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Report to Congressional Requesters

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FRAUD AND ABUSE

Stronger Controls Needed in Federal Employees Health Benefits Program

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The Honorable William L. (Bill) Clay
Chairman, Committee on Post Office
and Civil Service
House of Representatives

The Honorable Gary L. Ackerman
Chairman, Subcommittee on Compensation
and Employee Benefits
Committee on Post Office
and Civil Service
House of Representatives

In response to your request, we have reviewed fraud and abuse controls in the Federal Employees Health Benefits Program. At a hearing held by the Subcommittee on May 24, 1989, we testified, on the basis of our preliminary observations, that the program was vulnerable to fraud and abuse and needed increased program oversight to identify internal control system weaknesses.[1] These weaknesses allowed improprieties by the health plan carriers to occur. We agreed with your staff to develop further information on the Office of Personnel Management's (OPM) efforts to identify and correct internal control deficiencies. This report presents the results of our review and contains our recommendations to the OPM Director concerning further actions needed to ensure that the funds are adequately protected from fraud and abuse.

Last year the Subcommittee held hearings on H.R. 4958, its bill to reform the health insurance program, and the Administration's broad outline for program reform. A revised bill, H.R. 1774, was introduced in April 1991 and is under consideration by the Committee. We believe the structural and administrative changes that have been proposed would not lessen or change the need for strong financial, accounting, and claims processing controls to protect program funds from loss.

Background

The Federal Employees Health Benefits Program is the largest employer-sponsored health insurance program in the country. Under the program, OPM's Retirement and Insurance Group (RIG) administers contracts with various types of organizations, known as carriers, that reimburse, provide, or pay for the cost of health care services and supplies under group insurance plans. Currently, about 4 million federal and U.S.

[1] Federal Employees Health Benefits Program (GAO/T-GGD-89-26, May 24, 1989).

Postal Service employees and annuitants are enrolled in over 300 plans. The premiums paid for these plans totaled about $12.2 billion in fiscal year 1990. The government's share of the premiums amounted to $8.9 billion, and the enrollees paid the remainder. In 1988, the 25 fee-for-service plans covered over 75 percent of the enrollees and accounted for about 80 percent of the health plans' costs. These plans provide health benefits by paying claims submitted by enrollees and providers of health care services.

In an attempt to improve the government's management of its programs, Congress passed the Federal Managers' Financial Integrity Act of 1982 (FIA) (P.L. 97-255, 96 Stat. 814). The act recognized that strong internal control systems help ensure proper use of funds, compliance with laws and regulations, and preparation of reliable financial reports. FIA requires agencies to evaluate, improve, and report on the adequacy of their internal controls. The act requires that agency FIA evaluations include assessments of the (1) vulnerability of funds to loss and (2) adequacy of controls used to protect funds. The act holds agency managers accountable for correcting control weaknesses the agency identifies in its evaluations. It also requires agency heads to annually report to the president and Congress on material internal control weaknesses the agency identified and agency plans for correcting the weaknesses.

Results in Brief

OPM has not fully accomplished the objectives of FIA with respect to the health insurance program. Although the act requires federal agencies' managers to evaluate internal controls in the programs for which they are responsible, the carriers themselves are not subject to the requirements of the act. However, we believe RIG needs to evaluate the controls used by the carriers as part of RIG's FIA responsibilities. We also believe the carriers' internal controls need to be evaluated because OPM determined the plans are highly vulnerable to fraud and abuse and misappropriations of carrier funds occurred in 7 of the 25 fee-for-service plans. The misappropriations of carrier funds included embezzlements, using plan funds to finance union or employee organization activities, improperly charging the plan for over $1 million of expenses not incurred, and improperly charging the program $7.2 million for federal income taxes paid on its service charges (profit) over a 5-year period.

Under the act, managers are required to improve control weaknesses. However, although RIG has determined through its FIA evaluation process that oversight of the carriers is too limited, it has not corrected this weakness. Rather, RIG continues to rely almost entirely on the Inspector

General to perform the oversight role, This decision stems from RIG's (1) desire to stay detached from plan management and (2) limited resources to conduct oversight. We believe oversight is a basic program function that RIG needs to perform more actively.

In addition to the limited oversight, there are other control weaknesses that need to be improved. OPM needs to (1) ensure that Inspector General recommendations for correcting deficiencies are implemented by the carriers and (2) develop an aggressive programwide antifraud policy for pursuing enrollee and provider fraud. OPM also needs to implement its statutory authority to administratively penalize providers who commit fraud or program-related offenses.

Finally, although the act requires agency heads to report material internal control weaknesses to the president and Congress, OPM determined that the program's control deficiencies did not meet Office of Management and Budget (OMB) criteria for reporting. We disagree with OPM's determination in part because the multibillion dollar health benefits program is one of OPM's major programs and an important component of the federal government's compensation package. We believe the health benefits program's internal control deficiencies should be reported as a material weakness until OPM can ensure that the carriers have established adequate controls to safeguard funds from loss.

OPM provided written comments on a draft of this report. OPM is in general agreement with our conclusions and recommendations and is taking steps to increase oversight of the program. Its comments are included in appendix III.

Objectives, Scope, and Methodology

Our objective was to determine if OPM's internal controls reasonably ensure that health benefits program funds are adequately protected from fraud and abuse within the context of FIA. To accomplish this objective, we (1) reviewed program regulations, contracts, and other requirements; (2) interviewed OPM officials; and (3) obtained pertinent documentation concerning the program's internal controls, including FIA evaluations and reports for fiscal years 1983 through 1990. We also met with OPM Inspector General officials and reviewed selected audit reports issued for the 25 fee-for-service plans offered in 1988.

We concentrated our review on the 25 fee-for-service plans because they provided insurance coverage for more than 75 percent of the enrollees and accounted for about 80 percent of the health plans' cost. These

plans were offered to government employees through Blue Cross and Blue Shield, Aetna,[2] and various employee organizations and unions. Fee-for-service plans provide health benefits by paying claims submitted by enrollees and providers. Our review did not include plans offered by health maintenance organizations or similar insurers, which provide health services to enrollees either directly or through contracts with physicians.

We also obtained information from officials in the Departments of Health and Human Services and Defense on the internal controls and control evaluations in the Medicare program and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), respectively. However, we did not evaluate the effectiveness of those programs' controls or evaluations. Although the Medicare and CHAMPUS programs differ from the Federal Employees Health Benefits Program in coverage and eligibility, their benefit claims are processed and paid by contractors—as is the case with the fee-for-service plans.

We did our work between September 1989 and February 1991 in accordance with generally accepted government auditing standards.

OPM Cannot Reasonably Ensure That Program Funds Are Adequately Protected From Fraud and Abuse

Federal agencies are responsible for establishing and maintaining cost-effective systems of internal controls that reasonably ensure that government resources are protected against waste, fraud, and abuse. Through the FIA evaluation process, RIG program managers responsible for administering the health benefits program have determined that health plan funds are highly vulnerable to fraud and abuse by the carriers, providers of health care services and supplies, and enrollees. While RIG managers have implemented or planned some improvements in the program's internal controls, they have not

- evaluated the adequacy of the financial and claims processing controls established by the carriers other than through limited information available from audit reports,
- exercised adequate oversight of the carriers, or
- provided leadership or direction to the carriers concerning the pursuit of fraud and abuse cases.

[2]Aetna's governmentwide indemnity plan was not offered after 1989 because it withdrew from the program.

Also OPM did not consider weaknesses in the administration of the carriers' contracts significant enough to report to the president and Congress.

Program Funds Are Highly Vulnerable to Fraud and Abuse

RIG'S FIA evaluation for 1989 found that health benefits program funds were highly vulnerable to fraud and abuse by the plan carriers. In addition, during the past 13 years, OPM auditors and others found that funds in 7 of the 25 fee-for-service plans were misappropriated.

- In 1984 and 1985 about $1.2 million was embezzled from the American Postal Workers Union.
- Three embezzlements occurred in the National League of Postmasters plan. About $132,000 was embezzled from the plan in 1978, and separate embezzlements of $36,000 and $23,000 occurred between 1980 and 1982.
- On a number of occasions in the past, at least three plans lost investment income because plan funds were used to finance organization activities that were unrelated to the health benefits program. The American Federation of Government Employees and the National Federation of Federal Employees plans each lost about $350,000, and the National Alliance of Postal and Federal Employees plan lost a total of about $400,000.
- Between 1981 and 1984, the Mail Handlers plan was improperly charged for expenses not incurred by the plan underwriter, CNA Insurance Company, and a CNA claims processing organization. The corporations agreed in an out-of-court settlement to reimburse the plan about $1 million and to pay damages and civil penalties of $150,000.

Finally, we found that from 1982 to 1987 Aetna improperly charged the program about $7.2 million for federal income taxes Aetna paid on its service charges (profit).[3] Appendix I provides additional information on these cases.

Additionally, the plans are inherently vulnerable to fraud and abuse by plan enrollees and providers of health care services and supplies because most program funds are spent for benefit payments. Because the benefit payments involve processing millions of claims, it is impractical to individually scrutinize each claim. For example, in 1988 the 25 fee-for-service carriers processed over 37 million claims for benefits

[3]Federal Compensation: Recovery of Improper Health Benefits Charges Needed (GAO/GGD-89-27, Dec. 13, 1988).

totaling about $6.7 billion. If only a small fraction of these claims were fraudulent, millions of dollars would be added to the program's costs.

The current and former OPM Inspector Generals believe that the adverse financial consequences of fraud in the health benefits program are substantial and can be reduced and offset by recoveries generated through investigations. Two major industry groups expressed similar concerns about fraud—the Health Insurance Association of America[4] and the National Health Care Anti-Fraud Association.[5] Both groups believe that provider and enrollee fraud and abuse are serious and growing industry-wide problems. The Health Insurance Association of America estimates the total cost of fraud and abuse throughout the country at between $5 billion and $50 billion annually.

Provider misuse of program benefits can range from deliberate schemes to defraud, such as billing insurers for tests not provided, to seemingly harmless practices, such as changing a diagnosis to correspond to the patient's insurance coverage. Enrollees may also falsify claims to obtain additional benefits. For example, enrollees may change the service dates shown on medical bills to correspond to dates of their insurance coverage or can change the amounts billed to increase the insurance reimbursement.

FIA Evaluations Did Not Cover the Adequacy of Carrier Controls

Because program funds are highly vulnerable to fraud and abuse, strong internal control systems need to be established and maintained within the plans to safeguard funds from loss. In conducting its FIA evaluations, RIG has not determined if the controls established by the plan carriers are adequate and are working effectively. RIG officials told us that the FIA requirements apply only to federal agencies and do not extend to the controls used by government contractors, such as the health plan carriers. While we agree that the act does not require the carriers to evaluate and report on their internal controls, we interpret the act to require that RIG ensure that the carriers' controls are adequate.

The government's financial interest in plan funds does not cease when premiums are transferred to the carriers—that is, the government retains a financial interest in the premiums paid. The carriers are paid a

[4]The Health Insurance Association of America is a trade association of 300 commercial insurance carriers that provides health insurance for about 95 million people.

[5]The National Health Care Anti-Fraud Association is an association of health insurance companies, law enforcement organizations, and other organizations in the fraud and abuse area.

negotiated profit regardless of whether annual plan premiums cover costs. Excess premiums are held as plan reserves in a government revolving fund and carriers can draw on their individual reserves when the annual premiums do not cover plan costs. If reserves are insufficient, carriers must fund their losses. Carriers that leave the program cannot recover prior years' losses, but those that remain in the program generally can recover any losses by charging higher premiums in subsequent years. Conversely, surplus reserves can be used to lower the premiums paid by the government and enrollees or to increase the benefits offered. If a carrier terminates, however, surplus reserves belong to the program, not to the carrier. Thus, fraud and abuse in the plans affects the government and enrollees more than the carriers because it can add to premium costs and/or reduce program reserves.

RIG officials told us they are extremely concerned about fraud and abuse in the plans but do not believe that subjecting the carriers to the FIA evaluation and reporting process is appropriate. They said their primary concern, within the context of the act, is with identifying and correcting any weaknesses in RIG's contracting activities that allow fraud and abuse to occur in the health benefits program, as opposed to detecting weaknesses that may exist in the individual plans. RIG officials believe contract requirements, program regulations, and financial reporting requirements ensure the program is operating properly with respect to FIA, and Inspector General audits ensure each plan is operating properly.

For the most part, the regulatory and contractual requirements establish control objectives for the carriers, but the activities or procedures for accomplishing the objectives have been left to the discretion of the carriers until abuses are identified through audits or other means. For example, the plan contracts have required the carriers to invest funds on hand that were in excess of those needed to promptly discharge contract obligations. It was not until after OPM audits found that several carriers had misused funds that should have been invested (see app. I) that OPM issued regulations specifying that the plans' cash and investments be physically separated from the carriers' nonplan assets and that the plans' cash be kept in interest-bearing accounts.

RIG needs to ensure that the carriers have established effective financial and claims control procedures. This need can be approached in different ways as indicated by CHAMPUS, which in fiscal year 1991 has a budget of over $3.9 billion, and the Medicare program, which in fiscal year 1991 has a budget of over $100 billion. The Defense Department tries to ensure that contractors processing CHAMPUS claims have effective

internal controls by requiring them to comply with FIA requirements. While the Department of Health and Human Services does not require its contractors to comply with the act, it has numerous ongoing programs to try to effectively monitor and evaluate the controls used by the contractors that process Medicare claims. While we are not suggesting that OPM model its controls after those programs, they provide examples of two different approaches OPM could consider in determining the most cost-effective means for evaluating carrier controls in the health benefits program.

Oversight of the Carriers Was Limited

We also found that RIG conducted limited program oversight of the carriers' controls. FIA evaluations coupled with an active oversight program would better enable RIG to identify serious deficiencies in carrier controls and impose more specific requirements before serious abuses occur.

Over the past several years, RIG made a number of changes to strengthen program controls.

- Cash management was improved through letter-of-credit procedures that regulate the transfer of funds to carriers. OPM estimated the procedures reduced the amount of cash held by the carriers by about a billion dollars.
- Minimum standards of conduct requiring carriers to use prudent business practices were issued. Among other things, these standards require that carriers have acceptable accounting systems and internal controls.
- Regulatory authority was established allowing OPM to terminate contracts with carriers using poor business practices.

Notwithstanding these improvements, RIG's management of the program has been seriously deficient because it does not (1) conduct adequate program oversight of plan operations to identify internal control deficiencies or (2) hold the carriers accountable for correcting the internal control deficiencies. Although RIG requires and relies on the controls established by the carriers, it does not approve or evaluate the controls used. Nor does it require the carriers to submit reports that could be used to monitor claims operations and identify control deficiencies, such as payment accuracy rates and claims turnaround time.

Other than the Inspector General audits, the only program oversight routinely conducted is the monitoring of plan financial stability through annual financial reports submitted by the carriers. These reports

represent each plan's financial position on the basis of prior year's activities. Over the past few years, the reporting requirements were expanded and responsible carrier officials now are required to certify the authenticity of the reports. However, RIG's reviews of the financial reports do not verify whether the carriers' internal control systems ensure the accuracy of health benefits payments and administrative expense charges to the program.

Rather than conducting its own program oversight, RIG relies on the audit reports issued by OPM's Office of Inspector General for information on the carriers' financial and claims controls. While the audits provided valuable information, they generally covered carriers' activities that occurred 5 to 10 years ago. Also, our review of the audit reports showed that the primary purpose of the audits was to determine if the individual carriers had complied with the terms of their health plan contracts. While the audit reports identified weaknesses in the carrier's controls and recommended improvements, they did not contain the information or analysis RIG needs to monitor program operations on a continuous basis. For example, the audits did not address whether OPM's regulatory and contractual control requirements were being effectively implemented by the carriers on a programwide basis unless RIG specifically requested such an audit.

The only audit of carrier controls requested by RIG related to the regulations that had been issued requiring that plan cash and investments be physically separated from the carriers' nonplan assets and properly invested. The limited-scope audit verified cash and investments as of December 31, 1987, and July 30, 1988. The resulting June 1989 audit report showed that 5 of the 10 plans reviewed either commingled some health plan funds and/or deposited funds in noninterest-bearing accounts. The report recommended that RIG advise the carriers of the noncompliance. RIG officials in the Office of Financial Control and Management said they did not act on the report because they believed OPM's letter-of-credit initiative removed all idle cash from the plans, thus reducing the importance of the commingling restrictions. However, RIG officials responsible for the administration of the contract and following up on the audit recommendations said that they could not recall this audit report, and we could not find any evidence that the recommendations had been carried out.

An Inspector General official told us that some of the control weaknesses routinely cited in audit reports are common to many of the plans. Thus, RIG officials should be able to use the audit reports as one source

of information for the FIA evaluations. However, we do not believe that RIG can rely exclusively on these reports for oversight information on the carriers' controls because the audits are too infrequent, and the carriers are not held accountable for correcting the control weaknesses identified in the reports. Further, the concept that the primary responsibility for adequate internal control systems rests with management was established by the Accounting and Auditing Act of 1950. FIA reinforced that concept and went a step further by requiring program managers to evaluate their control systems and by holding managers publicly accountable for correcting weaknesses.

Inspector General Audits Were Infrequent

The Inspector General's goal is to audit the carriers on a 3-to 5-year cycle. Because of resource limitations, this goal has not been achieved since 1975, when the total number of plans was about 125. For example, the audit goal for the 71 organizations that make up the Blue Cross and Blue Shield plan network is every 3 or 5 years, depending on the organization's size, last year audited, and audit experience.[6] At the end of 1990, audit reports had not been issued for 34 of the organizations, or 48 percent, in over 5 years.

The audit goal for the governmentwide indemnity plan (Aetna) and the employee organization plan sponsors and underwriters is every 3 years. The latest audit report available for the Aetna plans was issued in November 1984 and covered the years 1980 through 1982. Appendix II shows the date of the last audit report issued and latest year covered by audits of employee organization plan sponsors and underwriters that participated in the program in 1988. During the 3-year period from 1988 through 1990, audit reports were issued for only 5 of the 23 employee organization sponsors and 3 of the 6 underwriters. Audit reports were not issued for the five plans that were established in 1986 or 1987 or for one underwriter that had participated in the program since 1984. The latest year covered by the issued reports was 1987, but for most of the plans, the latest year covered was 1984.

Problems Identified in Audits Were Not Corrected

Additionally, we found that when the audit reports identified serious internal control deficiencies, RIG did not determine if the carriers corrected the problems in a timely and effective manner. Generally, a letter

[6]The Blue Cross and Blue Shield plan is administered by the Blue Cross and Blue Shield Association in Chicago; the Federal Employee Program Director's Office in Washington, D.C.; the Federal Employee Program Operations Center in Washington, D.C.; and member Blue Cross and/or Blue Shield plans located nationwide.

was sent to the carriers directing that audit recommendations be implemented. A RIG official said deficiencies were considered to be resolved on the basis of the carriers' responses that corrective actions had or would be taken. RIG did not follow up on the carriers to ensure that the deficiencies had been corrected or hold the carrier officials accountable for improving plan controls.

Our review of the audit reports showed that some serious control deficiencies had not been effectively corrected. For example, funds were embezzled by the National League of Postmasters plan's accountants on two separate occasions (see app. I). In 1981, after the first embezzlement occurred, an audit report was issued that identified major internal control deficiencies, including the inadequate separation of duties and presigned checks. The next audit report, which was issued in 1984 after the second embezzlement occurred, documented that the control deficiencies had not been corrected. In response to each of these reports, the carrier said that corrective action would be taken. However, the draft of the next audit report, which is to be issued in 1991, indicated that the carrier had not yet implemented adequate controls pertaining to the separation of duties and presigned checks.

The audit reports of the American Federation of Government Employees plan provide another example of uncorrected control deficiencies. An audit report issued in May 1988 stated that the carrier's continued failure to invest plan funds violated agreements it had entered into with OPM. The same improprieties had been identified in audit reports issued in 1976, 1980, and 1982.

Corrective Actions Identified in FIA Reports Were Not Implemented

In response to a request by OMB for a mid-1989 assessment of agency FIA programs, the Director of OPM wrote that the Inspector General audits questioned whether RIG officials could be assured that health benefits funds were being used as intended because of the program's deficient internal controls and inadequate accounting systems. Through the FIA evaluation conducted at the end of that year, RIG identified limited oversight over carriers as an internal control weakness. RIG's December 1989 status report, used to monitor efforts to correct the weakness, showed that it planned to correct the weakness by instituting a policy of program analyses of the major carriers, which possibly would include periodic on-site visits to verify carrier performance. However, RIG did not further define what the program analyses were to entail. In addition, although the control weakness was not corrected, we were informed that RIG does not intend to conduct periodic on-site visits or initiate any other oversight activities of its own.

According to a RIG official, its resources are too limited to conduct oversight of the carriers. OPM's administrative expenses are covered by an annual premium add-on of 1 percent that is set aside in an administrative reserve account. However, we noted that RIG requests and uses only a small portion of the funds potentially available under the authorizing legislation for administration of the program. From 1982 through 1989, RIG's expenses averaged under $9 million, or only about 13 percent of the amount potentially available. Because OPM did not seek authority to use the entire 1-percent set-aside, the remaining funds were allocated to the plans' contingency reserve accounts. The RIG Deputy Associate Director believes that given RIG's historical level of funding for program administration and the continuing budget constraints, it was impractical to request additional funds for oversight. In commenting on a draft of this report, OPM said it can and should consider additional funding for oversight, but cautioned that the budget situation will make this difficult to accomplish.

Lack of Leadership and Direction Concerning the Pursuit of Fraud and Abuse Cases

Despite the potential cost to the program, we believe RIG did not provide adequate leadership or direction to the carriers concerning the pursuit of enrollee and provider fraud and abuse, and OPM did not implement its authority to administratively deal with provider fraud and abuse cases.

For example, RIG does not require the carriers to routinely submit information concerning their efforts to detect fraud and abuse. Thus, RIG has no information on the number, type, and disposition of cases to judge the magnitude of the problem or the adequacy of the carriers' efforts to address it. Officials at several of the largest plans told us that they handle fraud and abuse by denying payments and closely monitoring future claims but usually do not refer cases to law enforcement authorities for prosecution.

Enrollee Fraud Program Was Not Carried Out

According to documents we reviewed, an OPM survey conducted between 1981 and 1983 found that some of the carriers felt frustrated in their efforts to combat enrollee fraud because (1) law enforcement officials frequently declined to prosecute the cases because of their small dollar amounts, and (2) the program did not provide for other sanctions, such as terminating enrollment. The carriers felt that if the government was not interested enough in the integrity of the program to take disciplinary action against enrollees who abused the program, then they should not waste their resources investigating cases.

In August 1986, OPM instructed the carriers to attempt to resolve potential fraud cases with the enrollees and, when necessary, to refer them to law enforcement authorities for further investigation and possible prosecution. After the enforcement authorities prosecuted, declined to prosecute because of small dollar amounts, or otherwise completed action on the cases, the carriers were to submit them to OPM for referral to the employing agencies for disciplinary actions. OPM officials believe this approach is necessary because OPM lacks authority to discipline or drop an enrollee from the health benefits program because of fraud.

The carriers have submitted six cases to OPM since the instructions were issued. Because over 4 million enrollees are currently in the program, it seems reasonable to assume more cases might be identified if the carriers and OPM were more aggressive in the pursuit of enrollee fraud and abuse cases. At present, RIG has no controls to assure that carriers are (1) effectively detecting and dealing with enrollee fraud and abuse and (2) reporting on all enrollee fraud and abuse cases, regardless of their disposition.

Provider Fraud and Abuse Program Has Not Been Implemented

RIG has not given the carriers adequate leadership or direction concerning the pursuit of provider fraud and abuse, and OPM has done little to implement its authority to administratively penalize fraudulent or abusive providers. Through 1990, RIG did not specifically require the carriers to implement programs for identifying provider fraud and abuse. At the time of our review, RIG was in the process of negotiating a standard contract for 1991 that would include a provision requiring carriers to have quality assurance programs that include procedures for the "detection and recovery of fraudulent claims." The type of procedures to be implemented would be left to the discretion of the carriers.

In contrast, we found that the contractors that process claims for CHAMPUS and Medicare are required to have specific procedures for detecting fraudulent and abusive benefit claims. These procedures include computerized edits that are used to select questionable claims on the basis of dollar or frequency parameters. Some of these claims are manually reviewed by medically trained personnel prior to payment and are also used in postpayment analyses to identify providers who may be billing for unnecessary or inappropriate services.

Also, OPM has had the authority to impose administrative sanctions on providers since January 1, 1989. The sanctions were patterned after those that had been provided for Medicare, Medicaid, and CHAMPUS. They allow OPM to bar from program participation providers who have

been convicted of fraud and other specified criminal offenses; lost their licenses; or specifically abused the programs by, for example, submitting claims for services not rendered or bills substantially in excess of their customary charges. In addition to being debarred, providers who commit such offenses can be assessed monetary fines and assessments.

Regulations containing OPM's standards for imposing these administrative sanctions for program-related abuses were published in October 1989. However, as of April 1991, instructions had not been provided to the carriers concerning their responsibilities for investigating and referring cases, and no providers had been debarred or assessed a monetary penalty. According to RIG and Office of Inspector General officials, neither organization was willing to take full responsibility for implementing the administrative sanctioning authority. RIG's FIA evaluation for 1990 noted the delayed implementation as a problem but did not indicate what action would be taken. According to a RIG official, resolution of the organizational responsibility for the sanctioning authority was delayed until the appointment of a statutory Inspector General.

OPM Lacks an Aggressive Fraud and Abuse Program

OPM needs to become more aggressive in addressing enrollee and provider fraud and abuse in the health benefits program. The former Inspector General testified that fraud investigations can reduce the significant financial losses caused by fraud and abuse. More specifically, we note that other agencies' efforts to detect fraud and abuse have produced substantial results. For example, the Department of Health and Human Services' Inspector General is responsible for detecting or investigating fraud and abuse in the Medicare and Medicaid programs. The Inspector General reported that in fiscal year 1989 these activities led to 1,278 convictions; $5.6 billion in settlements, fines, restitution, recoveries, and savings; and administrative sanctioning (debarment from participation and/or financial penalties) of 846 providers.

In CHAMPUS, the program office is responsible for investigating or directing the contractors to investigate fraud and abuse cases involving $10,000 or less. Cases above $10,000 may be referred to the Department of Defense Inspector General's Criminal Investigative Service. In 1989, the program office closed about 375 cases and recovered about $2.2 million. Additionally, the contractors reported closing 1,102 fraud and abuse cases, which resulted in the denial of $652,000 in benefit payments and the recovery of $282,000 for claims previously paid.

Also, a growing number of private insurers are initiating antifraud programs as a cost-saving device. According to the Health Insurance Association of America, one-half of the 110 insurance companies that responded to its 1989 survey had developed antifraud programs. The 55 companies with health care antifraud programs represented more than half of the total commercial health insurance business. The survey also showed that the number of fraud cases investigated had dramatically increased. Between 1987 and 1989, the number of investigations increased by 50 percent, from 12,500 to 19,600, and the number of criminal convictions grew by more than 100 percent, from 156 to 323. Only 20 percent of the respondents were able to report their savings, which, for 1989, were estimated to total $45 million.[7]

Program Control Weaknesses Were Not Included in OPM's Annual FIA Reports

The RIG Associate Director is responsible for determining what internal control weaknesses are reported to the OPM Director and recommending which weaknesses should be included in the Director's annual report to the president and Congress. The Director receives additional advice on which weaknesses to report from the agency Internal Control Manager and the Inspector General.

The RIG Associate Director reported inadequate oversight of the health benefits carriers to the Director as a weakness for fiscal years 1987, 1989, and 1990. However, the weakness was not included in the Director's annual reports because OPM officials believed it did not meet the criteria in OMB Circular A-123 for determining which weaknesses were of sufficient importance to report. The circular provides for the reporting of weaknesses that

- significantly impair the fulfillment of an agency or component's mission;
- deprive the public of needed services;
- violate statutory or regulatory requirements;
- significantly weaken safeguards against waste, loss, unauthorized use, or misappropriation of funds, property, or other assets; or
- result in a conflict of interest.

Because the application of these criteria involves judgment, OMB issued additional guidance that each material weakness reported should meet one or more of the following:

[7]Findings: An HIAA Survey of Health Insurers' Anti-Fraud Programs, July 24, 1990; Department of Policy Development and Research, Health Insurance Association of America.

- merits the attention of the agency head/senior management, the Executive Office of the President, or the relevant Congressional oversight committee;
- exists in a majority of agency components or in a major program or activity;
- risks or results in the actual loss of either $10 million or 5 percent of the resources of a budget line item; or
- reflects adversely on the credibility of the agency report when subsequently made public.

In our judgment, the control deficiencies discussed in this report meet OMB criteria and are of sufficient importance to report to the president and Congress. The administration of the health benefits program is one of OPM's primary missions. Moreover, the program is of major importance to the government and its employees. It is an important component of the government's compensation package and, as such, is a factor in the government's ability to hire and retain quality personnel. Also, the program is the largest employer-sponsored health insurance program in the United States. In 1989 about 9 million employees, retirees, and dependents relied on the program for protection against both common and catastrophic health expenses. Thus, because of the importance of the health benefits program, we believe the OPM Director should report program control deficiencies as FIA material internal control weaknesses.

We also believe OPM should report the weakness because the potential dollar loss is high. The program involves billions of dollars of government and enrollee premiums that are spent primarily by the carriers for benefit payments and administrative expenses. In the past, several carriers have been caught misusing plan funds. Because the payment of benefits involves processing millions of claims, it would be impractical to individually scrutinize each claim. Thus, the inability to ensure that the carriers have established adequate controls to safeguard funds from loss is an important concern. If only a small fraction of the claims resulted from fraudulent or abusive activities, millions of dollars would be added to the program's costs.

Conclusions

Congress passed FIA to reduce waste, fraud, abuse, and misappropriation of federal program funds. Although OPM has made some improvements in the health insurance program's internal controls, it cannot reasonably ensure that program funds are adequately protected from fraud and

abuse. Program funds are spent mostly by the carriers for health insurance claims and administrative costs. Instances of financial abuses by carriers and an inherent vulnerability to fraudulent or abusive benefit claims by providers and enrollees necessitate effective financial and claims processing controls within the plans.

Despite the program's vulnerability to loss, RIG has not evaluated the carriers' controls and has conducted only limited oversight of plan operations because of its reliance on the audit staff. Thus, the officials responsible for managing the program do not know whether adequate controls are in place within the plans to protect program funds from fraud and abuse. The program managers relied too heavily on the Inspector General to provide management oversight of the plans. While the Inspector General auditors have an important role to play in evaluating internal controls, FIA clearly makes RIG's program managers responsible for identifying and correcting any weaknesses in the agency's internal control systems.

If the Inspector General audits were conducted more frequently, RIG could use the audit reports to identify major internal control weaknesses that need to be corrected programwide. This overview of the carriers' controls, together with the program analysis and on-site visits that RIG once proposed but did not initiate, should provide RIG with the information it would need to conduct adequate evaluations of the plans' controls and ensure that identified weaknesses have been corrected. Although the plans' controls are audited by the Inspector General, the weaknesses cited in the audit reports pertain to a single plan and are not current enough for RIG to use as a source of information for evaluating the adequacy of carriers' controls on a programwide basis.

RIG also has relied on the carriers to implement programs for preventing and detecting enrollee and provider fraud and abuse without providing adequate leadership or direction. Others in the health insurance business have found that the cost of these offenses is high and that their antifraud programs pay off. Yet, OPM has not aggressively pursued the problem of enrollee and provider fraud and abuse. RIG has not issued program directives or guidance concerning the pursuit of fraud and abuse cases nor has it determined on an ongoing basis what is being done within the plans to prevent and detect the payment of fraudulent claims. Additionally, the statutory authority to administratively penalize providers has not been implemented.

We believe that OPM cannot reasonably ensure that program funds are adequately protected from fraud and abuse until the weaknesses discussed in this report are corrected. One of FIA's intents is to hold program managers accountable for correcting internal control weaknesses. Thus, we believe that the health insurance program weaknesses should be included in OPM's annual FIA reports until an effective plan for correcting the weaknesses is developed and implemented.

Recommendations

To achieve the objectives of FIA within the Federal Employees Health Benefits Program, we recommend that the OPM Director require RIG to do the following:

- Assess the adequacy and effectiveness of the financial and claims processing controls used within the plans when conducting FIA evaluations of the health insurance program. An alternative approach for doing this would be to require the carriers to conduct FIA evaluations of their plans' controls and provide the results of their evaluations for RIG's review.
- Implement the program analysis and on-site visits RIG identified on December 31, 1989, as the corrective actions needed to address the problem of limited carrier oversight. RIG also needs to further define what the program analysis is to entail and identify the financial and claims processing information it will need from the carriers on an ongoing basis to perform its analyses.
- Make the carriers accountable for implementing Inspector General audit recommendations for correcting internal control deficiencies and ensure that corrective actions taken by the carriers are timely and effective.
- Develop and implement an aggressive program for preventing and detecting enrollee and provider fraud and abuse. In developing this program, RIG should determine the minimum claims processing controls that should be contractually required of the carriers. As a basis for making this determination, RIG should evaluate and compare the costs and results of the activities currently performed by the carriers and obtain information on the fraud and abuse prevention and detection activities used in other government and private sector insurance programs.
- Monitor the magnitude of enrollee and provider fraud and abuse in the program and the carriers' efforts to address the problem by, for example, requiring the carriers to submit periodic reports on the number, type, and disposition of the fraud and abuse cases pursued.

We also recommend that the Director

- determine where the responsibilities for implementing the authority to administratively penalize fraudulent and abusive providers should be organizationally placed within OPM (the Retirement and Insurance Group and/or the Office of the Inspector General) and require the responsible organization(s) to develop an action plan for implementing the authority as soon as possible.
- include the weaknesses discussed in this report in the annual FIA report to the president and Congress until the above recommendations are implemented.

Additionally, we recommend that the OPM Inspector General identify and implement the actions needed to achieve its goal of a 3- to 5-year audit cycle for the fee-for-service plans.

Agency Comments and Our Evaluation

OPM provided written comments on a draft of this report. OPM generally agreed with our conclusions and recommendations and described its efforts to implement each recommendation. (See app. III.) We believe the actions OPM has underway or planned, if effectively implemented, will improve the health benefits program's internal controls. Although OPM agreed that it needs to improve its program oversight capacity, it expects that resource increases will be hard won until the budget deficit subsides.

As agreed with your offices, we are providing copies of this report to OPM. Unless you publicly announce its contents earlier, we plan no further distribution until 7 days from the date of this report. At that time, we will send copies to interested parties and make copies available to others upon request.

The major contributors to this report are listed in appendix IV. Please contact me at (202) 275-5074 if you or your staff have any questions concerning the report.

Bernard L. Ungar

Bernard L. Ungar
Director, Federal Human Resource
Management Issues

Carrier Fraud and Abuse Cases

American Postal Workers Union

From June 1984 to June 1985, the plan comptroller and finance manager secretly invested and reinvested over $160 million of program funds in risky, high-yield savings and loan associations rather than in federally insured banks as required by program regulations. Interest above the amount expected from the federally insured banks was skimmed off by the officials and deposited into a personal account. To avoid detection, they altered plan financial records and transferred the funds to federally insured accounts prior to a scheduled audit. The audit did not detect the embezzlement and the funds were redeposited into the risky accounts.

A bank official became suspicious and alerted law enforcement officials. The plan officials were convicted of embezzling about $1.2 million and sentenced to 5 years in prison. They also were ordered to make full restitution of the plan's funds, plus interest.

National League of Postmasters

During 1978 an accountant who worked for both the plan and the League deposited about $132,000 of plan funds in a League account and used the funds to pay League operating costs. The misappropriation of funds was discovered during an OPM audit that was conducted after the accountant died suddenly. The League reimbursed the plan for the missing funds.

Between 1980 and 1982, another accountant who also worked for both the plan and the League embezzled $36,000 of plan funds. The embezzlement was discovered during an OPM audit requested by plan management. The accountant pleaded guilty and received a 2-year suspended sentence, 2 years of probation, and 200 hours of community service. He also was required to make full restitution of the plan's funds.

After these incidents, the League hired a consultant to review plan and League internal operations. During the review, it was discovered that a plan employee and a former plan employee had embezzled $22,775 of health benefit payments. In March 1984, the employee and former employee pleaded guilty and were placed on probation. They also were required to make full restitution of the plan's funds.

American Federation of Government Employees (AFGE)

Each of four OPM audit reports issued between 1976 and 1988 said that AFGE had failed to invest plan funds in excess of administrative expenses. Instead of being invested, the funds were deposited in AFGE accounts and used to finance its operations. As a result, from 1970 through 1985, the plan lost investment income totaling $350,000. AFGE reimbursed the plan for the lost investment income, plus interest.

National Alliance of Postal and Federal Employees

An OPM audit report issued in 1987, which covered the years 1976 through 1978, said that Alliance's improper handling of semimonthly premium checks cost the plan $138,000 of lost investment income. The next audit report, which was issued in 1986, said that the procedures implemented to correct the previously reported problem were inadequate and that an additional $265,000 of investment income was lost from 1979 to 1983. Alliance reimbursed the plan for the full amount of the lost income, plus interest.

National Federation of Federal Employees (NFFE)

A 1987 OPM audit report said that NFFE had improperly deposited plan funds in NFFE accounts. As a result, in 1984 and 1985 the plan lost investment income totaling $350,000. NFFE reimbursed the plan for the lost investment income.

Mail Handlers

An OPM audit report for the years 1981 through 1984 said that the Claims Administration Corporation (CAC), which administered the Mail Handlers plan, had charged the plan $1 million for facilities that had been subleased, legal expenses incurred in falsifying the sublease, and other improper lease costs. The matter was referred to the Justice Department. In 1986, an out-of-court settlement was reached with CAC, the Loews Corporation (parent company), and the CNA Financial Corporation (a related company). All three corporations agreed to reimburse the plan $1 million and pay an additional $150,000 in damages and civil penalties.

Aetna

In October 1988 GAO reported (Federal Compensation: Recovery of Improper Health Benefits Charges Needed GAO/GGD-89-27, Dec. 13, 1988) to OPM that from 1982 through 1987 Aetna improperly charged the program about $7.2 million for federal income taxes paid on its service charges (profit). Aetna repaid the plan $7.2 million. During that time

period the plan lost investment income that could have been earned, and Aetna had interest-free use of the program funds.

Last Audit Report Issued for Employee Organization Plans Offered in 1988 as of December 31, 1990

Plan	Date of report	Latest year covered by audit
Sponsors		
Mail Handlers	7/26/90	1987
Foreign Service	7/9/90	1986[a]
Foreign Service Overseas	7/9/90	1986[a]
Rural-Carriers	9/29/88	1984
AFGE	5/2/88	1985[b]
GEBA	12/28/87	1984[b]
Postal Supervisors	10/21/87	1985[b]
NFFE	3/9/87	1985[b]
NTEU	1/16/87	1984
GEHA	12/5/86	1984
APWU	6/2/86	1981
NAPUS	4/21/86	1984
NALC	3/24/86	1983
Alliance	2/3/86	1983
NAGE	10/10/85	1982[b]
Postmasters	12/31/84	1981
SAMBA	6/21/84	1982
Panama Canal Area	12/28/83	1982
BACE		[c]
Federal Managers		[d]
Secret Service		[e]
ACT		[f]
NATA		[g]
Underwriters		
Mutual of Omaha	2/9/89	1986
Group Hospitalization, Inc.	10/27/88	1985
Metropolitan Life	5/8/89	1984
Continental Assurance Company	9/16/85	1984
Prudential Insurance Company	9/20/85	1983
Union Labor Life		[h]

[a]These separate plans were covered by the same audit.

[b]Plan not offered after 1990.

[c]Plan first offered in 1986.

[d]Plan offered from 1986 through 1988.

[e]Plan first offered in 1987.

[f]Plan offered from 1987 through 1989.

[g]Plan offered from 1987 to 1988.

[h]Began underwriting plans in 1984.

Comments From the Office of Personnel Management

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

OFFICE OF THE DIRECTOR

APR 25 1991

Mr. Richard L. Fogel
Assistant Comptroller General
U. S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

Thank you for the opportunity to comment on your draft report, "FRAUD AND ABUSE, Stronger Controls Needed In Federal Employees Health Benefits Program."

I would like to express our appreciation for the cooperation shown by your staff in working with us on this draft report. We share with GAO a firm commitment to an FEHB free of fraud and abuse, and we have learned much that is useful in working with the GAO auditors who have produced this report

We have addressed your specific recommendations in the attachment. We are in agreement that it is desirable to devote more resources to monitoring plan operations, and we will look for opportunities to increase our oversight as fiscal constraints permit.

While there is room for improvements, we have seized upon opportunities to improve the financial integrity of FEHB, and we have used resources available.

For example, OPM has brought virtually all FEHB money into the Treasury and we have prepared new contracts incorporating quality control and other clauses which require FEHB carriers to meet strengthened financial and accounting requirements and guard against waste, fraud and abuse.

It is also worth noting that five of the seven examples of fraud in FEHB cited in the report were discovered by OPM in its oversight of carrier operations. GAO did not establish new incidences, but speculated that there could be some. It would be useful to have quantitative data on which to base our resource decisions.

The report suggests that OPM has been remiss in not spending all of the 1 percent of premium allowed by our authorizing legislation for administering FEHB. But, as you know, this 1 percent ceiling is very different from an appropriation. As with our salaries and expenses appropriation, we can spend each year

Mr. Richard L. Fogel

only what the Congress appropriates. We can and should consider increases to improve our oversight capacity, but we also know that increases will be hard won until the country's deficit subsides.

We agree with much of what the report recommends, and hope to continue our cooperative efforts with you towards the goal of a sound and efficient health insurance program for our employees.

Sincerely,

Bill R. Phillips
Deputy Director

Attachment

ATTACHMENT

OPM RESPONSES TO SPECIFIC RECOMMENDATIONS

RIG should assess the adequacy and effectiveness of the financial and claims processing controls used within the plans when conducting FIA evaluations of the health insurance programs...

We agree with your conclusions that carriers' internal controls need to be evaluated and monitored and safeguards initiated because of the vast sums of money involved in the FEHB Program and the potential for abuse. We have been working for some time to improve these control weaknesses. As you know, RIG instituted a letter-of-credit procedure which regulates the transfer of funds to the carriers and has reduced carrier-held assets by more than $1.5 billion. These funds are now safeguarded in Treasury accounts.

In addition, RIG revised our procurement regulations, the FEHB Acquisition Regulations (FEHBARs), to address such areas as minimum standards of conduct, acceptable accounting and financial practices, and the termination of contracts with carriers using poor business practices. The FEHBARs were first applied in the contract year beginning January 1, 1988.

More recently, RIG included a quality control clause in the FEHB contracts for 1991 which specifically addresses such matters as accuracy of payments, and detection and recovery of fraudulent claims and other overpayments. The standard contract also significantly strengthened accounting and financial requirements under the FEHB Program, including requirements for audited statements, certification of the accuracy of statements by CEOs and CFOs and specifications for investment income. Finally, the FEHBARs address levels of performance with regard to standards and objective measures for determining how well a carrier is performing.

Plans will be asked to provide descriptions of their internal controls and procedures relating to the requirements referenced above and these materials will be provided to the OIG so they can be included in future OIG audits. RIG also will seek the resources necessary to monitor carrier performance with respect to these matters on an on-going basis.

RIG should implement the program analysis and on-site visits it identified on December 31, 1989, as the corrective actions needed to address the problem of limited carrier oversight...

As noted above, RIG will seek the resources needed to perform these functions.

RIG should make the carriers accountable for implementing Inspector General audit recommendations for correcting internal control deficiencies and assure that corrective actions taken by the carriers are timely and effective.

RIG will begin to integrate the follow up of non-monetary audit findings into its annual service charge negotiations. RIG will also require the carriers to provide more specific indications or evidence that they have adopted the various audit recommendations. To further ensure that corrective actions have remained in effect and are in compliance with Government Auditing Standards, the OIG will continue to follow-up on previous audit findings to determine whether carriers have taken the necessary corrective action.

RIG should develop and implement an aggressive program for preventing and detecting enrollee and provider fraud and abuse. In developing this program, RIG should determine the minimum claims processing controls which should be contractually required of the carriers...

With respect to enrollees, RIG believes that it is better to hold plans accountable for the prevention and detection of enrollee fraud and abuse than to attempt to devise and prescribe a set of controls that will be effective in the many different environments in which claims are processed in the FEHB Program. In 1991 RIG initiated an annual conference of the fee-for-service plans to discuss common concerns, problems, and identify solutions. The prevention and detection of fraud and abuse will be slated for discussion in 1992 to determine what measures seem to work the best in the different processing environments found in the FEHB Program. If RIG is successful in obtaining the resources necessary to conduct on-site reviews and on-going monitoring, it is possible that minimum standards could be identified and tailored to specific processing environments. In the interim, the OIG is now in the process of developing a criminal investigation staff that will be available to accept carrier referrals for investigation of enrollee and provider fraud and abuse.

RIG should monitor the magnitude of enrollee and provider fraud and abuse in the program and the carriers' efforts to address the problem by, for example, requiring the carriers to submit periodic reports on the number, type, and disposition of the fraud and abuse cases pursued.

RIG will take prompt action to initiate the carrier reports suggested in your draft report. These reports should provide valuable insight into the carriers' efforts and assist us in trying to identify the magnitude of the problem Program-wide.

The Director should determine where the responsibilities for implementing the debarment authority should be organizationally placed within OPM (RIG and/or OIG...

The Office of the Inspector General will perform this function. An action plan to implement a debarment program is now being prepared in consultation with the Retirement and Insurance Group and numerous other Governmental agencies. The plan will be consistent with the "Federal Employees Health Benefits Amendments Act of 1988." It will establish the staffing level necessary to implement the program and seek requisite resources. The actual implementation date is dependent upon availability of funding.

The Director should include the FEHB internal control weaknesses cited in this report in the annual FIA report to the President and Congress until the recommendations are implemented.

We will need to assess the progress we have made by the end of the year when we actually prepare our certification under the FMFIA and determine at that time the degree of the remaining weakness and whether it represents a "material weakness" under OMB's guidelines reportable to the President and the Congress. This assessment will give significant weight to this report as well as to the OIG's opinion.

Additionally, we recommend that the Inspector General, OPM, identify and implement the actions needed to achieve its goal of a 3 to 5-year audit cycle for the fee-for-service plans.

The Office of the Inspector General has been concerned about the length of the audit cycle for the plans participating in the Program. They realize that, because of the current cycle, audit opportunities are missed that could otherwise result in significant savings to the Government and to the subscribers in the plans. The long audit cycle also inhibits OPM's ability to negotiate the most favorable contract terms and decreases the impact of the sentinel effect on contract operations.

Because of these concerns, OIG has conducted a thorough analysis of the audit process and the audit universe. A number of actions have been identified that they believe will enable them to achieve their goal of reducing the audit cycle for service benefit and indemnity plans to 5 years and community rated plans to 3 years. Most importantly, additional staff will be needed, therefore the OIG fiscal year 1992 budget request includes an increase in staff for the Insurance Audits Division. However, recruiting highly qualified individuals for these positions will be a time-consuming process. Further, adding staff inexperienced in auditing health plans will not

enable them to immediately reduce the audit cycle. Therefore, OIG does not expect to achieve their goal in fiscal year 1992. It can be anticipated, as the scope of the individual audits increase, they will need additional resources to maintain this objective in later years.

Major Contributors to This Report

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