U.S. OFFICE OF PERSONNEL MANAGEMENT
OFFICE OF THE INSPECTOR GENERAL
OFFICE OF AUDITS

Final Audit Report

AUDIT OF THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM OPERATIONS AT SELECTHEALTH INC.

Report Number 1C-SF-00-19-021
March 27, 2020

EXECUTIVE SUMMARY

Audit of the Federal Employees Health Benefits Program Operations at SelectHealth Inc.

Report No. 1C-SF-00-19-021 **March 27, 2020**

Why Did We Conduct The Audit?

The primary objective of the audit was to determine if SelectHealth Inc. (Plan) complied with the provisions of its contract and the laws and regulations governing the Federal Employees Health Benefits Program (FEHBP). To accomplish this objective, we verified whether the Plan met the Medical Loss Ratio (MLR) requirements and thresholds established by the U.S. Office of Personnel Management (OPM).

Due to changes to our audit procedures resulting from OPM's implementation of its MLR methodology, we cannot express an opinion on the fairness of the premium paid for benefits received. Our audit process was limited to an assessment of the Plan's MLR, which is representative of the Plan's cost of doing business with the FEHBP. In our opinion, the MLR calculation is neither transparent nor a fair assessment of the FEHBP rates, concerns that we are addressing with OPM through other channels.

What Did We Audit?

Under Contract CS 2925, the Office of the Inspector General (OIG) completed a performance audit of the FEHBP MLR submissions to OPM for contract years 2014 through 2016. We conducted our audit fieldwork from July 16, 2019, through November 19, 2019, at the Plan's offices in Murray, Utah, and in our OIG offices.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

We determined that portions of the MLR calculations were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM for contract years 2014 through 2016. This resulted in an overstated MLR credit of $54,807 for contract year 2014. Although we identified issues in contract years 2015 and 2016, they did not result in a penalty due to OPM or an adjustment to the credit amount due to the Plan. Specifically, our audit identified the following:

- The Plan included an overstated medical claims expense in its 2014 MLR filing, which caused a reduction in the MLR credit of $54,807.
- The Plan did not include chiropractic claims within its 2014, 2015, and 2016 MLR filings causing its incurred claims to be understated.
- The Plan did not properly terminate ineligible overage dependents during contract years 2014 through 2016.
- The Plan did not remove its access fees from the incurred claims amount in its 2016 MLR filing in accordance with 45 Code of Federal Regulations 158.140(b)(3)(i).
- The Plan reported an incorrect healthcare receivable amount in its 2016 MLR filing.
- The Plan did not apply a copayment to select generic drugs that were part of a Generic Sample Program, as required by the FEHBP benefit brochure.

ABBREVIATIONS

CFR	**Code of Federal Regulations**
Contract	**Contract CS 2925**
FEHBP	**Federal Employees Health Benefits Program**
GSP	**Generic Sample Program**
MLR	**Medical Loss Ratio**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**SelectHealth Inc.**
SSSG	**Similarly-Sized Subscriber Group**
U.S.C.	**United States Code**

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I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at SelectHealth Inc. (Plan). The audit was conducted pursuant to the provisions of Contract CS 2925 (Contract); 5 United States Code (U.S.C.) Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract years 2014 through 2016, and was conducted at the Plan's offices in Murray, Utah.

The FEHBP was established by the Federal Employees Health Benefits Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for Federal employees, annuitants, and dependents, and is administered by the U.S. Office of Personnel Management's (OPM) Healthcare and Insurance Office. The provisions of the Federal Employees Health Benefits Act are implemented by OPM through regulations codified in 5 CFR Chapter 1, Part 890. Health insurance coverage is provided through contracts with health insurance carriers who provide service benefits, indemnity benefits, or comprehensive medical services.

In April 2012, OPM issued a final rule establishing an FEHBP-specific Medical Loss Ratio (MLR) requirement to replace the similarly-sized subscriber group (SSSG) comparison requirement for most community-rated FEHBP carriers (77 Federal Register 19522). The MLR is the proportion of FEHBP premiums collected by a carrier that is spent on clinical services and quality health improvements.

The MLR was established to ensure that health plans are meeting specified thresholds for spending on medical care and health care quality improvement measures, and thus limiting spending on administrative costs, such as executive salaries, overhead, and marketing of the health plan. However, in our opinion, the FEHBP MLR is not as transparent as intended and does not provide an assessment of the fairness of the premium paid for benefits received. As this continues to be a significant Program concern for us, we are addressing this issue with OPM through other channels.

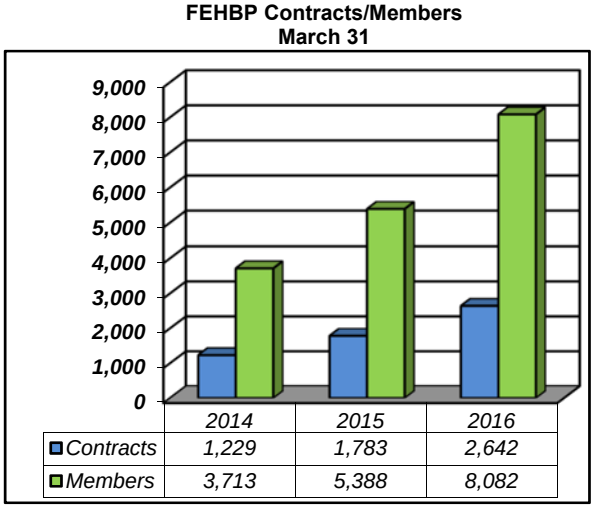
The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act (P.L. 111-148) and defined by the U.S. Department of Health and Human Services in 45 CFR Part 158. In 2012, community-rated FEHBP carriers could elect to follow the FEHBP-specific MLR requirements, instead of the SSSG requirements. However, beginning in 2013, the MLR methodology was required for all community-rated carriers, except those that are state-mandated to use traditional community rating. State-mandated traditional community-rated carriers continue to be subject to the SSSG comparison rating methodology.

Starting with the pilot program in 2012 and for all non-traditional community-rated FEHBP carriers in 2013, OPM required the carriers to submit an FEHBP-specific MLR. This FEHBP-

specific MLR calculation required carriers to report information related to earned premiums and expenditures in various categories, including reimbursement for clinical services provided to enrollees, activities that improve health care quality, and all other non-claims costs. If a carrier fails to meet the FEHBP-specific MLR threshold, it must make a subsidization penalty payment to OPM within 60 days of notification of amounts due.

Community-rated carriers participating in the FEHBP are subject to various Federal, state and local laws, regulations, and ordinances. In addition, participation in the FEHBP subjects the carriers to the Federal Employees Health Benefits Act and implementing regulations promulgated by OPM.

The number of FEHBP contracts and members reported by the Plan as of March 31 for each contract year audited is shown in the chart to the right.



	2014	2015	2016
Contracts	1,229	1,783	2,642
Members	3,713	5,388	8,082

The Plan has participated in the FEHBP since 2011 and provides health benefits to FEHBP members in the state of Utah and in the Midwest and Southern Idaho regions.

A prior audit of the Plan covered the 2012 MLR submission. In that audit, we determined that the Plan's 2012 FEHBP MLR submission was accurate, complete, and valid, and was developed in accordance with the applicable laws and regulations governing the FEHBP.

The preliminary results of this audit were discussed with Plan officials at an exit conference and in subsequent correspondence. A draft report was also provided to the Plan for review and comment. The Plan's comments were considered in preparation of this report and are included, as appropriate, as an Appendix to the report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The primary objective of this performance audit was to determine whether the Plan complied with the provisions of its Contract and the laws and regulations governing the FEHBP. Specifically, we verified whether the Plan met the MLR requirements and thresholds established by OPM and paid the correct amount to the Subsidization Penalty Account, if applicable.

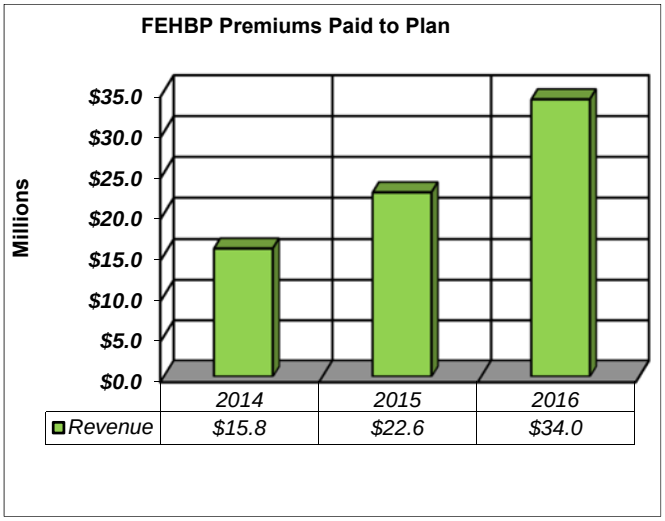
Our audits of the MLR submission filed with OPM are completed in accordance with the criteria expressed in OPM's rating instructions. The MLR audit evaluation includes an assessment of key components of the MLR calculation, including allowable claims, capitations, health care expenses, and quality health improvements (numerator), and the premium received, excluding applicable tax expenses (denominator). The result of the MLR calculation must meet OPM's prescribed thresholds. If the calculation falls below the threshold, the health plan must pay a penalty determined by the variance between the actual MLR ratio and the established threshold.

Although the FEHBP premiums used in the MLR calculation are ultimately determined by the premium rates proposed by the Plan and certified and paid by OPM, the OPM rating instructions no longer provide sufficient criteria to evaluate the fairness of those rates against the standard market value of similarly-sized groups. Furthermore, per the OPM rating instructions, health plans can utilize OPM's total reported premium as the denominator in the MLR calculation, which when utilized is not subject to audit. Since the majority of health plans choose this option, the premiums utilized in the MLR calculation are frequently not available for audit, and the fairness of the FEHBP premium rates cannot be evaluated. As this continues to be a significant Program concern for us, we are addressing this issue with OPM through other channels.

SCOPE

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

This performance audit covered contract years 2014 through 2016. For these years, the FEHBP paid approximately $72.4 million in premiums to the Plan.



The Office of the Inspector General's (OIG) audits of community-rated carriers are designed to test carrier compliance with the FEHBP contract, applicable laws and regulations, and the rate instructions. These audits are also designed to provide reasonable assurance of detecting errors, irregularities, and illegal acts.

We obtained an understanding of the Plan's internal control structure, but we did not use this information to determine the nature, timing, and extent of our audit procedures. Our review of internal controls was limited to the procedures the Plan has in place to ensure that:

- the FEHBP MLR calculations were accurate, complete, and valid;
- claims were processed accurately;
- appropriate allocation methods were used; and
- any other costs associated with its MLR calculations were appropriate.

In conducting the audit, we relied to varying degrees on computer-generated billing, enrollment, and claims data provided by the Plan. We did not verify the reliability of the data generated by the various information systems involved. However, nothing came to our attention during our audit utilizing the computer-generated data to cause us to doubt its reliability. We believe that the available data was sufficient to achieve our audit objectives. Except as noted above, the audit was conducted in accordance with generally accepted government auditing standards, issued by the Comptroller General of the United States.

We conducted our audit fieldwork from July 16, 2019, through November 19, 2019, at the Plan's offices in Murray, Utah, as well as in our office in Cranberry Township, Pennsylvania.

METHODOLOGY

We examined the Plan's MLR calculations and related documents as a basis for validating the MLR. Further, we examined medical claim payments, quality health improvement expenses, taxes and regulatory fees, premium income, and any other applicable costs to verify that the cost

data used to develop the MLR was accurate, complete, and valid. Finally, we used the Contract, the OPM rate instructions, the Federal Employees Health Benefits Acquisition Regulations, and applicable Federal regulations to determine the propriety of the Plan's MLR calculations.

To gain an understanding of the internal controls over the Plan's MLR process and claims processing system, we reviewed the Plan's MLR and claims policies and procedures and interviewed appropriate Plan officials regarding the controls in place to ensure that MLR calculations and claims pricing were completed accurately and appropriately. Other auditing procedures were performed as necessary to meet our audit objectives.

The tests performed on the medical and pharmacy claims, along with the methodology, are detailed in Exhibit C at the end of this report.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. MEDICAL LOSS RATIO REVIEW

The Certificate of Accurate MLR that the Plan signed for contract year 2014 was defective. The Certificate of Accurate MLR states that the FEHBP specific MLR is accurate, complete, and consistent with the methodology in Sec. 1615.402(c)(3)(ii). In accordance with Federal regulations and the OPM Community Rating Guidelines, our audit identified the following issues:

1. Overstated MLR Credit $54,807

During the 2014 MLR filing period, the Plan calculated an MLR ratio of 120.31 percent, which exceeded OPM's upper threshold of 89 percent and resulted in a credit to the Plan of $4,853,374. During our review of the FEHBP MLR filing, we identified an issue that resulted in a lower audited MLR of 119.96 percent. We determined that the Plan overstated its credit by $54,807. Discussion of the specific issue that led to the overstated credit, listed in Table I below, is in section A.3 of this report.

2. No Credit Adjustment Due to OPM $0

During the 2015 and 2016 MLR filing periods, the Plan calculated MLR ratios of 127.68 percent and 125.56 percent, respectively. Because these MLR ratios exceeded OPM's upper threshold of 89 percent, it resulted in credits to the Plan of $8,566,645 in 2015 and $12,262,155 in 2016. Our review of the Plan's MLR filings disclosed issues within the MLR calculation. These adjustments, while reportable, were not significant enough to result in a credit adjustment due to OPM as illustrated in Table I below.

	Table I – MLR Adjustments					
Year	Plan's MLR Ratio	Audited MLR Ratio	Plan's Current Credit	Plan's Current Penalty	Audited Credit	Credit Adjustment Due to OPM
2014	120.31%	119.96%	$4,853,374	$0	$4,798,567	$54,807
2015	127.68%	127.68%	$8,566,645	$0	$8,566,645	$0
2016	125.56%	125.56%	$12,262,155	$0	$12,262,155	$0

3. 2014 Medical Claims Variance

The Plan included an overstated medical claims expense in its 2014 MLR filing.

45 CFR 158.140(a) requires the Plan to "include direct claims paid to or received by providers, including under capitation contracts with physicians, whose services are covered by the policy" in its MLR form.

The Plan inadvertently used an erroneous medical claims expense amount in its 2014 MLR filing. Per the Plan, a miscommunication between Plan personnel caused an inaccurate data run to be used as the source for the medical claims figure, $18,519,186, used on the MLR filing. The medical claims data submitted to OPM OIG, per Carrier Letter 2015-11, totaled $18,464,379. This caused a variance of $54,807 in the incurred medical claims expense. As a result, the Plan was not in compliance with 45 CFR 158.140(a), which caused the MLR percentage to be overstated.

Plan's Response:

The Plan agreed with the medical claims variance finding. It stated that going forward, it has implemented a control document to be signed annually. The document attests that both the data and reporting teams understand the final claims data to be submitted and that any refinements to the data must be communicated to both teams.

Conclusion

We recalculated the Plan's 2014 FEHBP MLR, incorporating the above mentioned adjustment. A comparison of our audited MLR calculation to that submitted by the Plan showed an overstated FEHBP MLR credit amount by $54,807 in contract year 2014.

Recommendation 1

We recommend that the contracting officer reduce the MLR credit in contract year 2014 by $54,807.

Recommendation 2

We recommend that the Plan ensure its incurred medical claims expense reported on its MLR form is accurate, as required by 45 CFR 158.140(a).

B. PROCEDURAL FINDINGS

1. Exclusion of Chiropractic Claims

The Plan did not include chiropractic claims within its 2014, 2015, and 2016 MLR filings.

45 CFR 158.140(a) requires the direct claims paid to or received by providers, including under capitation contracts with physicians, whose services are covered by the policy for clinical services or supplies covered by the policy to be included in the MLR submission.

The Plan pays a third party vendor a capitated amount for chiropractic claims. It excluded those chiropractic claims from its MLR filing due to its interpretation of the language in the annual FEHBP Carrier Letters, which state, "All MLR carriers must submit to the OIG detailed FEHBP claims data used in its MLR calculation. The data should include FEHBP claims incurred during [the] calendar year … , and paid through June 30 … . No other claims will be considered." However, these annual Carrier Letters outline the requirements of the claims data submission to the OIG rather than detailing specific MLR requirements. The Plan also stated that its MLR percentage was already above the OPM threshold of 89 percent and including the chiropractic claims would only make the percentage higher. Because of not including the chiropractic claims, the Plan understated its MLR percentage and did not comply with 45 CFR 158.140(a).

Plan's Response:

The Plan agreed with the chiropractic claims finding and stated it will include the expense in future MLR calculations.

Recommendation 3

We recommend that the Plan ensure that all paid claims, including those capitated payments to third party vendors, are included in the MLR filing, as required by 45 CFR 158.140(a).

2. Untimely Dependent Terminations

The Plan did not properly terminate ineligible overage dependents during contract years 2014 through 2016, in accordance with guidelines set forth in the FEHBP benefit brochure.

The Plan did not properly terminate ineligible dependents during contract years 2014 through 2016.

Per the FEHBP benefit brochure, dependents are covered until their 26th birthday, unless they are incapable of self-support. A 31-day period of extended coverage begins when the member is no longer eligible.

We determined that the Plan's manual query process was configured to terminate dependents by auto-calculating the dependents birthday plus 31 days. However, the dependents' 31-day extension of coverage should begin on the day of their birthday, not the day after their birthday. For example, if a dependent turned 26 years old on October 1st, the Plan was beginning the 31 days of coverage beginning October 2nd. According to the benefit brochure, the 31 days of coverage should begin on October 1st, the day of the dependents birthday. Consequently, this inaccurate query configuration resulted in untimely FEHBP dependent terminations. In response to this finding, the Plan stated that it updated its query process to begin the 31 days of coverage on the day of the birthday, not the day after.

Plan's Response:

The Plan agreed with the dependent terminations finding. Its query runs were updated at the time of the audit and its administration has been corrected since it was brought to their attention.

Recommendation 4

We recommend that the contracting officer verify that the Plan has updated its query process to terminate dependents in accordance with the FEHBP benefit brochure.

3. 2016 Access Fees

The Plan did not remove its access fees from the incurred claims amount in its 2016 MLR filing.

Per 45 CFR 158.140(b)(3)(i), the amount paid to third party vendors for secondary network savings must be excluded from the incurred claims in the MLR submission.

The Plan paid access fees to a third party provider so that the provider would accept the Plan's in-network rate even though the provider was out of network. The purpose of the access fees was to ensure members who were out of the network area were not responsible for additional charges. The Plan stated that the access fees were not removed

from the 2016 incurred claims due to a misunderstanding related to a new basis used to pay access fees. As a result, the Plan did not report an accurate 2016 incurred claims expense and it was not in compliance with 45 CFR 158.140(b)(3)(i).

Plan's Response:

The Plan agreed with the access fee finding and stated it will exclude these fees from future MLR calculations.

Recommendation 5

We recommend that the Plan ensure it removes the access fees from the incurred claims as required by 45 CFR 159.140(b)(3)(i).

4. 2016 Healthcare Receivables

The Plan reported an incorrect healthcare receivable amount in its 2016 MLR filing.

45 CFR 158.140(b)(B)(i) requires plans to deduct prescription drug rebates received by the Plan from the incurred claims.

The Plan's 2016 MLR form stated an erroneous healthcare receivable amount.

The Plan recorded its 2016 pharmacy rebates on the healthcare receivables line of the 2016 MLR filing. We recalculated the Plan's pharmacy rebates for 2016 based on support provided by the Plan and determined a variance existed from the amount reported on the MLR filing. The Plan explained that it erroneously reduced its pharmacy rebates by an incorrect amount, which resulted in the variance. As a result, the Plan was not in compliance with 45 CFR 158.140(b)(1)(i) and did not report an accurate MLR to OPM.

Plan's Response:

The Plan agreed with the healthcare receivable finding. It stated that to ensure prior year roll-forwards are transferred completely, a checklist process will be implemented.

Recommendation 6

We recommend that the Plan ensure it calculates accurate pharmacy rebates to deduct from the incurred claims expense, per 45 CFR 158.140(b)(B)(i).

5. Generic Sample Program

The Plan did not apply a copayment to select generic drugs that were part of a Generic Sample Program (GSP).

The FEHBP benefit brochure states that a member's copayment was $5 for generic prescription medications prescribed by a Plan physician and obtained from a Plan pharmacy.

The Plan did not apply a copayment to select generic drugs that were part of a Generic Sample Program.

The Plan's GSP was in effect before our audit scope up until June 1, 2016. During this time period, members were able to receive their first 30-day fill of select generic prescriptions at participating retail pharmacies without paying a copayment. The Plan used the GSP to encourage the use of generic drugs. Although we do not disagree with the intent of the GSP, the Plan did not comply with the FEHBP benefit brochure regarding copay application. Additionally, it may have overpaid its portion of the claim costs by waiving the members' copayment.

Plan's Response:

The Plan agreed with the generic sample program finding and stated that the program has been discontinued.

OIG Comment

There is no specific recommendation for the discontinued GSP. Any future instances in which the cost-sharing arrangements administered by the Plan differ from the benefit brochure and any other materials provided to FEHBP members must receive explicit approval from OPM.

C. OTHER REVIEW AREAS

1. Medical Claims Review

Our review of a sample of 75 medical claims from 2014 determined the Plan is processing its medical claims correctly and in accordance with applicable guidance, laws, and regulations.

2. Taxes and Regulatory Fees

Our review determined that the Plan's reported taxes and regulatory fees were supported, allowable, and consistently based on the principles and methods described in the Public Health Service Act and the Federal Register for contract years 2014 through 2016.

EXHIBIT A

SelectHealth Inc.
Summary of 2014 MLR Adjustment

2014 Plan Filed MLR Credit	$4,853,374
2014 Audited MLR Credit	$4,798,567
Total Overstated MLR Credit Due to OPM	**$54,807**

EXHIBIT B

SelectHealth Inc.
2014 MLR Credit Adjustment

	Plan	Audited
2014 FEHBP MLR Lower Corridor (a)	85%	85%
2014 FEHBP MLR Upper Corridor (b)	89%	89%
Claims Expense		
Adjusted Incurred Medical and Pharmacy Claims	$18,519,186	$18,519,186
Less: Overstated Claims Variance		$54,807
Plus: Quality Health Improvement Expenses	$129,058	$129,058
Total MLR Numerator	**$18,648,244**	**$18,593,437**
Premium Income	$15,825,422	$15,825,422
Less: Federal and State Taxes and Licensing or Regulatory Fees	$325,568	$325,568
Total MLR Denominator (c)	**$15,499,854**	**$15,499,854**
FEHBP Medical Loss Ratio (d)	120.31%	119.96%
Credit Calculation (If (d) is greater than (b), ((d-b)*c)	$4,853,374	$4,798,567
Total Credit Adjustment Due to OPM		**$54,807**

EXHIBIT C

Claims Sample Selection Criteria and Methodology

Claims Sample

Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Medical claims incurred from 1/1/2014 through 12/31/2014	86,321 claims	$14,786,055	Utilized RAT-STATS (90% Confidence Level 50% Anticipated Rate of Occurrence and 20% Desired Precision Range), which generated a sample size of 75. Then utilized SAS to randomly select 75 incurred, unadjusted medical claims	Statistical and Random	No
Pharmacy claims incurred from 1/1/2014 through 12/31/2014	49,465 claims	$4,231,416	Utilized SAS Random Sample Query, which generated a sample size of 30.	Random	No

APPENDIX

SelectHealth

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Salt Lake City, UT 84130-0192
801-442-5038 / 800-538-5038
selecthealth.org

January 10, 2020

Deleted by the OIG – Not Relevant to the Final Report
Senior Team Leader Community Rated Audits Group
OPM — Office of the Inspector General
Deleted by the OIG – Not Relevant to the Final Report

Re: SelectHealth Requested Revisions to Draft Audit Report

Deleted by the OIG – Not Relevant to the Final Report

Sincerely,

Deleted by the OIG – Not Relevant to the Final Report

Encl.

Deleted by the OIG – Not Relevant to the Final Report

3. **2014 Medical Claims Variance**

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Plan Response:

The Plan agreed with the medical claims variance finding.
SelectHealth Response: AGREE
To improve the process going forward, the Plan has implemented a control document to be signed annually attesting that both the data team and reporting team understand the final claims data to be submitted and that any further refinements to the data must be communicated to both teams.

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1. **GENERIC SAMPLE PROGRAM**

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Plan Response:

The Plan agreed with the generic sample program finding.
SelectHealth Response: AGREE
The program has since been discontinued.

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2. **EXCLUSION OF CHIROPRACTIC CLAIMS**

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Plan Response:

The Plan agreed with the chiropractic claims finding
SelectHealth Response: AGREE
This additional expense will be included in future MLR calculations.

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3. UNTIMELY DEPENDENT TERMINATIONS

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Plan Response:

The Plan agreed with the dependent terminations finding.
SelectHealth Response: AGREE
The Plan has corrected the untimely filing dependent finding issue. The query SelectHealth runs to identify these members as updated at the time of the audit finding. Administration has been correct since.

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4. 2016 ACCESS FEES

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Plan Response:

The Plan agreed with the access fee finding
SelectHealth Response: AGREE
These expenses will be excluded from future MLR calculations.

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5. 2016 HEALTHCARE RECEIVABLES

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Plan Response:

The Plan agreed with the healthcare receivable finding.
SelectHealth Response: AGREE
A checklist process will be implemented to ensure that prior year roll-forwards are transferred completely.

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Report Fraud, Waste, and Mismanagement

Fraud, waste, and mismanagement in Government concerns everyone: Office of the Inspector General staff, agency employees, and the general public. We actively solicit allegations of any inefficient and wasteful practices, fraud, and mismanagement related to OPM programs and operations. You can report allegations to us in several ways:

By Internet: http://www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse

By Phone:

Toll Free Number:	(877) 499-7295
Washington Metro Area:	(202) 606-2423

By Mail:

Office of the Inspector General
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Room 6400
Washington, DC 20415-1100

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