

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Office of the Inspector General



**Semiannual Report
to Congress**

April 1, 2009 – September 30, 2009



Office of the Inspector General



PRODUCTIVITY INDICATORS

FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds	\$25,025,118
Management Commitments to Recover Funds	\$35,648,831
Recoveries Through Investigative Actions.	\$40,488,687
Fines, Penalties, and Forfeitures Through Investigations.	\$40,302,650

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.	44
Investigative Cases Closed	58
Indictments and Informations	87
Arrests.	76
Convictions	39
Hotline Contacts and Complaint Activity	618
Health Care Provider Debarments and Suspensions	468
Health Care Provider Debarment and Suspension Inquiries	1,095

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INSPECTOR GENERAL'S MESSAGE

In their 2008 financial statements, the Federal Employees Health Benefits Program's fee-for-service carriers reported to OPM that pharmacy benefits amounted to over \$7 billion, comprising more than 25 percent of the health care cost that they paid. These figures continue the pattern of steady and sizeable increases that has occurred during most of the past decade. For example, the BlueCross BlueShield (BCBS) Service Benefit Plan, which covers approximately half of the FEHBP's enrollees, reported a pharmaceutical claims cost per member of \$591 in 1999. The most current report indicates that this figure has virtually doubled to \$1,161, reflecting an average annual increase of 13.5 percent. In part, this is attributable to the overall increases in health care costs throughout the economy. However, it also calls into question the effectiveness of the pharmacy benefit managers (PBMs) which have been contracted by the BlueCross BlueShield Association and other fee-for-service plans with the expectation that they would help control the growth of prescription drug costs within the FEHBP.

In response to a request from the Subcommittee on the Federal Workforce, Postal Service, and the District of Columbia (the Subcommittee) of the House of Representative's Committee on Oversight and Government Reform, we recently detailed a senior staff member with extensive experience in auditing health care programs. This person has been working on health care issues directly related to the FEHBP and most specifically on matters regarding the effectiveness of the PBMs.

The Subcommittee examined the FEHBP's prescription drug benefits in a June 24, 2009, hearing titled "FEHBP's Pharmacy Benefit, Deal or No Deal?" In my testimony before the Subcommittee, I indicated that the lack of transparency in the PBM industry, and specifically in their contracts with the FEHBP carriers, prevented OPM from determining whether, in fact, the FEHBP was getting a good or bad deal on the cost of prescription drug benefits. Transparency in this context means that the PBM's actual cost data associated with the pharmaceutical products and services that it provides to enrollees would be made available to the FEHBP and be subject to audit by my office.

The witnesses at the Subcommittee's hearing who were not associated with the PBM industry generally agreed with the premise that PBM transparency would lower FEHBP's costs of providing pharmaceutical benefits, and they identified several methods of achieving this result. Their suggestions included treating PBMs as government subcontractors under cost-based contracts, which by regulation would require their disclosure of full cost data. Alternatively, prescription drug benefits, which are now administered separately



by the various FEHBP plans, could be “carved out” of the FEHBP and administered as a stand-alone benefit offered under a transparent contract directly between OPM and a PBM. Another approach would be for the FEHBP carriers, either directly or through their PBMs, to be given authority to purchase drugs from manufacturers under the special discounts and cost structures that are already available to certain Government agencies, such as the Defense Department and Department of Veterans Affairs.

It is our office's position, which we have stated repeatedly in prior editions of our semiannual reports and in communications with OPM program officials responsible for the FEHBP, that the Government's interest in obtaining the best possible value in PBM services demands disclosure and audit of full cost data. The current lack of transparency is a result not only of the prevailing practices in the PBM industry, but also of a series of decisions by OPM management over many years which have had the collective effect of excluding the PBMs under contract to the FEHBP carriers from any requirement to disclose their actual costs to the Government. For example, OPM chose to treat PBMs as health care providers on a par with individual medical practitioners. This meant that, despite the role they play as administrators of a large and critical element of the FEHBP benefits structure, OPM did not even require that the FEHBP carriers make their PBM contracts available for audit. Therefore, until the past two years, our office had essentially no access to any PBM-related cost data.

In its recent changes to FEHBP regulations, OPM created the category of “large providers,” which includes PBMs. The financial records of these providers' transactions with FEHBP are subject to review by OPM. Thanks to this change, the OIG can now audit the FEHBP carriers' contracts with their PBMs. However, this is only a partial solution. We still can not look behind the carrier contracts into the PBMs' internal cost structures to determine if the prices they charge to the carriers (and hence to the FEHBP) are fair and reasonable.

Our office is participating in a working group with FEHBP officials to identify the most feasible means of increasing PBM transparency and limiting pharmaceutical cost increases to the FEHBP and its enrollees. We are also assisting the Subcommittee as it continues to explore the need for legislative approaches that may facilitate these goals. Ultimately, I am confident that these combined efforts will produce a fully transparent FEHBP prescription drug benefit, so that the taxpayers and Federal employees who participate in the FEHBP will be readily able to assess the quality of the “deal” that they are receiving. Because pharmacy benefits comprise such a large portion of the FEHBP's expenditures, even relatively small percentage cost reductions, or limitations in the future growth of costs, would produce large savings. We look forward to informing you of our progress in future reports.

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 insurance through the Federal Employees Health Benefits Program (FEHBP). Our office is responsible for auditing the activities of this program to ensure that the insurance carriers meet their contractual obligations with OPM.

The Office of the Inspector General's (OIG) insurance audit universe contains approximately 260 audit sites, consisting of health insurance carriers, sponsors, and underwriting organizations. 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 premium payments for the health insurance program 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 26 final reports on organizations participating in the FEHBP, of which 14 contain recommendations for monetary adjustments in the amount of \$24.3 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 the FEHBP makes to the basic benefit package offered by a community-rated plan. For example, the FEHBP provides coverage for dependent children until age 22, while the plan's basic benefit package may provide coverage through age 19. Therefore, the FEHBP rates may be increased because of the additional costs the plan incurs by extending coverage to age 22.

During this reporting period, we issued 17 audit reports on community-rated plans. These reports contain recommendations to require the plans to return over \$12.7 million to the FEHBP.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Rockville, Maryland

Report No. 1C-E3-00-09-010

AUGUST 6, 2009

The Kaiser Foundation Health Plan (Kaiser) of the Mid-Atlantic States, Inc., provides comprehensive medical services to its members throughout the Metropolitan Washington, D.C., and Baltimore, Maryland areas. The audit covered contract years 2006 through 2008. During this period, the FEHBP paid Kaiser approximately \$1.5 billion in premiums.

We identified \$6,626,495 in inappropriate health benefit charges to the FEHBP, including \$2,593,923 in 2006, \$4,810,121 in 2007, and (\$777,549) in 2008. In addition, we determined the FEHBP is due \$919,280 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 Kaiser used incorrect enrollment data to develop the FEHBP rates in 2006, 2007, and 2008. Kaiser discovered the error during the audit and agreed with the questioned amounts.

**\$7.5 MILLION
RETURNED TO
THE FEHBP**

Kaiser returned \$7,545,775 to the FEHBP.



Univera Healthcare
Buffalo, New York
 Report No. 1C-Q8-00-09-008
 SEPTEMBER 8, 2009

Univera Healthcare provides comprehensive medical services to its members throughout the northern counties of western New York State. The audit covered contract years 2004, 2005, 2007, and 2008. During this period, the FEHBP paid the plan approximately \$77.1 million in premiums.

The audit identified \$3,627,982 in inappropriate health benefit charges to the FEHBP, consisting of \$226,404 in 2005, \$2,437,976 in 2007, and \$963,602 in 2008. In addition, we determined the FEHBP is due \$354,140 for investment income lost as a result of the overcharges. The overcharges occurred because the plan did not correctly identify the SSSGs nor identify the largest SSSG discounts in 2005, 2007, and 2008. As a result, the plan failed to give the FEHBP appropriate premium discounts.

Univera Healthcare agreed with our findings and subsequently returned \$3,982,122 to the FEHBP.

EXPERIENCE-RATED PLANS

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

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

- Appropriateness of FEHBP contract charges and the recovery of applicable credits, including refunds;

- Effectiveness of carriers' claims processing, financial and cost accounting systems; and,
- Adequacy of carriers' internal controls to ensure proper contract charges and benefit payments.

During this reporting period, we issued six experience-rated audit reports. In these reports, our auditors recommended that the plans return \$9.8 million in inappropriate charges and lost investment income to the FEHBP.

BLUECROSS BLUESHIELD SERVICE BENEFIT PLAN

The BlueCross BlueShield Association (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 the BCBS plans.

We issued four 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 \$8.8 million in questionable costs charged to the FEHBP contract, including lost investment income. The BCBS Association and/or plans agreed with \$5.9 million of the identified overpayments.

Global Claims-to-Enrollment Match for BlueCross and BlueShield Plans Washington, D.C.

Report No. 1A-99-00-08-065
 JUNE 23, 2009

We performed a limited scope performance audit to determine whether the BCBS plans complied with contract provisions relative to patient enrollment eligibility.



Our auditors performed a computer search on the BCBS claims database, using our data warehouse function, to identify claims paid during the period January 1, 2005 through June 30, 2008 that were potentially incurred when no patient enrollment records existed, during gaps in patient coverage, or after termination of patient coverage with the BCBS Service Benefit Plan. We found that 54 of the 63 plan sites paid claims for patients that met this search criteria. Specifically, these BCBS plans made 19,363 claim payments for patients that were not eligible for benefits.

As a result, we determined that the FEHBP was overcharged \$2,961,748 for these claim payments. The Association and/or plans agreed with \$2,046,647 of the questioned claim overcharges.

**AUDITORS
QUESTION OVER
\$2.9 MILLION
IN CLAIM
OVERCHARGES**

for services that were paid in 2007 and potentially not coordinated with Medicare. We determined that 58 of the 63 plan sites did not properly coordinate claim charges with Medicare. As a result, the FEHBP incorrectly paid these claims when Medicare was the primary insurer.

For 81 percent of the 12,751 claim payments questioned, there was no information in the BCBS Association's national claims system to identify Medicare as the primary payer when the claims were paid. However, even after the Medicare information was added to the claims system, the BCBS plans did not adjust the patients' prior claims retroactively to the Medicare effective dates. Consequently, these costs continued to be charged entirely to the FEHBP.

**FEHBP OVERCHARGED
\$4.3 MILLION FOR
COORDINATION OF
BENEFITS ERRORS**

We determined that the FEHBP was overcharged \$4,387,806 for these COB errors. The BCBS Association and/or plans agreed with \$2,536,354 of the questioned claim overcharges.

Global Coordination of Benefits for BlueCross and BlueShield Plans Washington, D.C.

Report No. 1A-99-00-09-011
JULY 20, 2009

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

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

Using our data warehouse, we performed a computer search on the BCBS claims database to identify claims

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 the: 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.



AXA Assistance as Administrator for the Panama Canal Benefit Plan

Miami, Florida

Report No. 1B-43-00-08-048

MAY 20, 2009

The Panama Canal Area Benefit Plan (PCABP) is an experience-rated employee organization plan. Enrollment in the PCABP is open to members of the Association of Retirees of the Panama Canal Area (Association) who are eligible for coverage under the FEHBP, and annuitants who reside in Panama that were previously enrolled in the PCABP. The Association is the sponsor and administrator for the PCABP. However, AXA Assistance (AXA), a Third Party Administrator, administers the claim payments for the PCABP.

Our audit of the FEHBP operations at AXA covered capitation payments, miscellaneous health benefit payments and credits, administrative expenses, and cash management activities for contract years 2006 and 2007 for the PCABP. For these contract years, AXA paid approximately \$102 million in FEHBP health benefit charges and \$10 million in administrative expenses for the PCABP.

AUDITORS QUESTION \$460,000 IN OVERCHARGES AND LOST INVESTMENT INCOME

Our auditors questioned \$460,191 in program overcharges and lost investment income. Of this amount, \$368,446 relates to administrative expense overcharges and

\$91,745 to lost investment income. AXA agreed with \$192,696 of this questioned amount.

EXPERIENCE-RATED COMPREHENSIVE MEDICAL PLANS

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

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

We issued one experience-rated comprehensive medical plan audit report during this reporting period.

BlueShield of California Access+ HMO San Francisco, California

Report No. 1D-SJ-00-09-021

JUNE 9, 2009

BlueShield of California Access+ HMO (Plan) is an experience-rated health plan offering comprehensive medical benefits to Federal enrollees and their families. Enrollment is open to all Federal employees and annuitants in the Plan's service area, which includes most of California.

The audit of the Plan's FEHBP operations covered miscellaneous health benefit payments and credits, administrative expenses, and cash management activities from 2003 through 2007. During this period, the Plan paid approximately \$419 million in FEHBP health benefit charges and \$19 million in administrative expenses.

PLAN AGREES WITH OVER \$580,000 IN QUESTIONED COSTS

The audit questioned \$581,735 as follows:

- \$402,805 for lost investment income on excess FEHBP funds that were held by the Plan;
- \$121,822 for an administrative expense overstatement in the Plan's 2007 FEHBP annual accounting statement; and,
- \$57,108 for administrative expense charges that did not benefit the FEHBP.

The Plan 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.

Our auditors 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.

Federal Information Security Management Act Audit FY 2009 Washington, D.C. Multiple Reports

The Federal Information Security Management Act of 2002 (FISMA) is designed to ensure that the information systems and data supporting operations are adequately protected. FISMA emphasizes that agencies implement security planning as part of their information systems. A critical aspect of

security planning involves annual program security reviews conducted or overseen by each agency's Inspector General.

Consequently, we audited OPM's compliance with FISMA requirements defined in the Office of Management and Budget's (OMB) fiscal year (FY) 2009 Reporting Instructions for FISMA and Agency Privacy Management. During the audit, we issued a Flash Audit Alert that reported on FISMA compliance for three OPM systems, and we notified the OPM Director that the agency has not fully documented information security policy and procedures nor established appropriate roles and responsibilities. The purpose of a Flash Audit Alert is to notify the OPM Director of issues that need to be addressed immediately.

In our FY 2007 and 2008 FISMA audit reports, we reported the lack of policies and procedures as a material weakness. While some progress was made in FY 2009, detailed guidance is still lacking. OPM has finalized an Information Security and Privacy Policy that outlines the IT security controls that should be in place for the agency's major applications. However, the policy does not specifically address OPM's IT environment and it lacks implementing guidance.

This year, we expanded the material weakness to include the agency's overall information security governance program and included our concerns about the agency's information security management



structure. For example in the last 18 months, there has not been a permanent Senior Agency Information Security Official (SAISO) or a Privacy Program Manager, resulting in a serious decline in the quality of the agency's information security and privacy programs. With the recent appointment of the new SAISO, and the planned Office of Chief Information Officer reorganization which may involve increased staffing levels, we will reevaluate this issue during the FY 2010 FISMA audit.

We audited major OPM computer systems, which included self-assessment, contingency plan testing, certification and accreditation (including risk assessment and security controls testing), and the plan of action and milestones (POA&M) process. Our audit revealed substantial compliance with FISMA requirements; however, we did identify weaknesses related to contingency planning, security controls testing, and the POA&M process.

The FY 2009 FISMA audit resulted in a total of four reports issued during this semiannual period; however, the report on OPM's overall compliance with FISMA will be issued during the next semiannual reporting period.

**Audit of Information Systems General
and Application Controls at
Kaiser Foundation Health Plan
NORTHERN AND SOUTHERN
CALIFORNIA REGIONS
Oakland and Pasadena, California
Report No. 1C-59-00-09-002
JUNE 18, 2009**

This audit focused on the information systems used to process data related to Kaiser Foundation Health Plan (Kaiser) members participating in the FEHBP. These include systems that record services provided by doctors and hospitals, membership information, analytical databases, pricing, and claims adjudication.

Entity-wide Security Program

The policies and procedures that comprise Kaiser's entity-wide security program appear to provide an adequate foundation to protect the organization's information resources. However, we determined that neither the Northern nor Southern California regions of Kaiser are routinely conducting business impact analyses and risk assessments in accordance with company policy.

Access Controls

Kaiser has implemented a variety of controls to prevent or detect unauthorized access to its physical and logical resources. Such controls include the: establishment of procedures for securing access to networks and applications; detection of unauthorized network activity; and encryption of data at rest and data transferred via email. However, we noticed several areas where controls should be improved, including: access security to its facilities; controls over wireless network devices; security of network incident logs; review of active user accounts; disabling inactive user accounts; and password controls.

Application Development and Change Control

Kaiser has adopted a traditional system development life cycle (SDLC) methodology that incorporates the use of formal change requests managed by a project tracking tool. Kaiser also uses a structured approval process for all changes to its applications.

System Software

Kaiser has implemented a thorough system software change control methodology. This process utilizes a change management tool to control and track changes and involves multiple levels of approvals. Kaiser has implemented policies and procedures for conducting emergency changes and limiting access to system software to the appropriate individuals.

Business Continuity

A Disaster Recovery Organization has been designated within Kaiser with the responsibility to develop, support, test, maintain, and execute disaster recovery



plans. However, we determined that a thorough business continuity and disaster recovery plan has not been implemented for the six information systems reviewed during this audit.

Application Controls

Kaiser has implemented a variety of controls to ensure that members' electronic transactions are valid, authorized, and processed accurately. However, we noted several weaknesses in how Kaiser's systems process FEHBP data. Kaiser's systems inappropriately processed several transactions tested by OIG auditors, including the following inconsistencies: procedure/diagnosis; procedure/gender; procedure/provider; procedure/age; non-covered benefits; and, emergency room to hospital transfers.

Health Insurance Portability and Accountability Act (HIPAA)

We did not discover any incidents of noncompliance with the HIPAA security, privacy, and national provider identifier regulations.

Audit of Information Systems Application Controls at AXA Assistance as Administrator for the Panama Canal Area Benefit Plan Panama City, Panama

Report No. 1B-43-00-08-066

JUNE 18, 2009

As stated previously in this semiannual report, AXA is the administrator for the Panama Canal Area Benefit Plan (PCABP). OPM's contracting officials requested that the OIG audit AXA's claims processing system because of concerns regarding the company's overall administration of the PCABP contract with OPM and specific concerns about the lack of system controls.

We reviewed the claims processing application used to adjudicate FEHBP claims and the various processes and systems used to support this application. We found that, overall, AXA had significantly improved its management of the PCABP contract with OPM; however, we identified several controls weaknesses, including:

- Lack of detailed procedures for the internal claims audit process;
- Uncontrolled ability to override claims processing system edits;
- Lack of segregation of duties in the process of enrolling new members and reconciling membership information with Government payroll office data;
- Insufficient medical edits that would prevent payments for inappropriate, inconsistent, or non-covered benefits; and,
- AXA's explanation of benefits (EOB) forms could be improved with multilingual versions and remarks codes. EOBs are an important tool for providing information and fighting fraud.

Review of the Consolidated Business Information System Implementation Project U.S. Office of Personnel Management Washington, D.C.

Report No. 4A-CI-00-09-066

SEPTEMBER 28, 2009

At the request of the OPM Director, we reviewed the agency's financial system development project, the Consolidated Business Information System (CBIS), to ensure the successful implementation of the new system. Our review was limited to the first phase of the project and focused on the OPM Revolving Fund and Salaries and Expenses accounts.



We reviewed the following critical project tasks: project management; testing; independent verification and validation; data conversion; IT certification and accreditation (C&A); operational readiness; compliance with Federal Systems Integration Office (FSIO) requirements and OPM custom requirements; and, application security.

Our auditors did not identify any issues which would appear to affect the successful October 2009 implementation of the CBIS first phase. However, we did note opportunities for improvement in four of the five critical sub-task areas:

- ***Project risk management:*** Although most project risks are properly managed, our examination of project risk meeting minutes and the risk inventory database revealed that several risks were closed without adequate documentation or justification.
- ***Resolution of independent verification and validation issues:*** There was no resolution process when there was disagreement concerning independent verification and validation recommendations by the contractor. As a result, potential concerns may not be properly tracked and mitigated by the CBIS project management office within the Office of the Chief Financial Officer (OCFO).
- ***IT Certification and Accreditation:*** The CBIS C&A was conducted in accordance with OPM's Certification and Accreditation Guide and the National Institute of Standards and Technology (NIST) guidance. However, we found that documentation could be improved as follows:
 - The CBIS privacy impact assessment contained the majority of the required elements; however, it did not include several requirements applicable to major information systems.
 - The CBIS contingency plan contains the majority of required NIST elements; however, there were discrepancies between two documents critical to the CBIS contingency planning methodology, and inadequate contact information for personnel essential to the disaster recovery process.
- ***Overall testing strategy:*** The CBIS project team should improve the user acceptance testing process by providing better qualified contractor personnel during the testing sessions, and more descriptive information and screen shots for system testing.



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. Our staff also conducts performance audits covering other internal OPM programs and functions.

Security of Personally Identifiable Information in OPM's Federal Investigative Services Division Washington, D.C.

Report No. 4A-IS-00-08-014

APRIL 21, 2009

At the request of former OPM Director Linda Springer, we conducted an audit of the security of personally identifiable information (PII) in OPM's Federal Investigative Services Division (FISD). Our main audit objective was to determine whether FISD had effectively implemented controls for the storage, security, and transmission of PII.

FISD conducts background investigations for Federal agencies so they can make suitability and national security decisions regarding personnel. They contract with private companies (contractors) to assist with conducting these background investigations. In addition, they are responsible for collecting and observing the destruction of documents containing PII.

FISD defines PII as information unique to an individual which, on its own or in aggregate with other information, would tend to specifically identify that individual. Examples would include full names and Social Security numbers.

FISD has developed and issued various policies to its employees and contractors on the protection of PII. These policies include protocols and timeliness standards for protecting PII while in an employee's possession or in transport; the storage of PII; and for reporting incidents of loss, theft, or abuse of PII. The policies also require training for employees and contractors.

Our auditors identified seven areas requiring improvement because the contractors did not follow FISD requirements or policies and procedures or because FISD controls were inadequate or absent.

Specifically, we noted that FISD:

- Contractors did not provide OPM Information Technology Security Awareness Training to new employees within 30 days of their initial hiring.
- Did not require contractors to be trained on the collection and handling of bins containing documentation to be shredded, observations of the shredding process, and safeguarding of PII.
- Contractors did not report the loss of PII in accordance with FISD's policy regarding such incidents.
- Controls for reporting the loss of PII do not ensure that incidents are reported timely in accordance with their policy on the loss or compromise of PII.

**IMPROVEMENTS
NEEDED
TO PROTECT PII
IN BACKGROUND
INVESTIGATIONS**



- Contractors did not have controls in place to ensure that background investigators' case notes are returned to their program management office within two weeks of the closing of the background investigation, as required by their FISD contract.
- Case notes were destroyed prior to the expiration of the three-year retention period. In addition, FISD does not have a method for ensuring that background investigators return case notes once the background investigation is closed.
- Does not have an adequate method of tracking telework employees' removal and return of background cases and related case materials.

FISD concurred with our findings and recommendations and is implementing corrective actions.

Inventory and Management of OPM's Sensitive Property Washington, D.C.

Report No. 4A-CA-00-08-036

JUNE 15, 2009

We conducted a performance audit of the inventory and management of OPM's sensitive property. Because of incidents of loss or theft of laptops and the risk that personally identifiable information may be compromised, securing mobile IT devices, such as

laptops, smartphones, and Global Positioning Systems (GPS), has become an important part of Federal agencies' asset management responsibilities.

Our auditors tested laptops, smartphones, and GPS devices from six of OPM's eight program divisions and determined that OPM does not have effective controls in place to safeguard and ensure accountability for sensitive property.

**OPM DOES NOT HAVE
SUFFICIENT CONTROLS
TO SAFEGUARD
SENSITIVE PROPERTY**

We identified five specific areas requiring improvement within OPM:

- Laptop inventory is incomplete;
- Controls to account for laptop inventory are inadequate;
- Noncompliance with inventory management controls as stated in its policies;
- Inadequate accounting for smartphone inventories; and,
- Insufficient controls to ensure that excess sensitive property is disposed of in accordance with Federal property regulations.

OPM agreed with our findings and is taking steps to implement our recommendations.



Special Audits

In addition to health and life insurance, OPM administers various benefit programs for Federal employees. These programs include the Federal Flexible Spending Account Program; the Federal Long Term Care Insurance Program; the Federal Employees Dental and Vision Insurance Program; and the Federal Employees' Group Life Insurance program. Our office also conducts audits of Pharmacy Benefit Managers that coordinate pharmacy benefits for the FEHBP carriers. The objective of these audits is to ensure that costs charged and services provided to Federal subscribers are in accordance with the contracts and applicable Federal regulations. Additionally, our staff performs audits of the Combined Federal Campaign to ensure that monies donated by Federal employees are properly handled and disbursed to charities according to the wishes of the employees.

FEDERAL LONG TERM CARE INSURANCE PROGRAM

The Federal Long Term Care Insurance Program (FLTCIP) was established by the Long Term Care Security Act of 2000, which directed OPM to develop and administer a long term care insurance program for Federal employees and annuitants, current and retired members of the uniformed services, and qualified relatives.

In December 2001, OPM awarded a seven year contract to the Long Term Care Partners (LTCP) to offer long term care insurance coverage to eligible participants. Originally, the LTCP was a joint venture between the John Hancock Life Insurance Company (John Hancock) and the Metropolitan Life Insurance Company. The contract began on March 25, 2002, and expired on April 30, 2009. A new contract was awarded to John Hancock upon the expiration of the original contract. The LTCP, with OPM oversight, is responsible for all administrative functions of the program, including marketing and enrollment, underwriting, policy insurance, premium billing and collection, and claims administration.

Federal Long Term Care Insurance Program Operations at Long Term Care Partners

Portsmouth, New Hampshire

Report No. 1G-LT-00-08-047

AUGUST 6, 2009

The audit covered the FLTCIP's claim benefit payments, administrative expenses, and cash management activities for October 1, 2006 through July 31, 2008 and Experience Fund activities for FY 2007. For FY 2007, premiums and net investment income totaled \$262 million. The LTCP paid \$31 million in claim payments and charged the FLTCIP administrative expenses of \$35 million for the period October 1, 2006 through July 31, 2008.

Our auditors identified \$475,951 in program overcharges and two procedural issues. Specifically, we found:

- \$301,416 resulting from an overstatement in the FY 2007 financial statements;
- \$10,638 in unallowable lobbying costs for FY 2002 through April 2009;
- \$146,979 in unallowable charges to the FLTCIP;



- \$16,918 in lost investment income;
- The LTCP's claims system is not programmed to show adjustments resulting from benefit checks that are voided or cancelled, which could result in the potential overstatement of claims paid amounts in the system; and,
- John Hancock did not promptly transfer retained premiums collected from enrollees from a general account to its FLTCIP Separate Account, which delayed the investment of the funds. In addition, the FLTCIP funds were commingled with funds from John Hancock's other lines of business while in this general account.

The LTCP agreed with all amounts questioned and has already addressed one of the two procedural issues.

FEDERAL FLEXIBLE SPENDING ACCOUNT PROGRAM

The Federal Flexible Spending Account Program (FSAFEDS) was established in October 2000. It was implemented by OPM as a Health Insurance Premium Conversion Plan and is available to active Federal employees. In March 2003, OPM contracted with SHPS, Inc., (SHPS) to administer the program.

During this reporting period, we issued one report on the program operations for contract years 2004 through 2007.

Federal Flexible Spending Account Program Operations at SHPS, Inc. Louisville, Kentucky

Report No. 4A-RI-00-08-015

APRIL 8, 2009

The audit encompassed the FSAFEDS operations at SHPS. Specifically, the audit covered claim benefit payments, administrative expenses, and cash management activities for contract years 2005 through 2007. Additionally, we reviewed SHPS's administration

of the FSAFEDS Risk Reserve account from contract years 2004 through October 2007.

In conducting the audit, we reviewed approximately \$1.3 million in claim payments made during contract years 2006 and 2007, for proper adjudication and to test SHPS's accounting of forfeitures and deficits.

A deficit occurs when an FSAFEDS participant's total payroll deduction is less than the annual election amount and the funds that have been collected are not adequate to cover the claims that SHPS has reimbursed to the participant. Conversely, a forfeiture occurs when amounts remain in an FSAFEDS participant's annual election account after reimbursement of all submitted claims in a contract year.

We also reviewed approximately \$44.1 million in cash management activities for compliance with SHPS's policies and procedures, the contract, the applicable procurement regulations, and the laws and regulations governing the program.

Our auditors identified \$153,080 in misclassified funds and \$267,596 in program overcharges. Specifically, we found:

- \$153,080 that was misclassified as FSAFEDS deficits instead of claim overpayments;
- \$32,273 in overpayment recoveries that were not returned to the FSAFEDS Election Account;
- \$165,354 in uncashed FSAFEDS participant checks that were not returned to the FSAFEDS Risk Reserve;
- \$37,570 in unspecified forfeitures for 2006 that were not transferred to the FSAFEDS Risk Reserve; and,
- \$32,399 in Risk Reserve funds that were not transferred to OPM.

OPM is currently in the process of resolving the audit recommendations with SHPS.



PHARMACY BENEFIT MANAGERS

Various health carriers participating in the FEHBP have entered into Government-wide Service Benefit Plan contracts with OPM to provide health benefit plans authorized by the Federal Employees Health Benefits Act. To further enhance benefits available to Federal employees, these carriers have contracted with PBMs to provide both mail order and retail prescription drug benefits. The PBMs provide retail pharmacy benefits, process pharmacy claims, and pay retail pharmacy providers on behalf of their contracted health carriers.

During this reporting period, we issued reports for audits of 10 PBM contracts. For six of these audits, which covered approximately \$3.1 billion in pharmacy claim payments, we did not find any indication of noncompliance with the contract. However, we believe contract changes are needed to strengthen the controls, oversight, and transparency of the FEHBP Pharmacy Benefits Program. The contracts currently do not require the PBMs to provide specific pricing information that would assist us in determining whether the contract provided a fair value to the Government. These PBMs limited our reviews to what was negotiated in the contract between the health carrier and the PBM. Consequently, we were unable to determine whether the contract negotiated was advantageous, or at least fair, to the FEHBP.

The remaining four audits of WellPoint's PBM contracts provided a different picture. Because of the unique relationship between each of the health carriers, which were subsidiaries of WellPoint, and NexRx PBM (a WellPoint subsidiary), the FEHBP benefited from a fully transparent carrier/PBM arrangement. In April 2009, however, Express Scripts (a large national PBM) acquired WellPoint's PBM business and, as a result, these favorable conditions no longer exist.

The four contracts reviewed included WellPoint's contracts with BlueCross of California (BCC), Federal Blue HMO Ohio (Blue HMO), Blue Choice of Missouri (Blue Choice), and UNICARE Life and Health Insurance (UNICARE).

WellPoint

Mason, Ohio

Report Numbers

- 1D-M5-00-09-015 (BCC)
- 1D-R5-00-09-016 (Blue HMO)
- 1D-9G-00-09-017 (Blue Choice)
- 1C-17-00-09-018 (UNICARE)

SEPTEMBER 30, 2009

Our audit of WellPoint's operations for contract years 2004 through 2007 attempted to determine whether:

- Administrative expenses charged to the FEHBP were allowable, reasonable, and allocable;
- Correct rebate percentages were utilized to calculate the FEHBP's drug manufacturer rebates;
- The appropriate amount of drug manufacturer rebates were credited in a timely manner;
- The FEHBP was credited for any administrative fees earned by WellPoint as a result of FEHBP rebates;
- The costs charged to the FEHBP reconciled to those reported to OPM on the annual accounting statement; and,
- WellPoint properly removed profit included in the mail order pharmacy charges to the FEHBP.

The audits revealed the following:

- Pharmacy operations were administered in accordance with the contract between WellPoint and BCC and the contract between BCC and OPM (BCC audit).
- WellPoint did not return 2006 and 2007 rebates totaling \$1,521,954 to the FEHBP in a timely manner (Blue HMO audit).
- WellPoint did not remove all of the operating gain (profit) included in the mail order drug charges to the FEHBP. As a result, the FEHBP was overcharged \$65,225 in contract years 2006 and 2007 (Blue Choice audit).
- WellPoint charged the FEHBP \$9,330 in unallowable administrative expenses in contract years 2005 through 2007 (UNICARE audit).

WellPoint agreed with our audit findings on all four audits.



COMBINED FEDERAL CAMPAIGN

Our office audits the Combined Federal Campaign (CFC), the only authorized charitable fundraising drive conducted in Federal installations throughout the world. OPM has the responsibility, 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 criminal investigators for potential fraudulent activity. OPM's Office of CFC Operations (OCFCO) 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 two audit reports of local CFCs. Our auditors identified several violations of regulations and guidelines governing local CFC operations. Specifically, they identified the following types of errors:

- **Unallowable Campaign Expenses**

One PCFO inappropriately charged expenses to the campaign which were either not related to the current campaign or was not applied to the correct campaign year.



■ *PCFO Expense Reimbursement Not Properly Authorized*

One PCFO's reimbursement for campaign expenses was not properly approved by the LFCC prior to payment.

■ *CFC Expenses Not Reconcilable to the Approved Budget*

One PCFO did not maintain its CFC expenses in a format that was reconcilable to the budget approved by the LFCC.

■ *CFC Funds Maintained Incorrectly*

One PCFO did not maintain CFC funds separate from its corporate funds and did not keep the funds in an interest bearing account.

■ *Incomplete Donor Lists*

One PCFO did not provide all federations with a donor list that included which member organizations were to receive the donor's information.

■ *Local Eligibility Solicitation Process Documentation Not Maintained*

One LFCC did not maintain documentation for the required number of days to support its acceptance of local charity applications for eligibility in the campaign.

■ *Lack of Audit Documentation*

Due to difficulties encountered obtaining audit documentation we were unable to express an opinion on whether the PCFO appropriately administered one of the two campaigns in accordance with the regulations. Consequently, that organization is no longer the PCFO for that campaign. For 2008, OPM's OCFCCO merged the campaign with another in the surrounding area.

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, with approximately \$825 billion in assets for all Federal civilian employees and annuitants participating in the Civil Service Retirement System, the Federal Employees Retirement System, FEHBP, and FEGLI. These programs cover over eight million current and retired Federal civilian employees, including eligible family members, and disburse about \$101 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 69 criminal investigations and closed 58, with 299 still in progress. Our criminal investigations led to 76 arrests, 87 indictments and informations, 39 convictions and \$40,488,687 in monetary recoveries to the OPM Trust Fund. For a complete statistical summary of our office's investigative activity, refer to the table on page 28.

HEALTH CARE FRAUD

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

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



Our 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's debaring official when investigations of FEHBP health care providers reveal evidence of violations that may warrant administrative sanctions.

HEALTH CARE FRAUD CASES

Pharmaceutical Company to Pay Over \$1 Billion for Fraudulent Marketing

In December 2007, the OPM OIG's Boston Field Office joined a national investigation of Pfizer, Inc., and its subsidiary Pharmacia & Upjohn Company, Inc., into allegations that the company marketed four drugs – Lyrica, Bextra, Geodon and Zyxon for uses not approved by the Food and Drug Administration (FDA), often called “off-label promotion”. This represents the largest health care fraud settlement in the history of the Department of Justice, which resolved criminal and civil liabilities arising from the illegal promotion of pharmaceutical products.

Pharmacia & Upjohn Company, Inc., agreed to plead guilty to a felony violation of the Food, Drug and Cosmetic Act for misbranding Bextra with the intent to defraud or mislead. Bextra is an anti-inflammatory drug that Pfizer pulled from the market in 2005. Under the provisions of the Food, Drug and Cosmetic Act, a company must specify the intended uses of a product in its new drug application to the FDA. Once approved, the drug may not be marketed or promoted for “off-label” uses. Pfizer promoted the sale of Bextra for several uses and dosages that the FDA specifically declined to approve due to safety concerns.

In August 2009, Pfizer agreed to pay \$1 billion to resolve allegations under the civil False Claims Act relative to their illegal promotion of Lyrica, Bextra, Geodon and Zyxon that caused false claims to be

submitted to Government health care programs for uses that were not medically accepted and therefore not covered by those programs. The civil settlement also resolves allegations that Pfizer paid kickbacks to health care providers to induce them to prescribe these drugs.

As part of the above civil settlement, the FEHBP will receive damages totaling \$33,993,827. Three percent of that sum is mandated by statute for the Health Care Fraud Accountability Control Fund.

The case was investigated by the FDA, Federal Bureau of Investigations (FBI), Department of Health and Human Services (HHS) OIG, Defense Criminal Investigative Service (DCIS), U.S. Postal Service (USPS) OIG and our office.

Pharmaceutical Company Agreed to Pay FEHBP Over \$1 Million in Civil Settlement

This investigation was initiated in October 2004 with allegations that the Nichols Institute Diagnostics (NID) knowingly profited from the sale and use of Parathyroid Hormone (PTH) tests and from the sale of Vitamin D analogue used to treat End Stage Renal Disease (ESRD) patients. These tests falsely over-diagnosed the level and extent of parathyroid and bone disease in ESRD patients.

The civil settlement resolves allegations that NID manufactured, marketed and sold the Intact PTH test kits, despite knowing that between May 1, 2000 and April 30, 2006, some of these kits produced results that were materially inaccurate and unreliable.

In April 2009, NID pled guilty in the Eastern District of New York to felony misbranding. As part of the plea, NID agreed to pay a criminal fine of \$40 million and civil settlement of \$262 million. The FEHBP received \$1,019,624 of the civil settlement.

This was a joint investigation between our office, HHS OIG, FBI, FDA, and the New York State Medicaid Fraud Control Unit.



Houston Strike Force Targets Health Care Fraud

Our office participated in a joint DOJ and HHS Medicare Fraud Strike Force (Strike Force) investigation that led to the indictment of 32 individuals for schemes to submit more than \$16 million in false Medicare and other Federal health benefits programs' claims. The Strike Force in Houston, Texas, is the fourth phase of a targeted criminal, civil, and administrative effort against individuals and health care companies that fraudulently billed the Medicare program and other Federal health benefits programs.

In July 2009, 32 individuals were arrested in various cities throughout the United States. In addition, Strike Force agents from OPM OIG participated in the execution of 12 search warrants at health care businesses and homes across the Houston area. Our office estimates over \$300,000 in illegal claims billed to the FEHBP by the targeted durable medical equipment companies.

The Strike Force is a multi-agency team of Federal, state, and local investigators. It is designed to investigate providers who fraudulently bill health benefits programs.

Border Patrol Agent Pled Guilty to Distributing FEHBP Acquired Prescription Drugs

In our semiannual report ending September 30, 2008, we reported on a border patrol agent who was charged with distributing controlled substance drugs. The investigators found that the agent had submitted several claims to an FEHBP carrier for prescription drugs.

This joint investigation determined that the agent had used and distributed the prescription drugs, and had participated in "doctor shopping," a practice of secretly consulting with multiple physicians to obtain duplicate prescriptions. The FEHBP carrier determined that

the agent had obtained prescription drugs for over 16 months.

In September 2009, the agent pled guilty in Chavez County, New Mexico, to 11 counts of controlled substance/prohibited acts. He was sentenced to 18 months probation.

This investigation was conducted by our office and the U.S. Customs and Border Protection.

Massages Led to Criminal Convictions

In our last semiannual report, we reported on two owners of a Tamarac, Florida, clinic who billed the FEHBP for physical therapy; but actually provided massages and facials, services not covered by the FEHBP. Most of the patients of the clinic worked for the United States Postal Service (USPS). The clinic submitted over \$1.2 million in claims to the FEHBP. As a result of an undercover operation and search warrant, criminal charges were filed.

In March 2009, the owners pled guilty to an organized scheme to defraud. They were sentenced to 10-years of probation and ordered to pay restitution of \$1 million to OPM and \$87,000 to the USPS. In addition to paying restitution, they agreed to have no direct involvement in preparing or submitting any bills to public or private insurance companies, and to provide truthful statements regarding on-going insurance and health care fraud investigations.

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

Clinic Business Manager Guilty of Fraud

In our last semiannual report, we reported on an Illinois respiratory clinic business manager who pled guilty to felony health care fraud and 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. From 1997 through 2006, the clinic engaged in a pattern of fraudulent and abusive billing and collections.

In September 2009, the clinic business manager was sentenced to over nine years incarceration and ordered to pay \$100,000 in restitution.

Southern California Lab Settles Civil False Claims Case for \$2.5 Million

In April 2009, an owner of the Cardiac Monitoring Services (CMS) and his wife agreed to a civil settlement of \$2.5 million for false claim allegations related to cardiac monitoring. The FEHBP will receive \$535,228 from this settlement.

CMS billed the patients' health insurance for cardiac monitoring services. Instead of billing for just the analysis of the cardiac data, CMS would submit claims for tests that the patients' physicians did not request and services they did not provide. In addition, they billed for a higher level of service than was actually provided.

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

Former Veterans Affairs Employee Sentenced for FEHBP Fraud

As reported in our last semiannual report, a U.S. 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 enrollment

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 enrollment form and as her brother on the Federal Employees' Group Life Insurance 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.

In May 2009, the employee pled guilty to one count of felony insurance written false claim. She was subsequently sentenced to five years of probation and ordered to pay \$12,000 in restitution to the Government.

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.



Son of Deceased Annuitant Ordered to Pay \$1.7 Million to the Civil Service Retirement System

The son of a deceased annuitant failed to notify OPM of his father's death in October 1995. Following his father's death, monthly Federal retirement benefits continued to be electronically deposited into his father's bank account. The son was a joint holder on the bank account with his father, and until August 2006, continued to use the benefits for his personal use, including payment of his mortgage. After his father's death, the son collected \$608,467. OPM was able to reclaim \$60,814 from the bank account through the U. S. Department of the Treasury, which left an overpayment of \$547,669.

In August 2008, the son, 71 years old, pled guilty to theft of Government funds. He faces up to 10 years in Federal prison and a \$250,000 fine.

In addition, the U.S. Attorney's Office reached a civil settlement of more than \$1.7 million with the son, for knowingly submitting false claims to the U. S. Government. The son agreed to pay over \$1.7 million, and forfeit his house and other property of which OPM will receive \$547,669.

This investigation was conducted by our office and prosecuted both criminally and civilly by the U.S. Attorney's Office District of Utah.

Daughter Pled Guilty to Theft of Government Funds

In our last semiannual report, we reported the indictment of the daughter of a deceased Federal annuitant. In June 2009, she pled guilty to theft of Government funds.

A death match conducted with SSA revealed that the Federal annuitant died in 1982. OPM was not notified of her death and continued to issue annuity payments until 2005, resulting in an overpayment of \$235,787.

Our investigators found documents in the annuitant's file that contained her alleged signature; however, the dates on the documents were after her death.

The daughter admitted to forging her mother's name on U.S. Treasury checks and opening several joint bank accounts to receive OPM electronic annuity deposits. The investigation also revealed that the daughter forged her mother's name on several OPM correspondence forms to make it appear that her mother was alive.

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

Con-Artist Sentenced to Over Six Years in Prison for Fraud and Conspiracy

In June 2009, a career con-artist pled guilty to wire fraud and conspiracy to commit theft of Government funds. She admitted to conspiring with others to fraudulently divert Federal benefits by stealing the identities of deceased Federal beneficiaries. After obtaining control of approximately 126 Federal beneficiaries accounts, the con-artist diverted the funds from the decedent's accounts to new bank accounts and addresses.

The con-artist would use internet search engines to identify online obituaries for deceased Federal employees and veterans. The con-artist posed as a physician and would contact the various hospitals to obtain personally identifiable information on the decedents. She would then contact the family by telephone, posing as an employee of either OPM, VA, or SSA. During the conversation, she convinced the family member that it was not necessary to further notify the agency of the death. Subsequently, she would contact the benefit paying agency posing as the beneficiary and change the electronic funds transfer to an account she controlled. To prevent the agencies from contacting the families of the decedents, she would also change the beneficiaries' correspondence address to a post office box or mail drop.



This case involved numerous investigative techniques, including undercover and electronic surveillance and the use of a wiretap. Several search warrants were executed in New Orleans that resulted in the seizure of numerous high-end electronics and other valuables traced back to the crime. The seized items were stored in the New Orleans area; however, all items seized were looted in the aftermath of Hurricane Katrina.

The con-artist perpetrated this scheme against OPM, VA, U. S. Department of Defense, and the Railroad Retirement Board (RRB) retirement systems, resulting in the theft of over \$700,000. The total loss to OPM's retirement programs was \$204,349. Through the U.S. Treasury Department reclamation process, OPM was able to recover \$138,048 of the fraudulent payments.

In September 2009, the con-artist was sentenced to over six years in prison on charges of wire fraud and conspiracy to commit theft of Government funds. She was also ordered to forfeit \$21,000 in cash and to pay restitution to OPM in the amount of \$66,303.

The case was investigated by the U.S. Secret Service, U. S. Postal Inspection Service, DCIS, and the OIGs from VA, SSA, RRB, and our office.

Former FDIC Employee Fabricated Documents for Early Retirement

In May 2009, a former Federal Deposit Insurance Corporation (FDIC) employee pled guilty to one count of theft of Government funds. We received information alleging that the former employee submitted fabricated military discharge documents, DD Form 214, increasing his active military duty time in order to receive an early retirement from the FDIC.

The former employee was granted early retirement from the FDIC in May 2000. During the execution of a search warrant on another complaint, agents discovered questionable military documents listing the former employee's rank as a Major, and indicating

that he received high level commendation medals. In addition, the forms credited the former employee with 11 years of active duty with classified duty assignments.

The former employee admitted to submitting the forged documents to FDIC's personnel officials in order to collect a higher annuity payment than he was entitled to receive. We determined that the former employee was overpaid \$137,704.

Daughter of Deceased Annuitant Pled Guilty to Theft of Government Funds

Through a computer match conducted between OPM's active annuity roll and SSA's death records, OPM determined that a retired Federal annuitant died in February 1993. However, benefits continued to be paid after her death, resulting in an overpayment of \$187,524.

Our investigators interviewed the deceased annuitant's daughter, who admitted to forging her mother's name on almost 400 personal checks payable to herself and written on her deceased mother's account. The daughter also wrote checks from her own bank account, payable to her mother. She then deposited the checks to her mother's account to make it appear that her deceased mother was alive.

The daughter pled guilty to theft of Government funds. In August 2009, she was sentenced to one year home detention and five years of probation. She was ordered to pay OPM \$187,524 in restitution.

Florida Man Attempts to Conceal Stolen Annuity with the Help of His Girlfriend

As a result of a death match with SSA, OPM became aware of the death of an annuitant whose annuity payments continued to be deposited into a joint bank account with his son. The annuitant died in June 1999, and his unreported death resulted in an overpayment of \$115,216.



Our investigators determined that the son was the only person with access to the joint bank account. They also determined that the deceased annuitant's retirement records contained documents, signed after his death, bearing his forged signature making it appear that the annuitant was still alive.

Using his deceased father's annuity benefits, the son wrote checks to his girlfriend. The girlfriend deposited the money into her bank account and in turn was instructed to return the funds to him. The girlfriend claimed that she feared being harmed by him and did not question his actions. She also believed that the money was from the deceased annuitant's will.

Based on testimony before the Federal grand jury in Fort Lauderdale, Florida, our investigator obtained an indictment for the son for theft of Government funds. Since the son was already incarcerated by the state on an unrelated matter, it was necessary to transfer him to Federal custody for his initial appearance in Federal court.

In June 2009, the son was sentenced to two years incarceration, followed by three years of supervised release, and ordered to pay \$115,216 in restitution to OPM.

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

SPECIAL INVESTIGATIONS

Former OPM Contractor Employee Confesses to Fabricating Record Checks

A former Washington, D.C. area background investigator employed by a contracting firm that conducts background investigations for OPM's Federal Investigative Services Division (FISD) pled guilty to one count of fraud.

The background investigator confessed to fabricating at least 10 employment verification records involving

potential Government employees receiving Top Secret clearances from January through June 2007. The background investigator's false representations in his reports of investigation (ROI) required OPM FISD to reinvestigate numerous background investigations to include conducting verifications of previous employment.

In June 2009, he was sentenced to 180 days incarceration (suspended); two years supervised probation; a \$1,000 fine; and ordered to pay \$10,000 in restitution to OPM.

Former OPM Employee Sentenced for Falsifying Records

A former background investigator employed by FISD, pled guilty in the District Court for the District of Columbia to making a false statement. In June 2009, she was sentenced to five months of imprisonment, five months house arrest with electronic monitoring via ankle bracelet, three years probation, and ordered to pay full restitution to OPM in the amount of \$101,180.

Our investigation revealed that between December 2004 and June 2006, in at least a dozen ROIs on background investigations, the former background investigator represented that she had interviewed sources when; in fact, she had not conducted the interviews.

Former OPM Contract Employee Falsifies Credit Checks

In August 2009, a former investigative specialist employed by a contracting firm that conducts background investigations for OPM's FISD pled guilty to one count of fraud. The specialist was tasked with conducting credit check verifications. However, our investigators found that between March 2007 and August 2008, she failed to conduct 1600 credit check verifications, and falsified the results of those verifications.



The investigative specialist's falsifications required her former employer to reinvestigate numerous background investigations and conduct credit check verifications, at a cost of \$95,275 to the FSD contractor and \$4,262 to OPM.

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 618 formal complaints and calls on these hotlines during the reporting period. The table on page 28 reports the activities of each hotline.

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

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

RETIREMENT FRAUD AND SPECIAL INVESTIGATIONS HOTLINE

The Retirement Fraud and Special Investigations Hotline provides a channel for reporting waste, fraud and abuse within the agency and its programs. During this reporting period, this hotline received a total of 283 contacts, including telephone calls, emails, 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 339 complaints during this reporting period, including telephone calls, emails, 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 31,017 active suspensions and debarments from the FEHBP.

During the reporting period, our office issued 468 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 1,095 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.

Five Detroit Area Health Care Providers Suspended from the FEHBP

In September 2009, our office suspended five individuals from the Detroit, Michigan area, consisting of three physicians, one physical therapist, and one occupational therapist, who had been indicted as the result of an investigation conducted by a multi-agency Medicare Fraud Strike Force. The five are part of a group of approximately 58 physicians, therapists, employees of clinics and billing companies, patients, and company owners who were indicted in June 2009 for various health care fraud-related violations, primarily involving infusion therapy and physical/occupational therapies. According to the



U.S. Attorney's Office for the Eastern District of Michigan, all 58 individuals allegedly participated in a scheme to defraud Federal health care programs of over \$50 million.

Under the FEHBP administrative sanctions statute authorizing suspension of a health care provider requires that reliable evidence exists that a violation has occurred. In addition, there must be a need for immediate action, to protect the health and safety of FEHBP covered persons. In this case, the reason for the urgent need for suspension was a U.S. Magistrate Judge's order which stipulated as a condition of release on bail, that each of the five providers would refrain from billing any Federal health care program for services or supplies.

These providers will remain suspended until final disposition of the criminal charges pending against them.

Louisiana Cardiologist and Practices Receive 10-Year Debarment

In our semiannual report for the period ending September 30, 2008, we reported our suspension of a Louisiana cardiologist and two medical facilities he owned, based upon the cardiologist's indictment on 92 counts of health care fraud. He was convicted in December 2008, and a judgment was entered against him in June 2009. The sentence included 120 months of incarceration per count to run concurrently; three years supervised release per count to run concurrently; a \$387,511 restitution; a \$175,000 fine; and a \$5,100 special assessment.

The convictions constitute a mandatory basis for debarment under the FEHBP's administrative sanctions statutory authority. During the current reporting period, we imposed a 10-year term of debarment, considering the doctor's association with the FEHBP and the repeated nature of his offenses. In addition, the risks that his offenses may have caused for patients by subjecting them to medically unnecessary cardiac procedures, and the false

diagnostic reports and other medical documents created to support fraudulent health insurance claims contributed to the aggravated nature of his conduct. The length of debarment includes the prior period of suspension. In addition, based upon ownership and control, we debarred his medical facilities, which were used in committing the fraudulent activities.

Texas Surgical Assistant Debarred

In our semiannual report for the period ending September 30, 2007, we reported our suspension of a physician and his surgical assistant because of the suspensions of their professional licenses by the Texas State medical board. In November 2007, the state medical board revoked the surgical assistant's license.

Under the FEHBP administrative sanctions statute, we may debar health care providers whose professional licensure has been revoked, suspended, restricted or deemed nonrenewable by a state licensing authority. In light of the egregious nature of the surgical assistant's actions (he represented himself as a physician to patients seeking breast augmentation or liposuction, even though he had no license or training to perform these procedures), we determined that his debarment was warranted. Under our sanctions regulations, it will run for a term concurrent with the period during which the assistant's license is revoked.

Convicted West Virginia Osteopath Debarred

In our semiannual report for the period ending September 30, 2008, we reported our suspension of a doctor of osteopathic medicine who had been indicted in Federal district court on 42 counts of conspiracy to sell, distribute, and/or dispense controlled substances. Evidence in the case indicated that the doctor conspired to obtain possession of controlled substances by fraud and deception by writing and



filling prescriptions for drugs in the name of his patients, without their knowledge or authorization. In August 2008, the doctor was convicted of these charges. Judgment was entered against him on the same date.

The convictions form a mandatory basis for debarment under the FEHBP's administrative sanctions statutory authority. In determining the appropriate length of debarment, we account for the presence of any of the aggravating or mitigating factors identified in our administrative sanctions regulations. We identified several aggravating factors in the doctor's case, including his submission of claims to the FEHBP carriers; the extended period during which his offenses occurred (2001 to 2007); the risk to patient safety associated with his creation of fraudulent prescriptions; and his practice of providing prescriptions in the names of individuals he did not know to other persons in exchange for sexual favors. Based on these factors, we imposed a five- year debarment.

Pennsylvania Chiropractor Debarred After Fraud Conviction

During a prior reporting period, the OIG's Office of Investigations referred to the administrative sanctions staff the case of a Pennsylvania chiropractor who had been convicted in September 2008 of insurance fraud and theft by deception.

The billing records maintained by the FEHBP carrier Highmark BlueShield indicated that from December 2003 through December 2006, the chiropractor's claims reflected a systemic pattern of fraud. The prosecution estimated that the total amount claimed falsely by the chiropractor in this period ranged between \$318,524 and \$447,703. In addition to submitting duplicate claims for the same services, he inflated the number of services he performed, and billed for services that he himself did not render. He also referred patients to Certified Massage Therapists (CMT) with whom he had contracted. While these persons were not licensed to provide health care services in Pennsylvania, the chiropractor nonetheless billed health insurance carriers as if they were licensed employees of his clinic. Health insurers do not consider CMT services to be reimbursable unless the services are performed by a physician or performed under the direct supervision of a physician, but neither of those criteria was present in this case.

The provider was required to pay the FEHBP \$318,524 in restitution.

We debarred the provider for five years based upon the aggravating factors associated with his offense, including the financial loss to an FEHBP carrier and the prolonged period during which he knowingly submitted false claims. In addition, based upon ownership and control, we debarred his clinic which was used in committing the fraudulent activities.



Statistical Summary of Enforcement Activities

JUDICIAL ACTIONS:

Arrests	76
Indictments and Informations	87
Convictions	39

JUDICIAL RECOVERIES:

Restitutions and Settlements	\$40,488,687
Fines, Penalties, Assessments, and Forfeitures	\$40,302,650

RETIREMENT AND SPECIAL INVESTIGATIONS

HOTLINE AND COMPLAINT ACTIVITY:

Retained for Further Inquiry	33
Referred to:	
OPM Program Offices	143
Other Federal Agencies	107
Total	283

HEALTH CARE FRAUD HOTLINE AND COMPLAINT ACTIVITY:

Retained for Further Inquiry	71
Referred to:	
OPM Program Offices	72
Other Federal/State Agencies	67
FEHBP Insurance Carriers or Providers	129
Total	339

Total Hotline Contacts and Complaint Activity 618

ADMINISTRATIVE SANCTIONS ACTIVITY:

Debarments and Suspensions Issued	468
Health Care Provider Debarment and Suspension Inquiries	1,095
Debarments and Suspensions in Effect at End of Reporting Period	31,017

APPENDICES

APPENDIX I Final Reports Issued With Questioned Costs for Insurance Programs April 1, 2009 to September 30, 2009

Subject	Number of Reports	Questioned Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	11	\$20,932,594
B. Reports issued during the reporting period with findings	16	25,025,118
Subtotals (A+B)	27	45,957,712
C. Reports for which a management decision was made during the reporting period:	15	35,381,218
1. Disallowed costs	N/A	35,648,831
2. Costs not disallowed	N/A	(267,613) ¹
D. Reports for which no management decision has been made by the end of the reporting period	12	10,576,494
E. Reports for which no management decision has been made within 6 months of issuance	0	0

¹Represents 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

April 1, 2009 to September 30, 2009

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	7	\$329,094
B. Reports issued during the reporting period with findings	1	85,328
Subtotals (A+B)	8	414,422
C. Reports for which a management decision was made during the reporting period:	5	241,164
1. Disallowed costs	N/A	241,164
2. Costs not disallowed	N/A	0
D. Reports for which no management decision has been made by the end of the reporting period	3	173,258
E. Reports for which no management decision has been made within 6 months of issuance	3	173,258

APPENDIX II – B

Final Reports Issued with Recommendations for Better Use of Funds

April 1, 2009 to September 30, 2009

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



APPENDIX III

Insurance Audit Reports Issued

April 1, 2009 to September 30, 2009

Report Number	Subject	Date Issued	Questioned Costs
4A-RI-00-08-015	SHPS, Inc., as Administrator of the Federal Flexible Spending Account Program for Contract Years 2004 through 2007 in Louisville, Kentucky	April 8, 2009	\$267,596
1B-43-00-08-048	AXA Assistance as Administrator for the Panama Canal Area Benefit Plan in Miami, Florida	May 20, 2009	460,191
1C-52-00-09-027	Health Alliance Health Plan in Detroit, Michigan	June 2, 2009	
1D-SJ-00-09-021	BlueShield of California Access+ HMO in San Francisco, California	June 9, 2009	581,735
1A-10-13-09-001	Highmark BlueCross BlueShield in Camp Hill, Pennsylvania	June 15, 2009	872,886
1A-10-15-09-009	BlueCross BlueShield of Tennessee in Chattanooga, Tennessee	June 16, 2009	537,568
1A-99-00-08-065	Global Claims-to-Enrollment Match for BlueCross and BlueShield Plans in Washington, D.C.	June 23, 2009	2,961,748
1C-6Y-00-09-004	Advantage Health Solutions, Inc., in Indianapolis, Indiana	June 24, 2009	439,823
1A-99-00-09-011	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.	July 20, 2009	4,387,806
1C-X4-00-09-055	GHI HMO Select, Inc., in Austin, Texas Proposed Rate Reconciliation	July 29, 2009	
1C-6U-00-09-059	FirstCare – Central Texas in Austin, Texas Proposed Rate Reconciliation	July 29, 2009	
1C-6V-00-09-054	GHI HMO Select, Inc., in Austin, Texas Proposed Rate Reconciliation	July 29, 2009	
1C-CK-00-09-058	FirstCare – West Texas in Austin, Texas Proposed Rate Reconciliation	July 29, 2009	
1C-51-00-09-050	Health Insurance Plan of New York in Austin, Texas Proposed Rate Reconciliation	July 29, 2009	



APPENDIX III Insurance Audit Reports Issued

April 1, 2009 to September 30, 2009

(Continued)

Report Number	Subject	Date Issued	Questioned Costs
1G-LT-00-08-047	Long Term Care Partners, LLC in Portsmouth, New Hampshire	August 6, 2009	475,951
1C-E3-00-09-010	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Rockville, Maryland	August 6, 2009	7,545,775
1C-63-00-09-034	Kaiser Foundation Health Plan, Inc., Hawaii Region in Honolulu, Hawaii	August 6, 2009	
1H-02-00-08-002	American Postal Workers Union's Pharmacy Operations as Administered by Medco Health Solutions in Franklin Lakes, New Jersey	August 14, 2009	
1H-02-00-08-004	Government Employees Hospital Association's Pharmacy Operations as Administered by Medco Health Solutions in Franklin Lakes, New Jersey	August 14, 2009	
1C-K9-00-09-007	PacifiCare of Nevada in Cypress, California	September 8, 2009	
1C-Q8-00-09-008	Univera Healthcare in Buffalo, New York	September 8, 2009	3,982,122
1C-26-00-09-022	HealthAmerica Pennsylvania, Inc., in Pittsburgh, Pennsylvania	September 8, 2009	
1C-GF-00-09-006	PacifiCare of Texas in Cypress, California	September 8, 2009	
1H-02-00-08-039	American Foreign Service Protective Association's Pharmacy Operations as Administered by Medco Health Solutions, Inc., in Franklin Lakes, New Jersey	September 10, 2009	
1H-02-00-08-041	Government Employees Health Association's Pharmacy Operations as Administered by Medco Health Solutions, Inc., in Franklin Lakes, New Jersey	September 10, 2009	
1H-02-00-08-040	American Postal Workers Union's Pharmacy Operations as Administered by Medco Health Solutions, Inc., in Franklin Lakes, New Jersey	September 15, 2009	



APPENDIX III

Insurance Audit Reports Issued

April 1, 2009 to September 30, 2009

(Continued)

Report Number	Subject	Date Issued	Questioned Costs
1H-02-00-08-042	Special Agents Mutual Benefits Association's Pharmacy Operations as Administered by Medco Health Solutions, Inc., in Franklin Lakes, New Jersey	September 15, 2009	
1C-17-00-09-018	UNICARE Life and Insurance Company's Pharmacy Operations as Administered by WellPoint Health Networks, Inc., in Mason, Ohio	September 30, 2009	10,628
1D-R5-00-09-016	Federal Blue HMO Ohio's Pharmacy Operations as Administered by WellPoint Health Networks, Inc., in Mason, Ohio	September 30, 2009	1,691,530
1D-9G-00-09-017	Blue Choice of Missouri's Pharmacy Operations as Administered by WellPoint Health Networks, Inc., in Mason, Ohio	September 30, 2009	74,380
1D-M5-00-09-015	BlueCross of California's Pharmacy Operations as Administered by WellPoint Health Networks, Inc., in Mason, Ohio	September 30, 2009	
1C-CK-00-08-063	First Care – West Texas in Austin, Texas	September 30, 2009	561,007
1C-6U-00-08-064	First Care – Central Texas in Austin, Texas	September 30, 2009	174,372
TOTALS			\$25,025,118



APPENDIX IV Internal Audit Reports Issued

April 1, 2009 to September 30, 2009

Report Number	Subject	Date Issued
4A-IS-00-08-014	Security of Personally Identifiable Information in the OPM's Federal Investigative Services Division in Washington, D.C.	April 21, 2009
4A-CA-00-08-036	Inventory and Management of Sensitive Property at OPM in Washington, D.C.	June 15, 2009

APPENDIX V Combined Federal Campaign Audit Reports Issued

April 1, 2009 to September 30, 2009

Report Number	Subject	Date Issued
3A-CF-00-08-035	The 2004 through 2006 Northern California Combined Federal Campaigns in Redding, California	April 10, 2009
3A-CF-00-08-031	The 2005 and 2006 North Central Texas Combined Federal Campaigns in Dallas, Texas	June 18, 2009



APPENDIX VI

Information Systems Audit Reports Issued

April 1, 2009 to September 30, 2009

Report Number	Subject	Date Issued
4A-CI-00-09-053	Information Technology Security Program at OPM in Washington, D.C.	May 27, 2009
4A-HR-00-09-033	Information Technology Security Controls of OPM's Enterprise Human Resources Integration Data Warehouse in Washington, D.C.	June 1, 2009
4A-HR-00-09-032	Information Technology Security Controls of OPM's Electronic Official Personnel Folder in Washington, D.C.	June 2, 2009
1C-59-00-09-002	Information Systems General and Application Controls at Kaiser Foundation Health Plan, Northern and Southern California Regions in Oakland and Pasadena, California	June 18, 2009
1B-43-00-08-066	Information Systems Application Controls at AXA Assistance as Administrator for the Panama Canal Area Benefit Plan in Panama City, Panama	June 18, 2009
4A-CI-00-09-052	Information Security Controls of OPM's Integrated Security Management System in Washington, D.C.	August 10, 2009
4A-CI-00-09-066	Consolidated Business Information System Implementation Project at OPM in Washington, D.C.	September 28, 2009



APPENDIX VII

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

April 1, 2009 to September 30, 2009

Report Number	Subject	Date Issued
1A-10-15-02-007	BlueCross BlueShield of Tennessee in Chattanooga, Tennessee; 13 total recommendations; 1 open recommendation	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; 1 open recommendation	March 31, 2004
1A-10-41-03-031	BlueCross BlueShield of Florida in Jacksonville, Florida; 19 total recommendations; 3 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; 2 open recommendations	July 28, 2004
1A-10-61-04-009	Anthem BlueCross BlueShield of Nevada in Reno, Nevada; 5 total recommendations; 1 open recommendation	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; 1 open recommendation	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; 1 open recommendation	December 15, 2004
4A-IS-00-05-026	OPM's Information Technology Security Controls of the Electronic Questionnaire for Investigative Processing; 20 recommendations; 1 open recommendation	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; 1 open recommendation	July 27, 2005
1A-10-83-05-002	BlueCross BlueShield of Oklahoma in Tulsa, Oklahoma; 16 total recommendations; 2 open recommendations	October 17, 2005



APPENDIX VII

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

April 1, 2009 to September 30, 2009

(Continued)

Report Number	Subject	Date Issued
1A-99-00-04-027	Global Duplicate Claim Payments for BlueCross and BlueShield Plans in Washington, D.C.; 16 total recommendations; 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
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; 2 open recommendations	July 3, 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 FY 2006; 12 total recommendations; 1 open recommendation	September 22, 2006
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; 3 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; 2 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; 1 open recommendation	March 29, 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



APPENDIX VII

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

April 1, 2009 to September 30, 2009

(Continued)

Report Number	Subject	Date Issued
1A-10-30-05-069	WellPoint BlueCross BlueShield of Colorado in Mason, Ohio; 18 total recommendations; 4 open recommendations	April 25, 2007
1A-10-03-06-079	BlueCross BlueShield of New Mexico in Albuquerque, New Mexico; 6 total recommendations; 2 open recommendations	June 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; 2 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; 3 open recommendations	July 25, 2007
3A-CF-00-06-056	The 2003 and 2004 Combined Federal Campaigns for Central Iowa in Des Moines, Iowa; 7 total recommendations; 1 open recommendation	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 FY 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
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
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
1A-10-84-07-023	Excellus BlueCross BlueShield in Utica, New York; 4 total recommendations; 1 open recommendation	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
1A-10-18-06-052	Anthem Midwest in Mason, Ohio; 16 total recommendations; 2 open recommendations	February 20, 2008



APPENDIX VII

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

April 1, 2009 to September 30, 2009

(Continued)

Report Number	Subject	Date Issued
4A-CI-00-06-031	OPM's Compliance with Federal Tax Laws in Washington, D.C.; 9 total recommendations; 1 open recommendation	February 27, 2008
4A-RI-00-05-037	OPM's Reclamation Process in Washington, D.C.; 10 total recommendations; 3 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; 1 open recommendation	March 20, 2008
1A-10-11-08-001	Information Systems General and Application Controls at BlueCross BlueShield of Massachusetts in Boston, Massachusetts; 7 total recommendations; 1 open recommendation	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 25, 2008
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
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
1A-99-00-07-043	Health Care Service Corporation in Chicago, Illinois and Richardson, Texas; 22 total recommendations; 3 open recommendations	September 5, 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-6Q-00-07-029	Universal Care, Inc., of California in Signal Hill, California; 2 total recommendations; 2 open recommendations	September 15, 2008



APPENDIX VII

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

April 1, 2009 to September 30, 2009

(Continued)

Report Number	Subject	Date Issued
4A-CI-00-08-022	Federal Information Security Management Act for FY 2008; 19 total recommendations; 12 open recommendations	September 23, 2008
4A-CF-00-08-025	OPM's FY 2008 Consolidated Financial Statement; 3 total recommendations; 3 open recommendations	November 14, 2008
1C-CY-00-08-012	PacifiCare of California, Cypress, California; 2 total recommendations; 2 open recommendations	November 28, 2008
1A-10-92-08-021	Information Systems General and Application Controls at CareFirst BlueCross BlueShield and the Federal Employees Operations Center; 13 total recommendations; 13 open recommendations	November 28, 2008
1A-10-53-08-045	BlueCross BlueShield of Nebraska in Omaha, Nebraska; 6 total recommendations; 2 open recommendations	January 7, 2009
1A-10-83-08-018	Health Care Service Corporation in Tulsa, Oklahoma; 16 total recommendations; 4 open recommendations	January 9, 2009
3A-CF-00-07-039	The 2004 and 2005 Combined Federal Campaigns of New York City in New York, New York; 11 total recommendations; 3 open recommendations	February 4, 2009
1C-NM-00-08-049	Health Plan of Nevada in Las Vegas, Nevada; 2 total recommendations; 2 open recommendations	February 5, 2009
3A-CF-00-07-037	The 2004 and 2005 Greater Los Angeles Area Combined Federal Campaigns in Los Angeles, California; 13 total recommendations; 5 open recommendations	February 18, 2009
1A-10-44-08-046	BlueCross BlueShield of Arkansas in Little Rock, Arkansas; 7 total recommendations; 2 open recommendations	February 25, 2009
1A-10-63-08-044	WellPoint Southeast in Mason, Ohio; 7 total recommendations; 4 open recommendations	March 3, 2009
1B-45-00-08-016	Coventry Health Care as Underwriter and Administrator for the Mail Handlers Benefit Plan in Rockville, Maryland; 16 total recommendations; 11 open recommendations	March 26, 2009



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