Office of the Inspector General

SEMIANNUAL REPORT TO CONGRESS

October 1, 2007 – March 31, 2008

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT

OFFICE OF THE INSPECTOR GENERAL

PRODUCTIVITY INDICATORS

FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds	$45,064,992
Management Commitments to Recover Funds	$36,894,589
Recoveries Through Investigative Actions	$7,107,270

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

ACCOMPLISHMENTS:

Audit Reports Issued	47
Investigative Cases Closed	51
Indictments and Informations	21
Arrests	20
Convictions	23
Hotline Contacts and Complaint Activity	595
Health Care Provider Debarments and Suspensions	492
Health Care Provider Debarment and Suspension Inquiries	3,008

Office of the Inspector General

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THE INSPECTOR GENERAL'S MESSAGE

PII . . . What is it? Why is it important?

Personally identifiable information, or PII as it is commonly referred to, is defined by the U.S. Office of Management and Budget (OMB) as "information which can be used to distinguish or trace an individual's identity, such as their name, social security number, biometric records, etc. alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc." Unfortunately, in today's high tech world, inappropriate access to this sensitive information can lead to adverse consequences for the American public we are sworn to protect and serve. Consequently, the Office of the Inspector General (OIG) has identified and reported the protection of personally identifiable information as a top management challenge for the U.S. Office of Personnel Management (OPM), and we believe it is a challenge that will be ongoing because of the dynamic and ever-evolving nature of information security.

Recognizing the adverse consequences of lost or stolen PII, including substantial harm, embarrassment and inconvenience to individuals, as well as potential identity theft, OPM's Director, the Honorable Linda M. Springer, initiated a series of actions beginning last fall. She wanted to make sure that all OPM employees clearly understood what PII meant, the importance of protecting PII, and their responsibilities in protecting it. Her November 2007 campaign of new procedures regarding PII, including strategically placed posters, informative emails, and notices in OPM's monthly on-line newsletter sent a clear message. The message … **protecting PII is everyone's responsibility!**

Furthermore, Director Springer requested that the OIG conduct an audit of one of OPM's largest program offices to ensure that they had developed and implemented effective controls over PII. This audit is currently ongoing. PII has also become a routine topic of discussion at the Agency's Information Technology Security Working Group meetings. The group was set up by the Chief Information Officer to ensure that information technology (IT) security and privacy policies, procedures and directives are communicated to all OPM program offices. On the technical side, OPM has made significant progress in implementing OMB requirements to safeguard PII.

The Office of the Inspector General has long understood the importance of securing sensitive information. The mere nature of our mission requires us to request, analyze, maintain, and secure sensitive documents containing PII in both hard copy and electronic medium. In addition, in the late 1990s we developed an information systems audit group. This group's responsibilities have grown over the years to include the annual Federal Information Security Management Act (FISMA) review. FISMA requires agencies to have a security program and controls for systems to protect their sensitive information. Last year, we completed an audit of OPM's privacy program, which documented OPM's commitment to securing its information assets while noting several opportunities for improvement.

We also perform IT security reviews of health insurance carriers participating in the Federal Employees Health Benefits Program. Our audits routinely cover the carriers' compliance with the Health Insurance Portability and Accountability Act (HIPAA), which covers protected health information (PHI). PHI is similar to PII in that it is sensitive, personally identifiable health care information that could negatively impact federal employees if improperly disclosed. To ensure that OIG staff members are taking every step necessary to protect PII data, I have set up our own PII working group to identify any weaknesses in our controls and develop and implement action plans to correct deficiencies, as appropriate.

To date, our combined efforts have resulted in significant progress towards improving the protection of OPM's PII data. However, it is clear that our job is not done! We must be ever vigilant in our efforts to improve and maintain the confidentiality of all sensitive information, thereby ensuring the trust of the American public.

Patrick E. McFarland

Inspector General

MISSION STATEMENT

Our mission is to provide independent and objective oversight of OPM services and programs.

WE ACCOMPLISH OUR MISSION BY:

- Conducting and supervising audits, evaluations and investigations relating to the programs and operations of the U.S. Office of Personnel Management (OPM).
- Making recommendations that safeguard the integrity, efficiency and effectiveness of OPM services.
- Enforcing laws and regulations that protect the program assets that are administered by OPM.

GUIDING PRINCIPLES

WE ARE COMMITTED TO:

- Promoting improvements in the agency's management and program operations.
- Protecting the investments of the American taxpayers, federal employees and annuitants from waste, fraud and mismanagement.
- Being accountable to the concerns and expectations of our stakeholders.
- Observing the highest standards of quality and integrity in our operations.

STRATEGIC OBJECTIVES

THE OIG WILL:

- Combat fraud, waste and abuse in programs administered by the agency.
- Ensure that the agency is following best business practices by operating in an effective and efficient manner.
- Determine whether the agency complies with applicable federal regulations, policies and laws.
- Ensure that insurance carriers and other service providers for OPM program areas are compliant with contracts, laws and regulations.
- Aggressively pursue the prosecution of illegal violations affecting agency programs.
- Identify, through proactive initiatives, areas of concern that could strengthen the agency's operations and programs administered by OPM.

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AUDIT ACTIVITIES

Health and Life Insurance Carrier Audits

The United States Office of Personnel Management (OPM) contracts with private-sector firms to provide health and life insurance through the Federal Employees Health Benefits Program (FEHBP) and the Federal Employees' Group Life Insurance (FEGLI) program. Our office is responsible for auditing the activities of these programs to ensure that the insurance carriers meet their contractual obligations with OPM.

The Office of the Inspector General (OIG) insurance audit universe contains approximately 270 audit sites, consisting of health insurance carriers, sponsors, and underwriting organizations, as well as two life insurance carriers. The number of audit sites is subject to yearly fluctuations due to the addition of new carriers, non-renewal of existing carriers, or plan mergers and acquisitions. The combined premium payments for the health and life insurance programs are approximately $35 billion annually.

The health insurance plans that our office audits are either community-rated or experience-rated carriers.

> *Community-rated carriers are comprehensive medical plans, commonly referred to as health maintenance organizations (HMOs).*

> *Experience-rated carriers are mostly fee-for-service plans, the largest being the BlueCross and BlueShield health plans, but also include experience-rated HMOs.*

The two types of carriers differ in the way they calculate premium rates. Community-rated carriers generally set their rates based on the average revenue needed to provide health benefits to each member of a group. Rates established by experience-rated plans reflect a given group's projected paid claims, administrative expenses and service charges for administering a specific contract.

During the current reporting period, we issued 34 final reports on organizations participating in the FEHBP, of which 23 contain recommendations for monetary adjustments in the amount of $45 million due the FEHBP.

Appendix III (page 31) contains a complete listing of all health plan audit reports issued during this reporting period.

COMMUNITY-RATED PLANS

The community-rated HMO audit universe covers approximately 170 health plans located throughout the country. Community-rated audits are designed to ensure that the premium rates plans charge the FEHBP are in accordance with their respective contracts and applicable federal laws and regulations.

Federal regulations require that the FEHBP rates be equivalent to the rates a plan charges the two groups closest in subscriber size, commonly referred to as *similarly sized subscriber groups (SSSGs)*. The rates are set by the plan, which is also responsible for selecting the two appropriate groups. When an audit shows that the rates are not equivalent, the FEHBP is entitled to a downward rate adjustment to compensate for any overcharges.

Community-rated audits focus on ensuring that:

- The plans select and rate the appropriate SSSGs;
- The FEHBP rates are equivalent to those charged the SSSGs; and,
- The loadings applied to the FEHBP rates are appropriate and reasonable.

__Loading__ is a rate adjustment that the FEHBP makes to the basic benefit package offered by a community-rated plan. For example, the FEHBP provides coverage for dependent children until age 22, while the plan's basic benefit package may provide coverage through age 19. Therefore, the FEHBP rates may be increased because of the additional costs the plan incurs by extending coverage to age 22.

During this reporting period, we issued 23 audit reports on community-rated plans. These reports contain recommendations that require the plans to return over $26 million to the FEHBP.

HealthPlus of Michigan, Inc.

Flint, Michigan

Report No. 1C-X5-00-06-013

NOVEMBER 14, 2007

HealthPlus of Michigan, Inc. provides comprehensive medical services to its members throughout the Greater Flint and Saginaw areas. This audit of the plan covered contract years 2000 through 2005. During this period, the FEHBP paid the plan approximately $27.3 million in premiums.

Our auditors identified $5,169,188 in inappropriate health benefit charges to the FEHBP, which includes $189,506 in 2000, $87,363 in 2001, $838,020 in 2002, $1,035,849 in 2003, $1,227,840 in 2004, and $1,790,610 in 2005. In addition, we determined the FEHBP is due $988,390 for lost investment income.

AUDITORS QUESTIONED INAPPROPRIATE CHARGES AND LOST INVESTMENT INCOME OF $6.2 MILLION

__Lost investment income__ represents the potential interest earned on the amount the plan overcharged the FEHBP as a result of defective pricing.

The overcharges occurred because HealthPlus of Michigan, Inc.:

- included unsupported charges in each year for the FEHBP benefits provided outside the basic plan;
- overstated the FEHBP pharmacy loading in 2004 and 2005; and,

- failed to give the FEHBP appropriate premium discounts in 2000 through 2005.

HealthPlus of Michigan, Inc. agreed with approximately $3 million of the findings.

Vista Healthplan

Hollywood, Florida

Report No. 1C-3N-00-06-011

JANUARY 18, 2008

Vista Healthplan provides comprehensive medical services to its members throughout South Florida. This audit of the plan covered contract years 2000 through 2005. During this period, the FEHBP paid the plan approximately $16 million in premiums.

$1.9 MILLION RETURNED TO THE FEHBP

The audit identified $1,464,646 in inappropriate health benefit charges to the FEHBP, consisting of $275,160 in 2000, $751,759 in 2001, and $437,727 in 2005. In addition, we determined the FEHBP is due $400,914 for lost investment income as a result of the overcharges.

The overcharges occurred because the plan:

- did not adequately support the rates charged to the FEHBP and the SSSGs in 2000 and 2001;
- incorrectly calculated the FEHBP rate in 2005; and,
- failed to give the FEHBP an appropriate premium discount in 2005.

Vista Healthplan agreed with our findings and returned the entire $1,865,560 to the FEHBP.

EXPERIENCE-RATED PLANS

The FEHBP offers a variety of experience-rated plans, including a service benefit plan and health plans operated or sponsored by federal employee organizations, associations, or unions. In addition, experience-rated HMOs fall into this category.

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

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

During this reporting period, we issued 11 experience-rated audit reports. In these reports, our auditors recommended that the plans return $18.6 million in inappropriate charges and lost investment income to the FEHBP.

BlueCross BlueShield Service Benefit Plan

The BlueCross BlueShield Association, which administers a fee-for-service plan known as the Service Benefit Plan, contracts with OPM on behalf of its member plans throughout the United States. The participating plans independently underwrite and process the health benefits claims of their respective federal subscribers and report their activities to the national BlueCross BlueShield (BCBS) operations center in Washington, D.C. Approximately 59 percent of all FEHBP subscribers are enrolled in BCBS plans.

We issued nine BCBS experience-rated reports during the reporting period. Experience-rated audits normally address health benefit payments, miscellaneous payments and credits, administrative expenses, and cash management activities. Our auditors identified $17 million in questionable contract costs charged to the FEHBP, including lost investment income on these questioned costs. The BCBS Association and/or plans agreed with $9.8 million of the questioned costs.

Global Coordination of Benefits for BlueCross and BlueShield Plans

Report No. 1A-10-99-06-001

MARCH 20, 2008

We performed a limited scope audit to determine whether the BCBS plans complied with contract provisions relative to coordination of benefits (COB) with Medicare.

Coordination of benefits occurs when a patient has coverage under more than one health insurance plan or program. In such a case, one insurer normally pays its benefits as the primary payer and the other insurer pays a reduced benefit as the secondary payer. Medicare is usually the primary payer when the insured is also covered under an FEHBP plan.

Our auditors performed a computer search on the BCBS claims database to identify claims for services that were paid in 2004. We determined that 51 of the 63 plan sites did not properly coordinate claim charges with Medicare. As a result, the FEHBP incorrectly paid these claims when Medicare was the primary insurer.

AUDITORS QUESTION $6.2 MILLION FOR COORDINATION OF BENEFITS ERRORS

For 81 percent of the 12,894 claim lines questioned, there was no information in the BCBS Association's national claims system to identify Medicare as the primary payer when the claims were paid. However, when the Medicare information was subsequently added to the claims system, the BCBS plans did not adjust the patients' prior claims retroactively to the Medicare effective dates. Consequently, these costs continued to be charged entirely to the FEHBP.

We determined that the FEHBP was overcharged $6,150,380 for these COB errors. The BCBS Association agreed with $2,807,759 of the questioned claim overcharges.

WellPoint Midwest

Mason, Ohio

Report No. 1A-10-18-06-052

FEBRUARY 20, 2008

WellPoint Midwest includes the Indiana, Kentucky, and Ohio BlueCross and BlueShield plans. Our audit of the FEHBP operations at WellPoint Midwest covered claims from 2003 through 2005, as well as miscellaneous health benefit payments and credits, administrative expenses, and cash management activities from 2002 through 2005. From 2002 to 2005, WellPoint Midwest paid approximately $2 billion in FEHBP health benefit charges and $122 million in administrative expenses.

BCBS ASSOCIATION AGREES WITH $3.6 MILLION IN QUESTIONED CHARGES

Our auditors questioned $4,956,328, consisting of $3,327,922 in health benefit charges and $1,628,406 in administrative expenses. Our most significant findings were:

- $1,699,541 in overpayments and $9,549 in underpayments due to pricing errors;
- $1,467,969 in overpayments and $108,695 in underpayments because claims were not paid in accordance with the Omnibus Budget Reconciliation Act of 1990 pricing requirements, which limit benefit payments for certain inpatient services provided to annuitants age 65 and older who are not covered under Medicare Part A;
- $986,453 in administrative expense charges that were unallowable and/or did not benefit the FEHBP;
- $593,388 for plan employee pension cost overcharges;
- $266,625 for unreturned health benefit refunds and recoveries from providers and subscribers, and $12,031 for lost investment income on these funds;

- $191,500 for a subcontract for which OPM's prior approval had not been obtained, as required by the federal regulations; and,
- $142,935 for executive compensation owed by the FEHBP to the plan.

Lost investment income on the questioned charges totaled $301,836.

Of the questioned charges, the BCBS Association and/or plan agreed with $3,604,977.

EMPLOYEE ORGANIZATION PLANS

Employee organization plans fall into the category of experience-rated plans. These plans either operate or sponsor participating federal health benefits programs. As fee-for-service plans, they allow members to obtain treatment through facilities or providers of their choice.

The largest employee organizations are federal employee unions and associations. Some examples are: American Postal Workers Union, Association of Retirees of the Panama Canal Area, Government Employees Hospital Association, National Association of Letter Carriers, National Postal Mail Handlers Union, and Special Agents Mutual Benefit Association.

We issued no audit reports on employee organization plans during this reporting period.

EXPERIENCE-RATED COMPREHENSIVE MEDICAL PLANS

Comprehensive medical plans fall into one of two categories: community-rated or experience-rated. As we previously explained on page 1 of this report, the key difference between the categories stems from how premium rates are calculated for each.

Members of experience-rated plans have the option of using a designated network of providers or using non-network providers. A member's choice in selecting one health care provider over another has monetary and medical implications. For example, if a member chooses a non-network provider, the member will pay a substantial portion of the charges and covered benefits may be less comprehensive.

We issued two experience-rated comprehensive medical plan audit reports during this reporting period.

Triple-S, Inc.

San Juan, Puerto Rico

Report No. 1D-89-00-06-043

MARCH 26, 2008

Triple-S, Inc. is an experience-rated health plan offering comprehensive medical benefits to members living in Puerto Rico. The audit of the plan's FEHBP operations covered miscellaneous health benefit payments and credits and cash management from 2000 through 2004, administrative expenses for 1999 through 2005, and the application controls for the 2006 claims processing system. For contract years 2000 through 2004, the plan paid out approximately $467 million in health benefit charges and $28 million in administrative expenses.

The audit identified $1,004,532 in questionable charges, including $342,263 in health benefit charges, and $662,269 in administrative expenses. Lost investment income on the questioned charges amounted to $232,596. In addition to the monetary findings, we identified a number of problems concerning the plan's cash management procedures and the application controls for its claims processing system.

AUDITORS FIND OVER $1 MILLION IN QUESTIONABLE CHARGES

The most significant monetary findings included:

- $342,263 in overcharges because, from 2000 through 2004, the plan did not properly refund pharmacy drug rebates due to the FEHBP;
- $410,027 in overcharges because, from 1999 through 2004, the plan did not calculate employee pension costs in accordance with federal regulations; and,

- $155,177 in overcharges because, from 1999 through 2005, the plan did not limit the executive compensation to the benchmark amount required by federal regulations.

We also audited their cash management and found that Triple-S did not manage FEHBP funds in accordance with its contract or the applicable laws and regulations. Specifically, we found that the plan did not credit the FEHBP for interest earned on FEHBP funds, and when drawing down funds from the letter of credit account, it did not have a system to verify that all expenses and credits were taken into account. In addition, the plan did not have policies and procedures to identify and pursue subrogation recoveries, which usually happen when a subscriber receives payments for the same claim from more than one insurance source.

As a result of testing the application controls in the plan's claims processing system, we identified a number of areas where improvements are needed. For example, our testing showed that:

- subscribers are not provided information as to why their claims are denied;
- the plan may not be consistently coordinating with Medicare before paying claims;
- the plan automatically assumes that Medicare deductibles are met by March 31, which may not be the case for all subscribers; and,
- subscribers are sometimes provided coverage beyond their termination dates.

Information Systems Audits

OPM relies on computer technologies and information systems to administer programs that distribute health and retirement benefits to millions of current and former federal employees. OPM systems also assist in the management of background investigations for federal employees, contractors, and applicants. Any breakdowns or malicious attacks (e.g., hacking, worms or viruses) affecting these federal systems could compromise the privacy of the individuals whose information they maintain, as well as the efficiency and effectiveness of the programs that they support. With recent high-profile security incidents involving personal information, privacy has emerged as a major management challenge for most federal agencies. OPM is no exception.

Our office examines the computer security and information systems of private health insurance carriers participating in the FEHBP by performing general and application controls audits. *General controls* refer to the policies and procedures that apply to an entity's overall computing environment. *Application controls* are those directly related to individual computer applications, such as a carrier's payroll system or benefits payment system. General controls provide a secure setting in which computer systems can operate, while application controls ensure that the systems completely and accurately process transactions. In addition, we are responsible for performing an independent evaluation of OPM's information technology (IT) security environment, as required by the Federal Information Security Management Act of 2002 (FISMA).

Issues related to properly securing the agency's sensitive information, especially personally identifiable information (PII), occupied much of our audit focus this semiannual reporting period. While we did not issue any final reports, we were nevertheless very active. We conducted an IT general and application controls audit of BCBS of Massachusetts and started a major audit of the Federal Employees Program (FEP) Operations Center – the entity that hosts the national claims processing system – and its corporate partner, CareFirst BCBS. We also audited two OPM systems that store sensitive PII of federal employees. We anticipate releasing the results of these audits during the next semiannual reporting period.

Internal Audits

COMBINED FEDERAL CAMPAIGN

Our office audits the Combined Federal Campaign (CFC), the only authorized charitable fundraising drive conducted in federal installations throughout the world. OPM is responsible, through both law and executive order, to regulate and oversee the conduct of fundraising activities in federal civilian and military workplaces worldwide.

Combined Federal Campaigns are identified by geographical areas that may include only a single city, or encompass several cities or counties. Our auditors review the administration of local campaigns to ensure compliance with federal regulations and OPM guidelines. In addition, all campaigns are required by regulation to have an independent public accounting firm (IPA) audit their respective financial activities for each campaign year. The audit must be in the form of an agreed-upon procedures engagement to be completed by an IPA. We review the IPA's work as part of our audits.

CFC audits do not identify savings to the government, because the funds involved are charitable donations made by federal employees. Our audit efforts occasionally generate an internal referral to our OIG investigators for potential fraudulent activity. OPM's Office of CFC Operations works with the auditee to resolve the findings after the final audit report is issued.

Local CFC Audits

The local organizational structure consists of:

- ***Local Federal Coordinating Committee (LFCC)***
  The LFCC is a group of federal officials designated by the Director of OPM to conduct the CFC in a particular community. It organizes the local CFC, determines local charities' eligibility to participate, supervises the activities of the Principal Combined Fund Organization (PCFO), and resolves issues relating to a local charity's noncompliance with the CFC policies and procedures.

- ***Principal Combined Fund Organization***
  The PCFO is a federated group or combination of groups, or a charitable organization, selected by the LFCC to administer the local campaign under the direction and control of the LFCC and the Director of OPM. Their duties include collecting and distributing CFC funds, training volunteers, and maintaining a detailed accounting of CFC administrative expenses incurred during the campaign. The PCFO is reimbursed for its administrative expenses from CFC funds.

- ***Local Federations***
  A local federation is a group of local voluntary charitable human health and welfare organizations created to supply common fundraising, administrative, and management services to its constituent members.

- ***Independent Organizations***
  Independent Organizations are organizations that are not a member of a federation for the purposes of the CFC.

During this reporting period, we issued six audit reports of local CFCs. These reports identified numerous violations of regulations and guidelines governing local CFC operations. The most significant problems were:

- ***Undistributed Campaign Receipts***
  The PCFO for one local campaign did not distribute $154,190 in campaign receipts during the 2004 CFC.

- ***Campaign Expenses***
  The PCFO for one local campaign charged the 2004 CFC $149,356 in unsupported expenses.

- ***Inadequate Cutoff Procedures***
  The PCFO for four local campaigns did not use appropriate cutoff procedures when determining which campaign should be credited for payroll deductions it received.

- ***Local Application Review Process***
  For four campaigns reviewed, we found that the LFCC's process for reviewing the eligibility of local charities was inadequate.

- ***Untimely Eligibility Decision***
  Three local campaigns did not render eligibility decisions to the local agencies that applied to the 2004 campaign within OPM's established timeframes.

- ***Agreed-Upon Procedures***
  The IPAs for five of the campaigns did not comply with the procedures prescribed in the January 2005 and 2006 CFC Audit Guides.

We provide audit findings and recommendations for corrective action to OPM management. OPM then notifies the various CFC organizations of our recommendations and monitors for corrective actions. If the CFC organization does not comply with the recommendations, the OPM Director can deny the organization's future participation in the CFC.

National Charitable Federation Audits

We also audit national charitable federations that participate in the CFC. National federations provide services to other charities with similar missions. They are similar to local federations, since they provide common fundraising, administrative, and management services to their members. Our audits of the national federations focused on the eligibility of member charities, distribution of funds, and allocation of expenses. During this reporting period, we issued one report on a national charitable federation that participated in the CFC.

OPM INTERNAL PERFORMANCE AUDITS

Our internal auditing staff focuses on improving the efficiency and effectiveness of OPM's operations and their corresponding internal controls. One critical area of this audit activity is OPM's consolidated financial statements audits required under the Chief Financial Officers Act of 1990 (CFO Act). Our staff also conducts performance audits covering other internal OPM programs and functions.

U.S. Office of Personnel Management's Compliance with Federal Tax Laws

Washington, D.C.

Report No. 4A-CF-00-06-031

FEBRUARY 27, 2008

At the request of the Internal Revenue Service (IRS), we conducted an audit of OPM's compliance with federal tax laws. Our audit scope covered tax years 1996 through 2006. During those years, the IRS indicated that OPM had outstanding tax liabilities.

Federal agencies are subject to the same tax reporting requirements as all other employers. The Internal Revenue Code and regulations require employers to pay employment taxes on wages and report those wages to the IRS. Federal employment taxes include income tax withholdings, social security payments, and Medicare taxes. Employers are required to make deposits of employment taxes on a periodic schedule depending upon the amount of tax they accumulate for deposit. OPM makes a bi-monthly tax deposit for its active employees and a monthly deposit for its annuitants.

OPM's Office of the Chief Financial Officer's Center for Financial Services (CFS) is responsible for ensuring that employment taxes for employees and annuitants are paid and returns are filed in accordance with federal tax laws. OPM has contracted with the General Services Administration (GSA) National Payroll Center, located in Kansas City, Missouri, to perform its active employees' payroll and reporting functions. The CFS performs the reporting functions related to annuitants' payroll taxes.

We identified four areas requiring improvement:

- CFS incorrectly withheld social security tax from a re-employed annuitant for calendar years 2001 and 2002;
- OPM's quarterly federal tax returns were not electronically filed by the IRS due date for five out of the six quarters we reviewed;
- OPM has an outstanding tax balance of $153,811 for the 2003 calendar year; and,
- For 1996, the IRS records show that the CFS did not file Form 1042, Annual Withholding Tax Return for U.S. Source Income of Foreign Persons, by the IRS deadline. OPM records indicate the form was sent to the IRS on December 24, 2002; however, the IRS has no record of receiving the form.

The CFS has agreed with our findings and has begun taking corrective actions.

Audit of OPM's Reclamation Process

Washington, D.C.

Report No. 4A-RI-00-05-037

MARCH 18, 2008

We conducted a performance audit of OPM's reclamation process, which is a procedure used to recover payments erroneously made to the account of a deceased annuitant. All annuity payments made after the date of death must be recovered and recredited to the Civil Service Retirement and Disability Fund.

The Department of the Treasury (Treasury) receives an electronic file of reclamation actions daily from OPM and establishes recovery actions with the financial institutions that received the overpayments. The reclamation actions are maintained on OPM's Accounting Control File System and are tracked by staff from OPM's CFS. The CFS staff reviews correspondence from Treasury pertaining to the recovery action for the overpayments. If Treasury does not collect the full amount of the overpayment, the CFS staff attempts to collect the remaining balance due.

Our audit consisted of a sample of reclamation actions selected from OPM's outstanding balance as of February 25, 2005. We reviewed the reclamation actions for compliance with OPM's policies and procedures and federal regulations for recovering benefit payments made electronically.

Based on the results of our audit, we identified eight areas requiring improvement:

- OPM is not listed as a benefit-paying agency in the Treasury regulations that would allow OPM to receive account holder information from financial institutions;
- The CFS has not maintained sufficient staffing levels, within the reclamation unit, for the volume of reclamations that must be processed;
- The CFS does not have written procedures for the write-off of reclamation receivables;
- The CFS' written procedures for processing reclamation actions do not provide adequate work instructions for technicians;
- The CFS' documentation supporting OPM's reclamation efforts was not provided for 13 of the 55 cases we sampled;
- OPM's Retirement Services Program did not initiate reclamation actions for 4 of the 55 reclamation cases within the legally mandated 120-day timeframe after learning of the date of death;
- The CFS does not have procedures to resolve reclamation actions rejected by the Treasury; and,
- The CFS does not have proper separation of duty controls in place to ensure that the adjudicator receiving reclamations is not the same person who prepares the demand letters.

OPM agrees with all of our findings and is currently working on implementing corrective actions to address our findings and recommendations.

OPM'S CONSOLIDATED FINANCIAL STATEMENTS AUDITS

The CFO Act of 1990 requires that audits of OPM's financial statements be conducted in accordance with generally accepted government auditing standards (GAGAS) issued by the Comptroller General of the United States. OPM contracted with KPMG LLP (KPMG) to audit the consolidated financial statements as of September 30, 2007. The contract requires that the audit be done in accordance with GAGAS and Office of Management and Budget (OMB) bulletin number 07-04, *Audit Requirements for Federal Financial Statements*.

OPM's consolidated financial statements consist of five reporting entities: the retirement program (RP), the health and life insurance benefit programs (HBP and LP), the revolving fund (RF), and the salaries and expenses accounts (S&E). The RF programs provide funding for a variety of human resource-related services to other federal agencies, such as pre-employment testing, background investigations, and employee training. The S&E funds pay for most of the administrative costs of the agency.

In performing the audit, KPMG is responsible for issuing an audit report including:

- An opinion on the consolidated financial statements and the individual statements for the three benefit programs;
- A report on internal controls; and,
- A report on compliance with laws and regulations.

In connection with the audit contract, we oversee KPMG's performance of the audit to ensure that it is conducted in accordance with the terms of the contract with OPM and is in compliance with GAGAS and other authoritative references.

Specifically, we were involved in the planning, performance, and reporting phases of the audit through participation in key meetings and by reviewing KPMG's work papers and reports. Our review disclosed no instances where KPMG did not comply, in all material respects, with GAGAS, the contract, and all other authoritative references.

In addition to the consolidated financial statements, KPMG performed the audit of the special-purpose financial statements (closing package) in accordance with the Department of the Treasury's Financial Manual, Chapter 4700. Treasury and GAO use the closing package in preparing and auditing the government-wide Financial Report of the United States.

OPM's FY 2007 Consolidated Financial Statements

Report No. 4A-CF-00-07-034

NOVEMBER 14, 2007

KPMG audited OPM's balance sheets as of September 30, 2007 and 2006, and the related consolidated financial statements. KPMG also audited the individual balance sheets of the retirement, health and life insurance benefits programs, as of September 30, 2007 and 2006, and the programs' related individual financial statements for those years. The benefits programs, which are essential to the payment of benefits to federal civilian employees, annuitants, and their respective dependents, operate under the following names:

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

CONSOLIDATED & BENEFITS PROGRAMS FINANCIAL STATEMENTS

KPMG reported that the fiscal year (FY) 2007 and 2006 consolidated financial statements and the individual statements of the three programs that govern the retirement, health, and life benefits of federal employees and retirees, were presented fairly, in all material respects, in conformity with generally accepted accounting principles. These reviews generally identify reportable conditions, significant deficiencies, and material weaknesses.

NO MATERIAL WEAKNESSES REPORTED IN FY 2007

*A **reportable condition** represents a significant deficiency in the design or operation of internal controls that could adversely affect OPM's ability to record, process, summarize, and report financial data consistent with management assertions in the financial statements (applicable to FY 2006 only).*

*A **control deficiency** exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis.*

*A **significant deficiency** represents a deficiency in internal controls, or a combination of deficiencies, that adversely affects OPM's or the programs' ability to initiate, authorize, record, process, or report financial data reliably in accordance with U.S. generally accepted accounting principles such that there is more than a remote likelihood that a misstatement of OPM's consolidated financial statements or the programs' individual financial statements that is more than inconsequential will not be prevented*

or detected by OPM's or the Program's internal control over financial reporting.

*A **material weakness** is a significant deficiency, or a combination of significant deficiencies, that results in more than a remote likelihood that a material misstatement of the financial statements will not be prevented or detected by OPM's or the program's internal control.*

KPMG reported two areas of significant deficiencies in the internal controls over financial reporting during FY 2007. All of the FY 2006 reportable conditions remained unresolved, except one which has been downgraded to a control deficiency in FY 2007. None of the significant deficiencies are considered to be a material weakness. The areas identified by KPMG are:

- ***Information Systems General Control Environment*** OPM has made continual enhancements to its technology and information security infrastructure; however, certain entity-wide, access, program changes, and system software control processes need to be strengthened.

- ***Financial Management and Reporting Processes of the OCFO*** Certain deficiencies continue to exist in the operations of the OCFO's internal controls over financial management and reporting, affecting the accuracy of the RF program and S&E funds.

Table 1 includes the significant deficiencies and reportable conditions that KPMG identified during its audit work on the financial statements for FY 2007 and FY 2006. OPM agreed to the findings and recommendations reported by KPMG.

Table 1: Internal Control Weaknesses

Title of Findings From FY 2007 Report	Program/Fund	FY 2007	FY 2006
Information Systems General Control Environment	All	Significant Deficiency	Reportable Condition
Financial Information Received from Experience-Rated and Life Insurance Carriers	HBP and LP	Control Deficiency	Reportable Condition
Financial Management and Reporting Processes of the OCFO	S&E and RF	Significant Deficiency	Reportable Condition
Managerial Cost Accounting to Determine Full Cost Associated with Strategic Goals and Major Outcomes	S&E and RF	Significant Deficiency – (included under Financial Management and Reporting Processes above)	Reportable Condition

KPMG's tests of internal controls over the design of key performance measures disclosed no deficiencies.

OPM's FY 2007 Special-Purpose Financial Statements

Report No. 4A-CF-00-07-061

NOVEMBER 16, 2007

The closing package financial statements, also referred to as special-purpose financial statements, are required to be audited in accordance with GAGAS and OMB's Bulletin No. 07-04. OPM's Closing Package Financial Statement includes:

NO SIGNIFICANT DEFICIENCIES OR MATERIAL WEAKNESSES REPORTED FOR FY 2007

- The reclassified Balance Sheets (formatted according to Treasury's specifications);
- The Statements of Net Cost;
- The Statements of Changes in Net Position (a statement that explains the changes in the financial status between two fiscal years) and the accompanying Financial Report Notes Report as of September 30, 2007 and 2006;
- The Additional Note No. 27 (discloses other data necessary to make the Special-Purpose Financial Statements more informative); and,
- The Trading Partner Balance Sheets (shows the funds due between OPM and other agencies).

KPMG did not identify any material weaknesses or significant deficiencies involving the internal controls over the financial process for the special-purpose financial statements, nor did they disclose any instances or other matters that are required to be reported.

ENFORCEMENT

Investigative Activities

The Office of Personnel Management administers benefits from its trust funds for all federal civilian employees and annuitants participating in CSRS, FERS, FEHBP, and FEGLI. These programs cover over eight million current and retired federal civilian employees, including eligible family members, and disburse about $91 billion annually. While we investigate OPM employee misconduct and other wrongdoing, the majority of our OIG investigative efforts are spent examining potential fraud against these trust funds.

During the reporting period, our office opened 64 criminal investigations and closed 51, with 299 still in progress. Our investigations led to 20 arrests, 21 indictments and/or informations, 23 convictions and $7,107,270 in monetary recoveries. For a complete statistical summary of our office's investigative activity, refer to the table on page 28.

HEALTH CARE FRAUD

Health care fraud cases are often time-consuming and complex, and may involve several health care providers who are defrauding multiple health insurance plans. Our criminal investigations are critical to protecting federal employees, annuitants, and members of their families who are eligible to participate in the FEHBP.

Whenever feasible, we coordinate our health care fraud investigations with the Department of Justice (DOJ) and other federal, state, and local law enforcement agencies. At the national level, we are participating members of DOJ's health care fraud working groups. We work directly with U.S. Attorney's offices nationwide to focus investigative resources in areas where fraud is most prevalent.

The OIG special agents are in regular contact with FEHBP health insurance carriers to identify possible fraud by health care providers and enrollees. Additionally, special agents work closely with our auditors when fraud issues arise during carrier audits. They also coordinate with the OIG debarring official when investigations of FEHBP health care providers reveal evidence of violations that may warrant administrative sanctions.

HEALTH CARE FRAUD CASES

Physician Pleads Guilty to Health Care Fraud and Tax Evasion

In January 2008, a primary care physician, who practiced in the Washington, D.C. metropolitan area, pled guilty to tax evasion and health care fraud. He submitted false claims to the FEHBP and other health care programs for hospital services that he supposedly rendered to his patients. In November 2002, the physician submitted claims for treating patients admitted to Providence Hospital in Washington, D.C., although he was actually in South Carolina. Potential health care program losses are $70,000.

In addition, from 1997 through 2005, the physician evaded payment of more than $400,000 in taxes by:

- reporting false information to the Internal Revenue Service (IRS) regarding his personal income and the gross receipts from his medical practice;
- establishing sham corporations in the Bahamas to create false expenses and disguise personal income;
- diverting money from his medical practice by writing checks from the corporate bank account for personal expenses; and,
- filing false income tax returns for his medical practice.

His sentencing is scheduled for June 2008.

This was a joint investigation between the IRS, Federal Bureau of Investigations (FBI), Department of Health and Human Services (HHS) OIG and our office.

Federal Employee Defrauds the FEHBP

A Department of Agriculture (USDA) employee claimed he was married to obtain FEHBP health care coverage for his girlfriend. In a call to the BCBS of Mississippi's customer service line to inquire on the status of a claim, the girlfriend referred to herself as the employee's "girlfriend", prompting the plan's customer service representative to question their marital status. The plan referred the case to our office.

When the employee was interviewed and asked to provide documentation of the marriage, he falsely claimed that he was unable to obtain documentation because the minister who performed the marriage had been robbed and murdered. The girlfriend wrongly received $2,194 in medical benefits from the FEHBP.

In June 2007, the employee was indicted on a single count of false statements for submitting false information to an FEHBP carrier. In October 2007, he pled guilty to making a false statement. In March 2008, the employee was sentenced to 60 months of probation, and ordered to perform 50 hours of community service and pay $9,518 in restitution to the FEHBP, which includes the government's cost of premiums for family coverage.

We found that the girlfriend was unaware that she was not entitled to FEHBP coverage.

This was a joint investigation between the USDA/OIG and our office.

Medical Center Settles for $1.9 Million After Cardiologist is Indicted on 94 Counts of Health Care Fraud

In February 2006, a Louisiana cardiologist was indicted on 94 counts of health care fraud. Our investigation revealed that the cardiologist allegedly:

- performed medically unnecessary angiograms and angioplasty procedures;
- falsely identified and diagnosed the existence and extent of coronary artery disease;
- recorded false diagnoses in patients' charts;
- falsely reported and identified coronary blockages; and,
- placed stents in arteries that did not have significant disease.

According to the indictment, the cardiologist allegedly performed the procedures even though they could cause blockages in the affected coronary arteries, thus endangering the lives of his patients. This could result in the need for additional medical procedures for which he could further bill health insurance carriers.

The cardiologist is currently awaiting trial. In addition to the indictment, the United States Attorney's Office initiated a civil false claims action against a medical center where the cardiologist performed the unnecessary medical procedures. In January 2008, the medical center agreed to a civil settlement in the amount of $1.9 million dollars. The FEHBP will receive $89,547 from the settlement.

This was a joint investigation with the FBI, HHS/OIG, and our office.

Rent-a-Patient Surgical Center Employees Convicted

In a previous semiannual report, we highlighted an investigation involving the recruitment of patients for unnecessary diagnostic services at a California outpatient surgical center.

This investigation was initiated in November 2003 with the National Health Care Anti-Fraud Association, private insurance companies, and the FBI. We found that the surgical center used patient recruiters throughout the United States. The recruiters offered money and discounted cosmetic surgery to patients with health insurance coverage. In return, the patients agreed to have multiple unnecessary outpatient medical procedures at the surgery center. The patients were directed to describe false and exaggerated symptoms to the treating physicians so the center could obtain authorization from health insurance companies. The ABC news program "20/20" highlighted this "rent-a-patient" scam in a March 2004 broadcast.

The FEHBP was billed over $1.4 million by the surgical center for a variety of outpatient diagnostic surgical services.

In December 2007, two of the five defendants were found guilty of mail fraud and conspiracy. The remaining three changed their pleas to guilty prior to the convictions.

Bio-Tech CEO Indicted

In a previous semiannual report, we reported on an investigation of a bio-technology company that manufactures Actimmune, a drug for the treatment of Cystic Fibrosis. The company was accused of illegally marketing this drug for a use not approved by the Food and Drug Administration (FDA), a practice called off-label promotion. In October 2006, the company agreed to a civil settlement in the amount of $42.5 million. The FEHBP recovered over $6 million in the settlement.

In March 2008, the former chief executive officer (CEO) of the company was indicted for wire fraud and violations of the Food, Drug and Cosmetic Act. The charges are related to his role in creating and disseminating false and misleading information about the effectiveness of Actimmune as a treatment for Idiopathic Pulmonary Fibrosis (IPF). The indictment alleged that the former CEO promoted and encouraged others to promote Actimmune for the treatment of IPF despite the lack of FDA approval. The off-label sale of Actimmune would generate more profits and revenue for the company.

This is an ongoing joint investigation with the FBI, FDA, Department of Veterans Affairs (VA) OIG, and our office.

Oregon Surgeons Enter into $2.5 Million Settlement Agreement

Our office with the HHS/OIG, Defense Criminal Investigative Service and the FBI conducted an investigation of four Oregon surgeons charged with billing federal insurance programs for a second surgeon's role as an "assistant at surgery." The second surgeon's participation was not authorized under billing guidelines. The billings occurred between 1993 and 2004 when the surgeons owned a group practice.

In December 2007, the four surgeons agreed to pay the government $2.5 million to settle the charges of alleged improper billings to federal health care plans, including Medicare, Medicaid, TRICARE and the FEHBP. The settlement requires that the surgical group plead guilty to misdemeanor charges. In addition to the fines and misdemeanor charges, the settlement agreement requires the two practicing surgeons to participate in an 18 month pre-charge diversion program. The other two surgeons are now retired and, therefore, were not required to partake in the diversion. The government agrees not to take further actions against the surgeons, providing there are no billing improprieties during the diversion period. The surgeons are also required to comply with an HHS corporate integrity agreement. The FEHBP will be reimbursed for actual losses and investigative costs of $38,956.

Pharmaceutical Company Agrees to $650 Million Civil Settlement

In February 2008, a pharmaceutical company agreed to pay more than $650 million to resolve a civil suit that alleged the manufacturer failed to pay proper rebates to government health care programs. They also paid illegal commissions to health care providers with the intent of inducing them to prescribe the company's products. This included a widely prescribed cholesterol lowering drug and acute pain treatment medications.

The company allegedly offered deep discounts for the two drugs if hospitals used large quantities of those medications in place of competitors' brands. The company was accused of not properly reporting these discounts to the federal government.

Additionally, the suit alleged that the company paid kickbacks to doctors whenever they prescribed these drugs. The kickbacks were disguised as reimbursements for training, consultation, and market research. This case was referred to our office by the Department of Justice. The FEHBP will receive $4,189,500 in the settlement.

Cardiologist to Pay Over $1.8 Million in Restitution

An Ohio physician pled guilty to a conspiracy to defraud Medicare, FEHBP and other health benefit programs by administering medically unnecessary cardiology tests. He admitted that this scheme lasted from October 1998 to September 2006 and included performing medically unnecessary nuclear stress tests that involved injecting nuclear medicine into patients. The decision to conduct tests was based on whether insurance carriers would agree to pay for a test and not based upon medical necessity. He received over $1.8 million in reimbursements for these tests.

The physician pled guilty in October 2007 and agreed to give up his medical license, forfeit more than $1.8 million, and be permanently excluded from participation in federal health care programs. In January 2008, the physician was convicted and sentenced to 37 months incarceration; 24 months supervised release; and, forfeiture of $1,884,343 to be used to reimburse the affected health benefit programs.

This case was investigated by the FBI, the HHS/OIG and our office.

Anesthesiologist Pleads Guilty to Falsifying Treatments

In February 2008, a Maryland physician pled guilty to making false statements on federal health care claims. His clinic submitted false claims to the FEHBP, Medicaid and Medicare programs, U.S. Department of Labor's (DOL) Office of Workers' Compensation Programs and private insurance companies.

The doctor and his staff submitted several claims for transforaminal epidural injections (TEI). TEIs are complex injections made around the spinal area for pain relief, and require specialized equipment, including fluoroscopic image guidance and the use of 3.5 inch long needles. The doctor admitted that he did not render TEI procedures for the claims that he submitted. The physician, an anesthesiologist, stated that he had received $1.75 million as a result of his illegal actions at his pain management clinics located throughout Maryland.

As part of the plea, the doctor agreed to pay $5 million in restitution and forfeitures, which included a Porsche Cayenne vehicle, stocks, bonds, and bank holdings. The sentencing has been scheduled for July 2008.

This was a joint investigation conducted by the FBI, HHS/OIG, DOL/OIG and our investigators.

Disabled Retiree Convicted of Drug Trafficking

As a result of a joint investigation with the FBI, HHS/OIG, District of Columbia Metropolitan Police Department and our investigators, a disabled civil service retiree pled guilty to the distribution of OxyContin within 1,000 feet of a school. This individual was a patient of the anesthesiologist highlighted in the prior case.

In June 2006, the retiree made four sales to a government informant. In one sale, the retiree directed the informant to follow his car as he drove to the front of an elementary school located in Washington, D.C. The retiree then sold the informant a factory-sealed bottle of 100 OxyContin 40 milligrams (mg)pills and 120 Percocet pills. As a result of the four sales and the execution of a search warrant at the man's residence, the government recovered 660 OxyContin or oxycodone 40 mg pills, 30 OxyContin 80 mg pills, 360 Percocet pills, and 1,135 methadone pills, which were obtained through his FEHBP prescription benefits.

In February 2008, he was sentenced to 57 months incarceration and 72 months supervised release.

RETIREMENT FRAUD

Under the law, entitlement to annuity payments ceases upon the death of an annuitant or survivor annuitant (spouse). Retirement fraud involves intentional receipt and use of CSRS or FERS benefit payments by an unentitled recipient.

Our Office of Investigations uses a variety of approaches to identify potential cases for investigation. One of our proactive initiatives is to review data to identify annuitant records with specific characteristics and anomalies that have shown, in the past, to be good indicators of retirement fraud. We also use automated data systems available to law enforcement agencies to obtain information on annuitants that may alert us of instances where payments should no longer be made.

We confirm the accuracy of the information through follow-up inquiries. Routinely, OPM's Center for Retirement and Insurance Services refers to our office potential fraud cases identified through computer death matches with the Social Security Administration. Other referrals come from federal, state, and local agencies, as well as private citizens.

Son Forges Mother's Signature for 40 Years

As part of our proactive initiative, our office verifies if annuitants who are 100 years or older are still living. In one particular case, we attempted to locate a survivor annuitant who was born in 1898. Our special agents visited her last known address in Boston, Massachusetts and spoke with her son and daughter, who both indicated that their mother was at a local hospital. After our agents suggested that they would check the hospital, the daughter stated that the survivor annuitant was actually staying with the annuitant's son; however, she would not provide the son's name. She later called the agents indicating that she spoke with her mother, the survivor annuitant, who told her that she did not want to receive any further OPM annuity payments.

The agents searched the death records at the Massachusetts Department of Vital Records and found that the mother died on June 10, 1965. OPM continued to issue survivor annuity payments, resulting in an overpayment of $127,946. Our agents returned to the residence and interviewed the son who admitted that he forged his mother's name on U.S. Treasury checks for over forty years. The son also acknowledged forging an OPM address verification form to make it appear that his mother was still alive. Additionally, he stated that he contacted OPM to change his deceased mother's address so he could continue receiving payments.

Further investigation revealed that the son also forged her signature on Department of Veterans Affairs benefit checks during the same time period. This resulted in additional illegal payments of approximately $27,000.

In November 2007, the son pled guilty to two counts of larceny in local court. He was sentenced to three years of probation and required to make restitution to OPM and the VA.

Civil Settlement Results in $126,000 Repayment to Retirement Fund

In another proactive investigation, we determined that an OPM annuitant died in May 1978; however, OPM was not notified of the annuitant's death, which resulted in an overpayment of $125,858. We were unable to locate a death certificate for the deceased annuitant. However, through further investigation, our agents were able to establish the date of death by contacting the cemetery and subsequently the funeral home. Once we verified the date of death, we subpoenaed the financial records for the account to which the annuity was deposited. These records allowed us to determine that her daughter was a joint account holder.

In an interview with the annuitant's daughter, she stated that she thought that she was entitled to the money because she believed it was part of the trust fund established by her mother. The daughter admitted that she spent the money on child support and living expenses.

Although the local U.S. Attorney's office declined criminal prosecution, the DOJ Civil Division accepted the case. As a result of their involvement, the daughter agreed to a civil settlement to repay OPM $125,858.

Daughter Fraudulently Receives Two Retirement Benefits

In February 2008, the daughter of two deceased former federal retirees was indicted for theft of government property, wire fraud, mail fraud, and false bankruptcy declaration. Our investigation revealed that the father, a federal retiree, died in May 1982 leaving his spouse, also a retired federal employee, a survivor benefit.

In February 1995, the mother died; however, the daughter failed to notify OPM of the death. As a result, the daughter continued to receive her mother's retirement annuity, as well as her father's survivor benefit. As a result, the daughter fraudulently received $292,891.

In addition to not notifying OPM of her mother's death, the daughter, on several occasions, falsely reported that her mother was still alive. In December 2004, the daughter filed for bankruptcy, but did not report the retirement benefits she was receiving. Additionally, from 2004 through 2007, she filed federal tax returns for her mother seeking refunds and stating that her mother was "retired", not deceased. In March 2008, the daughter failed to show for her initial court appearance and was later arrested and taken into custody.

Judicial action continues in this case. This is a joint investigation with the U.S. Postal Inspection Service and our office.

Deceased Annuitant's Daughter Pleads Guilty to Aggravated Identity Theft

As a result of a computer match, OPM determined that a federal annuitant died in Hawaii in December 1995. While investigating the case jointly with the FBI, we were able to determine that the deceased annuitant's daughter had access to the decedent's bank accounts after his death. When confronted, the daughter confessed that she intentionally failed to notify OPM of her father's death to continue to receive his annuity payments. She also admitted forging his signature on various OPM address verification forms. The overpayment totaled $208,493.

In December 2007, the daughter was indicted on charges of theft of government property and aggravated identity theft. In March 2008, she pled guilty to the charges and agreed to pay restitution of $208,493 to OPM.

Judicial action continues in this case.

Daughter Gambles Away Mother's Retirement Benefits

As the result of a computer match, our office, with the U. S. Secret Service, determined that a deceased Nevada annuitant's daughter fraudulently received retirement benefits totaling $339,059 after the annuitant's death in May 1995.

The daughter forged address verification letters which were signed and returned to OPM after the annuitant's death. Investigators found that after the annuitant's death, OPM staff spoke with the daughter on two separate occasions. On both occasions, she stated that her mother was alive and that she was handling her affairs. Our investigation also revealed that the daughter lived across the street from a casino where she gambled away most of the annuity payments.

In December 2007, the daughter pled guilty to the theft of government property. She was sentenced to six months incarceration; two years supervised probation, and ordered to pay $277,669 in restitution. We were also able to reclaim $63,690 from a check cashing company where the daughter forged and cashed many of the U.S. Treasury checks.

Son-in-Law Indicted for Embezzling Retirement Funds

OPM's retirement program office referred a case to us involving a retired annuitant who passed away in June 2000, but retirement benefits continued to be paid. In a joint investigation with the U.S. Secret Service, our agents determined that there were four individuals who had access to the account, however, only one, the deceased annuitant's son-in-law, was alive at the time of her death. The son-in-law allegedly received $115,777 in retirement benefits. The retirement records contain address verification correspondence with the annuitant's forged signature, dated six years after the annuitant's death.

In January 2008, the son-in-law was indicted on one count of theft, embezzlement, and converting the retirement benefits for his own personal use.

Judicial action continues in this case.

Nephews Steal Deceased Aunt's Annuity Checks

Through our proactive retirement fraud initiative, our investigators determined that a Food and Drug Administration retiree, who passed away in June 1995, continued to receive annuity checks. We determined that her two nephews stole and cashed her annuity checks. They illegally received $163,008 for their personal use.

In December 2007, one nephew was sentenced to six months incarceration; two years supervised release; and over 4,000 hours of community service. The other nephew was sentenced to three years supervised release; six months home confinement; and over 4,000 hours of community service. They were ordered to jointly pay restitution of $144,052.

SPECIAL INVESTIGATIONS

Former OPM Employee Indicted for Fabricating Background Investigations

In December 2007, a former OPM Federal Investigative Services Division (FISD) background investigator was indicted in Greenbelt, Maryland on two counts of making false statements. The former background investigator is charged with fabricating at least four background investigation interview reports provided to FISD from 2005 through mid 2006. FISD referred this case to the OPM/OIG after reviewing the former background investigator's past and current case files. FISD's follow-up contact with potential employees' references revealed that the former background investigator had never interviewed approximately 74 individuals that were listed on various background investigations.

Subsequently, FISD personnel contacted and re-interviewed the 74 individuals to ensure the integrity of the background investigations.

The purpose of background investigations is to provide the information used in determining federal employees, applicants and contractors' suitability to work in positions of public trust. The information is used to determine eligibility for positions impacting national security, and individuals' suitability for a security clearance or access to classified information. Falsified or inaccurate information provided by a background investigator may result in breaches in national security, or employment of unsuitable individuals.

On April 25, 2008, the former background investigator pled guilty to making false statements in an employment background investigation he was assigned to conduct.

Judicial action continues in this case.

Drug Addicted Son Illegally Obtains Father's Life Insurance Benefit

In January 2008, a former federal employee's son pled guilty to making a false statement and submitting fraudulent documents to obtain his elderly father's life insurance benefits from the Federal Employees Group Life Insurance (FEGLI) program.

As part of the FEGLI program, federal employees and retirees can elect to take a living benefit based on a life threatening illness to help off-set the costs of medical treatments. Eligible individuals who apply and qualify for the FEGLI living benefit may receive a reduced amount of their life insurance funds.

Our investigation found the son, a registered nurse who had a drug addiction, submitted fraudulent documentation which allowed the living benefit to be paid for his father, a retired federal employee. We further determined that the father did not have a life threatening illness. The son misled his father to believe that he could borrow against his federal life insurance

to purchase a car. In the documentation supplied to receive the benefit, the son created a fictitious physician to certify the diagnosis of terminal colon cancer. He also forged his father's signature to negotiate the insurance check. The son used the $22,824 insurance benefit to support his drug habit.

This case was referred to our office by the Metropolitan Life Insurance Company, the FEGLI contractor, after they received a complaint from other family members. Following our investigation, it was determined that the elderly father's life insurance would be reinstated.

Sentencing is scheduled for May 2008.

OIG HOTLINES AND COMPLAINT ACTIVITY

The OIG's health care fraud hotline, retirement and special investigations hotline, and mailed-in complaints also contribute to identifying fraud and abuse. We received 595 formal complaints and calls on these hotlines during the reporting period. The table on page 28 reports the activities of each hotline.

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

In addition to hotline callers, we receive information from individuals who report through the mail or have direct contact with our investigators. Those who report information can do so openly, anonymously and confidentially without fear of reprisal.

Retirement Fraud and Special Investigations Hotline

The Retirement Fraud and Special Investigations hotline provides a channel for reporting waste, fraud and abuse within the agency and its programs. During this reporting period, this hotline received a total of 217 contacts, including telephone calls, letters, and referrals from other agencies.

Health Care Fraud Hotline

The Health Care Fraud Hotline receives complaints from subscribers in the FEHBP. The hotline number is listed in the brochures for all the FEHBP health insurance plans, as well as on our OIG Web site at *www.opm.gov/oig*.

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

The Health Care Fraud hotline received 378 complaints during this reporting period, including both telephone calls and letters.

OIG-Initiated Complaints

We initiate our own inquiries by looking at OPM's automated systems for possible cases involving fraud, abuse, integrity issues and, occasionally malfeasance. Our office will open an investigation, if complaints and inquiries can justify further action.

An example of a complaint that our office will initiate involves retirement fraud. When information generated by OPM's automated annuity roll systems reflects irregularities such as questionable payments to annuitants, we determine whether there are sufficient grounds to justify an investigation. At that point, we may initiate personal contact with the annuitant to determine if further investigative activity is warranted.

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

Administrative Sanctions of Health Care Providers

Under the FEHBP administrative sanctions statute, we issue debarments and suspensions of health care providers whose actions demonstrate that they are not responsible to participate in the program. At the end of the reporting period, there were 30,295 active suspensions and debarments from the FEHBP.

During the reporting period, our office issued 492 administrative sanctions—including both suspensions and debarments—of health care providers who have committed violations that impact the FEHBP and its enrollees. In addition, we responded to 3,008 sanctions-related inquiries.

We develop our sanctions caseload from a variety of sources, including:

- Administrative actions issued against health care providers by other federal agencies;
- Cases referred by the OIG's Office of Investigations;
- Cases identified by our office through systematic research and analysis of electronically-available information about health care providers, referred to as e-debarment; and,
- Referrals from other sources, including health insurance carriers and state government regulatory and law enforcement agencies.

Sanctions serve a protective function for the FEHBP and the federal employees who obtain, through it, their health insurance coverage. The following articles, highlighting a few of the administrative sanctions handled by our office during the reporting period, illustrate their value against health care providers who have placed the safety of enrollees at risk, or have obtained fraudulent payment of FEHBP funds.

Debarment *disqualifies a health care provider from receiving payment of FEHBP funds for a stated period of time. The FEHBP administrative sanctions program establishes 18 bases for debarment. The ones we cite most frequently are for criminal convictions or professional licensure restrictions or revocations. Before debarring a provider, our office gives prior notice and the opportunity to contest the sanction in an administrative proceeding.*

Suspension *has the same effect as a debarment, but becomes effective upon issuance, without prior notice or process. FEHBP sanctions law authorizes suspension only in cases where adequate evidence indicates that a provider represents an immediate risk to the health and safety of FEHBP enrollees.*

West Virginia Physician's Medical Practice Debarred

In February 2008, we debarred a medical practice owned by a physician previously debarred by our office. The physician's debarment was based on his exclusion by another federal agency for fraud, kickbacks and other prohibited activity.

Under the FEHBP sanctions statute, the debarring official has authority to debar an entity which is owned or controlled by a debarred individual. Our Office of Investigations referred this case to Administrative Sanctions because of alleged false billing by the debarred physician.

Among other things, the investigation revealed that the other physicians employed by the debarred physician were filing claims against the FEHBP under the name of the medical practice. This method of filing claims could be perceived as an attempt by the debarred physician to circumvent his debarment and continue to receive FEHBP payments to which he is not entitled. The medical practice's debarment is for an indefinite period pending reinstatement of the debarred physician.

Virginia Physician Debarred after Guilty Plea to Illegal Distribution of Controlled Substances

In November 2007, we debarred a physician, after discovering through our proactive e-debarment research that in April 2007 he was sentenced for illegal distribution of controlled substances. At the time of his conviction, the physician was a participant in several FEHBP plans.

According to the charges which led to his guilty plea, the physician illegally distributed controlled substances (OxyContin, oxycodone, Codeine and hydrocodone) without a legitimate medical purpose on 23 occasions, and wrote a prescription to a police informant for 60 OxyContin pills in exchange for what the physician believed to be crack cocaine.

The physician's plea to illegally distributing controlled substances constitutes a mandatory basis for his debarment. We debarred him from participating in the FEHBP for three years.

Gastroenterologist Debarred

In January 2008, our office debarred a Texas physician based on a referral from our Office of Investigations. We reported the physician's conviction and subsequent sentencing in our last semiannual report.

The physician specialized in Gastroenterology. A large part of his medical practice was devoted to treatment of patients who suffered from Hepatitis C, a liver disease. This physician routinely billed for services not rendered, office visits at rates higher than the services provided, and unbundled laboratory tests. For example, he was paid over $10 million for administering injections of Interferon, Epogen and Neupogen, and other medications involved in the treatment of Hepatitis C. Even though he billed the FEHBP for the cost of administering the medication in his office, he actually provided the medications to his patients to self-administer.

The physician was convicted on 46 counts of mail and health care fraud, and was subsequently sentenced to 135 months imprisonment; three years supervised release; $4,400 assessment, and ordered to make restitution of $11,590,785. Of the restitution, the FEHBP will receive $649,309.

Additionally, the physician had a history of other criminal and administrative adjudications involving similar offenses or improper actions to include:

- November 2007 – an indictment for use of interstate commerce facilities in commission of a murder-for-hire, and influencing, impeding, or retaliating against a federal officer;
- March 2006 – an arrest and charge of arson for allegedly setting fire to a $3.2 million mansion he had purchased for his 6th wife;
- December 2005 – an agreed order he entered into with the Texas State Medical Board to voluntarily surrender his medical license permanently because of a violation of, or failure to comply with a licensing board order;

- March 2005 – a voluntary surrender of his New York medical licensure based upon the action by the Texas State Medical Board; and,

- October 2004 – an agreed order he entered into with the Texas State Medical Board for improper or abusive billing practices. He was assessed a $25,000 administrative penalty and a 5-year license restriction.

The physician's conviction constitutes a mandatory debarment under OPM's statutory authority. After considering the aggravating and mitigating factors in this case, particularly the very large monetary amounts that the physician defrauded from federal programs, and the series of state medical board disciplinary actions against him, we debarred him from the FEHBP for 10 years.

Texas Physician is Debarred

Through our proactive e-debarment research, we identified and debarred a Texas physician with a history of drug and alcohol abuse. The physician was arrested for misdemeanor theft in 2002 and felony cocaine possession in 2006. In February 2005, OPM suspended the physician based upon the Texas medical board's temporary suspension of his medical license. At that time, he was a preferred provider for at least one major FEHBP fee-for-service health insurance carrier.

Following the board's June 2007 decision to place the physician's license on probation for 15 years, we debarred the physician and his practice for an indefinite period pending resolution of his medical license. We also suspended and subsequently debarred his practice based on his ownership and controlling interest.

Chiropractor and Osteopath Convicted of Health Care and Bank Fraud

In March 2006, a chiropractor and an osteopath were convicted of health care and bank fraud in North Carolina. In addition, the chiropractor was convicted of money laundering and sentenced to 24 months imprisonment followed by a three-year period of supervised release, and assessed monetary penalties totaling more than $1.7 million. The osteopath was not incarcerated but was required to pay over $1.5 million in restitution.

In October 2007, we debarred the chiropractor from FEHBP participation for eight years and the osteopath for five years. Because we had suspended the osteopath in October 2005, subsequent to his April 2005 indictment, his debarment included the period during which the suspension was in effect. This case was referred by the OIG's Office of Investigations.

Beginning in 2000, the two individuals entered into a scheme to defraud private and federal health care benefit programs. Their partnership began at some point in 1998 and, shortly thereafter, they opened a clinic which they advertised as an "integrated medical practice" offering a full range of services. The nature of the services offered included medical, chiropractic, and physical therapy services.

However, under a North Carolina statute, a medical practice must be owned by a medical doctor. Since neither individual was a medical doctor, they hired one on a part-time basis whose role was, essentially, that of a "straw man." As for the clinic, it was merely a façade which enabled the individuals to circumvent reimbursement caps placed on chiropractic services by carriers, and submit claims which normally would not be covered by medical insurance. None of the services were rendered by a medical doctor or a physical therapist. All physical therapy treatments were performed by chiropractors, athletic trainers, and massage therapists and then billed as physical therapy sessions.

Further, in some cases, patients never received any treatments; yet, the two individuals submitted claims containing false statements that the services had been rendered by qualified professionals. Similarly, for the chiropractic services, they submitted fraudulent claims under the provider number of the part-time medical doctor to increase the level of reimbursement. Between March and October 2000, these individuals submitted more than $368,000 in false and fraudulent claims. The FEHBP portion was $32,746.

Washington Osteopath & Physician Assistant Suspended after Fraud Indictment

In December 2007, we suspended an osteopath and a physician assistant based upon their June 2007 indictment in Washington state for controlled substances violations and health care fraud. The case was a joint referral by our Office of Investigations and an FEHBP carrier.

From June 2001 through September 2005, the two individuals defrauded public and private health care insurers by submitting materially false statements relative to their prescribing highly addictive controlled substances, e.g., OxyContin and oxycodone. The osteopath had submitted claims to FEHBP carriers during the period in question.

Their prescribing practices resulted in at least one patient's death. The offenses led to more than $2.5 million paid to pharmacies. They dispensed prescriptions of Schedule II controlled substances that were not medically necessary or within the scope of standard medical practice. Although the osteopath knew that several of his patients were either abusing or diverting the prescribed drugs, he continued to provide them the prescriptions.

For those patients abusing their prescribed medication or using other illegal substances, the two conducted a counseling program, called "Celebrate Recovery," at a local church. Patients were required to attend weekly meetings to help them with their substance abuse problems. At the conclusion of the meetings, the osteopath and physician assistant would write prescriptions for controlled substances for those in attendance without providing an office exam or medical diagnosis.

STATISTICAL SUMMARY OF ENFORCEMENT ACTIVITIES

Judicial Actions:

Arrests	20
Indictments and Informations	21
Convictions	23

Judicial Recoveries:

Fines, Penalties, Restitutions and Settlements	$7,107,270

Retirement and Special Investigations Hotline and Complaint Activity:

Retained for Further Inquiry	25
Referred to:	
OPM Program Offices	101
Other Federal Agencies	91
Total	217

Health Care Fraud Hotline and Complaint Activity:

Retained for Further Inquiry	104
Referred to:	
OPM Program Offices	82
Other Federal/State Agencies	56
FEHBP Insurance Carriers or Providers	136
Total	378
Total Hotline Contacts and Complaint Activity	595

Administrative Sanctions Activity:

Debarments and Suspensions Issued	492
Health Care Provider Debarment and Suspension Inquiries	3,008
Debarments and Suspensions in Effect at End of Reporting Period	30,295

APPENDICES

APPENDIX I

Final Reports Issued With Questioned Costs

October 1, 2007 to March 31, 2008

	Subject	Number of Reports	Questioned Costs
A.	Reports for which no management decision had been made by the beginning of the reporting period	16	$23,982,441
B.	Reports issued during the reporting period with findings	23	45,064,992
	Subtotals (A+B)	39	69,047,433
C.	Reports for which a management decision was made during the reporting period:	20	36,031,056
	1. Disallowed costs	0	36,894,589[1]
	2. Costs not disallowed	0	(863,533)[2]
D.	Reports for which no management decision has been made by the end of the reporting period	19	33,016,377
E.	Reports for which no management decision has been made within 6 months of issuance	0	0

[1]Does not include $145,070 in investment income assessed by the program office in excess of questioned costs.

[2]Represents the net of allowed cost, which includes overpayments and underpayments to insurance carriers.

APPENDIX II

Final Reports Issued With Recommendations for Better Use of Funds

October 1, 2007 to March 31, 2008

	Subject	Number of Reports	Dollar Value
A.	Reports for which no management decision had been made by the beginning of the reporting period	6	$429,911
B.	Reports issued during the reporting period with findings	5	315,187
	Subtotals (A+B)	11	745,098
C.	Reports for which a management decision was made during the reporting period:	0	0
	1. Disallowed costs	0	0
	2. Costs not disallowed	0	0
D.	Reports for which no management decision has been made by the end of the reporting period	11	745,098
E.	Reports for which no management decision has been made within 6 months of issuance	0	0

APPENDIX III

Insurance Audit Reports Issued

October 1, 2007 to March 31, 2008

Report Number	Audits	Issue Date	Questioned Costs
1C-2U-00-06-035	Aetna Health Inc. – Athens and Atlanta, Georgia in Blue Bell, Pennsylvania	October 2, 2007	$ 0
1A-10-41-06-054	BlueCross BlueShield of Florida in Jacksonville, Florida	October 12, 2007	3,093,287
1C-51-00-07-052	Health Insurance Plan of Greater New York in New York, New York	October 19, 2007	0
1C-RL-00-06-026	Grand Valley Health Plan in Grand Rapids, Michigan	October 19, 2007	1,578,816
1C-DQ-00-05-088	Physicians Health Plan of Northern Indiana in Fort Wayne, Indiana	October 19, 2007	149,101
1C-X5-00-06-013	HealthPlus of Michigan, Inc. in Flint, Michigan	November 14, 2007	6,157,578
1A-10-05-06-008	WellPoint BlueCross BlueShield of Georgia in Atlanta, Georgia	November 16, 2007	822,339
1C-SW-00-05-015	Health America Pennsylvania, Inc. – Central Area in Harrisburg, Pennsylvania	November 20, 2007	7,483,890
1A-10-05-07-045	WellPoint BlueCross BlueShield of Georgia in Mason, Ohio	November 20, 2007	85,247
1D-9G-00-06-088	BlueChoice HMO Missouri in St. Louis, Missouri	November 20, 2007	299,412
1C-JV-00-06-086	Fallon Community Health Plan in Worcester, Massachusetts	December 12, 2007	1,165,560
1C-MM-00-07-003	Group Health Plan, Inc. in St. Louis, Missouri	December 12, 2007	481,738
1C-26-00-05-084	Health America Pennsylvania, Inc. – Greater Pittsburgh Area in Harrisburg, Pennsylvania	December 12, 2007	2,460,976
1C-7W-00-06-014	Coventry Health Care of Kansas, Inc. in Wichita, Kansas	December 12, 2007	267,254
1C-F8-00-07-020	Kaiser Foundation Health Plan of Georgia in Atlanta, Georgia	December 12, 2007	0
1A-10-42-07-004	BlueCross BlueShield of Kansas City in Kansas City, Missouri	December 14, 2007	197,702

APPENDIX III

Insurance Audit Reports Issued

October 1, 2007 to March 31, 2008

(Continued)

Report Number	Audits	Issue Date	Questioned Costs
1A-10-40-07-022	BlueCross BlueShield of Mississippi in Jackson, Mississippi	December 14, 2007	$ 735,843
1A-10-84-07-023	Excellus BlueCross BlueShield in Utica, New York	January 16, 2008	67,650
1C-3N-00-06-011	Vista Health Plan in Hollywood, Florida	January 18, 2008	1,865,560
1C-3U-00-05-085	United Healthcare of Ohio, Inc. in West Chester, Ohio	January 18, 2008	2,849,166
1C-76-00-06-073	Union Health Service in Chicago, Illinois	January 18, 2008	300,870
1A-10-07-07-016	BlueCross BlueShield of Louisiana in Baton Rouge, Louisiana	January 18, 2008	628,758
1C-P2-00-07-032	Presbyterian Health Plan, Inc. in Albuquerque, New Mexico	January 25, 2008	0
1A-10-18-06-052	Anthem Midwest in Mason, Ohio	February 20, 2008	5,258,164
1C-ED-00-07-053	Keystone Health Plan East, Inc. in Philadelphia, Pennsylvania	February 27, 2008	0
1C-Q1-00-06-083	Lovelace Health Plan in Albuquerque, New Mexico	February 27, 2008	0
1C-GF-00-06-002	PacifiCare Southwest Region – Texas in Cypress, California	February 27, 2008	0
1C-5W-00-06-047	SummaCare Health Plan in Akron, Ohio	February 29, 2008	1,728,573
1C-PU-00-07-021	Aetna Open Access of the Dallas/Ft. Worth Area in Blue Bell, Pennsylvania	February 29, 2008	0
1A-10-99-06-001	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.	March 20, 2008	6,150,380
1C-VR-00-08-010	Group Health Cooperative in Seattle, Washington	March 26, 2008	0
1D-89-00-06-043	Triple-S, Inc. in San Juan, Puerto Rico	March 26, 2008	1,237,128
1C-6V-00-07-031	GHI HMO Select, Inc. – New York City Area in New York, New York	March 31, 2008	0
1C-X4-00-07-030	GHI HMO Select, Inc. – Albany Capital District, Hudson Valley Area in New York, New York	March 31, 2008	0
TOTALS			$45,064,992

APPENDIX IV

Internal Audit Reports Issued

October 1, 2007 to March 31, 2008

Report Number	Subject	Issue Date
4A-CF-00-07-034	OPM's Fiscal Year 2007 Consolidated Financial Statements	November 14, 2007
4A-CF-00-07-061	OPM's Fiscal Year 2007 Special-Purpose Financial Statements	November 16, 2007
4A-WC-00-06-042	OPM's Post-Most Efficient Organization Review of the Employee Benefits Specialist Activity Competition	January 16, 2008
4A-CI-00-06-041	OPM's Post-Most Efficient Organization Review of the Network Management Group Competition	February 20, 2008
4A-CF-00-06-031	OPM's Compliance with Federal Tax Laws	February 27, 2008
4A-RI-00-05-037	OPM's Reclamation Process	March 18, 2008

APPENDIX V

Combined Federal Campaign Audit Reports Issued

October 1, 2007 to March 31, 2008

Report Number	Subject	Issue Date
3A-CF-00-07-040	The 2005 Combined Federal Campaign Activities for the Arts Federation in Salem, Massachusetts	October 19, 2007
3A-CF-00-06-059	The 2003 and 2004 Combined Federal Campaigns of Cocoa-Brevard County in Cocoa, Florida	November 13, 2007
3A-CF-00-06-050	The 2003 and 2004 Combined Federal Campaigns of San Diego in San Diego, California	November 13, 2007
3A-CF-00-06-067	The 2003 and 2004 Combined Federal Campaigns for the Coastal Georgia Area in Savannah, Georgia	January 4, 2008
3A-CF-00-06-057	The 2003 and 2004 Combined Federal Campaigns for Northern New Jersey in Newark, New Jersey	January 10, 2008
3A-CF-00-07-035	The 2004 and 2005 Combined Federal Campaigns for the Pikes Peak Region in Colorado Springs, Colorado	January 10, 2008
3A-CF-00-07-036	The 2004 and 2005 Combined Federal Campaigns of the Greater Pensacola Area in Pensacola, Florida	February 20, 2008

APPENDIX VI

Summary of Audit Reports More Than Six Months Old Pending Corrective Action

As of March 31, 2008

Report Number	Subject	Issue Date
1A-10-95-00-033	Trigon BlueCross BlueShield in Richmond, Virginia; 3 open recommendations	January 17, 2001
1A-10-59-01-022	Anthem BlueCross BlueShield of Maine in South Portland, Maine; 2 open recommendations	May 14, 2001
1A-10-56-01-049	BlueCross BlueShield of Arizona in Phoenix, Arizona; 2 open recommendations	October 22, 2001
1B-45-00-01-096	Claims Administration Corporation as Administrator for the Mail Handlers Benefit Plan in Rockville, Maryland; 1 open recommendation	January 24, 2002
1A-10-10-01-098	BlueCross of Idaho in Boise, Idaho; 1 open recommendation	January 28, 2002
1A-10-05-01-050	BlueCross BlueShield of Georgia in Atlanta, Georgia; 1 open recommendation	April 2, 2002
1A-10-40-02-006	BlueCross BlueShield of Mississippi in Jackson, Mississippi; 1 open recommendation	July 24, 2002
1B-47-00-01-080	American Postal Workers Union Health Plan in Silver Spring, Maryland; 3 open recommendations	August 20, 2002
1A-10-15-02-007	BlueCross BlueShield of Tennessee in Chattanooga, Tennessee; 2 open recommendations	October 1, 2002
1D-VT-00-02-004	KPS Health Plans in Bremerton, Washington; 2 open recommendations	November 25, 2002
1A-10-36-02-031	Capital BlueCross in Harrisburg, Pennsylvania; 2 open recommendations	November 25, 2002
1A-10-27-02-022	Anthem BlueCross BlueShield in Manchester, New Hampshire; 2 open recommendations	February 14, 2003
4A-CA-00-03-034	OPM's Security Guard Contract; 5 open recommendations	July 23, 2003
1A-10-60-03-020	BlueCross BlueShield of Rhode Island in Providence, Rhode Island; 1 open recommendation	November 3, 2003
1A-10-42-02-070	BlueCross BlueShield of Kansas City in Kansas City, Missouri; 1 open recommendation	December 10, 2003
1A-10-01-03-014	Empire BlueCross BlueShield in Albany, New York; 1 open recommendation	January 6, 2004
1A-10-13-03-025	Highmark in Camp Hill, Pennsylvania; 2 open recommendations	February 9, 2004
1A-10-00-03-013	Global Coordination of Benefits (Tier 1) for BlueCross and BlueShield Plans in Washington, D.C.; 2 open recommendations	March 31, 2004

APPENDIX VI

Summary of Audit Reports More Than Six Months Old Pending Corrective Action

As of March 31, 2008

(Continued)

Report Number	Subject	Issue Date
1A-10-41-03-031	BlueCross BlueShield of Florida in Jacksonville, Florida; 7 open recommendations	May 3, 2004
1A-10-18-03-003	Anthem BlueCross BlueShield of Ohio in Mason, Ohio; 1 open recommendation	May 4, 2004
1A-10-66-04-022	Regence BlueCross BlueShield of Utah in Salt Lake City, Utah; 2 open recommendations	June 7, 2004
1A-10-29-02-047	BlueCross BlueShield of Texas in Dallas, Texas; 3 open recommendations	July 28, 2004
1A-10-61-04-009	Anthem BlueCross BlueShield of Nevada in Reno, Nevada; 3 open recommendations	August 2, 2004
1A-10-17-02-048	BlueCross BlueShield of Illinois in Chicago, Illinois; 2 open recommendations	August 23, 2004
4A-RI-00-02-071	Internal Controls over Non-Recurring Payment Actions in the Retirement Services Program; 1 open recommendation	November 2, 2004
1A-10-00-03-102	Global Coordination of Benefits (Tier 2) for BlueCross and BlueShield Plans in Washington, D.C.; 2 open recommendations	November 9, 2004
1A-10-45-03-012	Anthem BlueCross BlueShield of Kentucky in Mason, Ohio and Indianapolis, Indiana; 2 open recommendations	November 17, 2004
1A-10-06-03-033	CareFirst BlueCross BlueShield of Maryland in Owings Mills, Maryland; 1 open recommendation	December 1, 2004
1A-10-55-04-010	Independence BlueCross in Philadelphia, Pennsylvania; 2 open recommendations	December 15, 2004
1A-10-62-04-003	Anthem BlueCross BlueShield of Virginia in Richmond, Virginia; 1 open recommendation	January 4, 2005
1A-10-82-04-028	BlueCross BlueShield of Kansas in Topeka, Kansas; 1 open recommendation	March 1, 2005
4A-OD-00-05-013	Information Technology Security Controls of the Enterprise Human Resource Integration, Washington, D.C.; 1 open recommendation	May 9, 2005
4A-IS-00-05-026	Information Technology Security Controls of the Electronic Questionnaire for Investigative Processing, Washington, D.C.; 4 open recommendations	June 16, 2005
1D-80-00-04-058	Group Health Incorporated in New York, New York; 7 open recommendations	June 20, 2005

APPENDIX VI

Summary of Audit Reports More Than Six Months Old Pending Corrective Action

As of March 31, 2008

(Continued)

Report Number	Subject	Issue Date
4A-CF-00-05-025	Information Technology Security Controls of the Personnel Investigation Processing System Financial Interface System, Washington, D.C.; 1 open recommendation	June 22, 2005
1A-10-85-04-007	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 2 open recommendations	July 27, 2005
1A-10-85-03-103	CareFirst BlueCross BlueShield (DC Service Area and Overseas Claims) in Owings Mills, Maryland; 3 open recommendations	August 19, 2005
1A-10-83-05-002	BlueCross BlueShield of Oklahoma in Tulsa, Oklahoma; 2 open recommendations	October 17, 2005
1A-10-24-05-004	BlueCross BlueShield of South Carolina in Columbia, South Carolina; 2 open recommendations	November 22, 2005
1A-99-00-04-027	Global Duplicate Claim Payment for BlueCross and BlueShield Plans in Washington, D.C.; 1 open recommendation	February 7, 2006
1C-JK-00-04-031	PacifiCare Asia Pacific in Tamuning, Guam; 1 open recommendation	February 22, 2006
1A-10-52-05-021	BlueCross of California in Woodland Hills, California; 3 open recommendations	February 22, 2006
1A-10-32-05-034	BlueCross BlueShield of Michigan in Detroit, Michigan; 3 open recommendations	March 24, 2006
1G-LT-00-05-080	Long Term Care Partners, LLC in Portsmouth, New Hampshire; 6 open recommendations	May 17, 2006
1A-10-31-05-068	Wellness BlueCross BlueShield of Iowa and South Dakota in Des Moines, Iowa; 2 open recommendations	May 22, 2006
1A-10-47-05-009	BlueCross BlueShield of Wisconsin in Milwaukee, Wisconsin; 2 open recommendations	June 5, 2006
3A-CF-00-04-038	The 2001 and 2002 Combined Federal Campaigns for Central Maryland in Baltimore, Maryland; 12 open recommendations	June 6, 2006
3A-CF-00-05-041	The 2002 and 2003 Combined Federal Campaigns for the Central Indiana Area in Indianapolis, Indiana; 1 open recommendation	June 13, 2006
1A-10-11-04-065	BlueCross BlueShield of Massachusetts in Boston, Massachusetts; 3 open recommendations	June 26, 2006
3A-CF-00-05-042	The 2002 and 2003 Combined Federal Campaigns for Northern Nevada in Las Vegas, Nevada; 11 open recommendations	July 3, 2006

APPENDIX VI

Summary of Audit Reports More Than Six Months Old Pending Corrective Action

As of March 31, 2008

(Continued)

Report Number	Subject	Issue Date
3A-CF-00-05-039	The 2002 and 2003 Combined Federal Campaigns for Southern Nevada in Las Vegas, Nevada; 11 open recommendations	July 3, 2006
3A-CF-00-05-079	The 2003 Combined Federal Campaign Activities for the Medical Research Charities Federation in Springfield, Virginia; 2 open recommendations	July 14, 2006
3A-CF-00-05-049	The 2002 and 2003 Combined Federal Campaigns for the Research Triangle Area in Morrisville, North Carolina; 9 open recommendations	August 10, 2006
3A-CF-00-05-076	The 2002 and 2003 Combined Federal Campaigns for Central Texas in Austin, Texas; 5 open recommendations	August 14, 2006
3A-CF-00-05-052	The 2002 and 2003 Combined Federal Campaigns for Fresno-Madera County in Fresno, California; 1 open recommendation	August 22, 2006
1B-43-00-05-081	Health Network America as Administrator for the Panama Canal Area Benefit Plan in Eatontown, New Jersey; 1 open recommendation	August 22, 2006
4A-IS-00-06-021	Information Technology Security Controls of the Office of Personnel Management's Fingerprint Transaction System; 6 open recommendations	August 29, 2006
4A-CA-00-05-086	OPM's Post-Most Efficient Organization Review of the Computer Assistants and Building Management Assistant Competition; 5 open recommendations	September 8, 2006
1A-10-78-05-005	BlueCross BlueShield of Minnesota in Eagan, Minnesota; 1 open recommendation	September 15, 2006
4A-CI-00-06-016	Federal Information Security Management Act for Fiscal Year 2006; 1 open recommendation	September 22, 2006
1A-10-49-04-072	Horizon BlueCross BlueShield of New Jersey in Newark, New Jersey; 5 open recommendations	October 5, 2006
4A-CF-00-06-045	Office of Personnel Management's Fiscal Year 2006 Consolidated Financial Statement; 6 open recommendations	November 13, 2006
3A-CF-00-05-040	The 2002 and 2003 Combined Federal Campaigns for San Bernardino in San Bernardino, California; 19 open recommendations	December 26, 2006
1A-10-69-06-025	Regence BlueShield of Washington in Seattle, Washington; 1 open recommendation	January 3, 2007

APPENDIX VI

Summary of Audit Reports More Than Six Months Old Pending Corrective Action

As of March 31, 2008

(Continued)

Report Number	Subject	Issue Date
3A-CF-00-06-062	The 2003 and 2004 Combined Federal Campaigns for the Piedmont Triad in Greensboro, North Carolina; 2 open recommendations	January 18, 2007
4A-CI-00-07-015	The Privacy Program at the Office of Personnel Management, Washington, D.C.; 6 open recommendations	January 25, 2007
1A-10-58-06-038	Regence BlueCross BlueShield of Oregon in Portland, Oregon; 3 open recommendations	January 31, 2007
1B-31-00-06-044	Government Employees Health Association in Lee's Summit, Missouri; 5 open recommendations	February 6, 2007
3A-CF-00-05-077	The 2002 and 2003 Combined Federal Campaigns for New Hampshire and Southern Maine in Portsmouth, New Hampshire; 2 open recommendations	February 12, 2007
1A-10-09-05-087	BlueCross BlueShield of Alabama in Birmingham, Alabama; 3 open recommendations	February 27, 2007
1A-99-00-05-023	Global Coordination of Benefits for BlueCross and Blue Shield Plans in Washington, D.C.; 2 open recommendations	March 29, 2007
3A-CF-00-05-075	The 2002 and 2003 Combined Federal Campaigns for the Smoky Mountain Region in Knoxville, Tennessee; 21 open recommendations	March 30, 2007
4A-CF-00-05-028	Administration of the Prompt Payment Act at the Office of Personnel Management, Washington, D.C.; 8 open recommendations	April 16, 2007
4A-CF-00-07-010	Information Technology Security Controls of the Government Financial Information System, Washington, D.C.; 8 open recommendations	April 25, 2007
1A-10-30-05-069	WellPoint BlueCross BlueShield of Colorado in Mason, Ohio; 8 open recommendations	April 25, 2007
1B-47-00-06-072	Information Systems General and Application Controls at American Postal Workers Union Health Plan in Glen Burnie, Maryland; 6 open recommendations	May 18, 2007
1A-10-12-06-080	BlueCross BlueShield of Western New York in Buffalo, New York; 3 open recommendations	May 21, 2007
4A-HR-00-07-009	Information Technology Security Controls of the Go Learn Learning Management System, Washington, D.C.; 3 open recommendations	May 31, 2007

APPENDIX VI

Summary of Audit Reports More Than Six Months Old Pending Corrective Action

As of March 31, 2008

(Continued)

Report Number	Subject	Issue Date
1A-10-03-06-079	BlueCross BlueShield of New Mexico in Albuquerque, New Mexico; 3 open recommendations	June 5, 2007
1C-3A-00-06-003	AultCare Health Plan in Canton, Ohio; 2 open recommendations	June 25, 2007
1C-64-00-05-082	Kaiser Foundation Health Plan of Ohio in Cleveland, Ohio; 4 open recommendations	June 29, 2007
3A-CF-00-06-074	The 2004 Combined Federal Campaign Activities for the National Black United Federation of Charities in Newark, New Jersey; 8 open recommendations	July 5, 2007
3A-CF-00-06-060	The 2003 and 2004 Combined Federal Campaigns for Long Island in Deer Park, New York; 8 open recommendations	July 17, 2007
3A-CF-00-06-055	The 2003 and 2004 Combined Federal Campaigns for the Chicago Area in Champaign, Illinois; 4 open recommendations	July 17, 2007
1C-DA-00-06-046	BlueChip Coordinated Health Partners in Providence, Rhode, Island; 1 open recommendation	July 24, 2007
1A-10-15-05-046	BlueCross BlueShield of Tennessee in Chattanooga, Tennessee; 4 open recommendations	July 25, 2007
3A-CF-00-06-061	The 2003 and 2004 Combined Federal Campaigns of the Niagara Frontier Area in Buffalo, New York; 14 open recommendations	July 25, 2007
1D-R5-00-06-069	Federal Blue HMO in Mason, Ohio; 11 open recommendations	July 25, 2007
3A-CF-00-06-051	The 2003 and 2004 Combined Federal Campaigns for the Mid-South in Memphis, Tennessee; 12 open recommendations	July 26, 2007
3A-CF-00-06-056	The 2003 and 2004 Combined Federal Campaigns for Central Iowa in Des Moines, Iowa; 7 open recommendations	August 28, 2007
1A-10-33-06-037	BlueCross BlueShield of North Carolina in Durham, North Carolina; 7 open recommendations	August 28, 2007
4A-CI-00-07-007	Federal Information Security Management Act for Fiscal Year 2007; Washington, D.C.; 8 open recommendations	September 18, 2007
4A-CI-00-07-008	Federal Information Security Management Act Follow-up for Fiscal Year 2007; Washington, D.C.; 13 open recommendations	September 18, 2007
1G-LT-00-07-005	Long Term Care Partners, LLC in Portsmouth, New Hampshire; 3 open recommendations	September 26, 2007

Index of Reporting Requirements

(Inspector General Act of 1978, As Amended)

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For additional information or copies of this publication, please contact:

Office of the Inspector General

U.S. OFFICE OF PERSONNEL MANAGEMENT

Theodore Roosevelt Building

1900 E Street, N.W., Room 6400

Washington, DC 20415-1100

Telephone: (202) 606-1200

Fax: (202) 606-2153

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