

*October 31, 1999*

*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, 1999 to September 30, 1999. 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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# Foreword

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One of the core functions of the U.S. Office of Personnel Management (OPM) is to administer the federal government's retirement, health and life insurance programs, covering approximately 9.5 million current and retired federal civilian employees and their family members, with annual disbursements of about \$61 billion. These figures remind us of the immensity of our responsibilities as an Office of Inspector General (OIG) to see that taxpayer dollars are not squandered or fraudulently abused.

As a result, we have taken a proactive approach to the legislatively mandated activities we perform as an OIG, which is reflected in the following pages of this report. We take pride in the work we have been able to accomplish using this approach, and we are convinced that it has made us more effective in our oversight of agency programs and private-sector businesses and contractors who participate directly or indirectly in programs administered by our agency.

I call your attention in particular to an article on pages 8-9 regarding an auditing initiative relating to health maintenance organizations participating in the Federal Employees Health Benefits Program (FEHBP) that began in 1996. We have termed this initiative "rate reconciliation auditing." It allows our auditors to review FEHBP premium rates before they are finalized by OPM. The bottom line has been a reduction in the government's overall costs by ensuring that insurance carriers set accurate rates for premiums before they go into effect. Under the traditional audit cycle, our auditors typically would not review the final rates until several years later. By that time, the costs to the government, FEHBP subscribers, and the American public, whose taxes support this program, could increase by several million dollars.

In another area that affects the FEHBP and reflects our office's active involvement in the legislative process, Congress amended the Federal Employees Health Benefits Act to give our agency broader authority to operate a health care administrative sanctions program. We have long strived for an enforcement tool that would more clearly and effectively protect the FEHBP and its subscribers from health care provider fraud. Because of how strongly we believed in this issue, we exercised great perseverance and maintained an ongoing dialogue with those in a position to help us realize this goal. Our office is pleased to have been tasked with drafting regulations to carry out this new sanctions authority, which we discuss on pages 1-2 of this report.

While these are not the only notable accomplishments cited in this report, all point to the importance of our OIG's underlying independence to carry out our mission that ultimately protects the integrity of our agency's operations and programs and helps minimize government costs.

# Productivity Indicators

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## FINANCIAL IMPACT:

<b>Audit Recommendations for</b>	
<b>Recovery of Funds</b> .....	<b>\$60,011,435</b>
<b>Recoveries Through</b>	
<b>Investigative Actions</b> .....	<b>\$1,350,465</b>
<b>Management Commitments to</b>	
<b>Recover Funds</b> .....	<b>\$32,670,399</b>

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

## ACCOMPLISHMENTS:

<b>Audit Reports Issued</b> .....	<b>47</b>
<b>Investigative Cases Closed.</b> .....	<b>21</b>
<b>Cases Accepted for Prosecution</b> .....	<b>8</b>
<b>Indictments</b> .....	<b>3</b>
<b>Convictions</b> .....	<b>9</b>
<b>Hotline Contacts and Complaint Activity</b> .....	<b>883</b>
<b>Health Care Provider Debarments</b> <b>and Suspensions</b> .....	<b>1,268</b>
<b>Evaluation and Inspections Reports Issued</b> .....	<b>1</b>

## Statutory and Regulatory Review

As is required under section 4 (a)(2) of the Inspector General Act of 1978 (IG Act), 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. While there were no major regulations proposed or published directly affecting our OIG operations, we did note, and have been closely monitoring, H.R. 1827, the Government Waste Corrections Act of 1999.

This legislation was introduced by Representative Dan Burton and referred to the House Committee on Government Reform, which he chairs. H.R. 1827 would require agencies to conduct, either directly or by contracting with the private sector, recovery audits to identify overpayments or improper payments to the federal government. 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.

As reflected in the article that follows in this section, we have made substantial progress in drafting the Federal Employees Health Benefits Program (FEHBP) sanctions regulations. We expect to address these regulations in more detail in future reports.

And, finally, as discussed in prior semiannual reports, we are continuing our efforts to obtain congressional reconsideration of the exclusion of the FEHBP from the civil enforcement and anti-kickback provisions of the Health Insurance Portability and Accountability Act of 1996. This exclusion continues to reduce our effectiveness in fighting health care fraud.

### ***Administrative Sanctions Update***

As we noted in our last semiannual report, we are drafting regulations and designing an administrative sanctions process to implement the Federal Employees Health Care Protection Act of 1998, P.L. 105-266. The new statute gives OPM an effective enforcement device against provider fraud and an efficient means of addressing the integrity

interests of the FEHBP, the financial interests of the taxpayers who share in the costs of the program, and the rights of beneficiaries to participate in a program that actively seeks to protect their health and safety. We anticipate issuing the first administrative actions under the Act in fiscal year 2000, with full implementation in fiscal year 2001.

As we proceed to implement the new statutory provisions, we continue to work closely with, and to receive extensive assistance from, the Office of Inspector General at the Department of Health and Human Services, which conducts the Medicare provider sanctions program. We are committed to exercising the newly enacted authorities in coordination with other federal sanctions programs as required by law and regulation in order to maximize their overall impact.

During the current reporting period, we continued to operate a limited debarment program under the authority of the government-wide debarment and suspension common rule. This enforcement mechanism has permitted us to bar from participation in FEHBP those health care providers who have previously been sanctioned by another federal agency. For the current reporting period, we debarred 1,268 providers by use of the common rule authority.

***Progress Being Made on FEHBP Sanctions Draft Regulations***

# Audit Activities

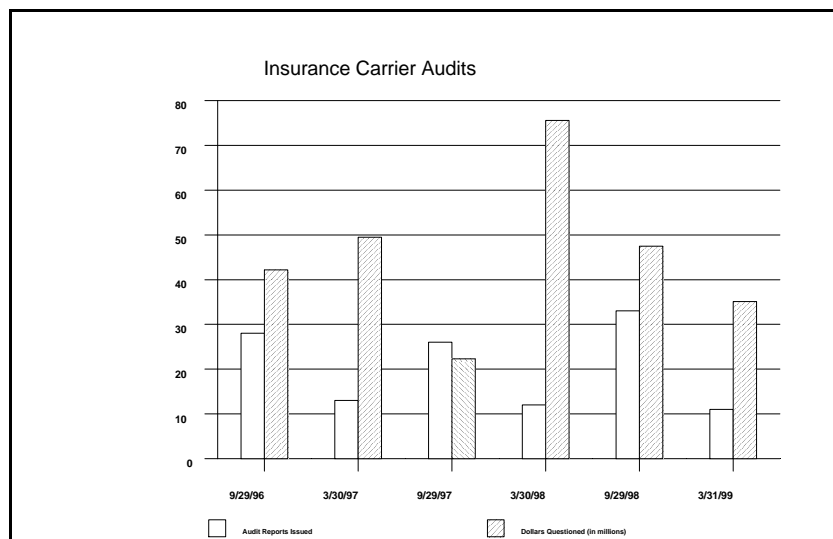
## Health and Life Insurance Carrier Audits

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 460 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 \$17.7 billion.

During the current reporting period, we issued 42 final reports on organizations participating in the FEHBP, 21 of which contain recommendations for monetary adjustment in the aggregate amount of \$60 million due the FEHBP. Of the 42 reports issued, 20 were for rate reconciliation audits (RRAs), which are referenced in an article on pages 8-9 of this section. A complete listing of all these reports is provided in Appendices III-A and III-B on pages 35-39 of this report. We also issued one report on the carrier that administers FEGLI for OPM, Metropolitan Life Insurance Company (MetLife).

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 123 reports and questioned \$272.2 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), the audit universe consists of approximately 360 rating areas. A community-rated carrier generally sets the subscription rates for benefits on the basis of an average revenue requirement for each member. Under current statutes for HMOs, subscription rates can vary from group to group as the result of adjustments for factors such as the age and sex distribution of a group's enrollees (community rating by class) or its projected utilization of benefits (adjusted community rating). However, once a rate is set, it may not be adjusted to actual costs incurred or actual utilization. The inability to adjust to actual costs or utilization distinguishes community-rated plans from experience-rated HMOs, indemnity, 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 those 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. These similarly sized subscriber groups are called SSSGs. Under these regulations, each carrier must certify that the FEHBP is being offered equivalent SSSG rates by submitting to the Office of Personnel Management a certificate of accurate pricing. These rates are determined by the FEHBP-participating carrier, which has the responsibility of selecting the two groups that qualify as SSSGs. During an audit, should our auditors determine that equivalent rates were not applied to the FEHBP or that the appropriate SSSGs were not selected, then 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 26 final audit reports, including six traditional HMO audits and 20 HMO rate reconciliation audits. The following summaries of two of these traditional HMO audits and an article discussing the results of our RRA audits will illustrate a number of problems we encounter in conducting HMO audits.

### **Scott and White Health Plan in Temple, Texas**

**Report No. UF-00-97-001**

**May 17, 1999**

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Scott and White Health Plan (Scott & White) is a group practice plan providing services to its members throughout central Texas. Scott & White began participation in the FEHBP as a community-rated carrier in 1983. As of March 1996, the FEHBP was one of the largest groups served by Scott & White, comprising about ten percent of its total membership. Our audit covered contract years 1991 through 1996. During this period, the FEHBP paid the plan over \$139 million in premiums.



As a result of our audit, we identified \$5,572,346 in questioned costs, including \$4,523,861 for inappropriate health benefits charges and \$1,048,485 for lost investment income due the FEHBP. While Scott & White has agreed with \$2,954,495 of the questioned amount, it contends that it was underpaid by \$1,226,854 under its FEHBP contract during the years audited. We are not in agreement with the plan's position on the latter issue.

### ***\$5.5 Million in Questioned Costs Identified***

#### **Premium Rates & Loadings**

The primary objectives of the audit were to verify that Scott & White offered market price rates to the FEHBP, that any loadings (contract charges and credits, also known as riders, that are not a part of the basic benefit package) to the rates were reasonable and equitable, and that the rates were in compliance with laws and regulations governing the FEHBP.

Overall, we found that Scott & White's inconsistency in rating the FEHBP and SSSGs was the primary reason the FEHBP was overcharged during the six years covered by the audit. Our questioned charges for contract years 1991 through 1996 were \$49,402; \$142,859; \$623,716; \$511,629; \$1,196,200; and \$2,000,055, respectively. Some of the specific findings from the audit are highlighted below.

*Discounted market rates.* In 1995, we found that both SSSGs received a four percent discount not given to the FEHBP. The discount occurred because of a change Scott & White made in 1994 in its rate calculations, separating the September community rates from the July and August community rates. The SSSGs, which constituted over a third of Scott & White's entire membership, both renewed in September. Inasmuch as the September community rates were lower than any other month during the year, we determined that the reduction in the September rates was a form of discounting to which the FEHBP was also entitled but did not receive.

*Copay adjustments.* In 1993, the FEHBP switched to a benefit package that was based on members having no copayments to make. However, we determined that FEHBP members did pay a \$5 copayment on outpatient office visits. Scott & White accounted for the copay difference in the FEHBP rates by lowering the filed community rates by specific dollar amounts for single and family rates. One of the SSSGs with the same benefit package, including a \$5 copayment stipulation, received a four percent reduction in the plan's filed community rates. To rectify this inequity, we used the four percent reduction given to the SSSG in redeveloping the FEHBP rates. This practice took place during contract years 1993-1996.

*Mental health loading.* We determined that Scott & White incorrectly calculated the FEHBP's mental health loading for contract years 1991 through 1995. The loading was developed using the FEHBP's mental health benefits utilization statistics. However, the same utilization statistics were also used to calculate the FEHBP's adjusted

community-rating factor used for adjusting community rates. Inasmuch as the mental health utilization statistics were accounted for twice in the FEHBP rates, this resulted in an overcharge to the FEHBP for those years.

*Premium tax credit.* In 1991 through 1994, the FEHBP did not receive the appropriate credit for premium taxes Scott & White paid to the state of Texas. FEHBP premiums are exempt from such taxes and, thus, the FEHBP is entitled to a credit to remove this tax when a plan includes them in its rate calculations.

### **Lost Investment Income**

In accordance with the FEHBP contract with community-rated carriers, the FEHBP is entitled to recovery of lost investment income on defective pricing findings. We found that the FEHBP is due \$1,048,485 in lost investment income through December 31, 1998. An additional amount is due for the period beginning January 1, 1999, until all funds have been returned to the FEHBP.

### **PacifiCare of Oklahoma in Tulsa, Oklahoma**

**Report No. PE-00-96-006**  
**September 23, 1999**

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PacifiCare of Oklahoma (PacifiCare) is a community-rated comprehensive medical plan providing primary health care services to its members throughout the Oklahoma City and Tulsa, Oklahoma, areas. The plan is a wholly owned subsidiary of PacifiCare Health Systems, Inc. Our audit covered both the Oklahoma City and Tulsa regions for contract years 1990 through 1995. During this period, the FEHBP paid the Oklahoma City region almost \$73 million in premiums and about \$28 million to the Tulsa region.

The audit identified \$10,336,280 in inappropriate charges to the FEHBP, including lost investment income. Of this amount, \$7,553,943 related to the Oklahoma City region and \$2,782,337 to the Tulsa region. Due to our concerns over the audit issues identified, we referred the audit report to the Department of Justice (DOJ) for review. DOJ's pursuit of our concerns led to a negotiated settlement and the return of \$9 million to the federal government, with \$8,730,000 being returned to the FEHBP trust fund. The following narrative discusses some of the more significant findings pertaining to both regions.

### ***Settlement Yields \$8.7 Million to the FEHBP***

### **Premium Rates**

*Oklahoma City region.* In conducting the audit, we found that PacifiCare of Oklahoma was unable to provide adequate documentation to support its rating of the FEHBP and SSSGs in 1990 and 1991. The documentation that was available indicated that the FEHBP

was rated differently than the SSSGs. Because of the lack of original documentation to support the rate development, PacifiCare suggested, during the course of the audit, rating the FEHBP and the SSSGs on its 1992 rating methodology. Because that alternative methodology treated the FEHBP and the SSSGs consistently, we accepted PacifiCare's suggestion. The alternative approach showed that the SSSGs received rate advantages in both 1990 and 1991. We applied the largest SSSG discount in each year, 14.88 percent and 10.94 percent, respectively, and determined that the FEHBP was overcharged \$784,859 in 1990 and \$1,341,757 in 1991.

### ***Oklahoma City Region Overcharges Total \$7.5 Million***

In 1992, the FEHBP was overcharged \$1,961,149. Findings relating to this overcharge involved the following issues: use of an incorrect age/sex factor and community rating factor; inflated capitation rates (a per member per month charge) for basic medical benefits and durable medical equipment (DME); and a seven percent rate advantage given to an SSSG not granted the FEHBP. In addition, the FEHBP did not receive a credit for premium taxes paid to the state of Oklahoma. As noted in the previous audit summary, the FEHBP is exempt from paying such taxes.

In 1995, inappropriate charges to the FEHBP relating to the Oklahoma City region amounted to \$731,104. We noted that the wrong pricing study was used in rating the FEHBP for that contract year. A pricing study contains the projected community rates for any groups renewing their contracts. In addition, the FEHBP was overcharged for certain health benefit loadings. These included inpatient mental health benefits, additional outpatient mental health visits not in the basic package, chemical dependency benefits, adult liver transplants, and an AZT (a drug used to combat AIDS) benefit.

*Tulsa region.* As we noted for the Oklahoma City region, the Tulsa region also did not have adequate documentation to support the rating of the FEHBP and SSSGs in 1990 and 1991. We again accepted an alternative rating of the FEHBP and SSSGs that the plan developed to treat them consistently. The alternative approach showed that the SSSGs received rate advantages in both years that were not given to the FEHBP. We applied the largest SSSG discount in each year, 26.41 percent and 15.81 percent, respectively, and determined that the FEHBP was overcharged \$680,513 in 1990 and \$851,706 in 1991.

### ***Tulsa Region Rating Problems Result in \$2.8 Million Loss to FEHBP***

In a finding similar to the Oklahoma City region, we determined that, in rating the FEHBP in 1992, PacifiCare of Oklahoma once again used inflated capitation rates for the basic medical and DME benefits and did not give the FEHBP a premium tax credit. After redeveloping the FEHBP rates to correct these problems, we calculated overcharges to the FEHBP at \$300,499 for 1992.

In 1993, FEHBP overcharges totaled \$233,774. We found that a majority of the same issues that occurred in 1992 contributed to the total overcharges by PacifiCare, including:

- Failing to use the same pricing study for rating the FEHBP and SSSGs, thus, adversely affecting the FEHBP's rates.
- Overcharging the FEHBP for inpatient mental health and chemical dependency loadings.
- Improperly changing demographic information in the rate reconciliation from what was submitted in the rate proposal in determining all employee and retiree rates.
- Not giving the FEHBP a premium tax credit as called for under its FEHBP contract.
- Providing a significant discount (6.14 percent) to an SSSG without granting an equivalent discount to the FEHBP.

#### **Lost Investment Income**

In accordance with the FEHBP contract with community-rated carriers, the FEHBP is entitled to \$1,916,593 for lost investment income on the overcharges we found for 1990 through 1995 for the Oklahoma City region. Lost investment income charges related to the Tulsa region during the same period amounted to \$651,636.

#### **Settlement**

As discussed previously, during the course of our audit, we identified questionable rating practices by PacifiCare of Oklahoma. Consequently, we referred the questionable issues to the U.S. Department of Justice for further review. DOJ shared our concern and joined OPM in pursuing a resolution of the audit issues presented in the report. Although PacifiCare of Oklahoma disagreed with the merits of our audit findings, it did consent to a negotiated settlement with DOJ and OPM, under which it agreed to return \$9 million to the federal government.

#### ***HMO Rate Reconciliation Audits***

In 1996, we initiated a new audit approach for FEHBP's community-rated carriers to supplement the standard community-rated audits we performed. The standard audits are performed on a post-award basis, usually several years after the completion of the contract year. The new approach, referred to as rate reconciliation audits (RRA), differs in that these audits are performed prior to the settlement of the final rates. OPM requires each community-rated plan to submit its proposed rates by May 31 of each year, seven months before the rates take effect. Because of these early submissions, each plan must estimate its community rate. The rate reconciliation then allows plans to adjust their estimated community rates to the rates that are actually in effect for the current contract year.

The RRA concept was designed to 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 provide significant benefits to OPM and participating community-rated carriers in the following ways:

- We can review data 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 the uncertainty for carriers regarding any future liabilities that could result from a post-award audit, including any potential interest accruals that may be due the FEHBP.

In addition, the RRAs have resulted in significant dollar savings to the FEHBP. Since inception in 1996, we have completed a total of 62 RRAs that identified over \$39.3 million in overcharges to the FEHBP. For the 20 RRAs completed during the current reporting period, we recommended premium rates changes amounting to \$11.5 million for five carriers. For example, our audit of the Health Insurance Plan of Greater New York identified \$3 million in inappropriate charges to the FEHBP. Almost \$2.9 million related to the Medicare loading was included in the rates. We found that the plan inappropriately decreased the FEHBP premium revenue by an administrative fee and used an incorrect FEHBP annuitant mix in determining the loading. As a result, the Medicare loading factor was too high. We determined that the loading should be 8.3 percent rather than the 13.5 percent used by the plan.

Due to the effectiveness of the RRA approach in carrying out the OIG's responsibility to provide effective and efficient oversight of the FEHBP, we plan to continue our RRA strategy in the future.

## **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 retentions. Each carrier maintains separate accounts for its federal contract, and future premiums are adjusted to reflect the federal enrollees' actual past use of benefits. The universe of experience-rated plans consists of approximately 100 audit sites.

Audits of these plans generally focus on the allowability of contract charges and the recovery of appropriate credits, the effectiveness of carriers' claims adjudication systems, and the adequacy of internal controls to ensure proper contract charges and benefit payments.

### ***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 45 percent of all FEHBP subscribers are enrolled in Blue Cross and Blue Shield plans nationwide.

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

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

### **Audit of Community Insurance Company d.b.a. Anthem Blue Cross and Blue Shield of Ohio in Cincinnati, Ohio**

**Report No. 10-18-97-004**  
**June 2, 1999**

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Our audit of the FEHBP operations at Anthem Blue Cross and Blue Shield of Ohio (Anthem BCBS) took place at the plan's headquarters in Cincinnati. We examined health benefits payments made by the plan from January 1, 1993 through June 30, 1996, as well as administrative expenses and supplementary and miscellaneous payments covering contract years 1991-1995.

In performing this audit, we determined 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 \$312,905 for inappropriately charged FEHBP claim payments; \$4,160,144 in unallowable administrative expense charges; \$1,452,842 in refunds, uncashed checks and discounts not credited to the FEHBP; and an additional \$1,810,606, representing lost investment income on questioned costs from our audit. Final calculations by our auditors regarding all inappropriate charges and lost investment income to the FEHBP totaled \$7,736,497. The BCBS Association agreed with \$455,484, disagreed with \$2,309,658, and indicated that it is still reviewing \$4,971,355.

***Auditors Calculate \$7,736,497 Owed to the FEHBP***

Insufficiently defined internal control processes pertaining to financial and accounting procedures and policies played a major part in many of the adverse findings we noted during this audit.

**Health Benefits**

During this period, the plan paid \$290 million in actual FEHBP claims payments. We selected claims at random as well as in specific health benefits categories, principally those concerning coordination of benefits, duplicate payments and coinsurance subscriber payments. We determined inappropriate charges to the FEHBP in these areas to be \$187,417, \$121,149, and \$4,229, respectively. Other areas of concern covered by our audit were financial and accounting problems affecting refunds (\$131,219), uncashed checks (\$7,814), and provider discounts (\$1,313,809). Our findings relating to health benefits charges totaled \$1,765,747. Significant findings in three of these areas are highlighted below.

*Coordination of benefits.* For the period July 18, 1995 through June 30, 1996, we identified 31 claims, totaling \$187,417, that the FEHBP paid in full when Medicare was the primary carrier. This type of inappropriate charge occurs when there is a failure to coordinate benefits properly with the Medicare coverage. We recommended that OPM's contracting officer direct Anthem BCBS to credit the FEHBP the full amount it erroneously paid for these claims.

*Duplicate payments.* Our auditors also determined that Anthem BCBS charged the FEHBP inappropriately for duplicate claims payments. During the review period of January 1, 1993 through June 30, 1996, there were 210 duplicate payment errors, totaling \$121,149. We recommended that OPM's contracting officer direct the plan to credit the FEHBP for any duplicate payment recoveries it receives.

*Provider discounts.* Our review of provider discounts resulted in identification of \$1,313,809 due the FEHBP. The plan reported to the BCBS Association in August 1996 that it inadvertently failed to apply provider discounts on some FEHBP institutional claims it processed in 1990 and through the first half of 1991. As a result, savings on those claims were not passed on to the FEHBP. Anthem BCBS believed the problem

was limited to outpatient, institutional claims that were processed manually. This problem has since been corrected.

## ***Inappropriate Claims Charges Cost FEHBP \$1,765,747***

### **Administrative Expenses**

During our review of administrative expenses from 1991-1995, we noted that Anthem BCBS overcharged the FEHBP for unallowable, unallocable, and unsupported costs, totaling \$4,160,144. Three areas in which a substantial number of these overcharges occurred were: inappropriate cost submissions (\$2,631,151); corporate overhead allocations (\$762,775); and franchise taxes (\$498,647). These are highlighted below.

*Cost submissions.* Anthem BCBS included unallowable and unallocable costs in its cost submissions to the FEP Director's Office of the BCBS Association. Federal regulations require that all unallowable and unallocable costs be excluded from cost submissions. The plan's internal controls did not properly identify and remove these costs.

*Corporate overhead allocations.* During 1991 through 1994, the plan's corporate overhead costs, which benefited its subsidiaries, were not allocated to all lines of business, including the subsidiaries. As a result, the FEHBP's allocated corporate overhead costs were overstated during this period. For 1991 through 1994, we recomputed the FEHBP's share of the corporate overhead costs based on the FEP total-cost ratio and determined that the FEHBP was overcharged. In 1995, Anthem BCBS implemented a new cost accounting system that allocates corporate overhead costs to all lines of business, including subsidiaries.

*Franchise taxes.* Anthem BCBS improperly charged the FEHBP a portion of its franchise tax. The Ohio state tax law allows the plan to base its franchise tax calculation on either capital/surplus or premiums. State taxes on FEHBP premiums are not allowable FEHBP expenses.

### **Cash Management**

The plan did not properly manage FEHBP funds. Specifically, the plan did not comply with federal regulations nor contract terms concerning drawdowns from the letter of credit (LOC) account. It is a legal requirement that FEHBP monies be made available for payment to a participating plan using the LOC arrangement *only after* checks are presented and paid by a bank. Under this checks-presented requirement, the drawdown on the letter of credit must be delayed until the checks issued for FEHBP disbursements are presented to the carrier's financial institution for payment. What we specifically found was that drawdowns by the plan were occurring on average 15 days for subscribers; 4 days for physicians, and 8 days for health facilities prior to the time frame stipulated under the FEHBP contract and federal regulations.

Because of Anthem BCBS's reimbursement arrangements for FEHBP claims, it not only maintained FEHBP funds on hand longer than it should, but it did not hold them in



separate FEHBP income-producing accounts. This also prevented crediting the FEHBP with the interest that should have been earned on the excess funds. This issue has been resolved as part of a global settlement with the Blue Cross and Blue Shield Association.

## ***Auditors Cite Cash Management Deficiencies***

### **Lost Investment Income**

Federal regulations require a carrier to invest and reinvest all excess FEHBP funds on hand and to credit all investment income earned on those funds. We computed lost investment income resulting from our audit findings in the amount of \$1,810,606 through December 1998. We have recommended to the contracting officer that this amount be returned to the FEHBP as well as additional lost investment income due after that date until Anthem BCBS has returned all monies owed to the FEHBP.

### ***Employee Organization Plans***

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

During the reporting period, we issued eight employee organization plan audit reports, two of which are summarized below.

### **Audit of National Association of Letter Carriers Health Benefit Plan in Ashburn, Virginia**

**Report No. 32-00-97-013  
June 14, 1999**

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The National Association of Letter Carriers health benefit plan (NALC) has its headquarters in Ashburn, Virginia. We examined health benefits payments made by the plan from 1994 through 1996 and its financial accounting activities for contract years 1991-1995. We also reviewed NALC's administrative expense charges covering the five-year period 1991-1995.

The purpose of this audit was to determine whether NALC charged appropriate costs to the FEHBP and provided services to FEHBP members in accordance with the terms of its contract. As a result, our auditors questioned \$3,838,501 related to inappropriately charged claim payments as well as \$1,203,229 in unallowable administrative expense charges. We calculated an additional \$463,744 for lost investment income on the questioned costs resulting from our findings. Our auditors determined that inappropriate

charges and lost investment income to the FEHBP totaled \$5,505,474. NALC agreed with \$1,476,021 and disagreed with \$4,029,453.

***Auditors Calculate \$5,505,474 Due the FEHBP***

Internal control deficiencies relating to financial and accounting procedures and policies were the primary cause of the findings we noted during the course of our audit.

**Health Benefits**

During the three-year period (1994-1996) under review, NALC made \$4 billion in actual claims payments. We selected FEHBP-related claims at random and, in addition, in specific health benefits categories. We identified significant findings relating to two such categories, coordination of benefits and state taxes on hospital claims, while others concerned financial and accounting problems affecting refunds and uncashed checks. These findings represent \$3,838,501 and are summarized below.

*Coordination of benefits.* For the period 1994 through 1996, we identified 165 claims, totaling \$1,322,000, that the FEHBP paid in full when Medicare was the primary carrier. As previously mentioned, this type of inappropriate charge occurs when there is a failure to coordinate benefits properly with Medicare coverage. We have recommended that OPM's contracting officer have NALC credit the FEHBP the full amount it paid for these claims in error.

*State taxes on Connecticut claims.* On April 1, 1994, the state of Connecticut imposed a six percent sales tax on hospital bills and an 11 percent tax on gross hospital receipts. Our analysis of claims paid from the state of Connecticut for the years 1994 through 1996 shows that the FEHBP indirectly paid taxes amounting to \$1,727,765. In accordance with federal regulations governing the FEHBP, the payment of state taxes with FEHBP funds is prohibited.

*Surcharge on New York claims.* NALC failed to request a refund for a 13 percent surcharge on New York hospital claims that was paid with FEHBP funds from January 1, 1994 through August 21, 1995. The refund amount totaled \$788,736.

***Inappropriate FEHBP Claims Charges Total \$3,838,501***

**Administrative Expenses**

During our review of administrative expenses that NALC had charged to the FEHBP from 1991-1995, we noted \$1,203,229 in unallowable costs. These overcharges resulted from cafeteria operating losses, a health benefits representatives' seminar, and a gain on the sale of certain assets.

In the case of the cafeteria operation losses, NALC had charged inappropriate operating losses to the FEHBP. Federal regulations state that losses of this type may be included

as contract costs under one condition: that the objective of a food service operation be to break even. Our analysis of the NALC's audited financial statements demonstrated no such intent. Based on our calculations, the FEHBP was overcharged \$1,049,208 in unallowable cafeteria losses.

**Audit of the General Controls Related to  
Government Employees Hospital Association, Inc.'s  
Computer-Based Information Systems  
in Lee's Summit, Missouri**

**Report No. 31-00-99-009  
September 30, 1999**

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The Government Employees Hospital Association, Inc. (GEHA) has its headquarters in Lee's Summit, Missouri. This employee organization plan offers FEHBP coverage to federal employees, retirees and their dependents. GEHA received over \$1 billion in program income from the FEHBP during the most recently completed contract year 1998. This audit covered information systems general controls that were in place during the current contract year 1999.

Unlike our standard audit of experienced-rated carriers that focuses primarily on health benefits charges and administrative costs assessed to the FEHBP, this particular audit was designed to review only current operational practices related to GEHA's computer-based information systems. In reviewing GEHA's information systems controls, our audit goal was to verify whether or not GEHA had implemented these controls properly to assure not only the confidentiality, integrity and availability of computerized data associated with its processing of FEHBP health benefits claims, but also the accurate reporting of costs to OPM.

We examined the general controls environment surrounding GEHA's computer-based systems, such as the structure, policies, and procedures that apply to its overall computer operations. If the controls were weak, they could severely diminish the reliability of individual application systems, increasing the risk of erroneous claim payments being made or reported to OPM on behalf of the FEHBP subscribers enrolled in the plan.

This audit was structured from procedures found in the General Accounting Office's (GAO) *Federal Information System Controls Audit Manual*. The GAO audit manual outlines six major categories of general controls that should be considered during such an audit. The six major categories include: (1) entity-wide security program, (2) access controls, (3) application software development and change controls, (4) segregation of duties, (5) system software controls, and (6) service continuity controls.

As a result of our audit, we identified several areas where improvements could be made, including the development of a comprehensive security plan. We also made a number of recommendations intended to improve logical and physical access controls, controls over software development and changes, systems software, disaster recovery, and Year 2000 (Y2K) compliance.

In response, GEHA has agreed to implement many of our recommendations. For example, GEHA has assigned various teams to document and address our concerns related to security and access controls. This includes developing a presentation on security practices and system rules which will be given at GEHA's new employee orientation program. GEHA is also developing a plan to monitor and report security violations in both the mainframe and network environment. It is also reviewing its security software settings to ensure that access paths to the system are adequately controlled.

In other general control areas, GEHA has a project currently underway to formalize policies and procedures related to application software development and change control. It has purchased and installed a library management software tool to protect programs from unauthorized changes. In addition, GEHA continues to make significant progress on the Year 2000 issue. They are completing the development of a comprehensive Year 2000 test plan to include testing in a Y2K-simulated environment and developing a business continuity and contingency plan.

### ***Auditors Identify Need for Improved Information System Controls***

## **Other External Audits**

*Pre-award and post-award contracts.* As requested by OPM procurement officials, our OIG conducts pre- and post-award contract audits relating to the acquisition of goods and services by agency program offices. During this reporting period, no pre- or post-award audits were requested.

*Combined Federal Campaign (CFC).* Our office has oversight responsibility over the operations of local organizations of the Combined Federal Campaign, the solely authorized fund-raising drive conducted in federal installations throughout the world.

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

During this reporting period, we issued three CFC reports, which are identified on page 40 in Appendix V of this report.

## **OPM INTERNAL ACTIVITIES AUDITS**

Our office also has responsibility for conducting a wide range of audit activity covering the Office of Personnel Management (OPM) programs and administrative operations. This activity includes such diverse areas as financial statement audits required by the Chief Financial Officers Act (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.

As we have mentioned in prior semiannual reports, resource limitations have made it necessary for us to limit the scope of our internal audits workload. Consequently, during this reporting period, we concentrated our efforts on the essential pre-audit work needed to conduct the FY 1999 audits of OPM's financial statements and certain other internal audit work deemed critical to our agency. While we did not issue any traditional internal audit reports during this reporting period, we did participate within the IG community in a government-wide study of non-tax delinquent debt and reviewed this issue as it pertained to our agency. This report is referenced in Appendix IV on page 39.

Previously, we have reported on our inability to conduct a full range of independent performance audits. When we performed these audits in the past, we examined how well OPM's program offices had been able to meet the challenges of carrying out our agency's mission, legislative and regulatory mandates, as well as executive orders issued by the President.

To mitigate the absence of these audits in recent years, we used both our CFO Act financial statement audits together with our office's evaluation and inspections work relating to agency program and administrative activities to make constructive recommendations to agency program offices for improving efficiency and effectiveness and correcting deficiencies where indicated. However, we fully recognized that neither of these could replace performance audits and have since made a decision to request additional OIG staff resources to correct this situation. Please also refer to the Evaluation and Inspections Activities section of this report on pages 27-29.

### **OCFO's FFMIA Compliance Efforts**

Our audits of the financial statements for OPM's revolving fund (RF) and salaries and expenses accounts (S&E) for the last three years have resulted in disclaimers of opinion. A summary of the FY 1998 audits pertaining to these two entities can be found in our last semiannual report. Our FY 1997 and FY 1998 audit reports on compliance with laws and regulations for OPM's revolving fund and salaries and expenses accounts detail our conclusions regarding the agency's compliance with the Federal Financial Management Improvement Act. 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. As of September 1999, ten of these items had not been completed. In addition, five new items have been added to the remediation plan. The main reasons cited by the OCFO for items not being completed are limited programmer support due to other computer-related work and the need for greater than anticipated systemic and procedural changes within the organization.

As a result of our audits of the FY 1998 RF and S&E financial statements, we made several recommendations to address the key material weaknesses noted that resulted in our disclaimers of opinion and our conclusion that the RF and S&E financial management systems did not substantially comply with the requirements included in the FFMIA. These recommendations were for the OCFO to:

- Maintain complete and accurate subledgers or other detailed support for general ledger balances and for performing periodic reconciliations between them.
- 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.

### ***OIG Reviews FFMIA Remediation Efforts***

#### **OPM FACTS Transmissions Procedures**

In order to prepare the government-wide consolidated financial statements (CFS) and notes that are issued March 31 of each year, the U.S. Treasury Department (Treasury) requires each agency's Office of the Chief Financial Officer to transmit audited financial statement amounts and notes via an online computer system called FACTS (federal agencies centralized trial balance system). The notes are a vital component, reflecting both key accounting policies and procedures and other accounting data that assist the reader in interpreting the CFS.

The Office of Management and Budget (OMB) requires OCFOs and OIGs to perform certain agreed-upon procedures (AUPs) on these transmissions to ensure their accuracy and completeness. For OPM, this consists of ten transmissions, including those pertaining to OPM's S&E, RF, and federal benefits programs entities. After the amounts are transmitted, Treasury provides a schedule of the data that they received. The OCFO and OIG and the independent accountant responsible for auditing OPM's benefits programs financial statements then perform the AUPs against the data sent to Treasury and data received by Treasury. What sounds like a simple procedure of transmitting and verifying data is complicated by the many transmissions and parties involved. In this instance, difficulties also arose from insufficient planning and control over this process.

In order to complete this work, OIG staff went above and beyond the procedures required by OMB. As a result, we significantly improved the process by performing the following additional tasks:

- Assisted the OCFO in documenting OPM's transmissions to Treasury.
- Assisted in identifying differences between OPM's and Treasury data that led to the identification of communication problems between OPM and Treasury on transmission deadlines.
- Assisted the OCFO and Treasury in preparing journal vouchers to correct the latter's data received from OPM.

Through these additional efforts, we facilitated the FACTS process for all parties involved, thus ensuring that the process was completed along with improved communications between OPM and the Treasury Department. We believe these efforts reduced the risk for OPM being the cause for delay in the preparation and audit of the government-wide consolidated financial statements and accompanying notes.

### ***OIG Improves FACTS Transmission Procedures***

## Investigative Activities

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

During this reporting period, we have continued to aggressively pursue criminal and civil sanctions against both individuals and corporate entities. These efforts have produced five arrests and nine convictions. More importantly, however, they have resulted in judicial and administrative monetary recoveries to the OPM-administered trust funds totaling \$1,350,465. Other investigative efforts resulted in the detection of 15 ongoing frauds in the Civil Service Retirement System (CSRS), with a projected savings of \$384,540 to the Civil Service Retirement and Disability trust fund over the next five years. Overall, we opened 29 investigations and closed 21 during this reporting period, with 87 still in progress at the end of the period. (See Table 1 for investigative activity highlights on page 26 of this section.)

Calls received on our health care fraud hotline and our retirement and special investigations hotline, along with complaints mailed in, totaled 883. As we typically experience during the second half of the fiscal year, our complaint activity has decreased from the previous reporting period. Complaint activity is usually more active in the fall of each year when the FEHBP open season brochures, which contain information on how to report fraud to the OIG, are distributed. Additional information, including specific activity breakdowns for each hotline, can be found on pages 24-25 in this section.

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

In the retirement area, we have continued our proactive efforts to identify fraud by routinely reviewing CSRS annuity records for indications of unusual circumstances, as well as maintaining contact with the federal annuitant population. While our recoveries in this area are, for the most part, smaller than in the health care fraud area, criminal prosecutions and sentences tend to be more significant.

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



On the following pages, we have provided narratives relating to health care and retirement fund fraud we conducted 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, we work closely with our own Office of Audits 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.

### ***Physician's Fraudulent Billing Practices Uncovered***

A physician who operated a clinic specializing in preventive medicine in Vienna, Virginia, was sentenced on June 18 of this year in U.S. District Court in Alexandria, Virginia, to 27 months in prison. In addition, he was ordered by the court to make restitution to the federal government in the amount of \$1.4 million, with the FEHBP receiving \$238,984 of this amount.

This sentence was handed down following the doctor's guilty plea of conspiracy to commit mail and wire fraud. It came as a result of a three-year investigation conducted by our office in cooperation with the Federal Bureau of Investigation (FBI) and the Defense Criminal Investigative Service.

The investigation revealed that the physician knowingly submitted bills to federal and private health insurance plans over a six-year period for purportedly covered medical services when, in fact, the services he actually supplied to patients were never covered by these plans.

***FEHBP Receives \$238,984 in Restitution***

### ***Company Exposed in Emergency Room Billing Scheme***

A five-year investigation of the practices of an emergency room billing service in Oklahoma City, Oklahoma, has resulted in that company agreeing this past June to a monetary settlement with the federal government for \$300,000.

The allegations against the company, which acted as a billing service for hospital and

clinic emergency rooms nationwide, were brought to the attention of our OIG by a health insurance plan that participates in the FEHBP. Specifically, the health insurance carrier alleged that the billing service routinely charged the federal government for high-end services involving emergency room physicians when, in reality, lower-priced basic services had been provided.

This investigation, conducted under the auspices of the Department of Justice, revealed that the billing service had changed specific treatment codes to indicate higher-priced services than those actually rendered. This type of billing fraud is known as “upcoding.” In this instance, upcoding was used to obtain a significantly greater reimbursement from the FEHBP than otherwise would have resulted for the type of non-emergency services provided.

### ***Investigators’ Efforts Result in \$300,000 Return to FEHBP***

#### ***South Florida Physician Guilty of Billing Fraud***

Based on information received from an FEHBP carrier, our office, in conjunction with the FBI and the carrier, conducted an investigation of a South Florida-based physician in Fort Lauderdale for billing for services not rendered. The two-year investigation disclosed that the physician submitted bills to both federal and private health insurance plans for medical services he never performed.

As a result of evidence of the extensive fraud, including records obtained during the execution of a search warrant, the physician was arrested and later pleaded guilty to health care fraud and mail fraud on June 11 of this year. On July 16, he was sentenced in U.S. District Court in Miami to 15 months in prison, three years’ probation, and a \$54,000 fine. He also was ordered to make restitution in the amount of \$200,000 to the health insurance plans that had suffered claim losses.

### ***15-Month Prison Term Ordered for Physician***

#### **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 is a narrative related to one of the cases in this area that we completed during this reporting period.

### ***Federal Retirement Fund Theft***

As a result of a referral from OPM's Retirement and Insurance Service, our office initiated an investigation during August 1998 regarding the theft of CSRS funds intended for a deceased annuitant who had resided in Columbus, Ohio, prior to her death. Our office was informed that one or more unknown persons may have forged the annuitant's signature on \$25,000 worth of U.S. Treasury checks after her death in 1993.

Our investigation revealed that the daughter of the deceased annuitant had shared an account with her mother and continued to deposit these fraudulently endorsed checks in that account after she died. The daughter was interviewed and admitted to misappropriating the funds. On June 8, 1999, in Columbus, she was indicted on 29 counts of mail fraud and agreed to plead guilty to the theft of U.S. Government funds. Sentencing is pending, and an update will be provided in our next semiannual report.

### ***Forgery of U.S. Treasury Checks Results in Guilty Plea***

## **OIG Hotlines**

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 39 telephone calls, 46 letters, 14 agency referrals, 1 walk-in, and 203 complaints initiated by the OIG, for a total of 303. Our administrative monetary recoveries resulting from retirement and special investigation complaints totaled \$213,073.

*OIG-initiated complaints.* Complaints initiated by our office can be one of two types. The first occurs when the agency has already received information indicating an overpayment to an annuitant has been made, and our review leads us to determine there are sufficient grounds to justify our involvement due to the potential for fraud. There were 36 such complaints associated with agency inquiries during this reporting period.

The second type of OIG-initiated complaint occurs when we review the agency's automated annuity records system for certain items that may indicate a potential for fraud. At that point, we initiate personal contact with the annuitant to determine if further investigation is warranted. This investigative activity resulted in 167 instances where our office initiated personal contacts to verify the status of the annuitant.

### ***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 the reporting period involved 385 telephone calls and 195 letters, for a total of 580. During this period, the administrative monetary recoveries pertaining to health care fraud complaints totaled \$500,039.

## Investigative Activity Tables

**TABLE 1: Investigative Highlights**

<b>Judicial Actions:</b>	
Arrests . . . . .	5
Indictments . . . . .	3
Convictions . . . . .	9
<b>Administrative Actions:<sup>1</sup></b> . . . . .	<b>0</b>
<b>Judicial Recoveries:</b>	
Fines, Penalties, Restitutions and Settlements . . . . .	\$637,353
<b>Administrative Recoveries:</b>	
Settlements and Restitutions . . . . .	\$713,112
<b>Total Funds Recovered</b> . . . . .	<b>\$ 1,350,465</b>

<sup>1</sup>Includes suspensions, reprimands, demotions, resignations, removals, and reassignments.

**TABLE 2: Hotline Calls and Complaint Activity**

<b>Retirement and Special Investigations Hotline and Complaint Activity:</b>	
Retained for Investigation . . . . .	221
Referred to:	
OIG Office of Audits . . . . .	0
OPM Groups and Offices . . . . .	45
Other Federal Agencies . . . . .	37
<b>Total</b> . . . . .	<b>303</b>
<b>Health Care Fraud Hotline and Complaint Activity:</b>	
Retained for Investigation . . . . .	142
Referred to:	
OPM Groups and Offices . . . . .	162
Other Federal/State Agencies . . . . .	75
Health Insurance Carriers or Providers . . . . .	201
<b>Total</b> . . . . .	<b>580</b>
<b>Total Contacts</b> . . . . .	<b>883</b>

## Evaluation and Inspections Activities

Section 4(a)(3) of the Inspector General Act provides a broad mandate to IGs to assist their respective departments and agencies in promoting economy and efficiency and in preventing and detecting fraud and abuse with respect to their programs and operations. It calls for IGs to be proactive in their activities beyond those specifically prescribed under its audit and investigation responsibilities to make sure the intent and purposes of the Act are met.

Within this context, evaluation and inspections activities have become a core function within our OIG. Through these activities, we are providing assistance to agency program managers in an effort to determine the feasibility of new initiatives and the effectiveness and efficiency of existing operational methodologies. We conduct independent analytical reviews that often serve as the cornerstone for strategies to improve the delivery of services throughout the agency.

The Office of Personnel Management has been in the forefront of the Administration's efforts to improve the quality of its services and reduce the size of government. The agency's program offices have experienced reorganizations, staff reductions and new program mandates during the last few years, with the intended goal of becoming a "model agency" for the twenty-first century. Our office provides this agency with a unique tool to address a variety of the pressing issues associated with today's government reorganizing. The evaluative process we employ, whether requested by our agency's program offices or initiated from within the OIG, focuses on current issues, such as reduced funding, increased workloads, decreasing staffing levels, inefficient or ineffective services, private or public-sector inquiries concerning delivery of services, and the absence of objective evaluative data to use in determining the impact of programs.

An ongoing area of review is the agency's compliance with the Government Performance and Results Act of 1993 (GPRA). Signed by President Clinton on August 3, 1993, the Act was designed to produce improvements in government performance and accountability in federal programs. GPRA, more recently referred to as the Results Act, includes directives for federal agencies and departments to follow regarding strategic planning and performance management processes that emphasize goal-setting, customer satisfaction and results measurements. The Act requires all executive branch departments and agencies to submit five-year strategic plans and annual performance plans (APP) linked to their respective budgets. Prior to their submission to Congress, these APPs must be reviewed by OMB along with each agency's and department's traditional budget request.

In response to a request from Congress, we prepared a plan that will be used by the OIG in our efforts to review OPM activities under the Results Act. This plan was detailed in the previous semiannual report. Actions reportable under this plan are anticipated during the next six months.

In past semiannual reports, we have reported on our efforts to review the functions of the agency's Office of Contracting and Administrative Services (OCAS). During this reporting period, we completed the third review from this series and began a fourth. A summary of the completed review follows.

### ***OCAS Service Delivery Review***

As stated in the April 1998 issue of our semiannual report, we have been conducting a series of administrative reviews of OPM's Office of Contracting and Administrative Services. The purpose of these reviews is to determine whether the level of service being provided by OCAS is commensurate with customer expectations, especially since our agency began downsizing in the middle of the decade. Additionally, these studies are useful in assessing the degree of compliance with federal regulations and established agency policy and procedures.

During this reporting period, we conducted a review of the agency's printing procurement services function within OCAS. Throughout the course of our research, we found that, despite the decline in staff resources, the level of staff performance relating to all phases of the printing process appear to be functioning efficiently and effectively. This success is due in part to the replacement of a manual, paper-driven procurement request and tracking system by an online printing procurement process that is further enhanced by a sophisticated tracking system that interfaces with one used by the Government Printing Office (GPO).

#### ***Online Printing Procurement Process Improves Efficiency***

Although the implementation of these electronic-driven processes has significantly increased the efficiency of the overall operations, the study of the publications procurement function did reveal three significant areas of concern.

The first involves the absence of established, comprehensive agency guidelines for the preparation and approval of printed documents. It was determined that many customers remain uninformed of the appropriate procedures required which led to our recommendation to correct this deficiency.

The second concern centers around the responsibilities of the agency's publication review panel. The panel is comprised of representatives of each of the core services within OPM as well as OCAS staff. In our agency, most publications for both internal or external distribution must be reviewed and approved by all the members of this panel before the printing process can begin. Although time-sensitive materials are subject to a more expeditious review process, even these have fallen victim to the panel's review procedures, resulting in some important printing deadlines being missed. It should be pointed out that many of

these publications are printed for distribution to interested parties outside our agency, including the general public. There have been instances wherein information was delivered outside the time frame when it could have been more useful to OPM's internal and external customers. All agencies want to be viewed favorably, and we determined that a number of key program offices within OPM have expressed frustration at the apparent inability of panel members to speed up the review process when tight deadlines demanded it, leading at times to public embarrassment for the agency. We have suggested two courses of action that might improve this situation: (1) reduce the size of the panel, and (2) educate and heighten the awareness of the panel members to the negative impact failing to meet tight deadlines have on our agency and its program offices.

The third issue surrounds the level of familiarity of OPM in-house customers with the governing printing procurement regulations. Under Title 44 of the U.S. Code, GPO is the mandatory source for all congressional and executive branch printing. As specified in the regulation, GPO satisfies most congressional printing requirements through its in-house printing facilities, while meeting executive branch needs primarily through commercial contracts.

As alluded to previously, OPM customers have not always been satisfied with the length of time it takes to get their products through the review and printing process. In addition to the in-house problems stated above, additional time-related issues have surrounded GPO's role in the contract award process, as well as the final delivery of the product. Suffering repeated time delays in-house and then with GPO has caused some OPM program offices to act on their own to contact outside printing vendors in the belief that the time it will take to print and deliver their time-sensitive products will be minimized along with cost. Consequently, they have resorted to using government-issued credit cards to circumvent the process.

No matter how well-intentioned, we believe our agency must find constructive ways to discourage this type of activity. As a result, we have recommended to our agency that they maintain the dialogue they have established with the General Services Administration, which oversees the federal government's credit card contracts, to discourage this practice that has affected all executive branch agencies. We have also recommended that OPM educate its program offices that acts of this nature are in violation of the U.S. Code.

### ***OIG Cites Need for Improved Printing Regulations Compliance***

Our report contained other recommendations to improve OCAS printing procurement operations. In its response, OCAS indicated its plans for implementing several of these recommendations while others are still under review.



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

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<b>Section 5 (a) (1):</b> Significant problems, abuses, and deficiencies .....	3-19
<b>Section 5 (a) (2):</b> Recommendations regarding significant problems, abuses, and deficiencies .....	18
<b>Section 5 (a) (3):</b> Recommendations described in previous semiannual reports on which corrective action has not been completed .....	32
<b>Section 5 (a) (4):</b> Matters referred to prosecutive authorities .....	6-8, 22-24
<b>Section 5 (a) (5):</b> Summary of instances where information was refused during this reporting period .....	No Activity
<b>Section 5 (a) (6):</b> Listing of audit reports issued during this reporting period .....	34-40
<b>Section 5 (a) (7):</b> Summary of particularly significant reports .....	3-19
<b>Section 5 (a) (8):</b> Audit reports containing questioned costs .....	34-38
<b>Section 5 (a) (9):</b> Audit reports containing recommendations for better use of funds .....	No Activity
<b>Section 5 (a) (10):</b> Summary of unresolved audit reports issued prior to the beginning of this reporting period .....	33
<b>Section 5 (a) (11):</b> Significant revised management decisions during this reporting period .....	No Activity
<b>Section 5 (a) (12):</b> Significant management decisions with which OIG disagreed during this reporting period .....	No Activity

**APPENDIX I**  
**Final Reports Issued With Questioned Costs**  
**April 1, 1999 to September 30, 1999**

	Number of Reports	Questioned Costs	Unsupported Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	10	\$ 37,352,689	\$ 0
B. Reports issued during the reporting period with findings	21	60,011,435	1,319,853
Subtotals (A+B)	31	97,364,124	1,319,853
C. Reports for which a management decision was made during the reporting period:	12	41,275,824	0
1. Disallowed costs		32,670,399	0
2. Costs not disallowed		8,605,425	0
D. Reports for which no management decision has been made by the end of the reporting period	19	56,088,300	0
Reports for which no management decision has been made within 6 months of issuance	4	10,423,823 <sup>1</sup>	0

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<sup>1</sup>Resolution of these items has been postponed at the request of the OIG.

**APPENDIX II**  
**Final Reports Issued With Recommendations**  
**For Better Use of Funds**  
**April 1, 1999 to September 30, 1999**

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

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**APPENDIX III-A**  
**Insurance Audit Reports Issued**  
**April 1, 1999 to September 30, 1999**

<b>Subject (Standard Audits)</b>	<b>Report Number</b>	<b>Issue Date</b>	<b>Questioned Costs</b>	<b>Unsupported Costs</b>
PacifiCare (FHP) of Utah in Fountain Valley, California	KU-00-98-046	April 19, 1999	\$	\$
PacifiCare of California, Inc. in Cypress, California	CQ-00-98-047	May 5, 1999		
Blue Cross and Blue Shield of Tennessee in Chattanooga, Tennessee	10-15-98-002	May 18, 1999	1,127,069	24,374
Scott & White Health Plan in Temple, Texas	UF-00-97-001	May 17, 1999	5,572,346	
Kaiser Foundation Health Plan of Georgia, Inc., in Atlanta, Georgia	F8-00-99-007	May 26, 1999		
Community Insurance Company d.b.a. Anthem Blue Cross and Blue Shield in Cincinnati, Ohio	10-18-97-004	June 2, 1999	7,736,497	1,295,479
Blue Cross and Blue Shield of Tennessee in Memphis, Tennessee	10-46-98-013	June 4, 1999	95,778	
National Association of Letter Carriers Health Benefits Plan in Ashburn, Virginia	32-00-97-013	June 14, 1999	5,505,474	
Blue Cross and Blue Shield of North Carolina in Durham, North Carolina	10-33-97-017	June 17, 1999	2,804,351	
Metropolitan Life Insurance Company in New York, New York	II-00-99-018	July 14, 1999		
Blue Cross and Blue Shield of Rhode Island in Providence, Rhode Island	10-60-98-023	July 20, 1999	467,815	
Supplemental Report on Blue Cross and Blue Shield of the National Capital Area as the Underwriter for the National Alliance of Postal and Federal Employees (NAPFE) Health Benefit Plan in Washington, D.C.	YA-03-98-007	July 30, 1999	5,742,552	
Supplemental Report on Blue Cross and Blue Shield of the National Capital Area as Underwriter for the National Association of Postmasters of the United States (NAPUS) Health Benefit Plan in Washington, D.C.	YP-03-98-009	August 3, 1999	1,464,768	

**APPENDIX III-A**  
**Insurance Audit Reports Issued**  
**April 1, 1999 to September 30, 1999**

<b>Subject (Standard Audits)</b>	<b>Report Number</b>	<b>Issue Date</b>	<b>Questioned Costs</b>	<b>Unsupported Costs</b>
Supplemental Report on Blue Cross and Blue Shield of the National Capital Area as Underwriter for the Secret Service Employees Association Health Benefit Plan in Washington, D.C.	Y7-03-98-006	August 4, 1999	\$ 389,423	\$
Blue Cross and Blue Shield of Oklahoma in Tulsa, Oklahoma	10-83-97-046	August 9, 1999	214,827	
George Washington University Health Plan in Bethesda, Maryland	E5-00-97-047	August 9, 1999	3,297,884	
Supplemental Report on Blue Cross and Blue Shield as Underwriter for the National Capital Area for the Beneficial Association of Capitol Employees Health Benefit Plan (BACE) in Washington, D.C.	Y2-03-98-010	August 10, 1999		
Supplemental Report on Blue Cross and Blue Shield as Underwriter for the National Treasury Employees Union Health Benefit Plan for the National Capital Area in Washington, D.C.	YY-03-98-008	August 10, 1999		
Panama Canal Area Benefit Plan in West Long Branch, New Jersey	43-00-99-019	August 20, 1999	4,614	
Medical Service Corporation of Eastern Washington in Spokane, Washington	10-75-99-006	September 1, 1999	96,069	
PacifiCare of Oklahoma for the Oklahoma City and Tulsa Regions in Tulsa, Oklahoma	PE-00-96-006	September 23, 1999	10,336,280	
Anthem Blue Cross and Blue Shield of Connecticut in North Haven, Connecticut	10-50-97-012	September 24, 1999	3,630,588	
Report on Information System General Controls at the Government Employees Hospital Association, Inc., in Lee's Summit and Independence, Missouri	31-00-99-008	September 30, 1999		
<b>TOTALS</b>			<b>\$ 48,486,335</b>	<b>\$ 1,319,853</b>

**APPENDIX III-B**  
**Insurance Audit Reports Issued**  
**April 1, 1999 to September 30, 1999**

<b>Subject (<i>Rate Reconciliation Audits</i>)</b>	<b>Report Number</b>	<b>Issue Date</b>	<b>Questioned Costs</b>	<b>Unsupported Costs</b>
NYLCare Mid-Atlantic of Greenbelt, Maryland, Proposed Rate Reconciliation	JN-00-99-025	May 26, 1999	\$	\$
FreeState Health Plan of Owings Mills, Maryland, Proposed Rate Reconciliation	LD-00-99-031	June 8, 1999		
PacifiCare of Colorado Proposed Rate Reconciliation	D6-00-99-022	June 11, 1999		
PacifiCare of California Proposed Rate Reconciliation	CY-00-99-028	July 8, 1999		
Aetna U.S. Healthcare of the Mid-Atlantic Proposed Rate Reconciliation	V8-00-99-024	July 9, 1999		
Aetna U.S. Healthcare of New Jersey Proposed Rate Reconciliation	P3-00-99-023	July 9, 1999		
Aetna U.S. HealthCare of Philadelphia, Inc. Proposed Rate Reconciliation	SU-00-99-040	July 9, 1999		
Aetna U.S. HeathCare New York Plan Proposed Rate Reconciliation	JC-00-99-039	July 9, 1999		
Health Insurance Plan of Greater New York Proposed Rate Reconciliation	51-00-99-032	July 19, 1999	3,009,394	
Healthnet of Woodland Hills, California, Proposed Rate Reconciliation	LB-00-99-029	July 22, 1999		
Group Health Coop Puget Sound of Seattle, Washington, Proposed Rate Reconciliation	54-00-99-033	July 23, 1999	158,558	

**APPENDIX III-B**  
**Insurance Audit Reports Issued**  
**April 1, 1999 to September 30, 1999**

<b>Subject</b> <i>(Rate Reconciliation Audits)</i>	<b>Report Number</b>	<b>Issue Date</b>	<b>Questioned Costs</b>	<b>Unsupported Costs</b>
Humana Health Plan of Chicago Proposed Rate Reconciliation	75-00-99-027	July 23, 1999	\$ 1,168,449	\$
George Washington University Health Plan Proposed Rate Reconciliation	E5-00-99-042	July 28, 1999		
Humana Health Plan of Texas Proposed Rate Reconciliation	TW-00-99-026	July 28, 1999	216,605	
MD-Individual Practice Association, Inc. Proposed Rate Reconciliation	JP-00-99-044	July 29, 1999		
Keystone Health Plan East Proposed Rate Reconciliation	ED-00-99-034	August 6, 1999		
Kaiser Foundation Health Plan of Northern California Proposed Rate Reconciliation	59-00-99-041	August 13, 1999		
Kaiser Foundation Health Plan Mid-Atlantic States Proposed Rate Reconciliation	E3-00-99-037	August 20, 1999	6,972,094	
Kaiser Foundation Health Plan of Southern California Region Proposed Rate Reconciliation	62-00-99-038	August 23, 1999		
Kaiser Foundation Health Plan of the Pacific Northwest, Inc. Proposed Rate Reconciliation	57-00-99-036	August 23, 1999		
<b>TOTALS</b>			<b>\$ 11,525,100</b>	<b>\$ 0</b>

**APPENDIX IV**  
**Internal Audit Reports Issued**  
**April 1, 1999 to September 30, 1999**

<b>Subject</b>	<b>Report Number</b>	<b>Issue Date</b>	<b>Funds Put to Better Use</b>	<b>Questioned Costs</b>
President's Council on Integrity and Efficiency/Executive Council on Integrity and Efficiency Review of Non-Tax Delinquent Debt	2F-00-98-104	April 15, 1999	\$	\$
<b>TOTALS</b>			<b>\$ 0</b>	<b>\$ 0</b>



**APPENDIX V**  
**Combined Federal Campaign Reports Issued**  
**April 1, 1999 to September 30, 1999**

<b>Subject</b>	<b>Report Number</b>	<b>Issue Date</b>	<b>Funds Put to Better Use</b>	<b>Questioned Costs</b>
The 1996 Combined Federal Campaign of America's Charities National Federation in Fairfax, Virginia	2A-CF-98-038	June 2, 1999	\$	\$
The 1995 Overseas Area Combined Federal Campaign in Washington, D.C.	2A-CF-98-039	June 8, 1999		
The 1996 Children's Charities of America, a National Federation in the Combined Federal Campaign, in Conte Madera, California	2A-CF-98-040	July 13, 1999		
<b>TOTALS</b>			<b>\$ 0</b>	<b>\$ 0</b>