

OFFICE OF THE
INSPECTOR GENERAL



SEMIANNUAL REPORT TO CONGRESS

April 1, 2004 – September 30, 2004



UNITED STATES *Working for America*
OFFICE OF PERSONNEL MANAGEMENT

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OFFICE OF
THE INSPECTOR GENERAL

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, D.C. 20415-1100

November 1, 2004

*Honorable Kay Coles James
Director
U.S. Office of Personnel Management
Washington, D.C. 20415*

Dear Mrs. James:

I respectfully submit the Office of the Inspector General's Semiannual Report to Congress for the period April 1, 2004 to September 30, 2004. 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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THE INSPECTOR GENERAL'S MESSAGE

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While the contents of this report represent only a small portion of our activities, they are indicative of the various types of issues we encounter in our sanctions, audits and investigative activities. We highlight many examples of the fundamental changes our office is making in the way that we approach our work and the methods we use to accomplish our mission.

I view these changes as positive developments for our office. As the organization charged by law with preventing waste, fraud, abuse, and mismanagement within OPM and its programs, we can never let our operations become static or routinized. With the support of OPM Director Kay Coles James and her senior staff, we are making every effort to apply the most advanced technology and efficient methods to our audit, investigation, and administrative sanctions activities.

■ **Nationwide Field Office Structure**

By the end of the reporting period, we had established 15 investigative field offices throughout the United States, and opened our first audit field office, in the Pittsburgh, PA metropolitan area. We expect to open additional field locations for both auditors and investigators in the future. Establishing a field structure has been a long-held objective for our office, and was very much needed for operational purposes. The new field offices allow us to place our staff closer to their work, thereby enhancing our efficiency in conducting nationwide activities. Additionally, our presence in field locations will enable us to continue to attract and retain a highly competent and productive workforce. The map on page iv shows the distribution of OIG's headquarters and field facilities.

■ **Administrative Sanctions**

The FEHBP administrative sanctions law and regulations afford a high degree of due process protection to the subjects of proposed sanctions, while allowing the use of informal decision-making procedures that emphasize efficiency and substance. As reflected in this report, we are using this flexibility to apply techniques — similar to those which are coming into widespread use in both government and the private sector — to obtain information about violations through electronically-available information sources. This process, which we term "e-debarment," allows us to issue debarments quickly, and with a relatively low expenditure of resources, while focusing on health care providers who are most likely to become involved in transactions with FEHBP. The body of this report contains examples of cases which we developed through e-debarment methods. Further, we also have the authority to suspend, on a highly expedited basis, providers who pose direct risks, or potential risks, to the health and safety of FEHBP enrollees. One of the administrative sanctions cases in this report reflects the type of situation in which suspension is particularly appropriate, and emphasizes our commitment to using administrative sanctions vigorously to protect FEHBP and its enrollees.



THE INSPECTOR GENERAL'S MESSAGE

■ **Auditing FEHBP Pharmacy Benefits Contracts**

The Office of Audits' section of this report discusses issues regarding the BlueCross BlueShield Association's handling of pharmaceutical manufacturers' rebates and credits that were due to the FEHBP. This audit identified significant amounts of funds that should have been paid into FEHBP's account. Further, we are now planning a large-scale, comprehensive approach to auditing FEHBP's prescription drug benefits. FEHBP paid over \$6 billion in pharmacy benefits in 2003 — almost one-quarter of its total health insurance costs. As is the case in the health insurance industry at large, most of these benefits are administered by third party subcontractors, called pharmacy benefits managers (PBMs). They are responsible for obtaining the best pharmaceutical values for FEHBP. However, the relationships among the pharmaceutical manufacturers, PBMs, FEHBP carriers, and FEHBP itself is characterized by a complex and potentially conflicting series of rebates, incentive payments, refunds, credits, and other transactions. Regulatory changes soon to be released by OPM will open the PBMs' contracts with the FEHBP carriers to direct audit by our office for the first time. We anticipate that these audits will recover any inappropriate costs that may have been charged to the FEHBP in previous years, identify areas that require improvement for future contracts, and impact positively on the future costs and benefits provided to FEHBP enrollees.

■ **Data Warehouse Enhancements**

We have continued to improve our ability to use our data warehouse, which contains the latest three years of claims data from FEHBP-participating BlueCross BlueShield plans nationwide. A series of standardized computer applications lets our auditors analyze claims payments in the warehouse quickly and directly from their own desks. This has allowed greater flexibility in audit scheduling and more reliable data analysis, while increasing the number of annual audits that our staff can perform.

In addition, relying upon the warehoused data, we can conduct simultaneous audits of particular issues at all BCBS plans, rather than doing piecemeal audits at each individual plan. This plan-wide approach more effectively identifies the total impact of the issue on the FEHBP, and improves the likelihood of corrective action. In every case, our goal is to find the root cause of errors, eliminate or significantly reduce their future impact, and achieve significant cost savings to the FEHBP.

The data warehouse has also benefited our criminal investigators and administrative sanctions staff, who use it to identify potentially fraudulent activity by health care providers in the FEHBP. Before the warehouse was established, this process could take days or weeks. With a direct search of the warehouse's database, reliable and accurate information can be obtained in a matter of minutes. We are now taking steps to expand the warehouse to include payment data from all experience-rated carriers.

THE INSPECTOR GENERAL'S MESSAGE



In addition, I would like to draw attention to the Senate's October 1, 2004 passage of the Missing Child Cold Case Review Act of 2004. This legislation authorizes special agents of offices of inspector general to work, on a limited and voluntary basis, on the cold case backlog at the National Center for Missing and Exploited Children.

I have strongly supported this legislation for several years. It involves no additional cost or expense to the American taxpayer, and will not interfere with the investigative activities of any office of inspector general. However, reviews by highly trained criminal investigators from the inspector general community may be instrumental in resolving cold cases. While the best possible result would be the safe return of a missing child to his or her family, at the very least, we may be able to provide some measure of comfort to the families involved.

The legislation is now pending action by the House of Representatives prior to adjournment of the 108th Congress.

Patrick E. McFarland
Inspector General
Office of Personnel Management



OFFICE OF THE INSPECTOR GENERAL FIELD OFFICES





PRODUCTIVITY INDICATORS

SEMIANNUAL REPORT TO CONGRESS
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FINANCIAL IMPACT:

| | |
|---|--------------|
| Audit Recommendations for Recovery of Funds | \$47,433,701 |
| Recoveries Through Investigative Actions | \$4,843,463 |
| Management Commitments to Recover Funds..... | \$33,355,899 |

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 | 53 |
| Investigative Cases Closed | 23 |
| Indictments..... | 13 |
| Convictions | 11 |
| Hotline Contacts and Complaint Activity | 439 |
| Health Care Provider Debarments and Suspensions..... | 1,983 |
| Health Care Provider Debarment and Suspension Inquiries | 1,776 |



STATUTORY AND REGULATORY REVIEW

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Our office monitors and reviews legislative and regulatory proposals for their impact on the Office of the Inspector General and the Office of Personnel Management's programs and operations. Our reviews focus on the effect such proposals will have in encouraging economy and efficiency and preventing fraud, waste, and mismanagement. We also monitor legal issues that pertain to the Inspector General community government-wide and, through testimony and other communications, inform Congress of our interests and concerns.

There were no significant legislative or regulatory proposals subject to our review during this reporting period. However, through the administrative sanctions program, our office achieved significant accomplishments in protecting the Federal Employees Health Benefits Program and its enrollees from health care providers who have committed violations resulting in their exclusions from the FEHBP.

HEALTH CARE PROVIDER ADMINISTRATIVE SANCTIONS

Background

This reporting period marked the first full period during which all of the authorities established by the FEHBP administrative sanctions statute were fully in place and operational. These authorities include:

Debarment, which disqualifies a health care provider from receiving payment of FEHBP funds for a stated period of time. There are 18 statutory bases for

debarment; before imposing such a sanction our office gives providers written notice and the opportunity to contest the proposed debarment in an administrative proceeding.

Suspension, which has the same effect as a debarment, but becomes effective immediately, without prior notice or procedures. The FEHBP sanctions statute and regulations authorize suspensions only in cases where reliable evidence indicates that a provider has committed a violation for which he could be debarred, and that he poses a risk to the health or safety of FEHBP enrollees.

Financial sanctions, which impose civil monetary penalties of up to \$10,000 for each item in false, fraudulent, or improper claims submitted to an FEHBP carrier and assessments of up to twice the amount of such claims. Procedural requirements for financial sanctions are essentially identical to debarment cases.



STATUTORY AND REGULATORY REVIEW

Workload Indicators

During this reporting period, our office:

- Issued 1,983 debarments and suspensions of health care providers.
- Responded to 1,776 inquiries related to FEHBP administrative sanctions from insurance carriers, health care providers, and members of the public.

At the end of the reporting period, there were 27,079 active FEHBP suspensions and debarments of health care providers.

Managing and Improving Administrative Sanctions Operations

We noted in the prior edition of our semiannual report that, among other initiatives, a pilot project to obtain sanctions-related information through electronically-accessible sources had yielded promising results. This technique is becoming increasingly widespread in the private sector, as well as in government, for decision-making regarding participation in programs and access to benefits.

During the period covered by this report, we continued this project by refining our analytical techniques to accommodate electronically-available data in our decisions to suspend or debar health care providers. By the end of the current reporting period, we concluded that we would be able to effectively use electronically-accessed information across the full range of suspensions and debarments predicated on previously adjudicated violations, including criminal convictions and professional licensing and regulatory board actions. (These form the underlying basis for a large majority of suspension and debarment cases.) Further, we found that these information sources yield sufficiently

detailed information to support specific determinations regarding the length of debarments, even in cases where the aggravated nature of an offense may call for a relatively long debarment period (10 years or more). Three of the administrative sanctions cases described in the following section — two debarments and a suspension — reflect cases that we developed during this period through electronically-available information.

We have also verified that there is a very large and previously unaddressed body of violations among health care providers. In fact, our research indicates that the universe of potential cases is so large that it would not be feasible to attempt to address every one. Therefore, in selecting cases to pursue, we have focused closely on their relevance to the principal objective of the FEHBP administrative sanctions statute — protection of FEHBP enrollees and the program itself from the harm or risk associated with untrustworthy health care providers. Generally, the providers whose cases we pursue reflect some or all of the following factors:

- Membership in a health care profession that bills FEHBP directly for services or supplies furnished in the provider's own name.
- Receipt of FEHBP funds, either through payment of claims or as a member of the preferred provider network of an FEHBP carrier.
- Violations involving physical or psychological harm to patients or clients.
- Subject of an investigation by the OIG's Office of Investigations.

All of the cases described in the following section meet at least three of these factors.



ADMINISTRATIVE SANCTIONS ISSUED DURING THE REPORTING PERIOD

Pennsylvania Physician Debarred after Pleading Guilty to Drug and Assault Charges

As part of our e-debarment activities, we screen the websites of state Attorneys General offices, which highlight successful prosecutions in significant cases. The Pennsylvania Attorney General's site contained information regarding the case of a physician practicing in western Pennsylvania who pleaded guilty to seven criminal charges, including assault, wrongful prescription of controlled substances outside the bounds of medical practice, and several conspiracy counts.

We obtained more detailed information from the county prosecutor who tried the case and from a variety of publicly-accessible and subscription electronic sources. The material

Physician Debarred for 10 Years After Criminal Convictions

supporting the guilty plea indicated that this doctor arranged parties at his home where he provided teenage attendees alcohol, as well as drugs obtained through illegal prescriptions. He had met some of the youths through his medical practice. He sexually assaulted a number of the attendees while they were under the influence of the drugs and alcohol. The doctor was sentenced to 5 to 10 years' incarceration, followed by 10 years' probation. In addition, his Pennsylvania medical license was revoked.

Because this doctor caused physical harm to individuals and used his stature and professional privileges as a health care provider as instrumentalities of criminal conduct, we

deemed his offenses to be aggravated violations for purposes of applying the FEHBP administrative sanctions statute. Accordingly, we debarred him for a period of 10 years.

Florida Psychologist Debarred after Guilty Plea to Felony Theft Charges

A case investigated by the OIG's Office of Investigations resulted in a south Florida clinical psychologist's pleading guilty to felony charges in state court in connection with payments obtained from FEHBP carriers through fraudulent claims.

The provider accepted referrals of clients from the employee assistance program of the U.S. Postal Service. His therapy services were covered by the FEHBP plans in which the clients were enrolled. In the cases of at least three such enrollees who discontinued treatment with him after only a few visits, the provider continued to submit claims to the respective FEHBP plans for as long as two years. Through this scheme, he wrongfully received payment of \$17,191 in FEHBP funds.

Clinical Psychologist Debarred for Theft Charges

Based on the findings of the OIG investigation, the Florida state insurance fraud prosecutor charged the psychologist with grand theft. The provider cooperated with the prosecutor, pleading guilty and agreeing to make full restitution to the affected insurance carriers. In exchange, the provider was sentenced to one year's probation, and was allowed to enter a deferred adjudication program.

Under the FEHBP sanctions statute, such a judicial disposition constitutes a mandatory basis for debarment. Taking into account the psychologist's cooperation with law enforcement authorities and his willingness to pay



STATUTORY AND REGULATORY REVIEW

back the proceeds of his illegal activities, we imposed the statutory minimum 3-year period of debarment.

Maryland Internist Suspended after State Regulatory Board Takes Summary Action Against Licensure

In a case generated through our screening of state medical licensing boards' websites, we learned that the Maryland Board of Physicians imposed an emergency suspension of a southern Maryland internist's license. The Board acted after receiving complaints from 24 of the doctor's patients, alleging that he engaged in improper physical contact with them and made suggestive remarks during examinations in his clinic. The state attorney's office for the county in which the doctor practiced also brought charges of assault and sexual assault against the provider.

The Board's order constituted a basis for debarment of the doctor, and therefore also supported our suspension as well. In addition, the Board's suspension order rested on the patients' allegations of physically improper

Internist Suspended for Claims of Physical Abuse

conduct, which clearly indicated that the patients were harmed, or placed at risk of harm, by the physician's acts. This case also directly involved FEHBP enrollees, because the doctor was a preferred network provider for one of the largest FEHBP insurance carriers, and had a clientele that included FEHBP enrollees. Based on these facts, we suspended the provider, pending the outcome of the Board of Physicians' formal investigation of the patients' allegations. Once the Board determines its findings, we will take commensurate action to discontinue the suspension or debar him, as warranted by the facts of the case.

conduct, which clearly indicated that the patients were harmed, or placed at risk of harm, by

Virginia Doctor is Debarred on Health Care Fraud Conviction

During this reporting period, our review of the websites of United States Attorneys offices identified a Virginia physician who pleaded guilty to federal health care fraud charges in U.S. District Court for the Eastern District of Virginia. His offenses involved systematic up-coding of health insurance claims submitted to federal and private-sector health insurance carriers over an approximately three-year period.

Physician Debarred for 10 Years After Conviction and Loss of Licensure

(Up-coding involves claiming payment for a longer or more complex type of service than was actually provided, resulting in higher payments to the provider than are properly due.)

The provider made restitution of approximately \$200,000 to the affected insurance carriers, and, as part of the plea agreement, received a sentence of 18 months' incarceration.

Our office's review of claims records associated with this provider indicated that he had a substantial clientele of FEHBP enrollees and had received a significant volume of payments from FEHBP carriers during the period of his fraudulent activities. In addition, we noted that he had a record of complaints, reprimands, license suspensions and revocations in all five states in which he had practiced, dating at least to 1995. The violations underlying these state regulatory actions included charges of unprofessional conduct, failure to provide adequate medical care, and making false statements in applications and certifications to medical licensing boards. Based on this extended series of professional violations, as well as the criminal conviction, we debarred this provider for a period of 10 years.



AUDIT ACTIVITIES

SEMIANNUAL REPORT TO CONGRESS
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HEALTH AND LIFE INSURANCE CARRIER AUDITS

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

The OIG insurance audit universe contains approximately 260 audit sites, consisting of health insurance carriers, sponsors and underwriting organizations, as well as two life insurance carriers. The number of audit sites is subject to yearly fluctuations due to the addition of new carriers participating in the FEHBP, non-renewal of other carriers, or because of plan mergers and acquisitions. Annual premium payments are approximately \$27 billion.

The health insurance plans that our office is responsible for auditing are comprised of community rated and experience-rated carriers.

Community-rated carriers are comprehensive medical plans, commonly referred to as health maintenance organizations (HMOs). Experience-rated carriers are mostly fee-for-service plans, the largest being the Blue Cross and Blue Shield health plans, but also include experience-rated HMOs.

The two types of carriers differ in the way they calculate premium rates. Community rated carriers generally set their subscription rates

based on the average revenue needed to provide health benefits to each member of a group. Rates established by experience-rated plans reflect a given group's projected paid claims, administrative expenses and service charges for administering a specific group's contract.

During the current reporting period, we issued 34 final reports on organizations participating in the FEHBP, of which 23 contain recommendations for monetary adjustments in the aggregate amount of \$47.4 million due the FEHBP.

A complete listing of all health plan audit reports issued during this reporting period can be found in Appendices III-A, III-B and V on pages 30-32 and page 33.

COMMUNITY-RATED PLANS

Our community-rated HMO audit universe covers approximately 150 rating areas throughout the country. Community-rated audits are designed to ensure that plans charge the appropriate premium rates in accordance with their respective contracts and applicable federal regulations.



AUDIT ACTIVITIES

FEHBP regulations require each carrier to certify that the federal government is being offered rates equivalent to the rates given to the two groups closest in subscriber size (*“similarly sized subscriber groups,” or SSSGs*) to the FEHBP. The rates are set by the FEHBP-participating carrier, which is responsible for selecting the two appropriate groups. When our auditors determine that equivalent rates were not applied, the FEHBP is entitled to a downward rate adjustment to compensate for any overcharges.

During this reporting period, we issued 19 audit reports on community-rated plans. These reports contain recommendations for OPM’s contracting officer to require the plans to return approximately \$6.3 million to the FEHBP. Nine of these reports, containing \$4.7 million in findings, relate to standard HMO audits. The remaining ten reports are HMO rate reconciliation audits (RRAs), with findings amounting to \$1.6 million.

Aetna Health Inc. of Tennessee in Blue Bell, Pennsylvania **Report No. 1C-6J-00-03-106** April 6, 2004

Aetna Health Inc. of Tennessee has participated in the FEHBP since 1998. It provides comprehensive medical services to its members in the Nashville and middle Tennessee areas. Our audit covered contract years 2000 through 2003 and was conducted at the plan’s corporate offices in Blue Bell, Pennsylvania. The FEHBP paid the plan about \$19.7 million in premiums from 2000 through 2003.

Plan Returns \$325,000 to the FEHBP for Overcharges

amounted to \$325,403. In addition, the FEHBP is due \$39,694 for lost investment income.

The audit showed that net overcharges to the FEHBP in contract years 2000 through 2003

Lost investment income represents the interest the FEHBP would have earned on the money the plan overcharged the FEHBP as a result of defective pricing.

The plan agreed with the audit findings and fully reimbursed the FEHBP.

We found that the plan inappropriately charged the FEHBP for state premium taxes in contract years 2000 through 2002. Although the state of Tennessee requires all health maintenance organizations doing business in the state to pay a two percent tax on the gross amount of all premiums collected, the imposition of such taxes on FEHBP premiums is prohibited by federal law. FEHBP overcharges resulting from the premium taxes amounted to \$404,358.

In addition to the tax-related overcharges in 2001 and 2002, we determined that that plan understated certain elements of the FEHBP rates in both years. In 2001 and 2002, the plan undercharged the FEHBP through rate computation errors associated with inadequate demographic information and inconsistent application of rating methodologies. The total undercharges amounted to \$165,346. We subtracted the undercharges from the overcharges in each year to determine the net amount due the FEHBP.

For 2003, one of the SSSGs received a 1.32 percent discount that was not given to the FEHBP. After applying this discount to the FEHBP rates, we determined that the FEHBP was overcharged \$86,391.

The FEHBP contract and regulations permit OPM to recover lost investment income on certain types of audit findings. We calculated that \$39,694 was due the FEHBP for investment income it lost through January 31, 2004.



Keystone Health Plan Central, Inc.

in Camp Hill, Pennsylvania

Report No. 1C-S4-00-04-013

September 22, 2004

Keystone Health Plan Central, Inc. has participated in the FEHBP as a community-rated comprehensive medical plan since January 1985. The plan provides primary health care services to its members throughout the Harrisburg, Lehigh Valley, and Northern Tier areas of Pennsylvania. The audit of the plan covered contract years 1998 through 2000, 2002, and 2003. During this period, the FEHBP paid Keystone approximately \$46.9 million in premiums.

Our auditors found that the FEHBP rates were overstated by \$2,261,580 in contract year 1998. In addition, we determined that the

Auditors Identify \$2.3 Million Overcharge

FEHBP is due \$701,102 for lost investment income. It should be noted that lost investment

income will continue to accrue until all defective pricing amounts have been returned to the program.

Our review of the rates the plan charged SSSGs in 1998 revealed that the largest discount received amounted to 22.18 percent. However, the FEHBP did not receive an equivalent discount. The plan agrees that the FEHBP was overcharged but contends the amount of the discount was substantially lower than 22.18 percent.

Settlement Reached with Keystone Health Plan East

On July 1, 2004, OPM, the Department of Justice (DOJ), and Keystone Health Plan East signed an agreement to settle a case involv-

ing premium overcharges identified in an April 1998 audit report covering Keystone's FEHBP activities during contract years 1991 through 1996. The audit disclosed that an SSSG received a 3.9 percent discount that was not given to the FEHBP. Keystone agreed to

Settlement of 1998 Audit Results in Over \$1 Million Returned to the Government

return \$1,080,588 to the government to settle the findings discussed in the report.

HMO Rate Reconciliation Audits

Each community-rated health plan participating in the FEHBP must submit annually by May 31 the rates it proposes to charge beginning in January of the following year; seven months before the rates for the new contract year take effect. Because the rates have to be submitted so early, some of the data the plans use to develop the rates are based on estimated or preliminary information.

Plans are subsequently permitted to submit revised rates during the year the contract is in effect through what is known as a rate reconciliation. Although this process does not affect the rates charged subscribers during the year, the revised rates may impact on the rates the plan charges in the following year. Our rate reconciliation audits (RRAs) are designed to ensure the appropriateness of the rate adjustments before they are finalized. We conduct RRAs between May and July of each year concurrent with the rate adjustment process itself.

RRAs benefit both OPM and the plans. During an RRA, rating data is reviewed shortly after it is produced. OPM's Office of Actuaries, as well as plan officials, receive almost immediate feedback relating to our audit results. Also, audit issues are resolved before the final rates are set, thus reducing the uncertainty plans may have regarding future liabilities relating to



AUDIT ACTIVITIES

the rates charged. During the current contract year, we conducted 10 RRAs.

Our audit of Lovelace Health Systems, Inc. provides a good example of the results of an RRA audit. This community-rated plan provides primary health care services to its members in various counties in New Mexico. The audit covered the reconciliation of rates charged under the plan's 2004 contract with the FEHBP. We found several problems which

**Rate Reconciliation
Audit Identifies
\$486,000 in
Overcharges**

led to overcharges. We determined that the plan did not give the FEHBP a discount equivalent to the largest discount it gave to an SSSG

and used inappropriate enrollment figures, as well as making other errors in computing its rates. After adjusting the rates to correct these inaccuracies, we determined that the FEHBP was overcharged a total of \$485,849. Based on the audit, OPM subsequently recovered the full amount from the plan.

EXPERIENCE-RATED PLANS

The Federal Employees Health Benefits Program offers a variety of experience-rated plans, including fee-for-service plans, which constitute the majority of federal contracts in this plan category. Several experience-rated plans are operated or sponsored by federal employee organizations.

The universe of experience-rated plans currently consists of approximately 110 audit sites. When auditing these plans, our auditors generally focus on three key areas:

- Appropriateness of contract charges and the recovery of applicable credits, including refunds, on behalf of the FEHBP.

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

During this reporting period, we issued 14 experience-rated audit reports. In these reports, our auditors recommended that OPM's contracting officer require the plans to return \$41.1 million in inappropriate charges and lost investment income to the FEHBP.

BlueCross BlueShield Service Benefit Plan

The BlueCross BlueShield Association (BCBS Association) administers a fee-for-service plan, which contracts with OPM on behalf of its member plans throughout the United States. The participating plans independently underwrite and process the health benefits claims of their respective federal subscribers and report their activities to the national BCBS operations center in Washington, D.C. Approximately 50 percent of all FEHBP subscribers are enrolled in Blue Cross and Blue Shield plans.

We issued nine Blue Cross and Blue Shield experience-rated reports during the reporting period. Our auditors noted \$27.4 million in questionable contract costs charged to the FEHBP and an additional \$1.8 million in lost investment income on these questioned costs, totaling \$29.2 million owed to the FEHBP. The BCBS Association has agreed with \$22.3 million.



Blue Cross and Blue Shield of Illinois

in Chicago, Illinois

Report No. 1A-10-17-02-048

August 23, 2004

Our audit of Blue Cross and Blue Shield of Illinois reviewed health benefit payments made by the plan for contract years 1999 through 2001, as well as miscellaneous payments and credits, administrative expenses, and cash management activities for contract years 1998 through 2000. From 1999 through 2001, BCBS of Illinois paid \$794 million in FEHBP claims.

Our auditors determined that the plan owed a total of \$6,061,543 to the FEHBP. We identified inappropriate charges including

**Auditors Determine
\$6,061,543 Owed
the FEHBP**

\$4,808,805 in health benefit charges, \$113,035 in administrative expense charges, and lost

investment income on the questioned charges in the amount of \$1,139,703.

One significant finding in the report was that the Plan did not follow its procedures for coordination of benefits with Medicare for the period January 1999 through September 2000.

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

Our auditors identified 5,854 claim line payments for which FEHBP paid as the primary insurer when, in fact, Medicare was the primary insurer. Therefore, we recommended that the contracting officer disallow \$1,446,834 for uncoordinated claim payments.

Blue Cross Blue Shield Association in Washington, D.C. and Chicago, Illinois

Report No. 1A-10-91-03-032

June 14, 2004

We audited FEHBP operations at the Blue Cross Blue Shield Association (Association), covering administrative expenses and cash management for 1999 through 2002.

The primary objectives of this audit were to determine if:

- The Association charges for administrative expenses to the contract were actual, necessary and reasonable.
- The Association handled FEHBP funds in accordance with applicable laws and federal regulations concerning cash management in the FEHBP.
- The Association promptly returned FEP refunds (e.g., wire transfer by Blue Cross and Blue Shield plans for health benefit refunds, letter of credit drawdown errors, prior period adjustments, and uncontested audit findings) and pharmacy drug rebates to the FEHBP.



AUDIT ACTIVITIES

Pharmacy drug rebates are payments made by drug manufacturers to the pharmacy drug program vendors (Advance PCS and Merck Medco) for achieving a certain target market share with respect to a particular drug. Rebate amounts and specific market share requirements are detailed in contracts between the various manufacturers and the drug program vendor. The pharmacy program vendor sends the rebates to the Association, which is supposed to credit these amounts to FEHBP. These rebates should reduce overall pharmacy costs to the Program.

The Association did not return five Advance PCS pharmacy drug rebates, totaling \$5,469,280, and one Merck Medco pharmacy drug credit, totaling \$335,471, to the FEHBP

account. In addition, the auditors questioned \$3,876,935 in health benefit refunds; \$931,372

of investment income not credited to FEHBP; and \$136,835 in administrative expenses.

Of the \$10,749,893 in questioned charges, the BCBS Association agreed with \$10,615,766 and disagreed with \$134,127. Lost investment income on the questioned costs amounted to \$20,276.

Employee Organization Plans

The largest types of employee organizations are federal employee unions and associations, such as the American Postal Workers Union, the National Association of Letter Carriers, the Government Employees Hospital Association, and the Special Agents Mutual Benefit Association. During the reporting period, we issued four audits of employee organization plans.

Auditors Determined \$10,770,169 Owed the FEHBP

CNA as Underwriter for the Mail Handlers Benefit Plan

in Chicago, Illinois

Report No. 1B-45-02-02-069

September 22, 2004

The Mail Handlers Benefit Plan (Plan) is sponsored by the National Postal Mail Handlers Union (Union). For the audited period, the Union contracted with CNA for underwriting and administration services. This audit covered the CNA administrative expenses charged to the FEHBP for contract years 1999 through 2001, which amounted to approximately \$106 million. Our auditors questioned \$8,411,946 in administrative expenses. Lost investment income on the questioned charges totaled \$1,146,867.

\$9.6 Million Questioned in CNA Audit

CNA allocated home office expenses to the FEHBP based on FEHBP's percentage of total corporate operating costs.

Home office expenses are expenses associated with managing, supervising, or administering the operations of subordinate organizations.

CNA paid Private Health Care Systems (PHCS) and subsequently First Health a fee for accessing their preferred provider organization networks. For 1999, this charge was based on a monthly per enrollee fee. In 2000 and 2001, the fee was based on a percentage of claims savings. CNA included this fee as part of FEHBP operating expenses, and used the resulting figure to calculate FEHBP's ratio for allocating home office expenses. We determined that this procedure caused an unreasonable allocation of home office expenses relative to the benefits FEHBP received from them, and that FEHBP was overcharged by \$6.8 million as a result.



Federal Long Term Care Insurance Program

Long Term Care Partners, LLC
Portsmouth, New Hampshire
Report No. 1G-LT-00-03-115
August 9, 2004

The Federal Long Term Care Insurance Program (FLTCIP) was established by the Long Term Care Security Act of 2000. Under this act, OPM developed and has oversight of a long term care insurance program for Federal employees and annuitants, current and retired members of the uniformed services, and qualified relatives.

Long Term Care Partners, LLC (Company) was formed as a joint venture, owned equally

by John Hancock Life Insurance and Metropolitan Life Insurance Company. They provide and administer FLTCIP benefits. In December 2001, OPM awarded them a seven year contract. The Company with OPM oversight is responsible for all administrative functions of the FLTCIP, including marketing and enrollment programs, underwriting, policy issuance, premium billing and collection, and claim administration.

Our audit objective was to determine whether the Company charged costs to the FLTCIP and provided services to FLTCIP members in accordance with the terms of the contract. We reviewed administrative expenses from January 1, 2002 to July 31, 2003 and long term care charges from January 1, 2002 to September 8, 2003. We determined that the Company complied with the requirements of its contract.



AUDIT ACTIVITIES

INFORMATION SYSTEMS AUDITS

Computer-based information and its accessibility have become increasingly important to the Office of Personnel Management and its programs. We perform information systems audits of health and life insurance carriers that participate in the Federal Employees Health Benefits Program and the Federal Employees' Group Life Insurance program. We also audit elements of the agency's computer security environment.

OPM relies on computer technologies and information systems to carry out its work in administering various operations, including programs that distribute health and retirement benefits to millions of current and former federal employees. Any breakdowns or malicious attacks (e.g., hacking, worms or viruses) affecting these federal computer based programs could have a harmful effect, compromising efficiency and effectiveness and ultimately increasing the cost to the American taxpayer.

Our office also examines the computer security and information systems of private health insurance carriers participating in the FEHBP by performing general and application controls audits.

General controls refer to the policies and procedures that apply to an entity's overall computing environment. Application controls are those directly related to individual computer applications, such as a carrier's payroll system or benefits payment system. General controls provide a secure setting in which computer systems can operate, while application controls ensure that the systems completely and accurately process transactions.

Audit of Information Systems General and Application Controls at BlueCross BlueShield of Georgia

in Columbus, Georgia

Report No. 1A-10-05-03-114

August 2, 2004

BlueCross BlueShield of Georgia (BCBSGA) processes the claims of FEHBP subscribers at its Columbus, Georgia location. WellPoint, BCBSGA's parent company, provides security and access control for BCBSGA, including development and implementation of security policies and procedures, intrusion monitoring and detection, and review of the BCBSGA security program. BCBSGA's contract covers over 82,000 current and former federal employees and their families at a cost of \$322 million annually in health care premiums.

We reviewed BCBSGA's claims processing and check-writing systems, as well as its compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. We also evaluated the confidentiality, integrity and availability of BCBSGA's computer based information systems.



While our auditors determined that BCBSGA/WellPoint had a number of security controls in place that helped promote a secure computer environment, they found that there were opportunities

OIG Offers Recommendations to Improve Information System Controls

for improvement in the area of information systems internal controls. We recommended that BCBSGA implement:

- A formal risk assessment methodology.
- Procedures to periodically reinvestigate backgrounds of employees in sensitive positions.
- An employee training program for employees with information technology security responsibilities.
- Improved communications between the help desk and incident response team.
- Procedures for disposing unwanted printed material or source documents which could contain sensitive data.

BCBSGA officials have addressed or agreed to address many of our recommendations. These should enhance BCBSGA's information system general and application controls, and thereby help ensure the confidentiality, integrity, and availability of federal subscriber medical records.

Review of OPM Compliance with the Federal Information Security Management Act

The Federal Information Security Management Act of 2002 (FISMA) is designed to ensure that information resources and assets supporting federal operations are appropriately protected. FISMA emphasizes that agencies implement security planning as part of the life cycle of their information systems. A critical aspect of security planning involves annual program security reviews conducted or overseen by each agency's inspector general.

We performed an independent evaluation of OPM's computer security program and practices in accordance with the Office of Management and Budget's FISMA reporting instructions. We also conducted a review of several OPM systems and the compliance efforts of individual program offices responsible for these systems.

Our review of systems under the responsibility of OPM's program offices indicated substantial compliance with FISMA requirements. OPM's Center for Information Services and Chief Information Officer (CIS & CIO) maintains an up-to-date inventory of agency systems (although several systems may need to be added to the list of major systems) and evaluates the systems annually. OPM has implemented proper IT security measures for contractors. In addition, the agency has implemented a procurement system to control all IT-related investments and begun assessing systems for e-authentication risk as required by OMB.

OIG Identified Improvements in OPM System Security Controls



AUDIT ACTIVITIES

We noted, however, several opportunities for improvement. Program offices have not developed, documented, and tested contingency plans for many OPM systems, nor have they included contingency plans in their information system security plans. Program offices also did not include security costs for many systems in the capital budgeting process, as is required by law.

There were several elements of the agency's management of its overall IT security program that we also reviewed in accordance with OMB instructions. These included the Plan of Action and Milestone (POA&M) process; the Certification and Accreditation (C&A) process; agency-wide security configuration requirements; security incident detection, handling, reporting and analysis procedures; and security training.

Again, we found that the agency has made significant progress since our last evaluation of its computer security program. OPM has a POA&M process in place for managing IT security weaknesses, and has implemented a comprehensive C&A process in accordance with NIST guidance. The CIS&CIO has developed agency-wide policies that require specific, detailed security configurations for OPM servers, routers, switches, hubs, applications, and databases. In addition, OPM's CIS&CIO

developed an Incident Response and Reporting Implementation Guide, and we found that OPM's Computer Incident Response Team is, for the most part, meeting the FISMA reporting requirements associated with computer security incidents. Finally, OPM has implemented a security awareness training program. However, we did identify opportunities to improve or enhance information security practices. For example, several program officials indicated that security problems tracked through the POA&M process had been completely resolved before they, in fact, had been. OPM has not developed and implemented the specific, detailed security configurations required by FISMA. OPM's security awareness training course is not tailored to OPM's IT security policies and procedures and did not cover some important security awareness issues. Also, employees with significant security responsibilities did not receive specialized training during FY 2004. During the reporting period, we issued seven reports addressing various aspects of OPM's IT security programs. A listing of these reports is located in Appendix V on page 33.

OPM Has Made Significant Progress Since Last Computer Security Program Evaluation



COMBINED FEDERAL CAMPAIGN

We conduct audits of the local organizations of the Combined Federal Campaign (CFC), the only authorized fundraising drive conducted in federal installations throughout the world. OPM holds responsibility, through both law and executive order, to regulate and oversee the conduct of fundraising activities in federal civilian and military workplaces worldwide.

Campaigns are identified by geographical areas that can be as specific as a single city, or as large as several cities or counties. Our auditors review the eligibility of participating charities associated with a given campaign and the charities' compliance with federal regulations and OPM guidelines. In addition, all CFC organizations are required by regulation to have an independent public accounting firm (IPA) conduct an audit of their respective financial activities for each campaign year. As part of our audits, we review the IPA reports.

Combined Federal Campaign audits do not identify savings to the government, because the funds involved are charitable donations made by federal employees, not federal entities. While infrequent, our audit efforts can result in an internal referral to our OIG investigators for potential fraudulent activity.

A total of 344 local campaigns operating in the United States and overseas participated in the 2003 Combined Federal Campaign. For that year, federal employee contributions reached \$249,227,743, while campaign expenses totaled \$23,265,425.

During this reporting period we issued six audit reports on local CFCs and four audit reports on national charitable federations that participated in the CFC.

Local CFC Audits

The local organizational structure consists of:

- **Local Federal Coordinating Committee (LFCC).** The LFCC is comprised of federal employees. It is responsible for organizing the local CFC, determining local charities' eligibility to participate in the CFC, supervising the activities of the Principal Combined Fund Organization, and addressing any problems relating to a local charity's noncompliance with the policies and procedures of the CFC.
- **Principal Combined Fund Organization (PCFO).** The PCFO is a charity designated by the LFCC to be responsible for collecting and distributing CFC charitable funds, training volunteers, and maintaining a detailed accounting of CFC administrative expenses incurred during a given campaign.
- **Local Federations.** A local federation is an association of local charitable organizations with similar objectives and interests that provides common fundraising and administrative services to its members.
- **Individual charities.**



AUDIT ACTIVITIES

During the current period, we issued audit reports on six local CFCs. These reports identified numerous violations of regulations and guidelines governing local CFC operations. Among the most frequently occurring problems were the following:

- **Local/Federation Applications.** For the 2000 and 2001 CFCs, over 80 percent of the applications of local charities and federations we reviewed did not meet one or more of the regulatory eligibility requirements. Our findings did not necessarily imply that these charities were ineligible to participate in the campaigns, but did reveal shortcomings in the reviews conducted by the respective LFCCs.
- **Pledge Cards.** For the 2001 CFC, in three local campaigns, we identified a small number of pledge card processing errors in which the donor's requests were not honored.
- **Unsupported Expenses.** The PCFOs for two local campaigns did not have documentation to support \$29,546 in campaign expenses for the 2000 and 2001 CFCs. Regulations require that they recover expenses as approved by the LFCC, reflecting the actual costs of administering the campaign.
- **CPA Audit Report.** The PCFO for two local campaigns submitted audited financial statements to the LFCC based on calendar years rather than campaign years. Since campaign years extend over several calendar years, these audits are not a complete reflection of the financial activities of the campaign.

Based on the findings of our audits, we recommended that:

- LFCCs ensure local organizations provide accurate supporting documentation to demonstrate that they specifically meet the regulatory eligibility requirements.

- PCFOs institute controls over pledge data entry detail to verify that all pledge information is entered and processed correctly.
- PCFOs maintain supporting documentation for all expenses. Funds associated with expenses that are not appropriately documented should be distributed to the participating charities.
- PCFOs ensure that their independent certified public accountants conduct audits based on campaign years, not calendar years.

Audits Reveal Deficiencies in Conduct of Local CFC Campaigns

To address these program-related deficiencies, OPM's Office of CFC Operations (OCFCO) has issued memoranda and conducted training for PCFOs and LFCCs. In addition, the OCFCO has added staff to focus on the compliance of campaign participants with the regulations.

**Audit of the 2001 and 2002
Combined Federal Campaigns
for the San Francisco Bay Area
in San Francisco, California
Report No. 3A-CF-00-03-111
May 24, 2004**

We also completed an audit of the San Francisco Bay Area CFC campaign. This review was conducted at the request of the Director of OPM, in response to the sudden cessation of operations by PipeVine, Inc.

The San Francisco Bay Area CFC campaign, along with several others, contracted with PipeVine, Inc. to process the receipts of the campaign and make disbursements to the designated charities. In the summer of 2003, PipeVine suddenly ceased its operations and closed amid allegations that they had used funds designated for charitable organizations



to pay for their own expenses. OPM's Director asked the OIG to determine whether CFC funds had been affected.

While our audit disclosed regulatory and procedural violations similar to those found in our routine audits of local campaigns, we found no evidence that any CFC funds were used improperly by PipeVine, Inc.

National Charitable Federation Audits

We also audit national charitable federations that participate in the CFC.

National charitable federations are similar to local federations in providing common fundraising, administrative and management services to their members.

For example, Educate America! is a national federation providing services to other charities concerned with the education of America's children. Our audits of national federations focused on the eligibility of member charities, distribution of funds and allocation of expenses.

Audits of CFC National Federations that Contracted with Maguire/Maguire, Inc.

As of the 2001 campaign, there were 23 national federations participating in the CFC, 12 of which contracted for administrative services with Maguire/Maguire, a management consulting and marketing firm. In campaign year 2001, the federations that contracted with Maguire/Maguire represented 620 charities that received pledges totaling over \$42 million, or 17 percent of the total CFC pledges for the campaign.

As reported in our last semiannual report, our office received a letter in April 2002, from a coalition of federations alleging violations of several provisions of the CFC regulations by the national federations contracting with Maguire/Maguire. In addition, OCFCO expressed concerns regarding the release of donor names to Maguire/Maguire by the federations and their member charities.

In response to the allegations, we audited each of the 12 federations that contracted with Maguire/Maguire to determine if they were in compliance with the CFC regulations cited in the allegations. In addition, we reviewed the financial management of the federations. The audits covered campaign years 1998 through 2001.

During this reporting period, we issued final reports on four of the 12 federations. Reports on the other eight federations were previously issued and were discussed in the prior semiannual report. The auditors found that there were numerous violations of the CFC regulations, although not of the severity claimed in the allegations. In order to provide a complete picture of our findings, the summary below includes results from all 12 audits:

- *Inadequate controls over CFC contributors list.* All 12 federations allowed Maguire/Maguire to use the lists of donor names without the consent of the donors.
- *Designations of contributions were not verified.* The Independent Certified Public Accountants' audit reports for all 12 federations did not include verifications that designations of contributions made to charities were being honored as required by regulations.



AUDIT ACTIVITIES

- ***Decision-making authority improperly delegated to contractor.*** The process used by 10 of the federations to review member applications effectively delegated to Maguire/Maguire the decision-making function of deciding whether an applicant met one of the requirements for participation in the CFC.
- ***Board of Directors size and term violations.*** In four federations, the size of the Board of Directors was not in compliance with the federation bylaws, or a member of the board served for a period longer than the bylaws allowed.
- ***Board member conflict of interest.*** Board members of three federations had conflicts of interest because of financial relationships with Maguire/Maguire.

- ***Improper certification of member agencies.*** One federation certified a charity for membership in its organization that had left it for another federation.

As a result of these audits, the OCFCO placed each of the federations on warning for one year, and will be conducting site visits in November 2004 to assess compliance with OPM-imposed corrective actions. If non-compliances are found, the federations may be subject to decertification (suspension) from the CFC. A listing of the four reports issued this period can be found in Appendix VI on pages 34.

**Additional Audits
of National
CFC Federations
Reveal Systematic
Regulatory Violations**



OPM INTERNAL AUDITS

Our internal auditing staff focuses on improving the efficiency and effectiveness of OPM's operations and their corresponding internal controls. Two critical areas of this audit activity are OPM's consolidated financial statements required under the Chief Financial Officers Act of 1990 (CFO Act), as well as the agency's work required under the Government Performance and Results Act of 1993 (Results Act or GPRA).

GOVERNMENT PERFORMANCE AND RESULTS ACT AUDITS

The Results Act was intended to improve government performance and accountability through better planning and reporting of government-wide agency results. The Act seeks to increase the efficiency, effectiveness, and public accountability of federal agencies, as well as to improve the information used for congressional decision-making.

Each agency is required under the Results Act to develop five-year strategic plans, annual performance plans and annual performance reports. These requirements create a recurring cycle, beginning with setting a strategic direction, followed by defining annual goals and measures, and, finally, reporting on performance.

The OPM Strategic Plan 2002-2007 provides the framework for implementing the Results Act. OPM implements its strategic plan through an annual performance plan that includes goals and measures for key program offices. OPM describes its achievement of the goals and measures through the annual performance report.

During this reporting period, we continued to monitor OPM's implementation of the Results Act.

OPM'S CONSOLIDATED FINANCIAL STATEMENTS AUDITS

OPM's consolidated financial statements include the retirement, health and life insurance benefit programs, the revolving fund (RF) and the salaries and expenses accounts (S&E). The RF programs provide funding for a variety of human resource-related services to other federal agencies, such as pre-employment testing, security investigations, and employee training. The RF is not derived from congressionally-appropriated funds, but rather from interagency agreements to reimburse OPM for services. The S&E accounts, which represent congressionally-appropriated funds, cover the costs of administering the operations of the agency.

OPM contracts with an independent public accounting firm, KPMG LLP (KPMG), to audit the agency's annual consolidated financial statements. In performing these audits, KPMG is responsible for providing audit reports that contain KPMG's opinion as to the fair presentation (absence of material misstatements) of OPM's consolidated financial statements and their conformance with generally accepted accounting principles.



AUDIT ACTIVITIES

KPMG also reports on OPM's internal control efforts concerning financial reporting and OPM management's compliance with laws and regulations that could have a material impact on how the agency determines the financial statement amounts.

We monitor KPMG's performance during these audits to ensure that they are conducted in accordance with the terms of the contract and in compliance with government auditing standards and other authoritative references,

such as OMB Bulletin No. 01-02, *Audit Requirements for Federal Financial Statements*. Specifically, we are involved in the planning, performance and reporting phases of the audit through participation in key meetings, discussion of audit issues, and reviewing KPMG's work papers and reports. During this period the bulk of the work that will culminate in KPMG's reports was completed. This is the first year those reports are due to be issued by the accelerated date of November 15.



INVESTIGATIVE ACTIVITIES

SEMIANNUAL REPORT TO CONGRESS

April 1, 2004 – September 30, 2004

The Office of Personnel Management administers benefits from its trust funds for all federal civilian employees and annuitants participating in the Civil Service Retirement System (CSRS), the Federal Employees Retirement System (FERS), FEHBP, and FEGLI. These programs cover over eight million current and retired federal civilian employees, including eligible family members, and disburse about \$77 billion annually. While we investigate employee misconduct and other wrongdoing brought to our attention, the majority of our OIG investigative efforts are spent examining potential fraud involving these trust funds.

OIG's investigative activities produced significant results during the reporting period. We opened 42 investigations and closed 23 with 118 still in progress at the end of the period. Our investigations led to three arrests, 13 indictments, 11 convictions and monetary recoveries totaling \$4,843,463. For a complete statistical summary of our office's investigative activity in this reporting period, refer to the Investigative Activity Table on page 26.

HEALTH CARE FRAUD

Whenever feasible, we coordinate our health care fraud investigations with the Department of Justice (DOJ) and other federal, state and local law enforcement agencies. At the national level, we are participating members of DOJ's health care fraud working groups. We actively work with U.S. Attorney's offices nationwide to focus investigative resources in areas where fraud is most common. OIG special agents also are in regular contact with health insurance carriers participating in the FEHBP to identify possible fraud by health care providers and subscribers. Additionally, special agents

work closely with our Office of Audits when fraud issues arise during health carrier audits. They also coordinate with the OIG debaring official when investigations of health care providers reveal evidence of violations that may warrant administrative sanctions.

Physician Found Guilty in Jury Trial

In May 2003, our agents became involved in a joint investigation with the FBI and the State of Texas Medicaid Fraud Control Unit regarding a physician specializing in pediatric immunology and allergies in Odessa, Texas. This doctor was suspected of submitting health insurance claims for allergy tests on children that had not been performed. He also allegedly created false records including documentation of false diagnoses to support the medical claim forms.

**Physician Sentenced
to Six Months'
Imprisonment and
Restitution**



INVESTIGATIVE ACTIVITIES

In January 2004, the physician was indicted by a federal grand jury in the Western Judicial District of Texas on one count of health care fraud and aiding and abetting health care fraud. He was found guilty of these charges at a May 2004 trial. He was subsequently sentenced to six months' incarceration, 36 months' probation, a fine of \$15,000 and restitution of \$21,191 to Medicare and the Blue Cross and Blue Shield of Texas.

The OIG debaring official suspended this doctor from the FEHBP at the time of his indictment, and is now in the process of debaring him as the result of his conviction.

USDA Employee Sentenced for Defrauding the FEHBP

In our previous semiannual report, we noted that an U.S. Department of Agriculture (USDA) employee pleaded guilty in U.S. District Court in Maryland to one count of mail fraud on

Court Orders Five Months in Prison and Full Restitution

not rendered to him and his family. The employee's claims falsely indicated that all the family members had the same diagnoses and received the same medical treatment. On June 18, 2004, he was sentenced to five months' imprisonment, five months' home detention, and three years' supervised release. He was also ordered to pay OPM \$69,488 in restitution and was fined \$3,100.

RETIREMENT FRAUD AND SPECIAL INVESTIGATIONS

We identify fraud by proactively reviewing retirement records for irregularities, such as

individuals who have greatly exceeded normal life expectancy. Using automated data systems available to law enforcement agencies, we screen the list of older annuitants to identify persons that may be deceased but are still actively receiving an annuity benefit. We confirm the accuracy of the information through follow-up inquiries. In some cases, these evolve into full investigations, if it appears through analysis of subpoenaed bank records that funds have been used by someone other than the intended recipient.

We also receive information from our agency's Center for Retirement and Insurance Services (CRIS) through the computer matches it performs using OPM's annuity rolls and the Social Security Administration's death records to identify payments to deceased annuitants. These computer matches have proven very helpful to OPM since many annuitants or those receiving survivor benefits may also be eligible for Social Security benefits.

Annuitant's Daughter Indicted for Retirement Fraud

We identified a deceased survivor annuitant continuing to receive retirement benefits after her death in June 1994 in Ventura County, California. Our resulting investigation revealed that the deceased annuitant's daughter did not report her mother's death and converted the annuity payments to her own use. The daughter was indicted by a federal grand jury in Los Angeles, California on one count of theft of U.S. government funds. She subsequently pleaded guilty and agreed to make restitution to OPM in the amount of \$100,766. Sentencing is scheduled for December 2004.

Daughter Pleads Guilty to Retirement Fraud in the Amount of \$100,766



Granddaughter Pleads Guilty in Retirement Fraud Case

In another case, our investigators identified a deceased survivor annuitant continuing to receive retirement benefits after her death in March 1993 in Los Angeles, California. Our investigation revealed that the deceased survivor annuitant's granddaughter received her grandmother's retirement benefits and failed to report her death to OPM.

Investigation Reveals \$121,814 Theft from the Retirement Trust Fund

The granddaughter was indicted by a federal grand jury for theft of U.S. government funds. On September 13, 2004 she pleaded guilty and agreed to continue to pay restitution to OPM in the amount of \$121,814 under a voluntary repayment agreement. Sentencing is scheduled for December 2004.

OPM EMPLOYEE INTEGRITY

Retirement Benefits Specialist Receives Ten-Year Prison Term for Theft of Retirement Trust Funds

We previously reported on a joint investigation with the FBI, which found that two OPM retirement benefits specialists had conspired with a number of federal annuitants to misappropriate money from OPM's retirement trust fund.

Court Orders Restitution of \$3.2 Million

In this scheme, one of the OPM retirement benefits specialists authorized over 100 fraudulent non-recurring payments (NRPA), totaling more than \$3.7 million.

NRPA's are one-time payments made to federal annuitants or their survivors and are normally used to provide retroactive benefits or adjustments to regular annuity benefits.

One of the retirement benefits specialists, with over 20 years of government service, was sentenced in June 2004 to 10 years' incarceration and was ordered to make restitution to OPM in the amount of \$3,179,000. The other retirement benefits specialist is awaiting sentencing.

By the end of the reporting period, 15 federal annuitants have been charged in this case and 14 pleaded guilty to theft of U.S. government funds in U.S. District Court in Maryland. The remaining annuitant will be tried in the fall of 2004. Of the 14 annuitants who pleaded guilty, 13 have been sentenced. Seven received probation, while the others were sentenced to terms ranging from six months' home confinement to two years' incarceration. One annuitant is awaiting sentencing. All convicted defendants were ordered to make complete restitution to OPM. Most of the federal annuitants who received probation have already made complete or partial restitution to OPM. Some have made arrangements to have their monthly annuities garnished in order to repay their debt.

Former OPM Employee Pleads Guilty to Theft from Retirement Trust Fund

In a similar but separate investigation, we found that another OPM employee illegally diverted NRPA's to her personal bank account. This person, who had worked for OPM for 14 years, voluntarily confessed her complicity to her supervisor. She indicated that she used the funds to support her gambling habit.



INVESTIGATIVE ACTIVITIES

In this scheme, the employee authorized non-recurring payment actions in the names of four different federal annuitants who were

Former OPM Employee Admits Diverting \$63,000 in Annuity Funds

bank account. When the annuitants received financial statements from OPM regarding the NRPAs, she instructed them to ignore the statements because they reflected computer errors.

The former OPM employee admitted to illegally diverting \$63,300 in retirement benefits, and was charged with one count of theft of U.S. government funds. On July 23, 2004, she pleaded guilty in U.S. District Court in Maryland and is scheduled to be sentenced in October 2004.

OIG HOTLINES AND COMPLAINT ACTIVITY

OIG's health care fraud hotline, retirement and special investigations hotline, and mailed-in complaints also contribute to identifying fraud and abuse. We received 439 formal complaints and calls on these hotlines during the reporting period. Additional information, including specific activity breakdowns for each hotline, can be found in the Investigative Activity Table on page 26.

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

her personal friends. She then routed these monies to her own

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

Retirement Fraud and Special Investigations

The Retirement and Special Investigations hotline provides a channel for reporting waste, fraud and abuse within the agency and its programs. During this reporting period, this hotline received a total of 149 contacts, including telephone calls, letters, and referrals from other agencies.

Health Care Fraud

The primary reason for establishing an OIG hotline was to handle complaints from subscribers in the Federal Employees Health Benefits Program. The hotline number is listed in the brochures for all the health insurance plans associated with the FEHBP, as well as on our OIG Web site at www.opm.gov/oig.

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

The Health Care Fraud hotline received 290 complaints during this reporting period, including both telephone calls and letters.



OIG-Initiated Complaints

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

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

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

Correction of Prior Period Investigative Reporting Error

We incorrectly reported \$2,959,428 as investigative recoveries for the two semiannual reporting periods in fiscal year 2003. The correct amount of recoveries for the period was \$915,956. This error occurred during the transition from the prior investigative tracking system to the current one. In this transition, some long-term cases were closed in the old system and reopened in the new system.

However, cases that were pending prosecution or settlement were left open in the old system. In developing the amount of recoveries to be reported, we relied on both systems, causing an overlap in the number of cases closed, and resulting in a duplication of the amounts reported as recovered. We have taken action to ensure that errors of this nature do not occur in the future. We apologize for this inaccurate reporting of recoveries.



INVESTIGATIVE ACTIVITIES

INVESTIGATIVE ACTIVITY TABLE

Judicial Actions:

| | |
|------------------|----|
| Arrests..... | 3 |
| Indictments..... | 13 |
| Convictions..... | 11 |

Judicial Recoveries:

| | |
|--|-------------|
| Fines, Penalties, Restitutions and Settlements | \$4,843,463 |
|--|-------------|

Retirement and Special Investigations Hotline and Complaint Activity:

| | |
|-----------------------------------|-----|
| Retained for Further Inquiry..... | 17 |
| Referred to: | |
| OIG Office of Audits | 0 |
| OPM Program Offices..... | 83 |
| Other Federal Agencies | 49 |
| Total | 149 |

Health Care Fraud Hotline and Complaint Activity:

| | |
|--|-----|
| Retained for Further Inquiry..... | 122 |
| Referred to: | |
| OPM Program Offices..... | 35 |
| Other Federal/State Agencies | 59 |
| FEHBP Insurance Carriers or Providers..... | 74 |
| Total | 290 |

| | |
|--|------------|
| Total Hotline Contacts and Complaint Activity | 439 |
|--|------------|

INDEX OF REPORTING REQUIREMENTS

(Inspector General Act of 1978, As Amended)



| | | |
|----------------------------|--|-------------|
| Section 4 (a) (2): | Review of legislation and regulations | No Activity |
| Section 5 (a) (1): | Significant problems, abuses, and deficiencies..... | 3-25 |
| Section 5 (a) (2): | Recommendations regarding significant problems, abuses, and deficiencies | 5-20 |
| Section 5 (a) (3): | Recommendations described in previous semiannual reports on which corrective action has not been completed | 29 |
| Section 5 (a) (4): | Matters referred to prosecutive authorities..... | 21-25 |
| Section 5 (a) (5): | Summary of instances where information was refused during this reporting period..... | No Activity |
| Section 5 (a) (6): | Listing of audit reports issued during this reporting period..... | 30-34 |
| Section 5 (a) (7): | Summary of particularly significant reports..... | 5-20 |
| Section 5 (a) (8): | Audit reports containing questioned costs..... | 29 |
| Section 5 (a) (9): | Audit reports containing recommendations for better use of funds | No Activity |
| Section 5 (a) (10): | Summary of unresolved audit reports issued prior to the beginning of this reporting period | 29 |
| Section 5 (a) (11): | Significant revised management decisions during this reporting period | No Activity |
| Section 5 (a) (12): | Significant management decisions with which OIG disagreed during this reporting period | No Activity |



APPENDICES

SEMIANNUAL REPORT TO CONGRESS
April 1, 2004 – September 30, 2004

APPENDIX I
FINAL REPORTS ISSUED WITH QUESTIONED COSTS
April 1, 2004 to September 30, 2004

| Reporting Category | Number of Reports | Questioned Costs |
|--|-------------------|------------------|
| A. Reports for which no management decision had been made by the beginning of the reporting period | 13 | \$20,888,465 |
| B. Reports issued during the reporting period with findings | 23 | 47,433,701 |
| Subtotals (A+B) | 36 | 68,322,166 |
| C. Reports for which a management decision was made during the reporting period: | 22 | 35,933,108 |
| 1. Disallowed costs | | 33,355,899 |
| 2. Costs not disallowed | | 2,577,209 |
| D. Reports for which no management decision has been made by the end of the reporting period | 14 | 32,389,058 |
| Reports for which no management decision has been made within 6 months of issuance | | |

APPENDIX II
FINAL REPORTS ISSUED WITH RECOMMENDATIONS
FOR BETTER USE OF FUNDS
April 1, 2004 to September 30, 2004

No activity during this reporting period



APPENDICES

APPENDIX III – A INSURANCE AUDIT REPORTS ISSUED April 1, 2004 to September 30, 2004

| Report Number | Standard Audits | Issue Date | Questioned Costs |
|-----------------|---|---------------|------------------|
| 1C-6J-00-03-106 | Aetna Health Inc. of Tennessee in Blue Bell, Pennsylvania | April 6, 2004 | \$365,097 |
| 1A-10-41-03-031 | BlueCross BlueShield of Florida in Jacksonville, Florida | May 3, 2004 | 3,135,230 |
| 1C-8J-00-03-107 | Aetna Health Inc. of Washington in Blue Bell, Pennsylvania | May 3, 2004 | 310,069 |
| 1A-10-18-03-003 | Anthem BlueCross BlueShield of Ohio in Mason, Ohio | May 4, 2004 | 1,702,847 |
| 1C-J6-00-04-026 | Vytra Health Plans in Melville, New York | May 5, 2004 | |
| 1C-53-00-03-112 | Health Partners, Inc. in Minneapolis, Minnesota | May 11, 2004 | 208,177 |
| 1C-EM-00-04-011 | Av-Med Health Plan in Gainesville, Florida | May 26, 2004 | |
| 1C-A3-00-03-027 | PacifiCare of Arizona in Phoenix, Arizona | May 27, 2004 | 222,161 |
| 1C-EA-00-03-016 | Capital Health Plan of Tallahassee in Tallahassee, Florida | June 7, 2004 | 266,290 |
| 1A-10-66-04-022 | Regence BlueCross BlueShield of Utah in Salt Lake City, Utah | June 7, 2004 | 1,521,248 |
| 1A-10-91-03-032 | BlueCross BlueShield Association in Washington, D.C. and Chicago, Illinois | June 14, 2004 | 10,770,169 |
| 1A-10-50-03-021 | Anthem BlueCross BlueShield of Connecticut in North Haven, Connecticut | June 24, 2004 | 727,869 |
| 1C-EG-00-04-002 | M-Care in Ann Arbor, Michigan | July 14, 2004 | 337,793 |



APPENDIX III – A
INSURANCE AUDIT REPORTS ISSUED
April 1, 2004 to September 30, 2004
(Continued)

| Report Number | Standard Audits | Issue Date | Questioned Costs |
|-----------------|---|--------------------|---------------------|
| 1B-38-00-04-023 | National Rural Letter Carrier's Association as Sponsor for the Rural Carrier Benefit Plan in Alexandria, Virginia | July 19, 2004 | |
| 1A-10-29-02-047 | BlueCross BlueShield of Texas in Dallas, Texas | July 28, 2004 | 4,036,470 |
| 1B-YQ-00-03-110 | National Alliance of Postal and Federal Employees as Sponsor for the Alliance Health Benefit Plan in Washington, D.C. | July 28, 2004 | 2,306,778 |
| 1A-10-61-04-009 | Anthem BlueCross BlueShield of Nevada in Reno, Nevada | August 2, 2004 | 1,061,614 |
| 1D-22-00-04-029 | Aetna HealthFund's Fixed Administrative Rates ¹ | August 9, 2004 | |
| 1G-LT-00-03-115 | Long Term Care Partners, LLC in Portsmouth, New Hampshire | August 9, 2004 | |
| 1A-10-17-02-048 | BlueCross BlueShield of Illinois in Chicago, Illinois | August 23, 2004 | 6,061,543 |
| 1B-40-00-04-079 | American Foreign Service Protective Association as Sponsor for the Foreign Service Benefit Plan in Washington, DC | August 30, 2004 | |
| 1C-S4-00-04-013 | Keystone Health Plan Central, Inc. in Campbell, Pennsylvania | September 22, 2004 | 2,962,682 |
| 1B-45-02-02-069 | CNA as Underwriter for the Mail Handlers Benefit Plan in Chicago, Illinois | September 22, 2004 | 9,558,813 |
| 1A-10-85-03-105 | CareFirst BlueCross BlueShield in Owings Mills, Maryland | September 29, 2004 | 228,306 |
| TOTALS | | | \$45,783,156 |

¹*This was a limited review that was not conducted in accordance with Government Auditing Standards.*



APPENDICES

APPENDIX III – B INSURANCE AUDIT REPORTS ISSUED April 1, 2004 to September 30, 2004

| Report Number | Rate Reconciliation Audits | Issue Date | Questioned Costs |
|-----------------|--|----------------|--------------------|
| 1C-5W-00-04-068 | SummaCare Health Plan of Akron, Ohio Proposed Rate Reconciliation | July 19, 2004 | \$662,635 |
| 1C-KA-00-04-071 | OmniCare Health Plan of Detroit, Michigan Proposed Rate Reconciliation | July 22, 2004 | |
| 1C-U2-00-04-067 | Paramount Health Care of Maumee, Ohio Proposed Rate Reconciliation | July 22, 2004 | 24,780 |
| 1C-5E-00-04-089 | Vista HealthPlan of South Florida Proposed Rate Reconciliation | July 28, 2004 | 16,078 |
| 1C-Q1-00-04-070 | Lovelace Health Plan of Albuquerque, New Mexico Proposed Rate Reconciliation | July 28, 2004 | 485,849 |
| 1C-9F-00-04-061 | OSF Health Plans, Inc. of Peoria, Illinois Proposed Rate Reconciliation | July 28, 2004 | 461,203 |
| 1C-MX-00-04-063 | MVP Health Plan of the Mid-Hudson Region of Schenectady, New York Proposed Rate Reconciliation | July 28, 2004 | |
| 1C-65-00-04-062 | Kaiser Foundation Health Plan of Colorado Proposed Rate Reconciliation | August 2, 2004 | |
| 1C-ML-00-04-069 | Av-Med Health Plan of Gainesville, Florida Proposed Rate Reconciliation | August 2, 2004 | |
| 1C-3A-00-04-066 | AultCare HMO of Canton, Ohio Proposed Rate Reconciliation | August 2, 2004 | |
| TOTALS | | | \$1,650,545 |



APPENDIX IV
INTERNAL AUDIT REPORTS ISSUED
April 1, 2004 to September 30, 2004

| Report Number | Subject | Issue Date |
|-----------------|------------------------------------|---------------|
| 4A-CA-00-04-086 | Rural Development Act ¹ | July 21, 2004 |

¹This was a limited review that was not conducted in accordance with Government Auditing Standards.

APPENDIX V
INFORMATION SYSTEMS AUDIT REPORTS ISSUED
April 1, 2004 to September 30, 2004

| Report Number | Subject | Issue Date |
|-----------------|--|--------------------|
| 1A-10-05-03-114 | Information Systems General and Application Controls at BlueCross BlueShield of Georgia in Columbus, Georgia | August 2, 2004 |
| 4A-CA-00-04-073 | Information Technology Security Controls of the Identipass Badging System | September 28, 2004 |
| 4A-CI-00-04-099 | Information Technology Security Controls of the Enterprise Server Infrastructure | September 28, 2004 |
| 4A-CI-00-04-098 | Information Technology Security Controls of the LAN/WAN | September 28, 2004 |
| 4A-CF-00-04-077 | Information Technology Security Controls of the Benefits Financial Management System | September 28, 2004 |
| 4A-RI-00-04-074 | Information Technology Security Controls of the Coverage Determination Application | September 28, 2004 |
| 4A-CI-00-04-033 | Federal Information Security Management Act | September 29, 2004 |
| 4A-CI-00-04-076 | Federal Information Security Management Act Fiscal Year 2003 Follow-Up | September 30, 2004 |



APPENDICES

APPENDIX VI COMBINED FEDERAL CAMPAIGN AUDIT REPORTS ISSUED April 1, 2004 to September 30, 2004

| Report Number | Subject | Issue Date |
|-----------------|--|-----------------|
| 3A-CF-00-03-067 | The 2001 Combined Federal Campaign for Christian Charities USA in Corte Madera, California | April 8, 2004 |
| 3A-CF-00-03-062 | The 1998 through 2001 Combined Federal Campaigns for Educate America in Corte Madera, California | April 21, 2004 |
| 3A-CF-00-03-063 | The 2001 Combined Federal Campaign for Hispanic United Fund in Corte Madera, California | April 29, 2004 |
| 3A-CF-00-03-052 | The 2000 and 2001 Combined Federal Campaigns for the Sacramento Area in Sacramento, California | May 5, 2004 |
| 3A-CF-00-03-064 | The 1998 through 2001 Combined Federal Campaigns for Human and Civil Rights Organizations of America in Corte Madera, California | May 5, 2004 |
| 3A-CF-00-03-047 | The 2000 and 2001 Combined Federal Campaigns for the Suncoast Area in Tampa, Florida | May 11, 2004 |
| 3A-CF-00-03-055 | The 2000 and 2001 Combined Federal Campaigns for the San Antonio Area in San Antonio, Texas | May 24, 2004 |
| 3A-CF-00-03-111 | The 2001 and 2002 Combined Federal Campaigns for the San Francisco Bay Area in San Francisco, California | May 24, 2004 |
| 3A-CF-00-03-080 | The 2000 and 2001 Combined Federal Campaigns for the Fort Campbell Area in Fort Campbell, Kentucky | August 23, 2004 |
| 3A-CF-00-03-081 | The 2000 and 2001 Combined Federal Campaigns for the Nashville and Middle Tennessee Area in Nashville, Tennessee | August 23, 2004 |

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