

Office of the Inspector General

**SEMIANNUAL
REPORT
TO CONGRESS**

April 1, 2000 - September 30, 2000

U.S. Office of Personnel Management

OIG-SAR-23
October 2000

October 31, 2000

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

Dear Ms. Lachance:

I respectfully submit the Office of the Inspector General's Semiannual Report to Congress for the period April 1, 2000 to September 30, 2000. This report describes our office's activities during the past six-month reporting period.

Should you have any questions about the report or any other matter of concern, please do not hesitate to call upon me for assistance.

Sincerely,

*Patrick E. McFarland
Inspector General*

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Message from the IG

Before our next semiannual report is issued, a new administration will be in place. Reflecting back on two major messages of this most recent presidential campaign, it was very noticeable how often the themes of cooperation and bipartisanship, along with a lean and efficient federal government, were expressed over and over.

The overriding reality of our present operating environment is that, at least on the federal level, government programs must operate effectively with absolute minimum resource allocations. This has shaped the activities of our office, along with the other Offices of Inspector General (OIG) in several ways. For example, it has challenged us to conduct our activities in the most resource-efficient manner possible. In doing so, we have remained absolutely committed to producing results that provide value to the taxpayer. Further, as an entity specifically tasked to address efficiency and integrity issues, there are expectations that we take the broadest possible interpretation of our responsibilities and expand the depth and breadth of our coverage of agency programs.

And, with respect to a cooperative spirit in government, our OIG recognizes, along with the rest of the federal IG community, that it is neither possible nor desirable for an IG to assume sole responsibility for combating fraud, waste and abuse in agency programs. In fact, the combined and coordinated efforts of an agency and its IG are absolutely necessary to achieve the level of integrity and efficiency that the public justifiably expects.

Our office has used partnerships with our agency's program offices to address issues that were, and would otherwise have remained, unsolvable if addressed by IG efforts alone. For example, a joint IG-OPM quality improvement team developed an innovative approach to the problem of a long audit cycle for the Federal Employees Health Benefits Program (FEHBP) health insurance carriers. The long audit cycle had been reported as an agency material weakness.

The team's solution was to have these carriers include coverage of the financial management and internal control functions of their FEHBP activities with their own annual financial statements audits (performed by independent public accountants). This leveraging, coupled with improvements within the OIG audit approach, such as the use of electronic workpapers and increased reliance upon computer-assisted audit techniques, has led to more efficient use of resources. Together with more risk-based audit selection, these innovations have allowed us to increase audit coverage. The overall result is twofold: we have been able to expand significantly the level of oversight of FEHBP carrier operations and eliminate the long audit cycle as a material weakness.

Turning to another area where OIG and agency management have teamed together, we have frequently addressed in past semiannual reports the progress of our long-term initiative to establish a statutory administrative sanctions program in OPM to minimize the FEHBP's vulnerability to fraud and abuse committed by health care providers.

This effort has, in fact, been a shared project between OIG and many other OPM components from its inception. After a former OPM Director delegated administration of the administrative sanctions program to our office in 1991, we found the existing statutory procedural requirements, enacted in 1988, to be so cumbersome as to be unworkable. Our efforts to obtain new legislation and develop a debarment program in which we could initiate actions against abusive providers was a cooperative action with the full support of OPM's Retirement Insurance Service, the Office of General Counsel and the Office of Congressional Relations.

Together, we were ultimately successful in getting legislation passed in the 105th Congress that would authorize our agency to write definitive regulations to implement the FEHBP administrative sanctions program as originally envisioned by the 1988 statute. We also received agency support and cooperation during the past year in the drafting of these regulations.

There has been and still is concern throughout the Inspector General community that the dynamics of the OIG and agency partnership could compromise the IG's impartiality and call the objectivity of our work into question. However, in our experience, these cooperative and coordinative projects with OPM have not placed us in situations or led to any where our independence was ever at issue. Of course, I can offer the absolute assurance that we would never allow this to occur in any context. The Inspector General's daily practice of independence and objectivity can never wane.

In closing this message, I would like to emphasize that the success of our joint efforts with OPM program offices is directly attributable to the spirit of cooperation prevailing in the agency. Director Janice Lachance and Deputy Director John Sepulveda consistently have supported our initiatives, respected our statutory independence, and generated a leadership environment that encourages the agency to work together with us.

Productivity Indicators

FINANCIAL IMPACT:

Audit Recommendations for	
Recovery of Funds	87,903,875*
Recoveries Through	
Investigative Actions	\$1,513,017*
Management Commitments to	
Recover Funds	\$52,156,938

**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	49
Investigative Cases Closed.	19
Cases Accepted for Prosecution	7
Indictments	8
Convictions	8
Hotline Contacts and Complaint Activity	716
Health Care Provider Debarments and Suspensions	1,555

Statutory and Regulatory Review

As is required under section 4 (a)(2) of the Inspector General Act of 1978, as amended, our office monitors and reviews legislative and regulatory proposals for their impact on the Office of the Inspector General (OIG) and the Office of Personnel Management (OPM) programs and operations. Specifically, we perform this activity to evaluate their potential for encouraging economy and efficiency and preventing fraud, waste and mismanagement. We also monitor legal issues that have a broad effect on the Inspector General community and present testimony and other communications to Congress as appropriate.

During the current reporting period, we continued to exercise our oversight responsibilities regarding regulatory and legislative issues, examining in particular those having a direct effect on our Office of Inspector General mission.

In that regard, this office continues to be concerned about the exclusion of the Federal Employees Health Insurance Program (FEHBP) from most of the health care fraud provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This issue remains this OIG's highest legislative priority, and our incentive to see legislation passed that would place the FEHBP under the provisions of HIPAA remains strong.

Several pieces of legislation have been acted upon during this session of the 106th Congress that bear directly on our office's activities and could have a significant impact on how we perform our work. The articles contained in the Legislative Review portion of this section summarize our legislative concerns and activities during the current reporting period.

With respect to our regulatory review activities, we have made substantial progress toward promulgation of FEHBP administrative sanctions regulations during this reporting period. We also reviewed and provided comments on a proposed Office of Management and Budget (OMB) circular to implement P.L. 104-106, the Clinger-Cohen Act of 1996. Both of these items are addressed under the Regulatory Review portion of this section.

Legislative Review

Inspector General McFarland Testified on IG Act Legislation

Inspector General Patrick McFarland testified as a representative of the IG community before the Senate Committee on Governmental Affairs, along with Inspectors General Kenneth Mead, U.S. Department of Transportation, and Gaston Gianni, Federal Deposit Insurance Corporation.

This hearing on July 19, 2000, was conducted by the Senate Committee on Governmental Affairs, chaired by Senator Fred Thompson. The legislative subject was the role of

Inspectors General and their respective offices. Two legislative proposals were discussed at the hearing: the Inspector General Act Amendments of 1999 (S.870), and draft legislation proposed by the Department of Justice (DOJ) to grant permanent law enforcement authorities to 24 OIGs. The testimony involved an extensive discussion of the role of OIGs.

Inspector General McFarland expressed his strong support for the original version of S.870, introduced by Subcommittee Chairman Susan Collins, Permanent Subcommittee on Investigations. Key provisions of this bill would:

- Establish nine-year terms for inspectors general.
- Prohibit Inspectors General from receiving cash awards or performance bonuses.
- Provide an external review of OIG operations every three years.
- Change the semiannual report to an annual one, with new reporting requirements.
- Increase the rate of pay for IGs.

Both Chairman Fred Thompson and Chairman Collins have worked closely with this office, as well as several other members of the IG community, to bring this important bill to the Senate floor for action. We feel that this bill will improve OIG functions and resolved many of the issues that the IG community faces as a whole.

Closely associated with S.870 is a bill that Chairman Thompson has indicated he will introduce before adjournment that will grant permanent, limited law enforcement authority to special agents in 24 Offices of Inspector General, including OPM. This legislation would replace a cumbersome and time-consuming process through which the Department of Justice now grants law enforcement authority to special agents in most OIGs.

The bill under consideration was authored by DOJ and has its full support. If this bill is not passed, the IG community has been advised by the Department of Justice that the U.S. Marshals Service may require deputation for special agents to be processed on an agent-by-agent and case-by-case basis.

Inspector General McFarland has been actively involved in the drafting and support of this critical legislation. While hopeful that both bills will be signed into law by the time this report is released, should this not be the case, we will continue to support any efforts to pass the legislation in the 107th Congress.

Inspectors General Seek Statutory Law Enforcement Authority

Recovery Audit Legislation (H.R. 1827)

During this reporting period, we provided comment on several drafts of HR.1827 and S.3030, companion bills that propose the establishment of recovery auditing procedures

in the federal government. This legislation would require agencies to conduct, either directly or by contracting with the private sector, recovery audits to identify over-payments or improper payments by the federal government.

At the time of introduction of H.R.1827, we worked with the House Committee on Government Reform to ensure that IGs would have a consultation role in implementing the provisions of the Act. We also supported a provision in this legislation, requiring notification to an IG by a recovery audit contractor of any instances of potential fraud.

Working closely with the other members of the Inspector General community, we recommended collectively to Chairman Burton that the bill be amended to require that the head of an agency consult with the Inspector General prior to implementing a recovery audit plan. We made this recommendation to ensure that there would be no overlapping audits with audits performed by an agency's Office of Inspector General and that such a recovery audit plan would be complete and efficient.

H.R. 1827 passed the U.S. House of Representatives on March 8 of this year and was referred to the Senate Committee on Governmental Affairs on March 9. It is not expected that this legislation will be acted upon before Congress adjourns at the end of this session.

Health Care Provider Bill of Rights (S.2999)

Of the several legislative reviews our office was involved in during this reporting period, one of particular concern to all health care investigators was the Health Care Provider Bill of Rights, S.2999. This bill would require the extraordinary approval of the Department of Justice's Assistant Attorney General for the Criminal Division to issue a search warrant at a health care facility.

The procedures outlined in the bill would be extensive and would have a chilling effect on all health care fraud investigations. The key issue is one of timeliness: We feel this bill would impede the ability of IGs with health care fraud investigative authorities to pursue and bring to prosecution cases of fraud due to the layers of review involved prior to a search warrant reaching the Assistant Attorney General's desk.

Regulatory Review

Review of Draft OMB Circular A-130

As a result of several data calls (requests for review) on drafts of the revised OMB Circular A-130, *Management of Federal Information Resources*, this office conducted a number of reviews of this proposed guidance to executive branch agencies during the reporting period. This circular is critical to the implementation of the Clinger-Cohen Act of 1996 (P.L. 104-106), formerly known as the Information Technology Management Reform Act of 1996.

The Clinger-Cohen Act requires each agency's Chief Information Officer to develop, maintain and facilitate implementation of a sound and integrated information technology architecture. Following this series of reviews, our office fully supports the language in the final draft.

Administrative Sanctions Update

During this reporting period, we completed drafting regulations detailing the administrative process by which our agency can debar or suspend health care providers who have committed fraud or who otherwise have been involved in other types of irregularities. These regulations are authorized by the administrative sanctions provisions of Public Law 105-266, the Federal Employees Health Care Protection Act of 1998.

As envisioned by the statute, these new regulations will provide an equitable and efficient sanctions process that protects both the FEHBP itself and the individuals who receive their health insurance coverage through it. As of this writing the regulations are being reviewed by the Office of Management and Budget, prior to issuance in the *Federal Register* as a proposed rule for public comment.

Meanwhile, we continue to operate a limited debarment program under the authority of the government-wide debarment and suspension common rule. For the current reporting period, we debarred 1,555 providers by use of the common-rule authority.

FEHBP Sanctions Regulations Under OMB Review

Audit Activities

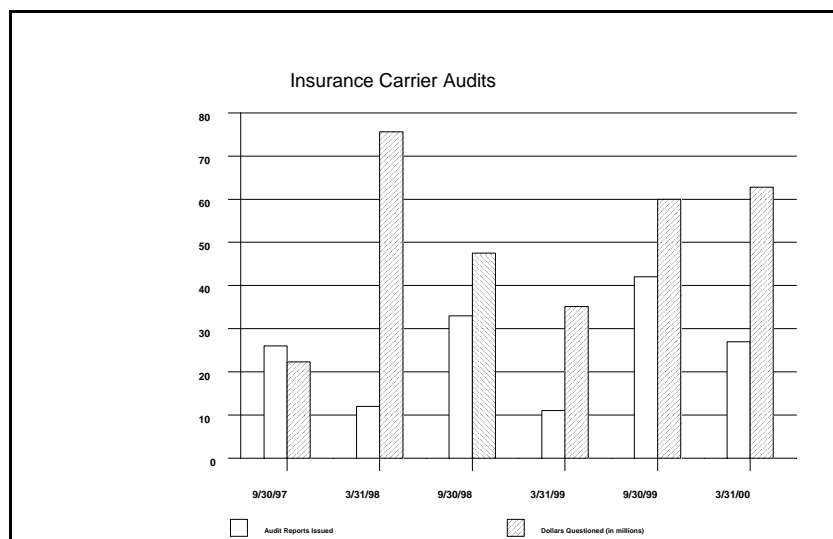
Health and Life Insurance Carrier Audits

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

Our audit universe contains approximately 435 audit sites, consisting of health insurance carriers, sponsors, and underwriting organizations, as well as two life insurance carriers, all of which share in annual premium payments in excess of \$19.4 billion.

During the current reporting period, we issued 41 final reports on organizations participating in the FEHBP and one report on the carrier that administers the Federal Employees Group Life Insurance program for OPM, Metropolitan Life Insurance Company. Of these reports, 29 contain recommendations for monetary adjustment in the aggregate amount of \$87.9 million due the FEHBP. Of the 42 reports issued, 18 were for rate reconciliation audits (RRAs), which are referenced in an article on pages 10-11 in this section. A complete listing of all these reports is provided in Appendices III-A, III-B, and IV on pages 43-48 of this report.

We believe it is important to illustrate the dollar significance resulting from our audits of FEHBP carriers and what this means to the FEHBP trust fund. For instance, during the past six semiannual reporting periods, the OIG issued 151 reports and questioned \$303 million in inappropriate FEHBP charges as the graph below illustrates.



The sections that immediately follow explain the differences among the types of FEHBP carriers and provide audit summaries of significant final reports we issued during the past six months.

Community-Rated Plans

Within the community-rated, comprehensive medical plans, also known as health maintenance organizations (HMOs), our office is responsible for auditing approximately 335 rating areas. A community-rated carrier generally sets the subscription rates based on the average revenue it will need to provide health benefits to each member of a group, i.e., private companies, state or county entities, the FEHBP, etc.

Under current statutes for HMOs, subscription rates can vary from group to group. These rates are derived from two predominant rating methodologies. The key rating factors for the first methodology (*community rating by class*) are the age and sex distribution of a group's enrollees. In contrast, the second methodology (*adjusted community rating*) is based on the projected use of benefits by a group using actual claims experience from a prior period of time that is adjusted for increases in medical cost. However, once a rate is set, it may not be adjusted to actual costs incurred. The inability to adjust to actual costs, including administrative expenses, distinguishes community-rated plans from experience-rated HMOs, indemnity plans or service benefit plans.

For the period 1991 through 1994, regulations required that subscription rates charged to the FEHBP be equivalent to the rates charged the two subscriber groups closest in size to the FEHBP and whose respective contracts contain similar benefits. In 1995, the provision requiring similar benefits was eliminated. Under the regulations, each carrier must certify that the FEHBP is being offered rates equivalent to the rates given to the two groups closest in size to the FEHBP by submitting to OPM a certificate of accurate pricing. These rates are determined by the FEHBP-participating carrier, which is responsible for selecting the appropriate groups. Should our auditors determine that equivalent rates were not applied to the FEHBP, a condition of defective pricing (DP) exists. The FEHBP is entitled to a downward rate adjustment to compensate for any overcharges resulting from DP.

During this reporting period, we issued 28 audit reports on community-rated plans. Ten of these reports related to traditional HMO audits containing over \$29 million in recommended rate adjustments. The remaining 18 reports were on HMO rate reconciliation audits (RRA) that included recommendations for rate adjustments totaling around \$19.9 million. Below is a summary of two of the traditional HMO audits, as well as a discussion of the results of our RRA audits. Together, these will illustrate a number of problems we encounter in conducting HMO audits.

Aetna U.S. Healthcare of Pennsylvania in Blue Bell, Pennsylvania

**Report No. SU-00-98-018
May 2, 2000**

Aetna U.S. Healthcare of Pennsylvania (Aetna) has participated in the FEHBP as a community-rated comprehensive medical plan since 1982. Our audit covered two distinct

Aetna plans that provide health care services under one contract with OPM. The Philadelphia plan (plan code SU) provides primary health care services to its members throughout Philadelphia and surrounding counties. The Pittsburgh plan (plan code KL) provides similar services to members in the Pittsburgh area, along with central, north-eastern, and western Pennsylvania. We reviewed contract years 1993 through 1996 and 1998 for the Philadelphia plan and 1993 through 1998 for Pittsburgh. Total premiums paid to the Philadelphia and Pittsburgh plans during these periods amounted to \$517,896,000 and \$86,048,000, respectively.

The audit identified \$7,896,770 in inappropriate premium rate charges to the FEHBP. Of this amount, \$6,018,155 related to the Philadelphia plan and \$1,878,615 to the Pittsburgh plan. In addition, investment income lost as a result of the inappropriate charges totaled \$1,278,345 under both plans together. Aetna agreed that the FEHBP is entitled to a price adjustment of \$5,002,144: \$3,123,529 from the Philadelphia plan and \$1,878,615 from Pittsburgh.

Audit Identifies \$7.9 Million in Inappropriate Charges

Premium Rates

The primary objectives of the audit were to determine if Aetna U.S. Healthcare of Pennsylvania offered market price rates to the FEHBP and if loadings [contract charges and credits (riders) that are not part of the basic benefit package] to the rates were reasonable and equitable. We also looked at whether the rates were in compliance with the laws and regulations governing the FEHBP. Some of the more significant findings for both plans we audited are discussed below.

Philadelphia plan. The rates the plan charged the FEHBP in 1993, 1995 and 1996 were appropriate. However, in 1994 and 1998, the plan was not in compliance with its contract with OPM. We found that the FEHBP did not receive any discount, whereas one of the subscriber groups closest in size to the FEHBP received a 1.93 percent discount. For a discussion of community rates, see page 6. In addition, we determined that the FEHBP was inappropriately charged for an outpatient substance abuse loading and that the high- and standard-option loadings for needles and syringes were overstated. As a result of these inappropriate charges, we determined that the FEHBP was overcharged \$2,180,967 in 1994.

In 1998, overcharges to the FEHBP totaled \$3,837,188. Our analysis showed that one of the groups selected by the plan was not appropriate because another group was actually closer in size to the FEHBP. According to OPM's rating instructions, in selecting the two groups closest in size to the FEHBP, a carrier having multiple rating areas covered under the same contract must consider all groups it does business with regardless of the regions the groups are in. However, in choosing the two groups used for rate comparisons, the plan considered groups only in the Philadelphia region. We considered groups in both regions and determined that one of the groups from the Pittsburgh region should have been selected. This group received a 7.88 percent discount.

For contract year 1998, we also found that both the high and standard option rates included an inappropriate loading for needles and syringes. The cost for these items was already included in the prescription drug loading. Furthermore, the substance abuse loading for the FEHBP's high option rates was overstated because the plan used the wrong copayment level in determining the loading amount. After adjusting the FEHBP rates and applying the 7.88 percent discount granted to the appropriate group from the Pittsburgh region, we calculated the FEHBP overcharge to be \$3,837,188 in 1998.

Pittsburgh plan. Our analysis showed that the Pittsburgh plan rated the FEHBP appropriately for contract years 1993 through 1996. In 1997, however, one of the groups selected by the plan as closest in size to the FEHBP was not appropriate. As with the Philadelphia plan in 1998, the Pittsburgh plan selected groups from the Pittsburgh area only. Contrary to OPM's rate instructions, the plan excluded a group from the Philadelphia region that it should have selected. However, our analysis showed that this group did not receive the largest discount. Instead, the largest discount (1.32 percent) not received by the FEHBP went to the group from the Pittsburgh area.

We also determined that the standard-option needles and syringes loading and the high-option outpatient substance abuse loading were overstated and resulted in an overcharge to the FEHBP 1997 rates. We recalculated the FEHBP rates to reflect the 1.32 percent discount and the loading overcharge. As a result of these adjustments, we found that the FEHBP was owed \$91,860 in 1997 for these inappropriate charges.

In 1998, the plan again considered only the Pittsburgh region in selecting the groups closest in size to the FEHBP. We disagreed with one of the plan's selections and chose a group closer in size from the Philadelphia region. Although the group we chose received a discount, the plan gave the largest discount, 7.88 percent, to the group from the Pittsburgh region. As had occurred in 1997, we found similar problems with the loadings for needles and syringes and outpatient substance abuse. Just as we determined in 1998 under the Philadelphia plan, the needles and syringes loadings included in the high- and standard-option rates were not appropriate since these items were already included in the prescription drug loading. In addition, our auditors noted that the outpatient substance loading included in the FEHBP's high-option rates was excessive. Accordingly, we adjusted the FEHBP rates, applying the 7.88 percent discount, and determined that the FEHBP was overcharged \$1,786,755 in 1998.

Lost Investment Income

The FEHBP contract with community-rated carriers provides that the FEHBP is entitled to the recovery of lost investment income on defective pricing findings. We found that the FEHBP is due \$1,278,345 in lost investment income through 1999 on the overcharges identified for the Philadelphia and Pittsburgh plans in 1994, 1997 and 1998. The FEHBP is entitled to additional lost investment income for the period beginning January 1, 2000, until all funds due have been returned.

Audit Reveals Inappropriate Charge & Rates to FEHBP

**Humana Kansas City, Inc.
in Louisville, Kentucky**

**Report No. MS-00-00-005
September 20, 2000**

Humana Kansas City, Inc., is a community-rated comprehensive medical plan providing health care services to its members throughout the Kansas City metropolitan area. The plan has participated in the FEHBP since 1978. Our audit of the plan covered contract years 1995 through 1999. During this period, the plan received over \$78 million in premium payments from the FEHBP.

As a result of the audit, we identified \$7,285,511 in inappropriate charges to the FEHBP, including \$6,130,543 for defective pricing and \$1,154,968 for lost investment income. The plan agrees with \$5,128,914 of the questioned amount.

Auditors Determine FEHBP is Due \$7.3 Million

Premium Rates

Discounted rates. We found that the FEHBP did not receive a market price adjustment equivalent to the largest discount given to one of the two groups closest in size to the FEHBP in 1996 or 1997. Our review showed that one of the groups selected by the plan was not appropriate. We determined that, in both years, another group was closer in size to the FEHBP and, therefore, should have been selected. Our review of this group's rates showed that it had gotten market price adjustments significantly larger than the discount the plan gave the FEHBP.

In 1996 and 1997, the group received discounts of 36.40 percent and 19.60 percent, respectively, while the FEHBP discounts amounted to 14.04 and 3.39 percent. Therefore, we applied the 36.40 and 19.60 percent discounts to the FEHBP audited rates for its high- and standard-options and found that the FEHBP was overcharged \$3,528,114 in 1996 and \$2,563,660 in 1997.

Rating factors. For the large groups we reviewed, the plan applied an adjusted community rating methodology to determine each group's rates. Under this methodology, the plan used rating factors based on a group's actual medical claims experience to adjust the prior period rates to the current year rates. In this instance, rating factors from two different experience periods (prior and current year) were combined to determine the final factor that it used to calculate the rates. In reviewing the FEHBP's rate development for 1998 and 1999, we found that the plan had overstated the rating factors because the claims experience amount used in determining the factors was too high. The plan's use of the overstated factors caused the FEHBP to be overcharged \$20,345 in 1998 and \$18,424 in 1999.

Lost Investment Income Exceeds \$1.1 Million

Lost Investment Income

Consistent with the FEHBP contract with community-rated carriers, the FEHBP is entitled to lost investment income on all defective pricing findings. We determined that the FEHBP is due \$1,154,968 for lost investment income covering the years 1996 through 1999. In addition to this amount, we recommended that OPM's contracting officer assess the plan lost investment income on amounts due for the period beginning January 1, 1999, until the FEHBP has received all funds due from the plan.

HMO Rate Reconciliation Audits

In addition to the standard community-rated audits we perform, we also conduct what we refer to as rate reconciliation audits (RRA). These audits are performed prior to the settlement of the FEHBP's final rates. OPM requires each community-rated plan to submit its proposed rates by May 31 of each year, seven months before the rates are to take effect. Because of these early submissions, each plan must estimate its community rate. The rate reconciliation process allows plans to adjust their estimated community rates to the rates that are actually in effect for the current contract year.

The RRAs assist OPM contracting officials in negotiating the best premium rates possible by ensuring that they are provided with current, complete and accurate information by the participating plans. RRAs are limited to the current year's rate reconciliation and are performed and completed from mid-May through early August, just prior to the time OPM's Office of Actuaries finalizes the rates.

RRA Audits Find \$19.9 Million in Rate Overcharges

RRA audits provide significant benefits to OPM and participating community-rated carriers in the following ways:

- Rating data is reviewed shortly after it is produced when both carrier records and staff who prepare the reconciliation are usually readily available to assist in the audit and resolution of any audit issues that may arise.
- Representatives from OPM's Office of Actuaries and plan officials receive almost immediate feedback relating to the audit results.
- The audit resolution process begins immediately, thus benefiting both the plans and OPM through timely resolution of audit issues.
- RRAs result in more timely and frequent audit coverage of the HMOs participating in the FEHBP.
- The RRAs reduce carrier uncertainty regarding any future liabilities that could result from a post-award audit, including any potential interest accruals that may be due the FEHBP.

RRAs have resulted in significant dollar savings to the FEHBP. Since inception in 1996, we have completed a total of 80 RRAs that identified over \$59 million in overcharges to the FEHBP. For the 18 RRAs completed during the current reporting period, we recommended premium rate changes amounting to \$19.9 million for ten carriers.

For example, in our audit of the Fallon Community Health Plan in Worcester, Massachusetts, our auditors identified over \$2.3 million in unsupported charges to the FEHBP. The plan was unable to provide us with complete and accurate rate development documentation for either of the two groups closest in size to the FEHBP. However, the plan did acknowledge a six percent discount to one of the groups. When we calculated that group's rates using the unsupported data, we found that the discount actually amounted to 6.7 percent. We reduced the FEHBP rates to reflect the 6.7 percent discount.

We believe the RRA approach has proven to be a very effective and efficient means for the OIG to provide oversight to the FEHBP.

Experienced-Rated Plans

In addition to community-rated plans, the Federal Employees Health Benefits Program offers a variety of experience-rated plans, including the Government-wide Service Benefit Plan, those plans sponsored by employee organizations, and comprehensive medical plans (experience-rated HMOs). An experience rate is a rate that reflects a given group's projected paid claims, administrative expenses and service charges for administering the FEHBP contract. Each carrier maintains separate accounts for its federal contract, and future premiums are adjusted to reflect the federal enrollees' actual past use of benefits. The universe of experience-rated plans currently consists of 96 audit sites. The number of audit sites fluctuates due to contracts not being renewed or because of plan mergers and acquisitions.

Audits of these plans generally focus on the allowability of contract charges and the recovery of appropriate credits, including refunds, the effectiveness of carriers' claims processing systems, and the adequacy of internal controls to ensure proper contract charges and benefit payments. During this reporting period, we issued 12 audit reports on experience-rated plans, one of which was an experience-rated HMO.

Government-Wide Service Benefit Plan

This plan is administered by the Blue Cross and Blue Shield Association (BCBS Association) on behalf of its member plans. The association, headquartered in Chicago, Illinois, delegates authority to participating local Blue Cross and Blue Shield plans throughout the United States to underwrite and process the health benefits claims of its federal subscribers in the Service Benefit Plan. Approximately 46 percent of all FEHBP subscribers are enrolled in Blue Cross and Blue Shield plans nationwide.

For administrative purposes, the BCBS Association has established a Federal Employee Program (FEP) Director's Office in Washington, D.C., that provides centralized management for the Service Benefit Plan, including a claims control center known as the FEP Operations Center. The operations center verifies, among other things, subscriber eligibility; approves or disapproves the reimbursement of local plan payments of FEHBP claims (using computerized system edits); and maintains both a history file of all FEHBP claims and an accounting of all program funds.

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

Blue Cross and Blue Shield of Florida in Jacksonville, Florida

**Report No. 10-41-99-017
May 10, 2000**

Our audit of the FEHBP operations at Blue Cross and Blue Shield of Florida (BCBS of Florida) took place at the plan's headquarters in Jacksonville. We examined health benefits payments made by the plan from January 1, 1996 through December 31, 1998, as well as administrative expense and miscellaneous payments covering contract years 1994-1998.

In performing this audit, we were to determine whether the plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of its contract. As a result, our auditors questioned \$9,995,888 in health benefit payments, \$4,475,926 in unallowable administrative expense charges and \$11,626 in excess FEHBP funds held by the plan. Of these amounts, the BCBS Association agreed with \$11,192,693, disagreed with \$520,975, and is still reviewing \$2,769,502. Lost investment income on these questioned costs totaled \$1,817,817. Final calculations by our auditors regarding all inappropriate charges to the FEHBP totaled \$16,301,257.

Auditors Calculate \$16,301,257 Owed to the FEHBP

Health Benefits

From 1996 through 1998, BCBS of Florida paid \$1.1 billion in actual FEHBP claim payments. We selected claims in specific health benefit categories, principally those concerning duplicate payments and coordination of benefits (COB) with Medicare. We also examined financial and accounting problems affecting refunds and uncashed checks relating to FEHBP claim payments. Our finding relating to health benefits charges totaled \$9,995,888. Some of our primary findings in these areas were:

Coordination of benefits. During this review, we identified 6,506 claims, totaling \$2,256,558, where FEHBP paid primary benefits when Medicare was, in fact, the primary insurer. This type of inappropriate charge occurs when there is a failure to coordinate benefits properly with Medicare coverage. We recommended that OPM's

contracting officer disallow these uncoordinated claim payments and instruct BCBS of Florida to credit all overpaid amounts to the FEHBP should the plan be successful in its recoveries.

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

Refunds. BCBS of Florida did not return \$5,068,615 in refunds that the plan received in 1997 and 1998 for claim payments made in an undetermined number of years prior to 1997. The plan deposited these refunds into its bank account. We determined that the plan did not have controls in place to transfer funds to the FEHBP's separate bank account it also maintained. In addition to the loss of the refunds themselves, the consequence of this commingling of funds was detrimental to the FEHBP's ability to realize investment income on its own money. We recommended that OPM's contracting officer direct the plan to credit all those monies to the FEHBP.

Additionally, BCBS of Florida did not return \$2,308,927 in refunds that were received on checks that represented refunds to various subscriber groups of the plan, including the FEHBP. By not having controls in place to direct each group's money to their respective accounts, the same negative situation existed, i.e., the FEHBP again was effectively denied any chance to earn investment income on money derived from these particular refunds. We also recommended that these funds be returned to the FEHBP.

Inappropriate Health Benefits Charges Total \$9,995,888

Administrative Expenses

During our review of administrative expenses from 1994-1998, we noted that BCBS of Florida overcharged the FEHBP for unallowable, unallocable and unsupported costs totaling \$4,475,926. The most significant finding in this category pertains to unallowable state income taxes.

State income taxes. In 1997, BCBS of Florida charged the FEHBP \$2,367,145 as its share of the plan's state corporate income taxes for contract years 1989 through 1995. In addition, the plan charged the FEHBP \$1,260,952 for the years 1995 through 1998. The FEHBP's charges for these state income taxes between 1989-1998 totaled \$3,628,097.

These charges were based on the plan's net income. The FEHBP's only contribution toward the plan's net income is a service charge called for under the terms of the FEHBP contract. Based on the plan's income received from that service charge, our auditors determined that FEHBP's allocable share of state income taxes should have been \$858,595, not \$3,628,097. As a consequence, our auditors recommended that OPM's contracting officer direct the plan to credit \$2,769,902 back to the FEHBP for these unreasonable charges.

Auditors Determine \$4,475,926 Due for Administrative Expenses

Lost Investment Income

As a result of the audit findings presented in the report, we computed lost investment income in the amount of \$1,817,817 through December 1999. We recommended to the contracting officer that this amount be returned to the FEHBP in addition to any lost investment income due after that date until BCBS of Florida has returned all monies owed to the FEHBP.

**Triple-S, Inc.
in San Juan, Puerto Rico**

**Report No. 1D-89-00-00-015
August 16, 2000**

Triple-S, Inc., is an experience-rated health maintenance organization located in San Juan, Puerto Rico. Our audit covered health benefit payments made by Triple-S, Inc., from 1996 through 1998, and miscellaneous adjustments, administrative expenses and cash management issues covering a longer contract period, the years 1994 through 1998.

The purpose of this audit was to determine whether Triple-S, Inc., charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of its contract. As a result of this audit, our auditors questioned \$734,092 in health benefit costs; \$358,200 in administrative expense charges; \$5,970,564 in cash management; and \$635,454 in lost investment income. Final calculations by our auditors regarding amounts owed the FEHBP totaled \$7,698,310.

Auditors Determine \$7,698,310 Owed to the FEHBP

Health Benefits

Claim payment errors. In reviewing claim payments, we noted duplicate payment and other types of payment errors. For the period 1996-1998, our auditors identified numerous duplicate claim payments, totaling \$47,207. For the same period, we also identified six claim payments errors and one unsupported health benefit payment, resulting in overcharges of \$8,656 to the FEHBP.

Miscellaneous payments. In reviewing Triple-S, Inc.'s procedures for handling refund and uncashed health benefit checks we identified many instances where Triple-S, Inc., did not credit those funds to the FEHBP. We determined the total cost to the FEHBP at \$678,229.

Administrative Expenses

During our review of administrative expenses from 1994-1998, we noted that Triple-S, Inc., overcharged the FEHBP for unallowable, and unallocable cost totaling \$358,200. The most significant finding in this area was disallowed interest expenses. This finding is summarized below.

Disallowed interest expenses. Triple-S, Inc. charged the FEHBP for unallowable interest expenses from 1994 through 1998. The unallowable interest expenses represent costs to

the plan for funds it borrowed to maintain an FEHBP staff and other associated administrative costs. Our auditors also noted other interest expenses the plan charged the FEHBP pertaining to investment costs for the plan's building and equipment used while providing services to FEHBP members.

Since Triple-S, Inc.'s contract with OPM does not allow any of these interest expenses to be charged to the FEHBP, we determined that the FEHBP is due \$283,543 for this disallowed expense.

Cash Management

Triple-S, Inc., did not properly manage FEHBP funds. Specifically, the plan withdrew funds from the FEHBP letter of credit (LOC) account that exceeded the amounts needed by the plan to cover health benefit payments, administrative expenses and other expenses.

It is a contractual requirement that FEHBP monies be made available for payment to a participating plan using the LOC arrangement, but only after checks are presented and paid by a bank. In addition, the plan reported interest income earned on those excess funds but could not demonstrate that those funds were actually credited to the FEHBP. As a result, we determined that \$5,970,564 was owed for the improper management of FEHBP funds.

Auditors Question \$5,970,564 in Cash Management Charges

Employee Organization Plans

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

During the reporting period, we issued four employee organization plan audit reports. One of the employee organization plan reports is summarized below and includes some of the significant findings contained in that report.

Aetna U.S. Healthcare as Underwriter for National Alliance of Postal and Federal Employees Health Benefit Plan in Middletown, Connecticut

Report No. YA-11-98-049

June 15, 2000

Aetna U.S. Healthcare (Aetna) has served as the underwriter for the National Alliance of Postal and Federal Employees Health Benefit Plan (Alliance) since January 1, 1994. Aetna offers health benefits to Alliance's subscribers and processes benefit claims for

them. Aetna's corporate headquarters are located in Middletown, Connecticut, but its claims operations are in Dover, Delaware.

This was our first audit of Aetna as underwriter for Alliance. In performing this audit, we wanted to determine whether Aetna charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of its contract.

As part of that review, we examined health benefit payments processed by Aetna from 1995 through June 30, 1998. We paid special attention to duplicate claims payments and looked at administrative expenses and the financial aspects of these benefit payments, including refunds and uncashed claim payment checks, covering contract years 1994 through 1997.

After completing this audit, our auditors concluded that Aetna had charged the FEHBP a total of \$425,040 in claim payments that conflicted with the terms of the FEHBP contract. Along with these questioned charges was another \$324,579 in unallowable administrative expenses. Aetna has agreed with all the questioned costs contained in our audit report.

Additionally, our auditors calculated lost investment income associated with the questioned costs identified in our audit findings at \$78,436. After our auditors added this amount to all inappropriate health benefits charges and administrative expenses, they determined that \$828,055 is due the FEHBP.

Auditors Determine \$828,055 Owed the FEHBP

Health Benefits

During this period, Aetna paid out approximately \$111 million in claim payments on behalf of the Alliance plan. We reviewed claim payments processed by Aetna from 1995 through June 1998, taking special note of whether Aetna followed all appropriate steps in its claims processing operations. In addition to looking at the financial aspects of claim payments, including uncashed claim payment checks from 1994 through 1997, we also identified various types of claims processing errors. Some of our findings in these areas are described below:

Duplicate claim payments. Aetna improperly charged the FEHBP \$222,174 for 301 duplicate claim payments during the contract period 1995 through June 1998. These payments were unnecessary and unallowable charges to the FEHBP resulting from processing errors. We recommended that OPM's contracting officer disallow these duplicate payments and direct Aetna to make a diligent effort to collect this amount and credit all monies recovered to the FEHBP.

Claim payment errors. Our auditors reviewed a sample of 199 claims, consisting of 100 preferred provider organization (PPO) claims and 99 non-PPO claims processed by Aetna from 1996 through June 30, 1998.

A PPO is a group of health care providers (hospitals, doctors, laboratories, clinics, etc.) that agree to provide services, usually at a reduced rate, in exchange for a health benefits plan's commitment to provide financial incentives to its subscribers to motivate the latter to use the health care providers making up a specific PPO. The underlying concept behind PPOs is that all three parties benefit from such an arrangement.

In reviewing Aetna's claim payments, our auditors determined as part of their audit procedures whether these non-PPO claims were paid in accordance with the Alliance plan brochure and if the PPO claims were paid not only in accordance with the brochure but also with Aetna's negotiated contract rates.

Our review identified 43 claim payment errors, resulting in a net undercharge of \$4,619 to the FEHBP. In reviewing the claims in this sample, we noted that Aetna could not provide any of the negotiated provider contracts for the 59 claims in the sample, making it impossible for us to verify whether these claims were paid at the negotiated contract rates with the PPOs.

During our sample review, we also discovered a programming error in Aetna's claim payment system. Specifically, Aetna's claim payment system was programmed to pay PPO inpatient hospital claims incurred in 1996 at 100 percent of covered charges rather than 90 percent as required by the 1996 Alliance plan health benefits brochure. Consequently, we identified an additional 709 claim payment errors, resulting in overcharges of \$207,485 to the FEHBP.

In total, we identified 752 claim payment errors, resulting in a net overcharge of \$202,866 to the FEHBP. We recommended that OPM's contracting officer direct Aetna to recover the claim overpayments and credit all amounts recovered to the FEHBP. We also recommended that the contracting officer instruct Aetna to maintain adequate documentation, in particular, its negotiated provider contracts to support claim payments.

Uncashed claim payment checks. Our auditors found that Aetna does not promptly void uncashed claim payment checks. We reviewed Aetna's outstanding checks list for the Alliance account as of September 30, 1998. As a result, we identified 2,774 uncashed claim payment checks, totaling \$246,277. These checks had been outstanding for two or more years. However, since Aetna is reimbursed by Alliance for health benefit charges on a "checks-presented basis," this was a procedural finding with no financial consequences.

Inappropriate Claim Charges Total \$425,040

Administrative Expenses

During our review of administrative expenses, we noted that Aetna allocated unallowable costs to Alliance from 1994 through 1997. Aetna used a pricing formula from 1994 through 1997 to allocate all the administrative expenses across the plan's universe of subscriber groups, including the Alliance Health Benefit Plan.

We determined that Aetna's allocation method made no distinction between any of the subscriber group accounts, and, therefore, allocated all administrative expenses to these groups equally. Unlike other subscriber groups, the FEHBP's contract excludes certain specific administrative costs.

In this regard, we discovered that Aetna had no procedures in place to identify and exclude unallowable expenses from its allocation to the Alliance Health Benefit Plan. As a result, Aetna charged the FEHBP for such costs as advertising, marketing, sales, entertainment, social club dues, lobbying, state tax penalties, and international operations, all unallowable and unallocable under federal regulations. In total, our auditors identified \$324,579 in unallowable administrative expense charges for 1994 through 1997.

Auditors Identify \$324,579 in Unallowable Administrative Expenses

Information Systems Audits

In accordance with the Inspector General Act of 1978, as amended, we conduct and supervise independent and objective audits relating to agency programs and operations to prevent and detect fraud, waste and abuse. To assist in fulfilling this mission, we perform information systems computer-based audits of health and life insurance carriers that participate in the Federal Health Benefits Program (FEHBP) and the Federal Employees' Group Life Insurance program (FEGLI). This is in addition to conducting traditional audits of these groups. Other audit activities under this function include internal oversight of the agency's computer systems development and management activities.

Our office recently established an information systems audit function to evaluate the reliability of internal and external computerized systems that support OPM's various missions.

As computer technology has advanced, individuals, corporations and other organizations have become increasingly dependent on computerized information systems to assist directly or indirectly with their daily activities. As a result, computer-based information and its accessibility have become of paramount importance to government, private business and the general public alike.

It is readily apparent that the federal government must now rely heavily on information systems in one form or another to carry out its work in administering federal programs, managing federal resources, and reporting costs and benefits. Any breakdown or other untoward occurrence to federal computer-based programs along the way can have a harmful, domino effect, compromising efficiency and effectiveness, raising the costs of federal projects and programs, and ultimately increasing the cost of government to the American taxpayer.

In considering our agency's internal computer-based information systems as well as those of the health and life insurance carriers with whom OPM has contracts, we became convinced that we could do more to ensure that there were adequate controls in place to protect and secure the integrity of these various internal and external systems. We knew to do otherwise was to run the risk of lost data due to errors, fraud and other illegal acts and disasters or other incidents that could cause these systems to become unavailable.

We perform two different types of information systems audits: *general controls* and *application controls*. General controls are the policies and procedures that apply to all or a large segment of an entity's information systems and help ensure their proper operation. The effectiveness of general controls is a significant factor in determining the effectiveness of application controls. Application controls are directly related to individual computerized applications, such as a payroll system or a benefit payment system. Controls over applications help ensure that transactions are valid, properly authorized, and completely and accurately processed and reported.

During this reporting period, we completed one external general controls audit at an FEHBP health carrier. A summary of our findings, recommendations and the plan's response to our audit is described below.

Audit of the General Controls Related to Blue Shield of California's Computer-Based Information Systems

in San Francisco, California

Report No. 10-SJ-99-035

June 9, 2000

We conducted an audit of Blue Shield of California, whose headquarters are located in San Francisco, California, pursuant to two FEHBP contracts with OPM. This plan contracts as a traditional fee-for-service plan as part of the network of Blue Cross and Blue Shield Service Benefit plans. Blue Shield of California also participates in the FEHBP as an experienced-rated HMO named Access+. In total, the plan received approximately \$150 million in FEHBP program income during the most recently completed contract year 1999.

The goal of our audit of Blue Shield of California was to obtain reasonable assurance that the plan had implemented proper controls over the integrity, confidentiality and availability of computerized data associated with its FEHBP contracts. This would include information primarily pertaining to the processing of FEHBP health benefits claims and the accurate reporting of costs to OPM.

Our audit of Blue Shield of California was structured from processes found in the General Accounting Office's (GAO) *Federal Information System Controls Audit Manual*. The GAO audit manual contains six categories of general controls that should be considered during such an audit. The six prescribed categories include:

- Entity-wide security program
- Access controls
- Application software development and change controls
- Segregation of duties
- System software controls
- Service continuity controls

We also used various laws, regulations, and industry standards as a guide to evaluating Blue Shield of California's internal control structure. These criteria are described in the following publications:

- The Computer Security Act of 1987
- Office of Management and Budget Circular A-130, Appendix III
- The National Institute of Standards and Technology's Special Publication 800-12:
Introduction to Computer Security: The NIST Handbook

- Information Systems Audit and Control Foundation's *Control Objectives for Information and Related Technology* guide.

As a result of our audit, we identified several areas where the plan could make improvements, including the development of a comprehensive security plan. We also found that there are opportunities for improvement in Blue Shield of California's internal controls to ensure safeguarding its assets and data. As a result, our auditors made a number of recommendations intended to improve these internal controls.

In response, Blue Shield of California agreed to implement many of our recommendations, beginning with the development of a comprehensive security plan that will include the necessary security standards. Other areas of corporate security where Blue Shield of California has taken our recommendation to strengthen controls include:

- Security awareness training
- Security-related personnel controls
- Computer security incident handling
- Technical and physical access controls

In other general controls areas, the plan has accepted our recommendations to improve policies and procedures related to application software development and change control, system software, and service continuity. For example, Blue Shield of California has commenced planning for the testing of disaster recovery plans for each satellite Blue Shield of California claims processing site.

We believe that our review of the information system general controls at Blue Shield of California and our recommendations will help ensure the reliability, appropriate confidentiality and availability of critical automated information.

OIG Provides Recommendations to Improve FEHBP Carrier Computer Security

OTHER EXTERNAL AUDITS

As requested by Office of Personnel Management procurement officials, our OIG conducts pre- and post-award contract audits relating to the acquisition of goods and services by agency program offices. Our office also conducts audits of the local organizations of the Combined Federal Campaign (CFC), the solely authorized fund-raising drive conducted in federal installations throughout the world .

Pre-Award and Post-Award Contracts

These contract audits are performed to ensure that costs anticipated to be, or claimed to have been, incurred under the terms of these contracts are accurate and in accordance with provisions of the Federal Acquisition Regulation. The results of these audits provide OPM procurement officials with the best information available for use in contract negotiations and oversight. In the case of post-award contract audits, for example, the verification of actual costs and performance charges may be useful in negotiating contract modifications as these relate to cost-savings and efficiency.

We conducted one such post-award contract audit (a close-out audit) during this reporting period at the request of OPM's Office of Contracting and Administrative Services. The subject of this audit was the facilities management contractor at the Federal Executive Institute (FEI) in Charlottesville, Virginia. ARAMARK Services, Inc., has provided a full range of services to FEI, including food preparation, security, and grounds maintenance, during its multiple-year contract that will end December 31, 2000.

During this review, we verified actual expenses charged by ARAMARK to FEI for services performed from January 1996 through 2000. We completed our field work on this audit during the reporting period. We are in the process of issuing a draft audit report and anticipate releasing a final audit report during the next reporting period.

Combined Federal Campaign

On March 18, 1961, Executive Order 10927 transferred to the chairman of the U.S. Civil Service Commission (the precursor of OPM) the responsibility to arrange for national voluntary health and welfare agencies to solicit funds from federal employees and members of the armed services at their place of employment. Since then, there have been two more executive orders, one public law (P.L. 100-202), new federal regulations (5 CFR 950) detailing the eligibility of national and local organizations and charities as CFC participants, defining the role of local CFCs, and citing the Office of Personnel Management's oversight responsibilities relating to the Combined Federal Campaign.

Since 1961, the CFC has netted over \$4 billion in charitable contributions. Approximately 385 local campaigns participated in the 1999 Combined Federal Campaign, the most recent year for which statistical data is available. Federal employee contributions reached \$217.8 million for the 1999 CFC, while expenses totaled \$18 million.

Our audits focus on the eligibility of local charities participating in the campaigns, local campaign compliance with CFC regulations, and the testing of the various local campaigns' financial records. Combined Federal Campaign audits will not ordinarily identify savings to the government, because the funds involved are charitable donations made by federal employees.

However, our auditors referred a CFC fraud case to our OIG investigators in an earlier reporting period that has now been completed. Details concerning this case can be found in the Investigative Activities section of this report on page 32.

During the current reporting period, we issued seven CFC reports, a listing of which can be found in Appendix V on page 49.

OPM INTERNAL AUDITS

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

To provide greater oversight and audit coverage of OPM's programs and activities, we have rededicated a significant amount of our internal staff resources to performing comprehensive performance audits effective this reporting period. In this regard, we concentrated our audit efforts on reviewing our agency's compliance with the Government Performance and Results Act of 1993 (GPRA). This Act is described in greater detail on the following pages.

While we did not issue any internal audit reports during this reporting period, we do expect to complete and issue final audit reports concerning OPM's financial statements and controls over performance data during the next reporting period. In this period, our auditors reviewed OPM's efforts to comply with the Federal Financial Management Improvement Act (FFMIA) and provided financial accounting assistance to the Office of the Chief Financial Officer (OCFO).

The following narratives provide information on the results of our internal audit and review activities during the reporting period.

Performance Audits

As mentioned in our last semiannual report, the purpose of our performance audits is to provide an independent assessment of how well our agency operates its various programs and activities. We use these audits to improve public accountability and facilitate decision-making by those within the agency responsible for implementing changes in those programs and activities. We perform two types of performance audits. These are: (1) economy and efficiency audits, and (2) program audits.

During this reporting period we concentrated our performance audit efforts on program audits, more specifically, reviewing documentation relating to our agency's GPRA performance data.

OPM Compliance with GPRA

Our review of OPM's compliance with GPRA is an ongoing area of review. GPRA, commonly referred to as the Results Act, was designed to produce improvements in government performance and accountability in federal programs and includes directives for

federal agencies and departments to follow regarding strategic planning and performance management processes that emphasize goal-setting, customer satisfaction and results measurements.

In response to an October 1998 congressional request, we prepared an OIG GPRA oversight plan describing how our office intends to carry out our ongoing review of OPM activities under the Results Act. The congressional request stipulated that the respective OIGs include in their semiannual reports to Congress a summary of reportable actions falling under their individual plans.

While the agency strategic plan offers general agency-wide goals, many more specific annual goals and indicators appear in the agency's annual performance plan and which are later reported in OPM's annual performance report. As required under the Results Act, our agency's strategic plan is revised every three years, the annual performance plan is issued every February to coincide with the annual budget justification process, and the annual performance report is due each March 31.

During this year we developed a dynamic working relationship with the agency on GPRA related activities. With interactive involvement early and through-out the process we were able to provide meaningful and timely input and oversight. We completed reviews of OPM's fiscal year 1999 annual performance report, its FY 2001 annual performance plan, and its revised five-year strategic plan ending in fiscal year 2005. Also, we reviewed OPM's mid-year assessment of OPM's FY 2000 performance measures. A more detailed discussion of our efforts to carry out our OIG responsibility under the Results Act follows.

GPRA oversight. To assist OPM in meeting the requirement of the Results Act, we reviewed OPM's current strategic plan. We found an overall improvement of the plan over the agency's initial 5-year strategic plan that covered FY 1997-2002. The agency's current strategic plan meets all of the requirements of the Results Act. However, we believe that by identifying and describing those resources necessary to accomplish specific goals will improve the ability of interested parties to interpret and understand the strategic plan.

This year, OPM implemented a mid-year assessment process that is designed to provide a progress assessment of specific program goals and indicators. We believe this mid-year assessment is an excellent management control process for assessing data quality during the year instead of at the end of the year. While the overall result was that the agency benefited from the mid-year assessment, it would be more effective if agency management could provide more timely assessments. We recommended that OPM continue to improve GPRA control activities, such as mid-year assessments, to optimize results and obtain timely feedback.

OIG Recommends Improvement in OPM's Mid-Year Performance Assessment

Verification and validation reviews. We began verification and validation reviews of two OPM program offices. These reviews are performed in accordance with provisions

in GPRA. The objectives were to determine if documentation existed supporting the performance results and if results were fairly presented in the annual performance report. We also offered program offices our feedback--both positive and negative--on their compliance with the Results Act. This proactive approach will enable these agency programs to correct any data problems before the next annual performance report is issued.

Special congressional request. During this reporting period, Senator Fred Thompson, who chairs the Senate Committee on Governmental Affairs, asked our office to look at specific supporting goals and measures that agency officials had established in response to OPM's top management challenges to see if these goals and measures were sufficient in determining if those challenges could be met. This congressional request was issued to OIGs government-wide and supports an earlier congressional request to OIGs to define what the top management challenges were for their respective agencies.

Our review of selected FY 1999 program goals and measures showed that an audit trail was lacking in some instances, and certain performance results could not be supported. Furthermore, the agency did not identify strategies for goals not met or describe how it would meet those goals in the future.

In our response to Chairman Thompson, we reported that the agency should have:

- Tried to ensure that all results had supporting documentation.
- Included an explanation for each goal that was not met.
- Outlined a plan for achieving them in the future.

We also stated that the relationship between goals and measures in the plan should have corresponded more clearly to OPM's top management challenges.

Also, as part of this review for Senator Thompson, we reviewed OPM's FY 2001 annual performance plan. One of the objectives was to determine if the plan addressed OPM's management challenges as reported to Congress in December 1999. In reviewing the FY 2001 annual performance plan, we noted that goals and indicators could be clarified to better address the agency's management challenges.

Overall, our review showed that the agency's goals and measures had improved compared to earlier plans. We plan on reviewing OPM's FY 2002 annual performance plan when it becomes available.

As we continue to oversee the agency's compliance with the Results Act, our evaluators and auditors will continue to provide oversight and assistance to the agency in the preparation of its strategic plans along with the agency's annual performance plans and reports.

Agency Needs to Link Goals & Measures to Top Management Challenges

OCFO's FFIA Compliance Efforts

Our attempted audits of the financial statements for OPM's revolving fund (RF) and salaries and expenses accounts (S&E) for the last four years have left us unable to express an opinion on the fairness of the RF and S&E financial statements. A summary of the FY 1999 audits pertaining to these two entities can be found in our last semiannual report.

Our last three financial statement audit reports on compliance with laws and regulations for OPM's RF and S&E detail our conclusions regarding the agency's compliance with the Federal Financial Management Improvement Act (FFMIA). These reports cite specific instances where the RF and S&E financial management systems did not substantially comply with federal financial management system requirements, applicable accounting standards or the U.S. Standard General Ledger.

When such noncompliance is noted, the FFMIA, under section 803(c), provides for agencies to prepare a remediation plan with specific intermediate target dates designed to bring the financial systems into substantial compliance. In addition, under, section 804(b) of the Act, Inspectors General are required to report to Congress instances and reasons when an agency has not met the intermediate target dates established in the remediation plan.

The internal OPM organization responsible for correcting the noncompliance for the RF and S&E, the Office of the Chief Financial Officer (OCFO), has detailed its remediation plan for resolving material management deficiencies in quarterly letters to OMB, beginning in July 1998. The original remediation plan listed 21 items, all to be completed by August 1999.

Since then, five new items have been added to the remediation plan. As of September 2000, OCFO reported that 20 of these items had been completed. The six items left are scheduled to be completed by March 2001. We have not fully reviewed documentation supporting this assertion, but we are aware of two items we do not believe are fully completed. In addition, all of the target completion dates for the remaining items have been extended from their original target completion date.

The main reasons for these latter items being incomplete were due to the following:

- Changes in OCFO management.
- Plans to realign OCFO.
- Plans to replace the computer-based administrative financial system.

We made several recommendations to address the key material weaknesses and reportable conditions noted that resulted in our conclusion that the RF and S&E financial management systems did not substantially comply with the requirements included in the FFMIA during our audits of the FY 1999 RF and S&E financial statements. These recommendations were for agency management to:

- Implement monthly reconciliation processes of general ledger control accounts to subledgers or other detailed support.
- Establish procedures for supervisory review and approval of all material transactions.
- Implement periodic analytical reviews of general ledger balances.
- Continue the development and documentation of operating policies and procedures for all accounting and control activities.

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

OIG Reviews FFMIA Remediation Efforts

OIG Accounting Assistance

We cited several material internal control weaknesses and reportable conditions in our audits of OPM's revolving fund (RF) and salaries and expenses accounts (S&E) financial statements during the last reporting period. At the request of the Office of the Chief Financial Officer (OCFO), we have been providing accounting assistance to help improve and correct some of these material weaknesses. The most critical areas we targeted during this reporting period were training and management assistance (TMA) program, and OCFO's cash management and payroll accounting issues.

While we are encouraged that some progress has been made in these early stages of our assistance, significant improvements are still necessary to correct these material weaknesses. We have described these reviews in more detail below.

OCFO and TMA identified the total difference in certain types of revenue balances between the general ledger and TMA's record-keeping system. We are currently assisting OCFO in reconciling differences between TMA's record-keeping system and the general ledger system by comparing individual project balances and transactions. Because of scarce supporting documentation for the transactions in the general ledger system, the progress has been slow. We will continue working with OCFO to correct the TMA project balances in the general ledger.

We have been working with OCFO to improve internal controls over the agency's cash reporting process. These improvements have been focused on manual adjustments to the monthly cash management transactions report to the U.S. Treasury (reports otherwise generated automatically from the financial management system) and reconciling the significant differences between OPM's cash management records and Treasury's records. OCFO began implementing these improvements during the latter part of FY 2000. We have reviewed the documentation since implementation and have noted that the new controls could be applied more consistently.

An OIG and OCFO quality improvement team has begun reviewing the payroll accounting process. The team has identified numerous problems within the process and is developing methods to correct some of these problems identified, while continuing to research the various causes for others. The team's work will continue through fiscal year 2001.

OIG Assists OCFO in Improving Controls Over Material Weaknesses

Investigative Activities

The Office of Personnel Management administers benefits from its trust funds for all federal civilian employees and annuitants participating in the federal government's retirement, health and life insurance programs. These trust fund programs cover approximately 9.5 million current and retired federal civilian employees, including their family members, and disburse about \$61 billion annually. Other responsibilities of the agency include administration of the Combined Federal Campaign (CFC). The investigation of fraud involving OPM's trust funds, the CFC, and other agency programs occupies the majority of our OIG investigative efforts.

During this reporting period, we have continued to aggressively pursue criminal and civil prosecutions against both individuals and corporate entities. These efforts have produced seven arrests and eight convictions. More importantly, however, they have resulted in judicial and administrative monetary recoveries to the OPM-administered trust funds totaling \$1,513,017. Overall, we opened eight investigations and closed 19 during this reporting period, with 67 still in progress at the end of the period. (For additional information on investigative activity during this reporting period, refer to Table 1 on page 37 of this section.)

Calls received on our health care fraud hotline and our retirement and special investigations hotline, along with complaints mailed in, totaled 716. Additional information, including specific activity breakdowns for each hotline, can be found on pages 35-36 in this section.

In keeping with the emphasis that Congress and various departments and agencies in the executive branch have placed on combating health care fraud, we coordinate our investigations with the Department of Justice (DOJ) and other federal, state and local law enforcement agencies. At the national level, we are participating members of DOJ's health-care fraud working group. We work actively with the various U.S. Attorney's offices in their efforts to further consolidate and increase the focus of investigative resources in those regions that have been particularly vulnerable to fraudulent schemes and practices engaged in by unscrupulous health care providers.

In addition to health care fraud, our office works closely with other federal, state and local law enforcement officials to uncover other types of fraud. For this reason, we recently established our first criminal investigations duty station outside Washington, D.C., located in the San Francisco Bay area. While this step had been under consideration for some time, we did not proceed with it until we were able to determine definitively that it would be both more efficient than paying travel and associated costs from Washington several times each year. We also wanted to ensure that it would be more effective programmatically to maintain a continuous presence among federal law enforcement officials on the West Coast.

In the retirement area, we have continued our proactive efforts to identify fraud by routinely reviewing Civil Service Retirement System (CSRS) annuity records for indications of

unusual circumstances, as well as maintaining contact with the federal annuitant population. While our recoveries in this area are, for the most part, smaller than in the health care fraud area, criminal prosecutions and sentences tend to be more significant.

In addition to our responsibility to detect and investigate fraud perpetrated against the trust funds, this office conducts investigations of serious criminal violations and misconduct by OPM employees. These cases primarily involve the theft of government funds and property. However, we also examine instances of bribery involving federal officials or financial conflicts of interest.

We work with our OIG auditors and receive referrals from outside sources, regarding the possibility of fraud concerning the Combined Federal Campaign, the only authorized fund-raising drive conducted in federal installations around the world. A detailed discussion of our CFC audit responsibilities appears on pages 22-23 of this report).

On the following pages, we have provided narratives relating to health care fraud, employee integrity issues, retirement fund fraud, and one CFC investigation closed during the reporting period.

Health Care-Related Fraud and Abuse

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

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

Investigation Confirms Laboratory Billing Scheme

Our office has continued its investigative work in the area of laboratory billing fraud, working with various U.S. Attorney's offices around the country during the reporting period. The following case was referred to us jointly by the U.S. Attorney's offices in the District of Columbia and Massachusetts in May of 1999.

In this instance, it was alleged that a national corporation, LifeChem, with headquarters in Boston, Massachusetts, had engaged in "unbundling" laboratory tests for kidney dialysis patients. Unbundling occurs when, instead of charging services for a group of tests customarily performed at the same time under one billing code, the laboratory deliberately uses a separate billing code for each test to increase profits.

Using computer runs, we carried out an extensive review of payments to the corporation by FEHBP health plans, revealing that tests for kidney dialysis, in fact, had been unbundled. Following negotiations with the Department of Justice, the corporation agreed to a settlement resulting in an overall recovery to the government of \$125 million. This went toward covering financial losses to the FEHBP, Medicare, the state of Virginia, and specific health care plans with government contracts. The FEHBP's portion was \$581,133.

Settlement Yields \$581,133 Recovery for FEHBP

Corporation Engaged in Billing Fraud

Based on a referral in from a Blue Cross Blue Shield health plan, CareFirst, we began an investigation of a corporation based in California that provides health care services, including home infusion therapy services. This type of treatment usually requires that a nurse or nurse practitioner assist in administering an intravenous drip containing an antibiotic or some other therapeutic fluid to those who require such treatment in the home.

After opening this investigation, we determined that the corporation, CuraFlex, was not in a position to bill FEHBP health plans directly. To skirt this problem, they gained the cooperation of a Washington, D.C., area physician to use his name and provider number to submit billings to FEHBP-participating health plans for this specialized and costly service.

As a result of our investigation, we confirmed that CuraFlex engaged in this fraudulent billing practice extensively, resulting in the FEHBP paying 123 fraudulent claims, totaling \$269,014. As part of a negotiated settlement with the Department of Justice, the corporation agreed to provide restitution in the amount of \$254,000 to the FEHBP. This settlement culminated a five-year investigation.

FEHBP Receives \$254,000 in Settlement Agreement

U.S. Park Police Officer Involved in Health Benefits Fraud

Based on a referral from CareFirst, a Blue Cross Blue Shield plan, our office initiated an investigation in 1994 of a U.S. Park Service police officer, employed by the Department of the Interior (DOI), who had illegally obtained medical treatment for his girlfriend, using the health card he had been issued by a participating Federal Employee Health Benefits Program insurance plan.

Inasmuch as the police officer's girlfriend was not eligible to receive FEHBP health care benefits, this action resulted in the police officer making false claims against the federal government.

Our investigation was conducted jointly with the DOI Office of Inspector General. It disclosed that the police officer used his FEHBP health insurance identification card over several months in 1994 to obtain treatment for his girlfriend at the George Washington

University Medical Center in Washington, D.C. This included an initial visit to the emergency room and several follow-up visits. The total cost to the FEHBP was \$10,761.

Following our referral of this matter to the Department of Justice, and DOJ's subsequent filing of a civil action in U.S. District Court in Washington, D.C., the judge overseeing this case ordered the officer to pay \$32,285 in damages and a \$5,000 civil penalty for making these health benefits claims under fraudulent circumstances.

Court Orders Restitution and Imposes Penalties Totaling \$37,285

Combined Federal Campaign Investigations

OPM administers the Combined Federal Campaign program on behalf of the federal government. Our investigators work closely with our audit counterparts within the OIG when possible fraud or abuse in the CFC program is detected. These investigations usually concentrate on the operations of the local CFC organizations that collect and distribute federal contributions to designated charities around the country.

The narrative which follows summarizes a case closed during this reporting period that illustrates one type of irregularity that can occur involving CFC operations at the local CFC organization level.

Local CFC Organization in New York Fails to Distribute Funds

Our office initiated an investigation in 1994 based on an OIG audit regarding a local CFC organization based in New York City. This local CFC organization was responsible for distributing contributions to charities in the New York City area but failed to distribute all of the money it received for three consecutive CFC years: 1989, 1990 and 1991.

These local CFC organizations not only distribute funds donated by federal employees to the charities so designated by those employees, but they also collect the funds. Local CFC organizations are allowed to retain a portion of donated funds for administrative expenses.

In this instance, our investigation revealed that this particular local CFC organization did not distribute \$323,827 in donated funds, claiming it had excessive expenses in running the local CFC campaigns. OIG staff conducted an extensive review of the three campaigns, which included interviewing witnesses and issuing IG subpoenas for eleven businesses that provided campaign services to this organization. Based on our efforts, the U.S. Attorney's office for the Southern District of New York obtained a recovery of \$185,600 from the local CFC organization. This money was distributed among the original charities for which the money had been intended.

Investigation Yields \$185,600 Recovery for NY City Area Charities

Employee Integrity Investigations

One of the primary missions of any Office of Inspector General is to ensure that the federal work force maintains the highest standards of integrity in the performance of its duties. In order to maintain those standards within our agency, our OIG conducts investigations of OPM employee misconduct that may result in criminal, civil or administrative action.

The following narrative describes one of the cases we concluded in the area of employee misconduct during the reporting period.

OPM Employee Misuses Government Computer

Based on information provided by a government contractor in March of this year, our office initiated an investigation of an OPM employee alleged to have used an office computer to visit pornographic Internet sites, including sites depicting minors in sexually explicit images. Viewing such material involving a minor is a violation of federal law. Anyone convicted of this offense is subject to imprisonment.

Upon receipt of this referral in March 2000, we immediately requested the assistance of the Federal Bureau of Investigations (FBI), which has primary jurisdiction over this violation of the U.S. criminal code. With their assistance, we were able to substantiate the allegation.

This was accomplished in several ways. For example, our investigators reviewed all Internet usage by the employee over a significant period of time. The FBI, with our assistance, executed a search warrant at the employee's residence that provided additional evidence that the subject was using the Internet to access child pornography sites.

We provided the results of these findings in a report to the U.S. Attorney's office in Washington, D.C., recommending prosecution, and to our agency for administrative action. The employee resigned his position prior to the initiation of any action by the agency. The case is pending prosecution in U.S. District Court, Washington, D.C.

Inappropriate Internet Use Leads to OPM Employee Resignation

Retirement Fraud and Special Investigations

In accordance with our mission to prevent and detect fraud, OIG special agents routinely review CSRS annuity records for indications of unusual circumstances. Using excessive annuitant age as an indication of potential fraud, our investigators attempt to contact the annuitants and determine if they are alive and still receiving their benefits. In addition, we receive inquiries from OPM program offices, other federal agencies and private citizens

that prompt us to investigate cases of potential retirement fraud or alleged misconduct by OPM employees and contractors.

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

Son of CSRS Annuitant Engages in Annuity Fraud

After receiving information in 1997 from the Federal Bureau of Investigation (FBI), our office initiated an investigation of the son of a deceased Civil Service Retirement Service annuitant, the latter having died in 1987. The subject of the investigation, who lives in Baltimore, Maryland, was alleged to have received CSRS survivor benefits intended for his father.

Our investigation revealed, however, that the deceased annuitant's husband had actually died the year before the annuitant in 1986. We also learned that the son forged his deceased father's name on the application for survivor benefits and subsequent recertifications and submitted them to OPM. These were processed by our agency and annuity checks continued to be deposited electronically to the son's bank account for ten years. The total amount of CSRS funds misappropriated over this time period was \$108,000.

Based on our investigation, the U.S. Secret Service issued an arrest warrant for the son. During the course of the investigation, we learned that the son had a long criminal history, including arrests for carrying a stolen handgun, robbery, abduction and burglary. With the assistance of the U.S. Secret Service., he was located in Baltimore, Maryland, where he surrendered to authorities.

In June of this year, the son plead guilty to the theft of government funds. A U.S. District Court judge in Baltimore sentenced the son on September 11 to four months' home detention, five years' probation and ordered him to pay \$70,000 in restitution to the Civil Service Retirement Service trust fund.

CSRS Trust Fund to Receive \$70,000 in Fraud Case

CSRS Retiree's Son Guilty of Annuity Fraud

Our office received a referral from OPM's Retirement and Insurance Service in 1999 regarding retirement benefits distributed through 1995 to an annuitant whose death occurred in 1992. We soon thereafter opened an investigation into this matter.

We conducted this investigation with the assistance of the U.S. Secret Service. We learned that the annuitant's son, living in Boston, Massachusetts, had power of attorney over his mother's bank account. After failing to notify OPM of her 1992 death, the son was able to access his mother's retirement benefits through her bank account since her

annuity checks continued to be deposited electronically to her account. The son's misappropriation of these funds resulted in a \$38,898 loss to the federal government.

The subject was interviewed and acknowledged using the retirement funds. He was arrested and tried in federal court in Boston this year, where he was found guilty of the theft of government funds. He was subsequently sentenced to four months' home confinement and two years' probation and ordered to make full restitution to the government to cover this loss.

Trial of Annuitant's Son Ends in Conviction

Annuitant's Caregiver Admits to Retirement Fraud

OPM's Retirement and Insurance Service reported to us in April 1999 that it had just been made aware of the 1992 death of an annuitant, who had lived in Decatur, Georgia, and who received her annuity checks through electronic deposit to her bank account. At the time OPM was able to stop further payments to this account, the loss in U.S. government funds totaled \$53,279.

A short time after this referral, we opened a case to determine who was actually illegally receiving her annuity funds. Later, we issued a subpoena to a Georgia bank for financial records associated with the account. After reviewing these records, our investigators learned that account statements contained several address changes and all checks written on the account went to one individual at the last known address of the deceased annuitant.

We interviewed this individual, who advised us that she had lived with the annuitant as her caregiver until her death. She also admitted using the annuitant's bank funds following her death. Sometime after the interview, we were able to obtain a written statement from her in which she agreed to make full restitution to OPM for taking this money. The U.S. Attorney's office declined prosecution in this case.

OIG Investigators Play Key Role in \$53,279 Recovery to CSRS Trust Fund

OIG Hotlines and Complaint Activity

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

Retirement and Special Investigations Hotline

The Retirement and Special Investigations hotline provides the same assistance as traditional OIG hotlines. For example, we receive inquiries from OPM employees, contractors and others interested in reporting waste, fraud and abuse within the agency. Callers, or

those who choose to write letters, can report information openly, anonymously or confidentially without fear of reprisal.

The Retirement and Special Investigations hotline and complaint activity for this reporting period included 59 telephone calls, 77 letters, 3 agency referrals, and 185 complaints initiated by the OIG, for a total of 324. Our administrative monetary recoveries resulting from retirement and special investigation complaints totaled \$181,532.

Health Care Fraud Hotline

The Health Care Fraud hotline was established to handle complaints from subscribers in the Federal Employees Health Benefits Program administered by OPM. The hotline number is listed in the brochures for all the plans associated with the FEHBP.

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

The Health Care Fraud hotline and complaint activity for this reporting period involved 226 telephone calls and 166 letters, for a total of 392. During this period, the administrative monetary recoveries pertaining to health care fraud complaints totaled \$97,769.

OIG-Initiated Complaints

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

An example of a specific type of complaint that our office will initiate involves retirement fraud. This might occur when our agency has already received information indicating an overpayment to an annuitant has been made. At that point, our review would determine whether there were sufficient grounds to justify our involvement due to the potential for fraud. There were 46 such complaints associated with agency inquiries during this reporting period.

Another example of an OIG-initiated complaint occurs when we review the agency's automated annuity records system for certain items that may indicate a potential for fraud. At that point, we initiate personal contact with the annuitant to determine if further investigation is warranted. This investigative activity resulted in 139 instances where our office initiated personal contacts to verify the status of the annuitant.

We believe that these OIG initiatives compliment 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.

Investigative Activity Tables

TABLE 1: Investigative Highlights

Judicial Actions:	
Arrests	7
Indictments	8
Convictions	8
Administrative Actions:¹	0
Judicial Recoveries:	
Fines, Penalties, Restitutions and Settlements	\$1,233,716
Administrative Recoveries:	
Settlements and Restitutions	\$279,301
Total Funds Recovered	\$1,513,017

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

TABLE 2: Hotline Calls and Complaint Activity

Retirement and Special Investigations Hotline and Complaint Activity:	
Retained for Investigation	235
Referred to:	
OIG Office of Audits	0
OPM Groups and Offices	47
Other Federal Agencies	42
Total	324
Health Care Fraud Hotline and Complaint Activity:	
Retained for Investigation	124
Referred to:	
OPM Groups and Offices	79
Other Federal/State Agencies	56
Health Insurance Carriers or Providers	133
Total	392
Total Contacts	716

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

APPENDIX I
Final Reports Issued With Questioned Costs
April 1, 2000 to September 30, 2000

Subject	Number of Reports	Questioned Costs ¹	Unsupported Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	21	\$ 52,479,396	\$ 77,135
B. Reports issued during the reporting period with findings	29	87,903,875	5,611,160
Subtotals (A+B)	50	140,383,271	5,688,295
C. Reports for which a management decision was made during the reporting period:	31	74,709,701	77,135
1. Disallowed costs		52,156,938	26,285
2. Costs not disallowed		22,552,763	50,850
D. Reports for which no management decision has been made by the end of the reporting period	19	65,673,570	5,611,160
Reports for which no management decision has been made within 6 months of issuance	3	8,106,692 ²	0

¹Questioned costs represent recommendations for recovery of funds resulting from OIG audits.

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

APPENDIX II
Final Reports Issued With Recommendations
For Better Use of Funds
April 1, 2000 to September 30, 2000

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

APPENDIX III - A
Insurance Audit Reports Issued
April 1, 2000 to September 30, 2000

Subject (Standard Audits)	Report Number	Issue Date	Questioned Costs	Unsupported Costs
Horizon Blue Cross and Blue Shield of New Jersey in Newark, New Jersey	10-49-99-016	April 4, 2000	\$ 8,547,014	\$ 113,045
Metropolitan Life Insurance Company in New York, New York	2A-II-00-00-012	April 4, 2000	1,741	
United HealthCare of Illinois in Minneapolis, Minnesota	FP-00-99-011	April 12, 2000	1,665,320	
BlueLincs HMO Health Plan of Tulsa in Tulsa, Oklahoma	N5-00-98-045	April 12, 2000	3,036,246	
Postmasters Benefit Plan in Alexandria, Virginia	36-00-97-003	April 25, 2000	408,362	
Aetna U.S. HealthCare of Pennsylvania, in Blue Bell, Pennsylvania	SU-00-98-018	May 2, 2000	9,175,115	
Kaiser Foundation Health Plan of Ohio in Cleveland, Ohio	1C-64-00-00-020	May 9, 2000		
Blue Cross and Blue Shield of Florida in Jacksonville, Florida	10-41-99-017	May 10, 2000	16,301,257	11,626
Group Health Cooperative of Puget Sound in Seattle, Washington	54-00-99-003	May 11, 2000	1,516,003	
HealthPartners Classic in Minneapolis, Minnesota	53-00-99-053	May 23, 2000		
Aetna U.S. HealthCare as Underwriter for the National Association of Postmasters of the United States Health Benefit Plan in Middletown, Connecticut and Dover, Delaware	YP-11-98-051	May 25, 2000	218,162	

APPENDIX III - A
Insurance Audit Reports Issued
April 1, 2000 to September 30, 2000

Subject (Standard Audits)	Report Number	Issue Date	Questioned Costs	Unsupported Costs
Aetna U.S. HealthCare as Underwriter for the Beneficial Association of Capitol Employees Health Benefit Plan in Middletown, Connecticut and Dover, Delaware	Y2-11-98-050	June 9, 2000	\$	\$
Foundation Health in Woodland Hills, California	1C-C6-00-00-017	June 15, 2000		
Aetna US HealthCare as Underwriter for the National Alliance of Postal and Federal Employees Health Benefit Plan in Middletown, Connecticut and Dover, Delaware	YA-11-98-049	June 15, 2000	828,055	
Regent Blue Cross and Blue Shield of Utah in Salt Lake City, Utah	10-66-99-052	June 23, 2000	265,252	
Blue Cross and Blue Shield of Puerto Rico, in San Juan, Puerto Rico	1A-10-68-00-014	July 7, 2000	21,394	
Anthem Blue Cross and Blue Shield of Nevada in Reno, Nevada	1A-10-61-00-011	July 12, 2000	172,130	
Blue Cross and Blue Shield of Minnesota in Saint Paul, Minnesota	10-78-99-049	July 18, 2000	4,338,919	62,939
Blue Cross and Blue Shield of Hawaii in Honolulu, Hawaii	1A-10-38-00-029	August 16, 2000	(25,751)	
Triple-S, Inc., in San Juan, Puerto Rico	1D-89-00-00-015	August 16, 2000	7,698,310	5,423,550
Kaiser Foundation Health Plan of Colorado in Denver, Colorado	65-00-99-047	September 1, 2000	921,512	
Humana Kansas City, Inc., in Louisville, Kentucky	MS-00-00-005	September 20, 2000	7,285,511	

APPENDIX III - A
Insurance Audit Reports Issued
April 1, 2000 to September 30, 2000

Subject (Standard Audits)	Report Number	Issue Date	Questioned Costs	Unsupported Costs
Optima Health Plan in Virginia Beach, Virginia	V9-00-99-050	September 26, 2000	\$ 5,551,330	\$
TOTALS			\$ 67,925,882	\$ 5,611,160

APPENDIX III-B
Insurance Audit Reports Issued
April 1, 2000 to September 30, 2000

Subject (<i>Rate Reconciliation Audits</i>)	Report Number	Issue Date	Questioned Costs	Unsupported Costs
Independent Health Association of Buffalo, New York Proposed Rate Reconciliation	1C-QA-00-00-047	June 15, 2000	\$ 836,646	\$ 0
PacifiCare of Texas Proposed Rate Reconciliation	1C-GF-00-00-046	June 19, 2000		
Fallon Community Health Plan of Worcester, Massachusetts Proposed Rate Reconciliation	1C-JV-00-00-037	June 21, 2000	2,354,458	
Humana Health Plan of Chicago Proposed Rate Reconciliation	1C-75-00-00-041	July 17, 2000	423,601	
Rush Prudential HMO of Chicago Proposed Rate Reconciliation	1C-17-00-00-040	July 17, 2000	541,898	
CompCare Health Services of Milwaukee, Wisconsin Proposed Rate Reconciliation	1C-69-00-00-049	July 17, 2000		
The M Plan of Indiana Proposed Rate Reconciliation	1C-IN-00-00-056	July 19, 2000	65,761	
United HealthCare of Ohio Proposed Rate Reconciliation	1C-VC-00-00-055	July 24, 2000		
Dean Health Plan of Wisconsin Proposed Rate Reconciliation	1C-WD-00-00-048	July 25, 2000		
CIGNA HealthCare of Virginia Proposed Rate Reconciliation	1C-W2-00-00-066	July 26, 2000		
HIP of Greater New York Proposed Rate Reconciliation	1C-51-00-00-044	July 28, 2000	2,377,250	
Partners National Health Plan of Winston Salem, North Carolina Proposed Rate Reconciliation	1C-EQ-00-00-039	July 28, 2000		

APPENDIX III-B
Insurance Audit Reports Issued
April 1, 2000 to September 30, 2000

Subject (<i>Rate Reconciliation Audits</i>)	Report Number	Issue Date	Questioned Costs	Unsupported Costs
Health Partners of Alabama Proposed Rate Reconciliation	1C-DF-00-00-057	July 28, 2000	\$	\$
Prudential HealthCare HMO of Jacksonville Proposed Rate Reconciliation	1C-EC-00-00-038	August 1, 2000		
Aetna U.S. HealthCare of Philadelphia Proposed Rate Reconciliation	1C-SU-00-00-052	August 4, 2000	319,604	
Aetna U.S. HealthCare of New York Proposed Rate Reconciliation	1C-JC-00-00-054	August 7, 2000	2,554,195	
Aetna U.S. HealthCare of the Mid-Atlantic Proposed Rate Reconciliation	1C-JN-00-00-053	August 7, 2000	7,370,241	
Aetna U.S. HealthCare of New Jersey Proposed Rate Reconciliation	1C-P3-00-00-051	August 9, 2000	3,134,339	
TOTALS			\$ 19,977,993	\$

APPENDIX IV
Information Systems Audit Reports Issued
April 1, 2000 to September 30, 2000

Subject	Report Number	Issue Date	Funds Put to Better Use	Questioned Costs
The Information System General Controls at Blue Shield of California in San Francisco, California	10-SJ-99-035	June 9, 2000	\$ 0	\$ 0
TOTALS			\$ 0	\$ 0

APPENDIX V
Combined Federal Campaign Audit Reports Issued
April 1, 2000 to September 30, 2000

Subject	Report	Issue Date	Funds Put to Better Use	Questioned Costs
The 1997 and 1998 Combined Federal Campaigns of Northern New Jersey in Newark, New Jersey	2A-CF-99-060	April 11, 2000	\$ 0	\$ 0
The 1997 and 1998 Combined Federal Campaigns of Tennessee Valley in Huntsville, Alabama	3A-CF-00-00-013	May 1, 2000		
The 1997 and 1998 Combined Federal Campaigns of Central Alabama in Birmingham, Alabama	3A-CF-00-00-016	May 24, 2000		
The 1997 and 1998 Combined Federal Campaigns of the Pikes Peak Region in Manitou Springs, Colorado	3A-CF-00-00-023	May 24, 2000		
The 1997 and 1998 Combined Federal Campaigns of the Mid-South in Memphis, Tennessee ¹	3A-CF-00-00-004	June 20, 2000		
The 1997 and 1998 Combined Federal Campaigns of the Greater Pensacola Area in Pensacola, Florida	3A-CF-00-00-036	August 21, 2000		
The 1997 and 1998 Combined Federal Campaigns of South Puget Sound in Tacoma, Washington ¹	3A-CF-00-00-024	September 11, 2000		
TOTALS			\$ 0	\$ 0

¹ We found that the CFC had not distributed \$117,000 in funds to local charities. The funds have since been distributed.