs and expectations.

We made eight recommendations, all of which were accepted by OWR management. These recommendations focused on:

- Developing outcome-oriented performance measures to meet requirements of the Government Performance and Results Act.
- Formalizing additional operating procedures to ensure consistency of operations.
- Refining or modifying existing procedures in the competition of vendors so that vendor competitions could be held at interims less than every five years.

- Taking actions needed to provide OWR staff with the necessary financial systems internal controls to ensure the TMA program's financial accountability to client agencies.

We concluded that OWR management has made substantial improvements in TMA program operations since our 1991 audit, and appears to be a successful enterprise under very capable direction.

OIG Commends TMA Program as a Successful Enterprise

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

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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, 1999 to March 31, 2000

	Number of Reports	Questioned Costs	Unsupported Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	19	\$ 56,088,300	\$ 1,319,853
B. Reports issued during the reporting period with findings	21	62,842,859 ¹	155,031
Subtotals (A+B)	40	118,931,159	1,474,884
C. Reports for which a management decision was made during the reporting period:	19	66,451,763	1,397,749
1. Disallowed costs		49,345,197	77,896
2. Costs not disallowed		17,106,566	1,319,853
D. Reports for which no management decision has been made by the end of the reporting period	21	52,479,396	77,135
Reports for which no management decision has been made within 6 months of issuance	3	8,106,692 ²	0

¹This amount includes \$6 million, which was the subject of a joint effort by our Office of Audits and Office of Investigations and the Civil Division of the US Attorney's office for the District of Columbia. This amount is also reflected in Table 1, Investigative Highlights, page 35, of this report.

²Resolution of this item has been postponed at the request of the OIG.

APPENDIX II
Final Reports Issued With Recommendations
For Better Use of Funds
October 1, 1999 to March 31, 2000

	Number of Reports	Dollar Value
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No activity during this reporting period	0	\$ 0
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APPENDIX III
Insurance Audit Reports Issued
October 1, 1999 to March 31, 2000

Subject (Standard Audits)	Report Number	Issue Date	Questioned Costs	Unsupported Costs
Kaiser Foundation Health Plan, Inc. (Hawaii Region) in Honolulu, Hawaii	63-00-99-051	October 4, 1999	\$	\$
CareFirst in Owings Mills, Maryland	JQ-00-97-006	October 7, 1999	3,928,573	
Government Employees Hospital Association, Inc., in Kansas City, Missouri	31-00-97-030	October 7, 1999	4,330,699	
Blue Cross and Blue Shield of Wyoming in Cheyenne, Wyoming	10-16-99-005	October 18, 1999	160,892	
Health Alliance Plan of Michigan in Detroit, Michigan	52-00-99-010	November 10, 1999		
Premera Blue Cross in Mountlake Terrace, Washington	10-70-99-002	November 12, 1999	1,467,594	
Blue Cross and Blue Shield of Vermont in Berlin, Vermont	10-28-98-044	November 26, 1999	276,330	2,166
NYLCare Health Plans of the Mid-Atlantic, Inc., in Greenbelt, Maryland	JN-00-98-004	December 8, 1999	4,081,126	
HIGHMARK, Inc. in Camp Hill, Pennsylvania	10-13-98-001	December 16, 1999	2,502,502	50,850
Humana Health Plan of Texas in Louisville, Kentucky	UR-00-99-057	December 16, 1999		
PacifiCare of Colorado, Inc. in Denver, Colorado	D6-00-99-004	December 16, 1999		
Health Insurance Plan of Greater New York in New York City, New York	51-00-99-001	December 22, 1999		
Health New England in Springfield, Massachusetts	DJ-00-99-012	December 27, 1999	909,000	
Pan American Life Insurance Company as Underwriter for Panama Canal Area Benefit Plan in New Orleans, Louisiana	43-00-97-019	December 28, 1999	5,737,030	56,726
Blue Cross and Blue Shield of Indiana/Kentucky in Indianapolis, Indiana	10-39-98-012	January 6, 2000	\$ 3,102,194	\$ 45,289

APPENDIX III
Insurance Audit Reports Issued
October 1, 1999 to March 31, 2000

Subject (Standard Audits)	Report Number	Issue Date	Questioned Costs	Unsupported Costs
Free State Health Plan in Owings Mills, Maryland	LD-00-99-056	January 6, 2000		
Blue Cross and Blue Shield of Louisiana in Baton Rouge, Louisiana	10-07-98-017	January 14, 2000	892,730	
Columbia Medical Plan, Inc. in Owings Mills, Maryland	67-00-98-005	January 18, 2000	548,721	
NYLCare Health Plans of the Mid-Atlantic, Inc., in Greenbelt, Maryland	JN-00-99-009	January 21, 2000	108,835	
BlueCHOICE in St. Louis, Missouri	M4-00-95-003	January 21, 2000	8,574,771	
Prudential HealthCare HMO in Houston, Texas	UP-00-99-013	February 2, 2000	428,401	
Kaiser Foundation Health Plan Inc. (Northern California Region) in Oakland, California	59-00-98-019	February 9, 2000	193,749	
Arkansas Blue Cross and Blue Shield in Little Rock, Arkansas	10-44-99-48	February 10, 2000	433,316	
Blue Cross and Blue Shield of Kansas City in Kansas City, Missouri	10-42-99-021	February 23, 2000	1,204,471	
Letter of Credit Operations of Selected Blue Cross and Blue Shield Plans	10-85-98-043	February 23, 2000	21,565,704	
Group Health Incorporated in New York, New York	80-00-99-020	March 2, 2000	1,960,492	
Special Agents Mutual Benefit Association in Rockville, Maryland	44-00-98-020	March 29, 2000	435,729	
TOTALS			\$ 62,842,859	\$ 155,031

APPENDIX IV
Internal Audit Reports Issued
October 1, 1999 to March 31, 2000

Subject	Report Number	Issue Date	Funds Put to Better Use	Questioned Costs
Status of U.S. Office of Personnel Management's Year 2000 Compliance Project	99-00-99-030	December 23, 1999	\$ 0	\$ 0
U.S. Office of Personnel Management's Fiscal Year 1999 Benefits Programs Financial Statements	2F-00-99-106	February 28, 2000	0	0
U.S. Office of Personnel Management's Fiscal Year 1999 Revolving Fund and Salaries and Expenses Accounts Financial Statements	2F-00-99-105	March 2, 2000	0	0
TOTALS			\$ 0	\$ 0

APPENDIX V
Combined Federal Campaign Audit Reports Issued
October 1, 1999 to March 31, 2000

Subject	Report Number	Issue Date	Funds Put to Better Use	Questioned Costs
The 1997 and 1998 Combined Federal Campaigns for Orange County California in Irvine, California	2A-CF-99-059	December 16, 1999	\$ 0	\$ 0
TOTALS			\$ 0	\$ 0