

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Office of the Inspector General



**Semiannual Report
to Congress**

OCTOBER 1, 2008 – MARCH 31, 2009

Office of the Inspector General



Productivity Indicators

FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds	\$23,521,142
Management Commitments to Recover Funds	\$38,211,469
Recoveries Through Investigative Actions.	\$5,283,283
Fines, Penalties, and Forfeitures Through Investigations.	\$51,983,388

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.	29
Investigative Cases Closed	55
Indictments and Informations	33
Arrests.	29
Convictions.	37
Hotline Contacts and Complaint Activity	681
Health Care Provider Debarments and Suspensions	368
Health Care Provider Debarment and Suspension Inquiries	785

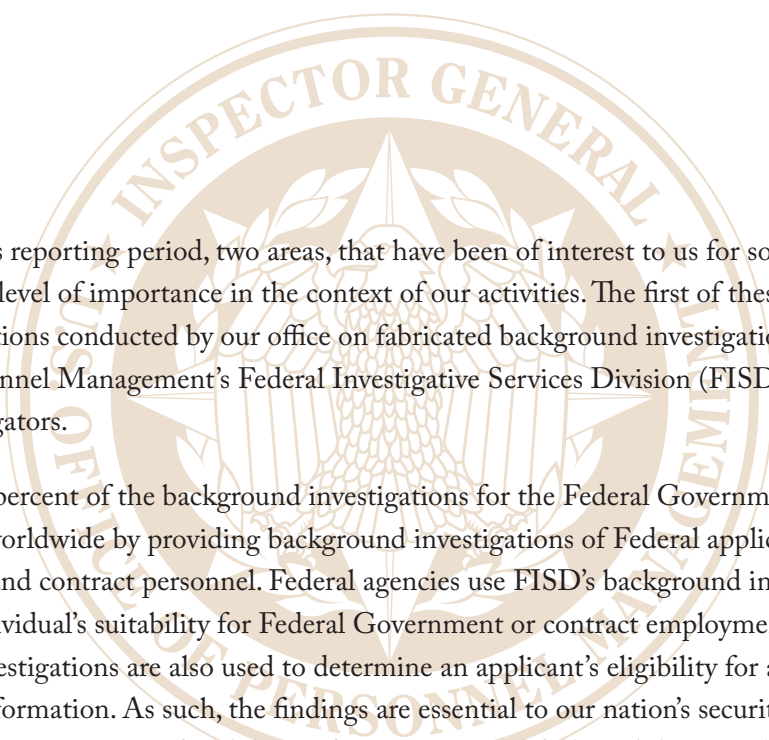
UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Office of the Inspector General



**Semiannual Report
to Congress**

OCTOBER 1, 2008 – MARCH 31, 2009

Inspector General's Message



During this reporting period, two areas, that have been of interest to us for some time, assumed a greater level of importance in the context of our activities. The first of these was the criminal investigations conducted by our office on fabricated background investigations performed by the U.S. Office of Personnel Management's Federal Investigative Services Division (FISD) and its contractor background investigators.

FISD conducts 90 percent of the background investigations for the Federal Government. They serve over 100 agencies worldwide by providing background investigations of Federal applicants, employees, military members, and contract personnel. Federal agencies use FISD's background investigations to determine each individual's suitability for Federal Government or contract employment. The results of the background investigations are also used to determine an applicant's eligibility for access to classified national security information. As such, the findings are essential to our nation's security. If a background investigation contains incorrect or fraudulent information, a qualified candidate may be wrongfully denied employment or an unsuitable person may be cleared and allowed access to Federal facilities or classified information.

FISD expects to conduct over 2.3 million background investigations during the current fiscal year. With approximately 7,500 Federal and contractor background investigators working throughout the United States and in overseas locations, FISD's ability to produce work that complies with its standards of quality and reliability depends primarily on the professionalism of its workforce.

Our office has developed an ongoing and expanding workload of FISD related cases and has obtained convictions and restitution in a number of fabrication cases. We have made these criminal investigations a priority and will continue to aggressively pursue prosecution and conviction of FISD employees engaged in fabricating background investigations. We appreciate the support of OPM Director John Berry and the U.S. Attorneys Office for the District of Columbia in our efforts to address this risk to national security interests.

The other area of recently heightened interest involves the implementation of the provisions of the Inspector General Reform Act of 2008 (Public Law 110-409), which was enacted on October 14, 2008. The Reform Act represents the most significant piece of legislation affecting the Inspector General (IG)



community since 2003, when most IG offices received law enforcement authority under the Homeland Security Act. Among the principal provisions of the Reform Act are the following:

- Establishment of the governmentwide Council of Inspectors General for Integrity and Efficiency (Council) as an independent statutory entity with dedicated staff and funding, and a broader mandate to provide policy leadership for the IG community. In its strengthened role, the Council is serving as a strong advisory voice for both Congress and the President on transparency and accountability of Federal activities. The Reform Act also specifically charges the Council with responsibility for policies that foster effective employee training and professional development for IG personnel. This area has been recognized for many years as one in which a cross-agency approach is essential, and the Council has fostered an active dialogue within the membership regarding various methods and models of sponsoring professional training.
- Establishment of the Council's Integrity Committee (IC) as a statutory entity. The IC previously operated under the authority of an Executive Order. It is charged with receiving and reviewing allegations of wrongdoing against the Inspectors General and certain designated members of their staffs, and arranging independent investigations and reports in cases involving potentially meritorious complaints. The Reform Act also formalized the IC's reporting channels and expanded the range of persons over whom it can exercise jurisdiction. Given the range of investigative and audit responsibilities assigned to IG offices, a strengthened and independent IC is critical to fostering adherence to the highest standards of professional conduct among senior members of the IG community.
- Improved the ability of the IGs to manage their respective workforces. The original Inspector General Act established the principle that IGs should manage the financial and personnel resources of their offices independently of their agencies, and it specifically provided full personnel management authority for positions in the General Schedule. However, it created a gap in the management authorities available to the IGs by leaving the Senior Executive Service (SES) employees subject to evaluation and pay setting by the agencies. The Reform Act addressed this problem by providing the IGs with a level of authority that is fully equivalent to that of an agency head for all personnel management matters affecting their SES workforce.

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 OPM'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 OPM.
- Ensure that OPM is following best business practices by operating in an effective and efficient manner.
- Determine whether OPM 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 OPM programs.
- Identify, through proactive initiatives, areas of concern that could strengthen the operations and programs administered by OPM.

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FIELD OFFICES



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 260 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 21 final reports on organizations participating in the FEHBP and FEGLI, of which 15 contain recommendations for monetary adjustments in the amount of \$23.5 million due the trust funds.



COMMUNITY-RATED PLANS

The community-rated HMO audit universe covers approximately 160 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 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 10 audit reports on community-rated plans. These reports contain recommendations to require the plans to return over \$5.3 million to the FEHBP.

Humana Health Plan, Inc. – Chicago Louisville, Kentucky

Report No. 1C-75-00-08-029

DECEMBER 16, 2008

Humana Health Plan, Inc. – Chicago provides comprehensive medical services to its members throughout the Chicago metropolitan area. This audit of the plan covered contract years 2005 through 2007. During this period, the FEHBP paid the plan approximately \$255 million in premiums.

We identified a total of \$692,044 in inappropriate health benefit charges to the FEHBP, including \$221,168 in 2005 and \$470,876 in 2006. In addition, we determined the FEHBP is due \$96,203 for investment income lost as a result of the overcharges.

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 the plan failed to give the FEHBP an appropriate premium discount based on an SSSG discount in 2005 and failed to apply the correct adjustment factor to the FEHBP rates in 2006 to account for the change in the office visit copay.

**\$788,247
RETURNED TO
THE FEHBP**

Humana Health Plan, Inc. – Chicago agreed with our findings and returned \$788,247 to the FEHBP.

Health Plan of Nevada Las Vegas, Nevada

Report No. 1C-NM-00-08-049

FEBRUARY 5, 2009

Health Plan of Nevada provides comprehensive medical services to its members in Las Vegas, Nevada. This audit of the plan covered contract years 2003 through 2008. For contract years 2003 through 2007,



the FEHBP paid the plan approximately \$51 million in premiums¹.

The audit identified \$2,064,680 in inappropriate health benefit charges to the FEHBP, consisting of \$52,414 in 2004, \$444,115 in 2007, and \$1,568,151 in 2008. In addition, we determined the FEHBP is due \$94,261

**QUESTIONED
CHARGES
AMOUNT TO OVER
\$2 MILLION**

for investment income lost as a result of the overcharges. The overcharges occurred because the plan did not correctly calculate the SSSG discounts in 2004, 2007, and

2008. As a result, the plan failed to give the FEHBP appropriate premium discounts.

Health Plan of Nevada does not agree with our findings.

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 six experience-rated audit reports. In these reports, our auditors recommended that the plans return \$17.6 million in inappropriate charges and lost investment income to the FEHBP.

¹The Subscription Income Report for 2008 was not available at the time this report was completed.

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 60 percent of all FEHBP subscribers are enrolled in BCBS plans.

We issued five 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 \$3.6 million in questionable costs charged to the FEHBP contract, including lost investment income. The BCBS Association and/or plans agreed with \$3.1 million of the identified overpayments.

Health Care Service Corporation BlueCross BlueShield of Oklahoma Tulsa, Oklahoma

Report No. 1A-10-83-08-018

JANUARY 9, 2009

Health Care Service Corporation (HCSC) includes the Illinois, New Mexico, Oklahoma, and Texas BlueCross BlueShield plans. Our audit of the FEHBP operations at HCSC covered claims from 2005 through 2007, as well as miscellaneous health benefit payments and credits, administrative expenses, and cash management activities from 2004 through 2006 for the Oklahoma plan only. From 2004 to 2007, HCSC paid approximately \$1.2 billion in FEHBP health benefit charges and \$75 million in administrative expenses for the Oklahoma plan.



Our auditors questioned \$2,220,983 in overcharges. The findings included the following:

- \$1,560,355 in net overpayments due to claim pricing errors;
- \$485,319 in net overpayments 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;
- \$108,220 in administrative expenses that were unallowable charges to the FEHBP;
- \$96,632 for plan employee pension cost overcharges;
- \$3,639 for lost investment income on health benefit refunds;
- \$2,047 for executive compensation overcharges in 2004; and,
- \$35,229 for executive compensation undercharges in 2005 and 2006.

**AUDITORS
QUESTION OVER
\$2.2 MILLION IN
OVERCHARGES**

The BCBS Association agreed with \$1,724,824 of the questioned charges. Additionally, lost investment income on the questioned charges totaled \$22,175.

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 one employee organization plan audit report during this reporting period.

Coventry Health Care as Underwriter and Administrator for the Mail Handlers Benefit Plan

Report No. 1B-45-00-08-016

MARCH 26, 2009

The Mail Handlers Benefit Plan (Plan) is an experience-rated employee organization plan. Enrollment in the Plan is open to all FEHBP eligible employees and annuitants who are members or associate members of the National Postal Mail Handlers Union (Union). The Union is the sponsor of the Plan. However, Coventry Health Care (Coventry) is the underwriter and administrator for the Plan.

Our audit of the FEHBP operations at Coventry covered claims from January 1, 2005 through September 30, 2007, as well as miscellaneous health benefit payments and credits, administrative expenses, and cash management activities from 2002 through 2006 for the Plan. For contract years 2002 through 2006, Coventry paid approximately \$9.8 billion in FEHBP health benefit charges and \$977 million in administrative expenses for the Plan.

Our auditors questioned \$13,921,340 as follows:

- \$6,000,000 in excess FEHBP funds that were held by Coventry;
- \$4,522,463 in overpayments because claims were not properly coordinated with Medicare as required by the FEHBP contract;
- \$2,529,912 for claims of ineligible patients;
- \$335,561 for duplicate claim payments;
- \$200,658 in net overpayments because claims were not paid in accordance with the Omnibus Budget Reconciliation Act of 1990 pricing requirements;
- \$211,154 due to other claim overpayment errors;
- \$108,015 in administrative expense charges that were unallowable and/or did not benefit the FEHBP; and,



- \$12,607 for an unreturned health benefit refund and \$970 for lost investment income on this refund.

**COVENTRY AGREES
WITH \$11.9 MILLION IN
QUESTIONED CHARGES**

Of these questioned charges, Coventry agreed with \$11,921,340. Additionally, lost investment income on

the questioned charges totaled \$31,454.

LIFE INSURANCE PROGRAM

The Federal Employees' Group Life Insurance (FEGLI) program was created in 1954 by the Federal Employees' Group Life Insurance Act (Public Law 83-598). OPM's Center for Retirement and Insurance Services (CRIS) has overall responsibility for administering the FEGLI program, including the publication of program regulations and agency guidelines, and the receipt, payment, and investment of agency withholdings and contributions. CRIS contracts with the Metropolitan Life Insurance Company (MetLife) to provide life insurance coverage to employees, annuitants, and their family members. Employee agencies are responsible for enrolling, informing and advising employees of program changes, determining eligibility, maintaining insurance records, withholding premiums from pay, remitting and reporting withholdings to OPM, and certifying salary and insurance coverage upon separation or death. MetLife's responsibilities under the contract are carried out by the Office of FEGLI, a separate unit of MetLife.

During this reporting period we issued one report on the program operations for fiscal years 2005 and 2006.

Federal Employees' Group Life Insurance Program Operations at the Metropolitan Life Insurance Company Jersey City, New Jersey

Report No. 2A-II-00-07-017

DECEMBER 15, 2008

This audit encompassed FEGLI's operations at MetLife. Specifically, the audit covered administrative expenses and cash management activity for fiscal years 2005 and 2006, and benefit payments for fiscal year 2006. During this period, benefit charges totaled approximately \$4.4 billion and administrative expenses totaled \$16.9 million.

In conducting the audit, we reviewed approximately \$29.3 million in benefit payments made in fiscal year 2006 for proper adjudication of claims. We also reviewed approximately \$3.6 million in benefit overpayments, approximately \$16.8 million in administrative expenses, and approximately \$850.2 million in letter of credit (LOC) drawdowns for compliance with cash management policies and procedures.

The audit identified \$537,465 in program overcharges. Of this amount, \$465,336 relates to administrative expense overcharges and \$72,129 to lost investment income. Specifically, we found:

- \$292,367 not credited to FEGLI by MetLife for FEGLI's portion of the gain on the sale of a building that housed FEGLI's operations from 1954 to 1993;
- \$151,885 in pension expense not calculated in accordance with the Federal regulations;
- \$21,084 in executive compensation allocated to FEGLI in excess of the amount allowed by the Office of Federal Procurement Policy;
- \$72,129 in lost investment income; and,
- MetLife commingled FEGLI cash and investment funds with its corporate cash and investment funds resulting in FEGLI assets not being separately identifiable from other MetLife assets.

**OVER \$500,000 TO
BE RETURNED TO
THE TRUST FUND**

MetLife agreed with all the questioned amounts.



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 personally identifiable information, privacy has emerged as a major management challenge for most Federal agencies and OPM is no exception.

We examine 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).

Audit of Information Systems General and Application Controls at CareFirst BlueCross BlueShield and the Federal Employees Program Operations Center Washington, D.C.

Report No. 1A-10-92-08-021

NOVEMBER 28, 2008

This audit focused on the system that processes FEHBP claims for CareFirst BlueCross BlueShield (CareFirst), as well as the business structure and control environment in which it operates. The BlueCross

BlueShield Association contracts with a CareFirst subsidiary to maintain the information technology infrastructure of the Federal Employees Program Operations Center (FEPOC). This organization is responsible for the Federal Employees Program (FEP) Express national claims processing system, which handles pricing, edits, enrollment, and other activities associated with processing FEP claims for all BCBS plans in the United States. The claims processing applications used by CareFirst and the FEPOC are run on a mainframe computer.

We audited the CareFirst and FEPOC claims processing applications used to adjudicate FEP claims, as well as the various processes and IT systems used to support these applications. In addition, we evaluated CareFirst's compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and costs associated with implementing the HIPAA requirements.

■ *Entity-wide Security Program*

CareFirst and the FEPOC have established a comprehensive series of IT policies and procedures to create an awareness of IT security at the CareFirst. CareFirst and the FEPOC have also implemented an adequate risk assessment methodology, incident response capabilities, and IT security related human resources controls. However, we recommended that the CareFirst and FEPOC Business Impact Analysis be updated on an annual basis in accordance with policies and procedures.



■ *Access Controls*

We found that CareFirst and the FEPOC have implemented numerous physical controls to prevent unauthorized access to its facilities, as well as logical controls to prevent unauthorized access to its information systems. However, we noted that the firewall configuration policy and the password complexity requirements of the mainframe security software used at CareFirst could be improved.

■ *Application Development and Change Control*

The FEPOC has established policies and procedures to ensure that modifications to application software occur in a controlled environment. Such controls include: appropriate levels of approval required prior to the migration of program changes; various levels and types of system testing in accordance with industry standards; and, segregation of duties along organizational lines.

■ *System Software*

CareFirst has implemented a thorough system software change control methodology. This includes: a change management tool to control and track changes; multiple levels of approvals; and the implementation of policies and procedures for

conducting emergency changes and limiting access to system software.

■ *Business Continuity*

We reviewed both CareFirst and FEPOC business continuity and disaster recovery plans and concluded that they contained many of the key elements suggested by relevant guidance and publications. We also determined that these documents are reviewed, updated, and tested on a periodic basis.

■ *Application Controls*

CareFirst and the FEPOC have implemented many controls in their claims adjudication process to ensure that FEHBP claims are processed accurately. However, we recommended that CareFirst and the FEPOC implement several system modifications to ensure that their claims processing systems adjudicate FEHBP claims in a manner consistent with their OPM contract and other regulations.

■ *Health Insurance Portability and Accountability Act*

We did not discover any instances of noncompliance with the HIPAA requirements. Furthermore, we did not uncover any weaknesses in CareFirst or the FEPOC's HIPAA cost allocation methodology.



Internal Audits

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 activity is the audit of OPM's consolidated financial statements required under the Chief Financial Officers Act of 1990 (CFO Act). Our staff also conducts performance audits covering other internal OPM programs and functions.

OPM'S CONSOLIDATED FINANCIAL STATEMENTS AUDITS

The CFO Act 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, 2008. The contract requires that the audit be done in accordance with GAGAS and the Office of Management and Budget (OMB) bulletin number 07-04, *Audit Requirements for Federal Financial Statements*.

OPM's consolidated financial statements include the Retirement Program (RP), Health Benefits Program (HBP), Life Insurance Program (LP), Revolving Fund Programs (RF), and Salaries and Expenses fund (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 provide the resources used by OPM for the administrative costs of the agency.

KPMG's responsibilities include, but are not limited to, issuing an audit report that includes:

- opinions 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 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, reviewing KPMG's work papers, and coordinating the issuance of audit reports. Our review disclosed that KPMG complied with GAGAS.

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

OPM's FY 2008 Consolidated Financial Statements

Report # 4A-CF-00-08-025

NOVEMBER 14, 2008

KPMG audited the consolidated balance sheets of OPM as of September 30 for both 2008 and 2007, and the related consolidated statements of net cost and changes in net position, and combined statements



of budgetary resources (hereinafter referred to as “consolidated financial statements”), for those years. KPMG also audited the individual balance sheets of the RP, HBP, and LP (programs), as of September 30, 2008 and 2007, and the related individual statements of net cost, changes in net position, and budgetary resources (hereinafter referred to as the programs’ “individual financial statements”), for those fiscal 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
- Federal Employees’ Group Life Insurance Program

CONSOLIDATED & BENEFITS PROGRAMS FINANCIAL STATEMENTS

KPMG reported that OPM’s consolidated financial statements and the programs’ individual financial statements for fiscal years (FY) 2008 and 2007, as presented in OPM’s Financial Year 2008 Agency Financial Report, were presented fairly, in all material

**NO MATERIAL
WEAKNESSES
REPORTED IN FY 2008**

respects, in conformity with generally accepted accounting principles (GAAP). These reviews generally include identifying

control deficiencies, significant deficiencies, and material weaknesses.

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 is a control deficiency, or combination of control deficiencies, that

adversely affects OPM’s or the programs’ ability to initiate, authorize, record, process, or report financial data reliably in accordance with GAAP 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 programs’ internal control.

A material weakness is a significant deficiency, or 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 programs’ internal control.

KPMG reported two areas of significant deficiencies in the internal control over financial reporting during FY 2008. All of the FY 2007 significant deficiencies remained unresolved in FY 2008; however, none of the significant deficiencies are considered to be material weaknesses. The areas identified by KPMG are:

- **Information Systems General Control Environment**
OPM has made continual annual improvements to the Information Systems General Control Environment; however, certain entity-wide, access, program changes and system software control processes need to be strengthened.
- **Financial Management and Reporting Processes of the Office of the Chief Financial Officer (CFO)**
OPM has made improvements; however, certain deficiencies in the operations of the Office of the CFO’s internal controls over financial management and reporting, affecting the accuracy of the RF Program and S&E Funds, continue to exist at OPM as a result of system limitations.

Table 1 includes the significant deficiencies identified by KPMG during its audit work on the financial statements for FY 2008 and 2007, respectively. OPM agreed to the findings and recommendations reported by KPMG.



Table 1: Internal Control Weaknesses

Title of Findings From FY 2008 Report	Program/Fund	FY 2008	FY 2007
Information Systems General Control Environment	All	Significant Deficiency	Significant Deficiency
Financial Management and Reporting Processes of the OCFO	S&E and RF	Significant Deficiency	Significant Deficiency

The results of KPMG’s tests of compliance with certain provision of laws, regulations, and contracts disclosed one instance of noncompliance or other matter related to the Federal Financial Management Improvement Act of 1996, that is required to be reported under GAGAS and OMB Bulletin No. 07-04, Audit Requirements for Federal Financial Statements.

- The reclassified financial statements (formatted according to Department of the Treasury’s specifications)
- The Additional Note No. 27 (discloses other data necessary to make the Special-Purpose Financial Statements more informative)
- The Trading Partner Summary Note Report (showing the funds due between OPM and other agencies)

**OPM’s FY 2008 Special-Purpose
Financial Statements**

Report No. 4A-CF-00-08-026
NOVEMBER 17, 2008

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

KMPG reported that these statements present fairly, in conformity with GAAP requirements, the financial position of OPM for FY 2008 and 2007.

KMPG did not identify any internal control deficiencies over financial reporting or noncompliance with requirements under GAGAS or OMB Bulletin No. 07-04.

**FY 2008 CLOSING
PACKAGE FINANCIAL
STATEMENTS RECEIVED
ANOTHER CLEAN
OPINION**



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.

CFCs 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 criminal 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 OPM Director to conduct the CFC in a particular community. It organizes the local CFC, determines the eligibility of local charities 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 members of a federation for the purposes of the CFC.

During this reporting period, we issued five audit reports of local CFCs and one report on a local federation. The auditors identified several violations of regulations and guidelines governing local CFC operations. Specifically, they identified the following types of errors:

- **Agreed-Upon Procedures Not in Compliance**

Three IPAs did not comply with the Agreed-Upon Procedures in the CFC Audit Guide. Specifically, they did not properly complete audit steps; did not maintain appropriate supporting documentation for other steps; and did not submit required financial reports to OPM by established deadlines.



- ***Campaign Expenses Charged to Incorrect Campaign Year***

Four PCFOs incorrectly charged the current campaign for audit fees related to a prior year's campaign.
 - ***Campaign Expenses Not Properly Supported***

One PCFO did not provide sufficient supporting documentation for some expenses charged to the campaign.
 - ***Campaign Expense Reimbursement***

Four PCFOs reimbursements for campaign expenses were not properly approved by the LFCC prior to payment.
 - ***Campaign Receipts Not Completely Disbursed***

Four PCFOs did not disburse all funds received to the member agencies and federations of the campaign.
 - ***Commingling of CFC Funds***

One PCFO commingled CFC cash receipts with another charitable campaign.
 - ***Cutoff Procedures***

Two PCFOs used an incorrect cutoff date to segregate payroll office deposits by campaign year.
 - ***Local Eligibility Determinations***

Three LFCCs did not inform member agencies and federations of their inclusion in the campaign, as required by the Federal regulations.
 - ***Application Screening Process***

One local agency and federation application screening process did not comply with Federal regulation requirements.
 - ***PCFO Application Not in Compliance***

One PCFO application, approved by the LFCC, did not comply with Federal regulations.
 - ***Pledge Card Error***

One PCFO inappropriately disbursed funds because of an improperly completed pledge card.
 - ***Pledge Notification Letters***

One PCFO did not maintain documentation to support pledge notification letters and donor lists that were sent to the member agencies and federations as required by Federal regulations.
 - ***Release of Donor Information***

One PCFO released personal donor information against the donor's wishes.
 - ***One-Time Disbursements***

Two PCFOs did not obtain approval from their LFCC to make one-time disbursements to organizations receiving a small donation. Therefore, payments were made to some agencies and federations above the established maximum threshold for one-time disbursements.
 - ***Pledge Loss***

Two PCFOs incorrectly calculated pledge loss, the amount projected as non-collectable funds, because contributors did not fulfill their entire pledge. Therefore, member agencies and federations received incorrect disbursements.
 - ***Uncashed CFC Distribution Checks***

Two PCFOs did not reissue uncashed CFC distribution checks, nor did they redistribute the funds.
 - ***Untimely PCFO Selection***

Two LFCCs did not select a PCFO by the date required by the Federal regulations.
- 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.

Enforcement Activities

Investigative Cases

The Office of Personnel Management administers benefits from its trust funds of approximately \$750 billion 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 criminal investigative efforts are spent examining potential fraud against these trust funds.

During the reporting period, our office opened 73 criminal investigations and closed 55, with 280 still in progress. Our investigations led to 29 arrests, 33 indictments and/or informations, 37 convictions and \$5,283,283 in monetary recoveries. For a complete statistical summary of our office's investigative activity, refer to the table on page 26.

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. Attorneys' 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

Pharmaceutical Company Agrees to \$1.4 Billion Settlement

In January 2009, the Eli Lilly and Company (Eli Lilly), a pharmaceutical company, agreed to plead guilty to marketing its antipsychotic drug Zyprexa for uses not approved by the Food and Drug Administration (FDA). The plea agreement stipulates that the company will pay a criminal fine of \$515 million, and forfeit assets of \$100 million. In a civil settlement, the company agreed that it will pay an additional \$800 million to the Federal and state governments to resolve civil allegations originally raised in four separate lawsuits.

The Government filed charges against Eli Lilly for promoting Zyprexa for unapproved uses, often called “off-label” marketing, such as treatment for dementia. This was in violation of the Food, Drug, and Cosmetic Act. As a result of the company’s off-label marketing campaign, health care providers prescribed Zyprexa for unapproved uses. These false claims for payment were submitted to Federal insurance programs such as Medicaid, TRICARE, and the FEHBP, none of which provided coverage for such off-label uses.

Eli Lilly used a variety of techniques to promote its practice of off-label marketing such as training its primary-care physician sales representatives to promote Zyprexa by focusing on symptoms, rather than Zyprexa’s FDA approved uses. Eli Lilly knew that there were virtually no approved uses for Zyprexa in the primary-care market.

The FEHBP received \$1.9 million in the civil settlement. Additionally, the company pled guilty to a misdemeanor criminal charge for off-label promotion.

This was a joint investigation with our office, the U.S. Attorney’s Office in the Eastern District of Pennsylvania, the DOJ Civil Division, FDA, Department of Health and Human Services (HHS) OIG, the Defense Criminal Investigative Service,

and the National Association of Medicaid Fraud Control Units.

Pharmaceutical Company Ordered to Pay Large Fines

In our semiannual report ending September 30, 2008, we reported on Cephalon Inc., a pharmaceutical company who agreed to pay the Federal government \$425 million to resolve civil suits that claimed the manufacturer marketed three drugs for uses not approved by the FDA. The FEHBP received \$13,967,347 in the settlement.

In October 2008, the company pled guilty to a misdemeanor charge of distribution of misbranded drugs and inadequate directions for use. In addition, the company was ordered to pay a criminal fine of \$40 million and \$10 million in forfeiture.

Texas Pharmacist Indicted for Distribution of Controlled Substances

In March 2009, a Texas pharmacist was indicted and arrested on several counts of possession and distribution of controlled substances as a result of a Drug Enforcement Agency (DEA) initiated investigation. The pharmacist allegedly sold Hydrocodone to his pharmacy’s clients after their legitimate prescriptions had expired. He insisted that these customers pay in cash and meet at his store after normal store hours. He also is accused of knowingly distributing Pseudoephedrine to individuals for the purpose of making Methamphetamine (meth). The investigators also found that he intended to create his own meth lab and distribute the illegal drug.

His pharmacy technician was also indicted and arrested for illegal possession and distribution of Hydrocodone. In addition, two additional individuals were later arrested and charged with distribution of controlled substances they acquired during the investigation of this case.



During a search of the pharmacist's residence, records were found that indicate he may have continued to bill the FEHBP and other health care programs for expired prescriptions and for nonexistent transactions. There is presently an on-going investigation that involves over \$6.5 million in possible fraudulent claims. It was determined that he may have billed for over 40 prescriptions per patient that were never dispensed nor received by the customers.

Following the pharmacist's arrest, investigators seized over \$1.55 million from five banks in the United States and one bank in Nigeria. The investigators also determined that the pharmacist was building a new home in Nigeria and planned to flee upon completion of the house. Considering this, the judge ordered him held without bond until the trial.

This is a joint investigation with the Federal Bureau of Investigation, DEA, FDA, the Texas Board of Pharmacy, Office of the Texas Attorney General, HHS/OIG, and our office. This prosecution and further charges will be handled by the U.S. Attorney's Office in El Paso, Texas.

Psychotherapist Sentenced to Three Years Incarceration

In April 2008, a Federal Grand Jury indicted a Baltimore psychotherapist on 10 counts of health care fraud. Subsequently, she pled guilty to one count of health care fraud. In October 2008, she was sentenced to three years incarceration, three years supervised release, and ordered to pay \$390,000 in restitution. The FEHBP will receive \$42,900 of the restitution.

The psychotherapist submitted claims for services not rendered. She billed health insurance programs using codes that require 45-50 minutes of individual, face-to-face, psychotherapy services with patients. However, interviews of patients and nursing home staff indicated that the psychotherapist would instead either:

- call the nursing home to check on her patients;
- visit patients anywhere from 5 to 20 minutes; or,

- not have contact at all with her patients.

The psychotherapist would subsequently falsify patient notes and submit claims using the incorrect codes.

Investigators executed a search warrant of her home office to obtain patient files and financial records. These financial records revealed that the psychotherapist was out of town, and sometimes out of the country, on days she claimed that she provided psychotherapy services.

This was a joint investigation by our office and the HHS/OIG.

Husband of Federal Employee Received Narcotic Prescriptions from at Least 313 Physicians in Alaska

In February 2009, the husband of a Federal employee was indicted in Anchorage, Alaska on 36 counts of fraudulently obtaining controlled substances and one count of forging a prescription.

The indictment alleged that he fraudulently obtained narcotic controlled substances (pain medications) from multiple physicians, dentists and a nurse practitioner. The husband is alleged to have lied to health care professionals concerning whether he was already taking narcotic pain medication. In addition, he allegedly falsified to health care professionals that he had undergone earlier medical procedures that required prescriptions for narcotic pain medication.

To encourage the health care providers to quickly prescribe his requested narcotics, he told health care providers on various occasions that his father and two brothers had been killed in a traffic accident, that his wife's grandmother had died, or that he had to hurry to get to the hospital because his wife was having a baby, all of which were false.

In over four years, the husband received prescriptions from at least 313 different medical providers and had the prescriptions filled at 62 different pharmacies. The cost to the FEHBP is approximately \$30,000 for



illegal prescriptions. In addition, the medical providers from whom he obtained the narcotics were paid over \$576,000 for unnecessary services during a five-year period.

The investigation is being conducted by the DEA and our office.

Massages Lead to Criminal Charges

In October 2008, two owners of a Tamarac, Florida clinic were arrested after criminal charges were filed in the Florida Circuit Court. The investigators in this case found that the clinic allegedly provided patients with massages and facials, while billing the FEHBP for physical therapy. Most of the patients worked for the U.S. Postal Service (USPS). The clinic submitted over \$1.2 million in claims to the FEHBP.

Agents conducted an undercover operation and executed a search warrant which resulted in sufficient evidence to charge and arrest the two owners. They were charged with a felony scheme to defraud.

This case was conducted by the USPS/OIG and our office.

Clinic Business Manager Guilty of Fraud

In February 2009, a Springfield, Illinois respiratory clinic business manager pled guilty to felony health care fraud charges in Federal court. He admitted to conspiring to defraud the Federal government, insurance plans, and patients out of more than \$800,000.

The business manager worked for his wife, the physician/owner of the respiratory clinic that specialized in allergies and immunology. The respiratory clinic engaged in a pattern of fraudulent and abusive billing and collections from about 1997 through at least October 2006.

In October 2007, the clinic pled guilty to health care fraud. The corporation was sentenced to five years of probation, ordered to pay a criminal fine of \$1.5 million and to pay restitution of \$934,068. Of this, the FEHBP received over \$56,000.

Sentencing of the business manager is scheduled for June 2009.

Son Uses Father's Name to Obtain Prescriptions

Our office received information from a pharmacy benefit manager that the adult son of an FEHBP member illegally used his father's benefits card to obtain FEHBP prescription benefits. Investigators found that he charged several narcotic prescriptions to his father's health benefits.

During our investigators' interview, the son stated that he was injured in a car accident and the prescriptions necessary for his treatment were not covered under his auto insurance policy. Since he did not have any health insurance coverage, he used his father's identity to obtain the necessary prescriptions. The pharmacy approved the transactions because he has the same name as his father. Although criminal prosecution was declined, the son entered into a voluntary payment agreement to repay \$9,378 to the FEHBP.

Orthopedic Clinic and Therapy Center Agree to Restitution for Kickback Violations

An orthopedic surgery and sports medicine clinic entered into an agreement with the U. S. Attorney's Office to settle claims that it created an improper referral arrangement with a physical and occupational therapy center in Baltimore, Maryland.

The clinic and the center allegedly violated the Federal Anti-Kickback Act, by submitting claims to Federal health care programs for payment of services that were the result of illegal referrals for services. A review



of claims data for the FEHBP and Medicare also disclosed instances of duplicate billing. From January 2002 to October 2004, the clinic allegedly referred patients to the center for physical therapy services. The center, in return, paid a referral fee of up to \$36 per patient for each referral.

The clinic and the center collectively paid over \$238,000 to the Government. Additionally, the clinic settled the double-billing claims to the FEHBP and Medicare. The clinic paid over \$158,000, and the center paid \$80,000 to settle the claims. OPM received \$29,821 of the settlement.

Two Southern California Brothers Sentenced for Health Care Fraud

In November 2008 two brothers were sentenced, after pleading guilty in September 2006 to health care fraud. The brothers owned and operated three cardiac monitoring laboratories in California.

In December 2003, the two brothers were indicted on 27 counts of health care fraud. Based on the indictment, in August 2005 our debarring official suspended one of the brothers and his business.

The brothers' grandfather invented the first lightweight ambulatory electrocardiographic heart monitoring device to record and interpret heart activity. The brothers utilized their grandfather's technology in their businesses to provide cardiac monitoring to physicians across the United States who prescribed the monitoring device be worn by their patients. The brothers analyzed cardiac data stored on the monitor and would provide detailed cardiac rhythm reports to the physician. They then billed the patient's insurance for the services. Instead of billing for just the analysis of the cardiac data, the brothers would submit claims for tests that the patient's physician did not request and services they did not provide. In addition, they billed for a higher level of service than was actually provided.

Each brother was sentenced to 12 months and 1 day incarceration and ordered to pay a \$500 special assessment. One brother was ordered to pay \$261,889 in criminal restitution. The other brother's restitution was waived. However, restitution may be included in his pending civil settlement. OPM will receive \$61,552.

One of the brothers has been proposed for debarment from FEHBP participation. For additional details about this debarment action, refer to page 24 in our administrative sanction activities section of this report.

This was a joint investigation by our office, the Defense Criminal Investigative Service, the Internal Revenue Service-Criminal Investigation Division, and the FBI.

Woman Claims Brother to be Husband on Her FEHBP Plan

In November 2008, a Department of Veterans Affairs (VA) employee was indicted by the State of California on two counts each of grand theft, false claims, and insurance fraud.

While working for the VA, the employee claimed her brother was her spouse on her FEHBP election form. The scheme was uncovered when a VA human resources staff member was reviewing the employee's retirement related paperwork and noticed that the employee listed the brother as her husband on the FEHBP election form and as her brother on the designated beneficiary form. After comparing the two documents, the reviewer confirmed that the brother and the supposed husband had the same name, date of birth and Social Security number.

After being confronted by special agents, she admitted that after the brother became seriously ill and lost his health insurance coverage, she falsely reported him as her supposed husband.

This was a joint investigation by our office, the VA/OIG, and the California Department of Insurance.



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 annuity benefit payments by an un-entitled 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 (SSA). Other referrals come from Federal, state, and local agencies, as well as private citizens.

Ex-wife of Missing Bedridden Annuitant Fraudulently Collects Federal Benefits

In October 2008, the ex-wife of a disabled annuitant was convicted, sentenced to three years probation, and ordered to pay restitution of \$114,892. The ex-wife pled guilty to theft of public funds. Her ex-husband received SSA, VA, and CSRS benefits. The annuitant and his wife were divorced in 1997.

The bedridden ex-husband disappeared in December 1999, has never been found, and is now presumed deceased. He was never reported missing to any of the Federal agencies. Therefore, the benefits continued to be paid. The ex-wife used multiple forged power of attorney documents to access funds from the disabled annuitant's accounts, and lied to investigators regarding her marital status.

She is the designated beneficiary of the disabled annuitant's FEGLI Insurance benefits totaling \$222,000. Her plea agreement stipulates that she use these benefits to pay for the court ordered restitution. OPM will receive \$10,386.

Daughter Steals Deceased Annuitant's Check

In November 2008, the daughter of a deceased survivor annuitant pled guilty to theft of public funds. The daughter, a bank manager, failed to notify OPM of her mother's death. Because of her banking knowledge, the daughter concealed the annuitant's death and was able to steal \$55,440 in annuity funds. She continued to have the annuities sent to the mother's existing account. The U.S. Secret Service requested assistance from our office in this investigation, after they received the referral from the U.S. Department of the Treasury.

The daughter was sentenced to 60 months probation and ordered to make full restitution.

Annuitant Mistakenly Declared Dead

As a result of a tip from a bank, we learned that an Army master sergeant receiving a civil service survivor annuity was reported dead in August 2000. The death was confirmed by the State of Illinois, and both OPM and the VA stopped paying benefits. According to the death certificate, his sister reported him killed when he was struck by a car when riding a bicycle. However, the annuitant contacted OPM and the VA to inform them that he was not deceased, that the information from the State of Illinois was incorrect, and that if his benefits payments were not reactivated, he would lose his house to foreclosure.

Through a joint effort of our office and VA/OIG, it was verified that the State of Illinois incorrectly listed him as deceased. In fact, at the time of the reported death he was on active military duty and the woman



identified as his sister on the death certificate was not a relative. The erroneous report of his death may have been the result of identity theft. Fortunately, his survivor annuity and veterans benefits were reinstated in sufficient time to stop the foreclosure on his home.

Daughter Indicted for Theft of Public Funds

In January 2009, the daughter of a deceased Federal annuitant from Vermont was indicted for theft of public funds.

OPM was not notified of the annuitant's death in February 1982; therefore, OPM continued to issue annuity payments via paper check and electronic payments until November 2005. This resulted in an overpayment of \$235,737.

Our office reviewed the retirement file and found six documents and two letters written to OPM after the annuitant's death bearing her forged signature. Our investigators also obtained copies of the U.S. Treasury checks that were negotiated after the annuitant's death. Agents interviewed the daughter of the annuitant who admitted that she received and signed the U.S. Treasury checks and forged her mother's name on various OPM documents.

This was a joint investigation by our office and the U.S. Secret Service.

Former Son-in-Law Admits Theft of Annuity

Through our proactive initiative, our office verifies if annuitants who are 90 years or older are still living. During a review, we determined that a retired Federal annuitant died in March 1981. However, benefits continued to be paid until January 2006, resulting in an overpayment of \$532,781. Through a reclamation process with the annuitant's bank the Treasury recovered \$122,165.

Our investigators found that the annuitant's former son-in-law stole the annuity payments. The son-in-law used an automatic teller machine (ATM) card to withdraw the annuity funds from a joint account shared with the deceased annuitant. He stopped withdrawing money from the account in October 2001. Therefore, the criminal statute of limitations on the case expired and the only recourse was to locate the son-in-law and attempt to obtain a repayment agreement.

The son-in-law was located in Wisconsin, and he admitted to withdrawing funds from the account of his former mother-in-law. He believed his ex-wife was entitled to the money as the sole heir and only child of the deceased. He also stated that he stopped withdrawing the funds from the account when he and his wife divorced.

In March 2009, the suspect signed a voluntary agreement, in which he agreed to repay OPM \$410,615 in monthly installments.

Son of Deceased Annuitant Stabs Himself After Failing to Surrender

Through our proactive initiative, our investigators showed that an annuitant had died in 1992 but was still being sent annuity payments. We subsequently found that at least two OPM address verification letters and several U.S. Treasury checks had been forged. The deceased annuitant's son was identified as the primary subject.

In August 2008, the son was indicted for violations of wire fraud, theft of government funds, and aggravated identity theft. The son was later arrested by OPM/OIG and FBI special agents in Honolulu, Hawaii. The son provided a complete confession to investigators.

In October 2008, the son pled guilty to wire fraud and aggravated identity theft. In February 2009, the son was sentenced to 39 months incarceration, ordered to make restitution to OPM for \$517,515, and pay a special assessment fee of \$200.



The son failed to surrender himself to authorities to begin his incarceration, which led to issuance of an arrest warrant. The U.S. Marshals Service located the son at his home. After the son refused to cooperate, the U.S. Marshals obtained a key and opened the door. Before the U.S. Marshals could execute the arrest, the son took a kitchen knife and stabbed himself in the stomach. The son was rushed to the hospital where he is recovering from his self-inflicted stab wounds.

The case was investigated jointly with the FBI in Honolulu, Hawaii and our office.

Arizona Woman Charged with Theft of Public Funds

In March 2009 the daughter of a Federal retiree and survivor annuitant was indicted on theft of public funds.

As a result of our proactive initiatives, we found that she knowingly continued to receive and use her mother's retirement and survivor annuity benefits. Even though her mother died in January 1999, she received approximately \$278,003 through 2006. However, because of the statute of limitations, the Government was only able to cover the period 2004 through 2006, which involved \$60,054 in retirement benefits and \$28,257 in survivor benefits.

Forger Sentenced in Check Cashing Case

In January 2009, the daughter of a deceased Federal annuitant was sentenced to 3 years probation, which included 150 hours community service and 30 days home detention. She also has been ordered to pay restitution of \$22,709 to OPM.

As reported in a previous semiannual report, the daughter pled guilty to theft of public funds. Based on a returned OPM address verification letter with the forged signature of the deceased annuitant, OPM continued issuing benefits checks after her death in June 1990. In 2005, the SSA/OIG notified our office of the forgery of OPM annuity checks at a New York check cashing store.

Son Sentenced for Theft of OPM and Social Security Benefits

In February 2009, the son of a deceased Federal annuitant was sentenced to three years probation, to include six months home confinement. He was ordered to pay restitution of \$253,154.

This case was based on information that we obtained from a Social Security death match, indicating that a Federal annuitant died in November 1986. His death was never reported to OPM. Retirement benefits continued to be issued to the deceased annuitant until June 2003, resulting in an overpayment of \$258,385.

The investigators determined that the annuitant's son received and used the annuity benefits. The SSA/OIG also identified the son as illegally receiving his father's Social Security benefits. He admitted withdrawing his father's social security benefits. He also stated that he used an ATM card to withdraw the annuity funds from a joint account that he had with the deceased.

In September 2007, a grand jury indicted the son. He was arrested in October 2007. In November 2008, the son pled guilty to theft of public funds.

This case was investigated jointly with SSA/OIG and our office.



SPECIAL INVESTIGATIONS

Former OPM Employee Sentenced for Falsifying Records

A former Georgia background investigator, employed by a contracting firm that conducts background investigations for OPM's Federal Investigative Services Division (FISD), was found guilty in November 2008 of making false statements. In February 2009, he was sentenced to 27 months incarceration and 3 years probation.

In 2005 and 2006, the background investigator falsely represented in his investigation reports that he had conducted certain interviews and record checks when, in fact, he had not. In addition, in a report of investigation (ROI) of an individual's background, he stated that he reviewed an employment record that he had not actually obtained. The individuals that he was investigating were applicants for top-secret security clearances for positions in the military and Federal agencies.

Former OPM Employee Confesses to Falsifying Background Investigations

In February 2009, a former Florida background investigator, employed by FISD, pled guilty to making a false statement. Her sentencing is scheduled for June 2009, and she could face up to 16 months incarceration.

During December 2004 through June 2006, in at least a dozen ROIs for background investigations, she represented that she had interviewed sources regarding a background investigation when, in fact, she had not conducted the interviews.

Due to her falsifications, the financial loss to the Government is estimated at \$101,180.

Former OPM Contractor Employee Falsifies Record Checks

A former Washington, D.C. records searcher, employed by a contractor that conducts background investigations for FISD, pled guilty to misdemeanor fraud in February 2009. His sentencing is scheduled for June 2009 and he could receive up to six months imprisonment.

The contractor background investigator reviewed records for background investigations. From January 2007 through August 2007, on several occasions, he represented that he had reviewed certain records obtained by him when, in fact, he had not. The records searcher electronically submitted the results of these reviews to FISD knowing that they contained false information.

His falsifications resulted in an estimated financial loss of \$10,000 to the Government for the cost of re-performing this work.

FISD Background Investigator Admits Falsifying Records

In November 2008, a former Connecticut FISD background investigator pled guilty to false statements. The investigator was sentenced to three years probation, 200 hours community service, and ordered to pay \$21,239 in restitution.

In August 2005, the investigator falsely stated in an ROI that he had interviewed an individual. The ROI falsely documented that he interviewed an individual who had daily contact for an extended period of time with the subject of the background investigation, and would recommend him for a security clearance. However, a subsequent follow-up investigation by other FISD background investigators determined that he never spoke to the background investigator about the subject. In fact, he did not even know the subject.



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 681 formal complaints and calls on these hotlines during the reporting period. The table on page 26 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 201 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 480 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 FEHBP 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 30,807 active suspensions and debarments from the FEHBP.

During the reporting period, our office issued 368 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 785 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.

Virginia Physician and Her Medical Practices Debarred After Physician Enters a Settlement Agreement

In a case referred to the administrative sanctions staff by the OIG's Office of Investigations, we debarred a Virginia physician and two medical practices she owned. The doctor had participated in FEHBP plans as a provider of medical services.

In May 2008, the physician entered into a settlement agreement which resolved certain civil claims the Government had against her. She was accused of falsely billing Federal health care programs for services provided from July 2003 to June 2006. The



Government alleged that she falsely billed for medical services that were not provided, including billing for the services of nurse practitioners as if she herself had provided the services.

Although the physician did not admit liability, as part of the settlement, she agreed to a three year debarment from participation in the FEHBP and other Federal health care programs. Our investigators found that in 2005 and 2006, the physician submitted approximately \$11,182 in fraudulent claims to FEHBP carriers.

Under the FEHBP administrative sanctions statute, the debaring official has permissive authority to debar an entity based upon its ownership or control by a sanctioned individual. We determined that the doctor used two medical practices that she owned as instrumentalities through which alleged false claims were billed. Accordingly, we debarred the practices for a period concurrent with the debarment of the physician.

Maine Chiropractor Proposed for Debarment

We have proposed a three year debarment of a chiropractor who was licensed in Maine and New York. Our Office of Investigations referred this case to the administrative sanctions staff based on the chiropractor's conviction of health care fraud and tax evasion.

From approximately January 2000 through December 2004, the chiropractor submitted false claims to health insurance carriers for services that were not provided nor rendered. The estimated loss to the health care benefit programs from these fraudulent claims was more than \$100,000. In addition, from 2001 through 2003, the chiropractor filed false joint income tax returns.

The chiropractor agreed to plead guilty to health care fraud and tax evasion. He was sentenced to two years

imprisonment and three years supervised release. He was ordered to pay fines of \$2,500, a \$100 assessment, and \$100,441 in restitution. He was also fined \$2,500 and a \$100 assessment for tax evasion. He has made full restitution.

Owner of California Cardiac Monitoring Company Proposed for Debarment

In our semiannual report for the period ending March 2006, our Office of Investigations reported on the owners of three cardiac monitoring companies. They were indicted on 27 counts of health care fraud for submitting false claims to health insurance programs for services that they did not render. The companies provided equipment to monitor patients' cardiovascular systems. They also performed computer data analyses and transmitted summary reports to physicians for review and interpretation. The owners and/or their companies participated as providers of medical services in the FEHBP. Based upon the owners' indictment, in August 2005, we suspended the owners, as well as the companies operated by them, pending outcome of the criminal charges.

In November 2008, one of the owners pled guilty to health care fraud. He was sentenced to 12 months and 1 day incarceration, 2 years supervised release, a \$500 special assessment, and \$261,889 restitution. Additionally, the owner agreed in a civil settlement to pay \$2.5 million.

The conviction is the basis for a mandatory debarment under OPM's statutory administrative sanctions statute. Therefore, we proposed debarment of this individual for a period of five years. As provided by OPM regulations, the length of debarment includes the prior period of suspension.

More detail concerning our investigation of this case and its legal consequences appear in the investigations activity section of this report on page 17.



Florida Physician Debarred After Surrendering Medical License

In October 2008, our office debarred a Florida physician for an indefinite period after he voluntarily surrendered his medical license to avoid further administrative action by the Florida State Board of Medicine (Board). At the time he relinquished his license, the doctor faced allegations concerning his level of patient care and his prescribing practices. According to the Board's January 2008 final order, the provider:

- engaged in gross or repeated malpractice;
- provided substandard patient care by inappropriately prescribing unnecessary and/or excessive controlled substances without routine patient work-ups; and,
- committed the violations in question for his own financial enrichment.

The surrender of the physician's medical license provided cause for debarment under the FEHBP administrative sanctions statute and regulations. Due to the seriousness of the allegations against the doctor and that he was paid to treat FEHBP enrollees, we concluded that sufficient evidence existed to debar.

Wisconsin Dentist Debarred Following Conviction for Drug Distribution

In November 2008, we debarred a Wisconsin dentist for five years after he was convicted for acquiring controlled substances by misrepresentation, fraud, and deception. In a plea agreement the dentist stated that he:

- knowingly or intentionally possessed a controlled substance as a result of misrepresentation, fraud, forgery, deception or subterfuge;
- used his professional license as a dentist to illegally obtain prescription drugs by writing prescriptions under his patients' names and that of his sister, who at the time was suffering from cancer; and,
- wrote more than 900 false prescriptions for narcotic drugs, which he then used to support his drug addiction.

The FEHBP administrative sanctions statute makes debarment of providers convicted of these types of offenses mandatory. In addition, information developed by the OIG's sanctions staff in the administrative record established that the dentist was paid for services to FEHBP enrollees. He was also a preferred provider for two major FEHBP carriers.

We concluded that sufficient evidence existed to debar.



STATISTICAL SUMMARY OF ENFORCEMENT ACTIVITIES

Judicial Actions:

Arrests	29
Indictments and Informations	33
Convictions	37

Judicial Recoveries:

Restitutions and Settlements	\$5,283,283
Fines, Penalties, Assessments, and Forfeitures	\$51,983,388

Retirement and Special Investigations Hotline and Complaint Activity:

Retained for Further Inquiry	33
Referred to:	
OPM Program Offices	81
Other Federal Agencies	87
Total	201

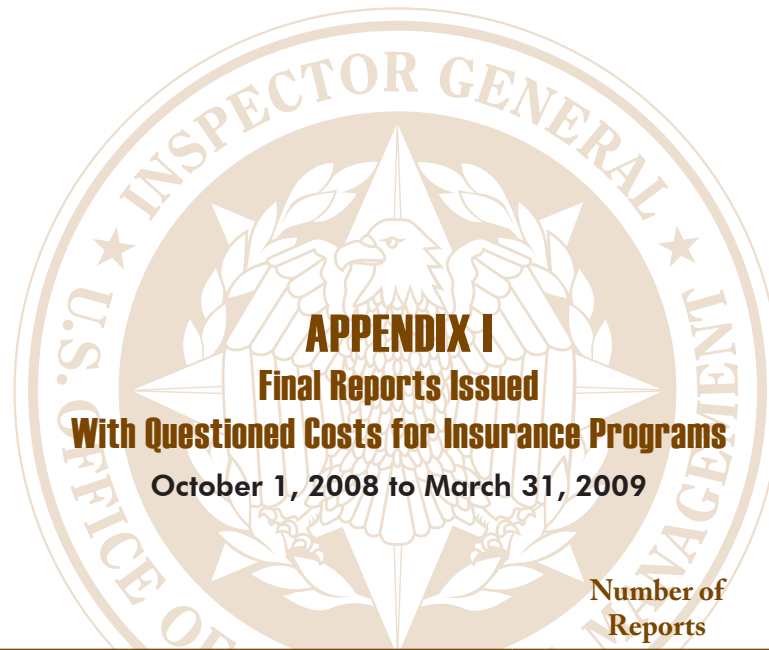
Health Care Fraud Hotline and Complaint Activity:

Retained for Further Inquiry	131
Referred to:	
OPM Program Offices	117
Other Federal/State Agencies	113
FEHBP Insurance Carriers or Providers	119
Total	480
Total Hotline Contacts and Complaint Activity	681

Administrative Sanctions Activity:

Debarments and Suspensions Issued	368
Health Care Provider Debarment and Suspension Inquiries	785
Debarments and Suspensions in Effect at End of Reporting Period	30,807

Appendices



Subject	Number of Reports	Questioned Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	15	\$34,264,863
B. Reports issued during the reporting period with findings	15	23,521,142
Subtotals (A+B)	30	57,786,005
C. Reports for which a management decision was made during the reporting period:	19	36,853,411
1. Disallowed costs	N/A	38,211,469
2. Costs not disallowed	N/A	(1,358,058) ²
D. Reports for which no management decision has been made by the end of the reporting period	11	20,932,594
E. Reports for which no management decision has been made within 6 months of issuance	0	0

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



APPENDIX II – A

Final Reports Issued with Recommendations for All Other Audit Entities

October 1, 2008 to March 31, 2009

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	6	\$404,201
B. Reports issued during the reporting period with findings	3	41,273
Subtotals (A+B)	9	445,474
C. Reports for which a management decision was made during the reporting period:	2	40,363
1. Disallowed costs	N/A	40,363
2. Costs not disallowed	N/A	0
D. Reports for which no management decision has been made by the end of the reporting period	7	405,111
E. Reports for which no management decision has been made within 6 months of issuance	7	405,111

APPENDIX II – B

Final Reports Issued with Recommendations for Better Use of Funds

October 1, 2008 to March 31, 2009

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



APPENDIX III
Insurance Audit Reports Issued
October 1, 2008 to March 31, 2009

Report Number	Subject	Date Issued	Questioned Costs
1C-CY-00-08-012	PacifiCare of California in Cypress, California	November 28, 2008	\$ 1,189,006
2A-II-00-07-017	Federal Employees' Group Life Insurance Program Operations at Metropolitan Life Insurance Company in Jersey City, New Jersey	December 15, 2008	537,465
1C-75-00-08-029	Humana Health Plan, Inc. – Chicago in Louisville, Kentucky	December 16, 2008	788,247
1C-UR-00-08-030	Humana Health Plan, Inc. – Texas in Louisville, Kentucky	December 16, 2008	328,992
1A-10-53-08-045	BlueCross BlueShield of Nebraska in Omaha, Nebraska	January 7, 2009	440,327
1A-10-83-08-018	Health Care Service Corporation in Tulsa, Oklahoma	January 9, 2009	2,243,158
1C-U4-00-08-013	Health Plan of the Upper Ohio Valley in St. Clairsville, Ohio	January 23, 2009	516,844
1C-65-00-08-057	Kaiser Foundation Health Plan of Colorado in Aurora, Colorado	January 30, 2009	0
1C-P3-00-09-013	Aetna Open Access – Plan Code P3 in Blue Bell, Pennsylvania	February 3, 2009	0
1C-JN-00-09-012	Aetna Open Access – Plan Code JN in Blue Bell, Pennsylvania	February 3, 2009	0
1C-57-00-08-028	Kaiser Foundation Health Plan of the Northwest in Portland, Oregon	February 3, 2009	259,816
1A-10-36-08-043	Capital BlueCross in Harrisburg, Pennsylvania	February 5, 2009	24,259
1C-NM-00-08-049	Health Plan of Nevada in Las Vegas, Nevada	February 5, 2009	2,158,941
1A-10-44-08-046	BlueCross BlueShield of Arkansas in Little Rock, Arkansas	February 25, 2009	255,472



APPENDIX III
Insurance Audit Reports Issued
October 1, 2008 to March 31, 2009

(Continued)

Report Number	Subject	Date Issued	Questioned Costs
1A-10-63-08-044	WellPoint Southeast in Mason, Ohio	March 3, 2009	\$ 693,795
1H-01-00-07-014	National Association of Letter Carriers' Pharmacy Operations as Administered by Caremark, Inc. in Northbrook, Illinois	March 17, 2009	0
1H-01-00-07-013	Rural Carrier Benefit Plan's Pharmacy Operations as Administered by Caremark, Inc. in Northbrook, Illinois	March 17, 2009	0
1B-45-00-08-016	Coventry Health Care as Underwriter and Administrator for the Mail Handlers Benefit Plan in Rockville, Maryland	March 26, 2009	13,952,794
1C-RD-00-08-056	Aetna Open Access – Plan Code RD in Blue Bell, Pennsylvania	March 26, 2009	86,743
1A-10-91-06-033	Medco Health Solutions, Inc. in Franklin Lakes, New Jersey	March 31, 2009	45,283
TOTALS			\$23,521,142



APPENDIX IV

Internal Audit Reports Issued

October 1, 2008 to March 31, 2009

Report Number	Subject	Date Issued
4A-CF-00-08-025	OPM's Fiscal Year 2008 Consolidated Financial Statements	November 14, 2008
4A-CF-00-08-026	OPM's Fiscal Year 2008 Special-Purpose Financial Statements	November 17, 2008

APPENDIX V

Information Systems Audit Reports Issued

October 1, 2008 to March 31, 2009

Report Number	Subject	Date Issued
1A-10-92-08-021	Information Systems General and Application Controls at CareFirst BlueCross BlueShield and the Federal Employees Program Operations Center in Washington, D.C.	November 28, 2008

APPENDIX VI

Combined Federal Campaign Audit Reports Issued

October 1, 2008 to March 31, 2009

Report Number	Subject	Date Issued
3A-CF-00-08-033	The 2005 and 2006 Midlands Area Combined Federal Campaigns in Columbia, South Carolina	October 29, 2008
3A-CF-00-08-038	The 2006 Combined Federal Campaign Activities of the Earth Share Federation in Bethesda, Maryland	October 29, 2008
3A-CF-00-08-032	The 2005 and 2006 East Alabama Area Combined Federal Campaigns in Anniston, Alabama	January 30, 2009
3A-CF-00-07-039	The 2004 and 2005 Combined Federal Campaigns of New York City in New York, New York	February 4, 2009
3A-CF-00-07-037	The 2004 and 2005 Greater Los Angeles Area Combined Federal Campaigns in Los Angeles, California	February 18, 2009
3A-CF-00-08-034	The 2005 and 2006 South Puget Sound Combined Federal Campaigns in Tacoma, Washington	February 19, 2009



APPENDIX VII

Summary of Audit Reports More Than 6 Months Old Pending Corrective Action

October 1, 2008 to March 31, 2009

Report Number	Subject	Date Issued
1A-10-15-02-007	BlueCross BlueShield of Tennessee in Chattanooga, Tennessee; 13 total recommendations; 2 open recommendations	October 1, 2002
1A-10-00-03-013	Global Coordination of Benefits (Tier 1) for BlueCross and BlueShield Plans in Washington, D.C.; 3 total recommendations; 2 open recommendations	March 31, 2004
1A-10-41-03-031	BlueCross BlueShield of Florida in Jacksonville, Florida; 19 total recommendations; 6 open recommendations	May 3, 2004
1A-10-18-03-003	Anthem BlueCross BlueShield of Ohio in Mason, Ohio; 2 total recommendations; 1 open recommendation	May 4, 2004
1A-10-29-02-047	BlueCross BlueShield of Texas in Dallas, Texas; 13 total recommendations; 3 open recommendations	July 28, 2004
1A-10-61-04-009	Anthem BlueCross BlueShield of Nevada in Reno, Nevada; 5 total recommendations; 2 open recommendations	August 2, 2004
4A-RI-00-02-071	Internal Controls over Non-Recurring Payment Actions in the Retirement Services Program; 6 total recommendations; 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 total recommendations; 2 open recommendations	November 9, 2004
1A-10-45-03-012	Anthem BlueCross BlueShield of Kentucky in Mason, Ohio and Indianapolis, Indiana; 4 total recommendations; 1 open recommendation	November 17, 2004
1A-10-55-04-010	Independence BlueCross in Philadelphia, Pennsylvania; 5 total recommendations; 2 open recommendations	December 15, 2004
4A-OD-00-05-013	OPM's Information Technology Security Controls of the Enterprise Human Resource Integration; 10 total recommendations; 1 open recommendation	May 9, 2005
4A-IS-00-05-026	OPM's Information Technology Security Controls of the Electronic Questionnaire for Investigative Processing; 20 recommendations; 2 open recommendations	June 16, 2005
1D-80-00-04-058	Group Health Incorporated in New York, New York; 21 total recommendations; 7 open recommendations	June 20, 2005
1A-10-85-04-007	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 3 total recommendations; 2 open recommendations	July 27, 2005



APPENDIX VII

Summary of Audit Reports More Than 6 Months Old Pending Corrective Action

October 1, 2008 to March 31, 2009

(Continued)

Report Number	Subject	Date Issued
1A-10-83-05-002	BlueCross BlueShield of Oklahoma in Tulsa, Oklahoma; 16 total recommendations; 2 open recommendations	October 17, 2005
1A-99-00-04-027	Global Duplicate Claim Payment for BlueCross and BlueShield Plans in Washington, D.C.; 1 total recommendation; 1 open recommendation	February 7, 2006
1A-10-32-05-034	BlueCross BlueShield of Michigan in Detroit, Michigan; 12 total recommendations; 1 open recommendation	March 24, 2006
1A-10-47-05-009	BlueCross BlueShield of Wisconsin in Milwaukee, Wisconsin; 6 total recommendations; 2 open recommendations	June 5, 2006
3A-CF-00-04-038	The 2001 and 2002 Combined Federal Campaigns for Central Maryland in Baltimore, Maryland; 17 total recommendations; 12 open recommendations	June 6, 2006
1A-10-11-04-065	BlueCross BlueShield of Massachusetts in Boston, Massachusetts; 14 total recommendations; 2 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 total recommendations; 7 open recommendations	July 3, 2006
3A-CF-00-05-039	The 2002 and 2003 Combined Federal Campaigns for Southern Nevada in Las Vegas, Nevada; 11 total recommendations; 6 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 total recommendations; 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; 16 total recommendations; 9 open recommendations	August 10, 2006
3A-CF-00-05-076	The 2002 and 2003 Combined Federal Campaigns for Central Texas in Austin, Texas; 18 total recommendations; 5 open recommendations	August 14, 2006
4A-IS-00-06-021	Information Technology Security Controls of OPM's Fingerprint Transaction System; 7 total recommendations; 2 open recommendations	August 29, 2006
1A-10-78-05-005	BlueCross BlueShield of Minnesota in Eagan, Minnesota; 11 total recommendations; 1 open recommendation	September 15, 2006
4A-CI-00-06-016	Federal Information Security Management Act for Fiscal Year 2006; 12 total recommendations; 1 open recommendation	September 22, 2006



APPENDIX VII

Summary of Audit Reports More Than 6 Months Old Pending Corrective Action

October 1, 2008 to March 31, 2009

(Continued)

Report Number	Subject	Date Issued
1A-10-69-06-025	Regence BlueShield of Washington in Seattle, Washington; 2 recommendations; 1 open recommendation	January 3, 2007
4A-CI-00-07-015	The Privacy Program at the OPM, Washington, D.C.; 7 total recommendations; 4 open recommendations	January 25, 2007
1A-10-58-06-038	Regence BlueCross BlueShield of Oregon in Portland, Oregon; 5 total recommendations; 2 open recommendations	January 31, 2007
1A-10-09-05-087	BlueCross BlueShield of Alabama in Birmingham, Alabama; 14 total recommendations; 3 open recommendations	February 27, 2007
1A-99-00-05-023	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 2 total recommendations; 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 total recommendations; 6 open recommendations	March 30, 2007
4A-CF-00-05-028	Administration of the Prompt Payment Act at the OPM, Washington, D.C.; 12 total recommendations; 8 open recommendations	April 16, 2007
1A-10-30-05-069	WellPoint BlueCross BlueShield of Colorado in Mason, Ohio; 18 total recommendations; 5 open recommendations	April 25, 2007
1A-10-03-06-079	BlueCross BlueShield of New Mexico in Albuquerque, New Mexico; 6 total recommendations; 3 open recommendations	June 5, 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 total recommendations; 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; 12 total recommendations; 4 open recommendations	July 17, 2007
1A-10-15-05-046	BlueCross BlueShield of Tennessee in Chattanooga, Tennessee; 11 total recommendations; 2 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 total recommendations; 9 open recommendations	July 25, 2007
1D-R5-00-06-069	Federal Blue HMO in Mason, Ohio; 19 total recommendations; 11 open recommendations	July 25, 2007



APPENDIX VII

Summary of Audit Reports More Than 6 Months Old Pending Corrective Action

October 1, 2008 to March 31, 2009

(Continued)

Report Number	Subject	Date Issued
3A-CF-00-06-051	The 2003 and 2004 Combined Federal Campaigns for the Mid-South in Memphis, Tennessee; 13 total recommendations; 11 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 total recommendations; 7 open recommendations	August 28, 2007
1A-10-33-06-037	BlueCross BlueShield of North Carolina in Durham, North Carolina; 19 total recommendations; 2 open recommendations	August 28, 2007
4A-CI-00-07-007	Federal Information Security Management Act for Fiscal Year 2007; 9 total recommendations; 3 open recommendations	September 18, 2007
1A-10-41-06-054	BlueCross BlueShield of Florida in Jacksonville, Florida; 11 total recommendations; 4 open recommendations	October 12, 2007
1C-RL-00-06-026	Grand Valley Health Plan in Grand Rapids, Michigan; 3 total recommendations; 2 open recommendations	October 19, 2007
3A-CF-00-06-050	The 2003 and 2004 San Diego County Combined Federal Campaigns in San Diego, California; 11 total recommendations; 3 open recommendations	November 13, 2007
3A-CF-00-06-059	The 2003 and 2004 Combined Federal Campaigns of Cocoa-Brevard County in Cocoa, Florida; 11 total recommendations; 2 open recommendations	November 13, 2007
1A-10-05-06-008	WellPoint BlueCross BlueShield of Georgia in Atlanta, Georgia; 15 total recommendations; 2 open recommendations	November 16, 2007
1A-10-40-07-022	BlueCross BlueShield of Mississippi in Jackson, Mississippi; 6 total recommendations; 2 open recommendations	December 14, 2007
1A-10-42-07-004	BlueCross BlueShield of Kansas City in Kansas City, Missouri; 5 total recommendations; 2 open recommendations	December 14, 2007
3A-CF-00-06-067	The 2003 and 2004 Combined Federal Campaigns for the Coastal Georgia Area in Savannah, Georgia; 11 total recommendations; 5 open recommendations	January 4, 2008
1A-10-84-07-023	Excellus BlueCross BlueShield in Utica, New York; 4 total recommendations; 2 open recommendations	January 16, 2008
1A-10-07-07-016	BlueCross BlueShield of Louisiana in Baton Rouge, Louisiana; 13 total recommendations; 2 open recommendations	January 18, 2008
1C-3U-00-05-085	United Healthcare of Ohio, Inc., in West Chester, Ohio; 2 total recommendations; 2 open recommendations	January 18, 2008



APPENDIX VII

Summary of Audit Reports More Than 6 Months Old Pending Corrective Action

October 1, 2008 to March 31, 2009

(Continued)

Report Number	Subject	Date Issued
1A-10-18-06-052	Anthem Midwest in Mason, Ohio; 16 total recommendations; 2 open recommendations	February 20, 2008
4A-CI-00-06-031	OPM's Compliance with Federal Tax Laws in Washington, D.C.; 9 total recommendations; 4 open recommendations	February 27, 2008
4A-RI-00-05-037	OPM's Reclamation Process in Washington, D.C.; 10 total recommendations; 8 open recommendations	March 18, 2008
1A-10-99-06-001	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 4 total recommendations; 4 open recommendations	March 20, 2008
1D-89-00-06-043	Triple-S, Inc. in San Juan, Puerto Rico; 20 total recommendations; 2 open recommendations	March 26, 2008
1A-10-56-07-024	BlueCross BlueShield of Arizona in Phoenix, Arizona; 10 total recommendations; 1 open recommendation	April 4, 2008
4A-RI-00-08-023	Information Technology Security Controls of OPM's Employee Benefits Information System; 5 total recommendations; 2 open recommendations	April 10, 2008
1C-WD-00-06-081	Dean Health Plan, Inc. in Madison, Wisconsin; 3 total recommendations; 1 open recommendation	April 15, 2008
4A-WR-00-08-024	Information Technology Security Controls of OPM's Central Personnel Data File; 1 total recommendation; 1 open recommendation	April 17, 2008
1A-10-11-08-001	Information Systems General and Application Controls at BlueCross BlueShield of Massachusetts in Boston, Massachusetts; 7 total recommendations; 5 open recommendations	May 28, 2008
1C-G2-00-07-044	Arnett HMO Health Plan in Lafayette, Indiana; 2 total recommendations; 2 open recommendations	June 12, 2008
1A-10-01-07-058	Empire BlueCross BlueShield in Albany, New York; 22 total recommendations; 3 open recommendations	June 25, 2008
1A-99-00-08-007	Global Coordination of Benefits for BlueCross and BlueShield Plans (Contract Year 2006) in Washington, D.C.; 3 total recommendations; 1 open recommendation	June 25, 2008
1C-SV-00-07-056	Coventry Health Care of Iowa, Inc. in St. Louis, Missouri; 2 total recommendations; 2 open recommendations	June 30, 2008
3A-CF-00-07-038	The 2003 and 2004 South Jersey Combined Federal Campaigns in Rancocas, New Jersey; 7 total recommendations; 7 open recommendations	July 24, 2008



APPENDIX VII

Summary of Audit Reports More Than 6 Months Old Pending Corrective Action

October 1, 2008 to March 31, 2009

(Continued)

Report Number	Subject	Date Issued
1C-8W-00-07-028	UPMC (University of Pittsburgh Medical Center) Health Plan in Pittsburgh, Pennsylvania; 2 total recommendations; 2 open recommendations	July 25, 2008
1C-A3-00-06-085	PacifiCare of Arizona in Cypress, California; 2 total recommendations; 2 open recommendations	July 25, 2008
1C-U2-00-07-002	Paramount Health Care in Maumee, Ohio; 2 total recommendations; 2 open recommendations	August 7, 2008
1A-99-00-08-009	Global Coordination of Benefits for BlueCross and BlueShield Plans (Contract Year 2005) in Washington, D.C.; 3 total recommendations; 1 open recommendation	August 11, 2008
4A-CA-00-07-054	The Agreement between the Office of Personnel Management and the National Archives and Records Administration for Storage and Servicing of Records in Washington, D.C.; 8 total recommendations; 8 open recommendations	August 26, 2008
4A-HR-00-08-058	Information Technology Security Controls of OPM's USAJOBS System in Washington, D.C.; 3 total recommendations; 3 open recommendations	September 5, 2008
1A-99-00-07-043	Health Care Service Corporation in Chicago, Illinois and Richardson, Texas; 22 total recommendations; 4 open recommendations	September 5, 2008
4A-MO-00-08-059	Information Technology Security Controls of OPM's Executive Schedule C System; 4 total recommendations; 3 open recommendations	September 8, 2008
1A-99-00-08-008	Global Duplicate Claim Payments for BlueCross and BlueShield Plans (Contract Years 2004 and 2005) in Washington, D.C.; 2 total recommendations; 1 open recommendation	September 11, 2008
1C-7Z-00-08-011	PacifiCare of Oregon in Cypress, California; 2 total recommendations; 2 open recommendations	September 15, 2008
1C-6Q-00-07-029	Universal Care, Inc. of California in Signal Hill, California; 2 total recommendations; 2 open recommendations	September 15, 2008
4A-CI-00-08-022	Federal Information Security Management Act for Fiscal Year 2008; 19 total recommendations; 19 open recommendations	September 23, 2008
1H-01-00-06-040	BlueCross and BlueShield Retail Pharmacy Drug Program Operations at AdvancePCS in Scottsdale, Arizona; 4 total recommendations; 4 open recommendations	September 29, 2008



Index of Reporting Requirements

(Inspector General Act of 1978, As Amended)

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Section 5 (a) (12):	Significant management decisions with which the OIG disagreed during this reporting period	No Activity



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