Office of the Inspector General

U.S. Office of Personnel Management

Semiannual Report to Congress

April 1, 2025–September 30, 2025

Financial Impact and Accomplishments

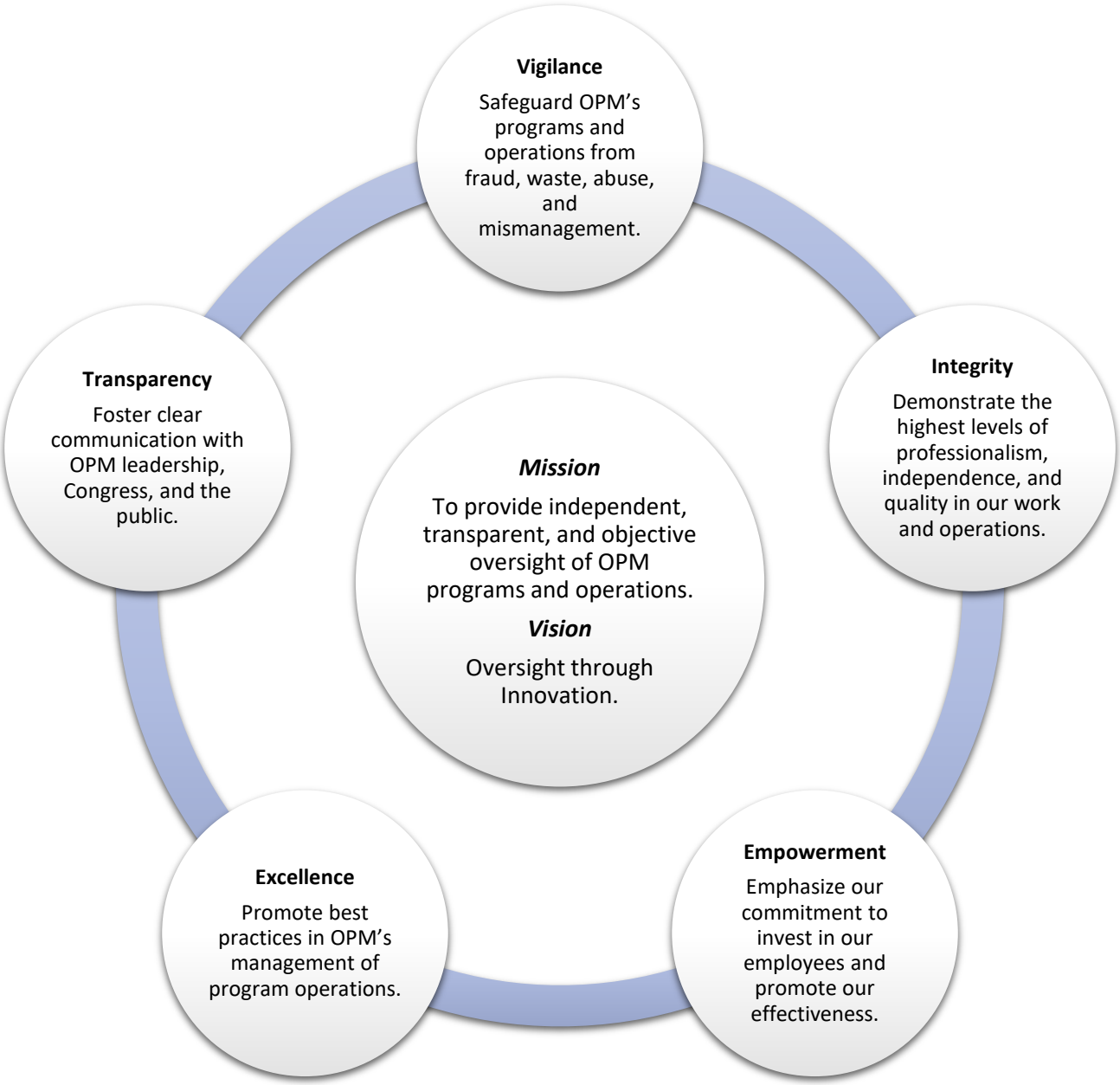
Audit Recommendations for Recovery of Funds	Management Commitments to Recover Funds	Recoveries Through Investigative Actions
$70,490,820	$14,610,708	$6,278,819

Note: OPM Management Commitments for Recovery of Funds during this reporting period reflect amounts covering current and past reporting period audit recommendations.

Audit Reports Issued	Evaluation Reports Issued	Flash Reports Issued	Data Briefs Issued	Investigations and Preliminary Investigations Closed	Indictments and Criminal Informations
5	1	2	1	60	18

Arrests	Convictions	Hotline Contacts and Complaints Received	Hotline Complaints Reviewed & Closed	Debarments and Suspen-sions of Federal Employees Health Benefits Program Providers	Debarment and Suspension Inquiries and Correspondence Related to Federal Employees Health Benefits Program Providers
13	6	1753	2256	498	1936

OIG Strategic Framework



Message From the Deputy Inspector General Performing the Duties of the Inspector General

On behalf of the OIG, I'm pleased to present this semiannual report to Congress for the U.S. Office of Personnel Management (OPM) Office of the Inspector General (OIG), covering the period from April 1, 2025, to September 30, 2025.

This year has been one of unprecedented change at the agency and across government, but our resolve to protect taxpayer dollars and root out fraud, waste, and abuse has remained constant. Financial stewardship is central to our mission. To that end, our work has identified and helped return dollars to the trust funds and contributed to efficiency gains across programs. In this report, we highlight quantifiable recoveries and measurable efficiency improvements from our audits, investigations, evaluations, and False Claims Act settlements.

This year's climate of change has presented us with opportunities. We've refreshed our organizational structure to better focus on the agency's highest-risk program areas while continuing to provide statutorily mandated oversight. We are committed to serving as a constructive partner to agency leadership by identifying practical solutions, strengthening internal controls, and improving the effectiveness of agency programs.

We're also modernizing how we work. Advancements to our data warehouse allow faster and more complete data querying and more robust analysis. As we continue to integrate AI-enabled analytics, these efforts will improve our oversight capabilities and reach, giving our auditors and investigators the ability to have the greatest potential impact for protecting OPM programs. Supported by appropriate safeguards for privacy and security, we aim to use the power of AI to deliver faster, more accurate, and more cost-effective oversight.

The work ahead will be demanding, but it will also be important. Our office remains committed to its duty to provide rigorous, independent oversight of the agency and its health care carriers, as well as keeping the Director and Congress fully and timely informed of our work. We also will continue to collaborate with the agency in support of the President's efforts to stop government fraud, waste, or abuse and improve program efficiency. We will continue to share risk insights, promote data-driven management, and identify opportunities to streamline processes. With a steadfast mission, a modernized toolkit, and an unwavering commitment to independence and results, our office is prepared to continue delivering the oversight that beneficiaries and taxpayers expect and deserve.

Norbert E. Vint
Deputy Inspector General
Performing the Duties of the Inspector General

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Introduction

The Office of the Inspector General (OIG) is an independent office within the U.S. Office of Personnel Management (OPM). The OIG is dedicated to promoting accountability and transparency both within and outside of the agency. Our mission is to provide independent and objective oversight of OPM services and programs by conducting audits, investigations, evaluations, and other reviews. The recommendations we provide help improve the efficiency and effectiveness of OPM's operations.

We strive for continuous improvement in our agency's management and program operations and in our own offices.

The OIG provides objective oversight and appraisal of the agency's responsibilities and its implementation to assure the integrity, efficiency, and effectiveness of the agency's services.

Our offices are in Washington, DC; Cranberry Township, Pennsylvania; and Jacksonville, Florida.

Figure 1. OIG Office Locations

Audit Activities

The OIG Office of Audits conducts comprehensive and independent audits of OPM programs, operations, and contractors. These audits assist the OPM Director and Congress by providing credibility and transparency to the information reported by the agency and providing information to improve accountability and facilitate decision-making.

Health Insurance Audits

OPM contracts with health insurance carriers to provide health plans under the Federal Employees Health Benefits Program (FEHBP) for federal employees, annuitants, their eligible family members, and other eligible populations. The Office of Audits handles auditing the activities of these health plans to ensure that they meet their contractual obligations with OPM. The selection of specific audits to conduct each year is based on a risk assessment model that considers various factors, including the size of the carrier, the time elapsed since the last audit, and our previous audit results.

The OIG's insurance audit universe encompasses more than 200 audit sites consisting of carriers, sponsors, and underwriting organizations participating in the FEHBP. The number of audit sites fluctuates due to the addition, nonrenewal, and merger of participating carriers. Combined premium payments for the FEHBP total more than $71 billion annually. The carriers audited by the OIG are classified as either community-rated or experience-rated.

Community-rated carriers offer comprehensive medical plans, commonly referred to as health maintenance organizations (HMOs). They are responsible for paying claims and administrative costs incurred, and they are paid an amount commensurate with the number of subscribing FEHBP enrollees and the premiums paid by those enrollees. Consequently, community-rated carriers suffer the loss if the costs incurred by the plan exceed the amount of premiums received.

Experience-rated carriers offer mostly fee-for-service plans (the largest being the Blue Cross and Blue Shield Service Benefit Plan), but they also offer experience-rated HMOs. These carriers are reimbursed for actual claims paid and administrative expenses incurred, and they are paid a service charge determined in negotiation with OPM. Experience-rated carriers will suffer a loss in certain situations if claims exceed amounts available in the Employees Health Benefits Fund, which is a fund in the U.S. Department of the Treasury that holds premiums paid by enrollees and from which carriers are reimbursed for claims paid and expenses incurred.

Community-Rated Health Plans

The community-rated carrier audit universe covers approximately 140 health plans located throughout the country. Community-rated carrier audits are designed to ensure that the premium rates health plans charge the FEHBP and the medical loss ratios (MLRs) filed with OPM are in accordance with their respective

contracts and applicable federal laws and regulations.

Premium Rate Review Audits

Our premium rate review audits focus on the rates set by the health plan and ultimately charged to the FEHBP subscriber, OPM, and taxpayers. When an audit identifies that rates are incorrect, unsupported, or inflated, the FEHBP is entitled to a downward rate adjustment to compensate for any overcharges. Any questioned costs related to the premium rates are subject to lost investment income.

Premium rate review audits of community-rated carriers focus on ensuring that the medical and prescription drug claims totals are accurate, and the individual claims are processed and paid correctly; FEHBP rates are developed in a model filed with and approved by the appropriate state regulatory body or used in a consistent manner for all eligible community groups that meet the same criteria as the FEHBP; and rate adjustments applied to the FEHBP rates for additional benefits not included in the basic benefit package are appropriate, reasonable, and consistent.

Medical Loss Ratio Audits

We also perform audits to evaluate carrier compliance with OPM's FEHBP-specific MLR requirements, which are based on the MLR standards established by the Affordable Care Act and apply to most community-rated carriers. State-mandated traditional community-rated carriers are not subject to the MLR regulations and continue to be subject to the similarly sized subscriber group comparison rating methodology.

Medical loss ratio is the portion of health insurance premiums collected by a health insurer that is spent on clinical services and quality improvement. The MLR for each insurer is calculated by dividing the amount of health insurance premiums spent on clinical services and quality improvement by the total amount of health insurance premiums collected. The MLR is important because it requires health insurers to demonstrate to consumers the value of their premium payments.

In 2012, OPM issued a final rule establishing an FEHBP-specific MLR requirement for most community-rated FEHBP carriers. The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act and defined by the U.S. Department of Health and Human Services (HHS). The MLR is a financial metric that measures the percentage of premium dollars a health plan spends on medical claims and quality improvements. The remaining percentage should be used to cover the health plan's administrative costs and profit. The MLR is important because it requires health insurers to demonstrate to consumers the value of their premium payments.

The premium rates charged to the FEHBP under the MLR methodology should be developed in accordance with OPM's rules and regulations and the plan's state-filed standard rating methodology. All FEHBP pricing data must be supported by accurate, complete, and current documentation. A rating methodology is defined as a series of well-defined procedures a carrier follows to determine the rates it will charge to its

subscriber groups. An independent professional must be able to follow the carrier's procedures and reach the same conclusion. OPM negotiates benefits and rates with each plan annually and all rate agreements between OPM and the carrier are subject to audit by the OIG. The results of such audits may require modifications to previous agreements and subsequent rate adjustments. 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 published by OPM.

No audit reports related to community-rated carriers were published during this reporting period.

Experience-Rated Health Plans

The FEHBP offers a variety of experience-rated plans, including a service benefit plan, an indemnity benefit plan, and health plans operated or sponsored by federal employee organizations, associations, or unions. Experience-rated HMOs also fall into this category. The universe of experience-rated plans currently consists of approximately 60 audit sites, some of which include multiple plans. When auditing these plans, our auditors generally focus on three key areas:

- appropriateness of FEHBP contract charges and the recovery of applicable credits, including health benefit refunds and drug rebates
- effectiveness of carriers' claims processing, financial management, cost accounting, and cash management systems
- adequacy of carriers' internal controls to ensure proper contract charges and benefit payments

During the current reporting period, we issued three final audit reports on experience-rated health plans (not including information security reports) participating in the FEHBP. The three final audit reports contained recommendations for the return of more than $70 million to the OPM-administered health care trust fund.

Blue Cross and Blue Shield Service Benefit Plan Audits

The Blue Cross Blue Shield Association (BCBSA), on behalf of 60 participating health insurance plans offered by 33 Blue Cross and Blue Shield (BCBS) companies, has a governmentwide Service Benefit Plan contract with OPM to provide a health benefit plan authorized by the Federal Employees Health Benefits Act of 1959. The BCBSA delegates authority to participating local BCBS plans throughout the United States to underwrite and process the health benefit claims of its federal subscribers. Over 67 percent of all FEHBP members are enrolled in the BCBS Service Benefit Plan.

The BCBSA established a Federal Employee Program (FEP) Director's Office in Washington, DC, to provide centralized management of the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the BCBSA, BCBS plans, and OPM.

The BCBSA also established an FEP Operations Center, the activities of which are performed by the service benefit plan Administrative Services Corporation, an affiliate of CareFirst BCBS, located in Washington, DC. These activities include acting as fiscal intermediary for claims processing between the BCBSA and member plans, verifying subscriber eligibility, adjudicating member claims on behalf of BCBS plans, approving or disapproving the reimbursement of local plan payments for FEHBP claims (using computerized system edits), maintaining a history file of all FEHBP claims, and maintaining claims payment data.

We issued three BCBS plan audit reports during this reporting period.

Audit of the Claims Processing and Payment Operations as Administered by Horizon Blue Cross and Blue Shield of New Jersey for Contract Years 2021 Through 2023

September 9, 2025 | 2024-CAAG-023

We audited the claims processing and payment operations at Horizon BCBS of New Jersey to ensure compliance with contracts and benefit brochures. The audit's monetary findings included potential net overcharges of $10,759,362 to the FEHBP and member overcharges of $254,952. Additionally, we found two procedural issues and one area for program improvement. Our key findings included the following:

- Claims system errors in the communication of claim allowances led to confirmed overcharges of $15,799 to the FEHBP and potential member overcharges of $254,952. An additional 4,805 claims are under review for potential overpayments totaling $10,634,756.
- Incorrect application of surprise billing protections resulted in $82,455 in net overcharges to the FEHBP and $247,852 in potential member overcharges.

BCBSA agrees with most of the findings and is working to recover and return funds questioned and implement corrective actions.

Audit of Blue Cross and Blue Shield of Alabama

September 15, 2025 | 2025-ERAG-004

Our audit of Blue Cross and Blue Shield of Alabama (BCBSAL) questioned $580,794 in health benefit charges, administrative expense overcharges, and lost investment income. We also identified a procedural finding where the BCBSA and BCBSAL were not in compliance with the communication and reporting requirements for fraud and abuse cases.

Our most significant finding was that BCBSAL overcharged the FEHBP $304,244 for unallowable and/or unallocable cost center expenses. Another significant finding was that BCBSAL had not returned two fraud recoveries, totaling $175,726, to the FEHBP.

The BCBSA and/or BCBSAL agreed with all questioned amounts and the procedural finding.

Audit of Anthem Blue Cross and Blue Shield

September 18, 2025 | 2024-ERAG-003

Our audit of Anthem Blue Cross and Blue Shield (Anthem) questioned $69,785,420 in health benefit charges, administrative expense overcharges, and lost investment income. We also identified procedural findings for Anthem's processing of cash receipt refunds, medical drug rebates, and special plan invoices where funds were not timely returned to the FEHBP. Additionally, we identified procedural exceptions where the BCBSA and Anthem were not in compliance with the requirements for submitting fraud and abuse cases to the OIG. Our most significant finding for miscellaneous health benefit payments and credits was that Anthem charged the FEHBP over $39 million for recovery fees that included unallowable and/or unreasonable profit costs. Another significant finding was that Anthem, because of a lack of due diligence with recovery efforts, had not recovered and/or returned funds to the FEHBP for 45 claim overpayments totaling $6,489,556. Also, Anthem had not returned 28 medical drug rebate amounts, totaling $2,931,821, to the FEHBP.

Our most significant administrative expense findings were that Anthem overcharged the FEHBP $7,739,902 for Affordable Care Act costs, $2,625,561 for claim overpayment recovery fees, and $923,964 for unallocable cost center expenses.

The BCBSA and/or Anthem agreed with $8,746,992 and disagreed with $61,038,428 of these questioned amounts and agreed with the procedural findings.

Oversight of OPM's Implementation of the Postal Service Health Benefits Program

The Postal Service Health Benefits Program (PSHBP) was established within the FEHBP by the Postal Service Reform Act of 2022 (PSRA) (Public Law 117–108), enacted on April 6, 2022, and is administered by OPM's Healthcare and Insurance program office. The PSHBP was created to provide health insurance benefits for U.S. Postal Service employees, annuitants, and eligible dependents beginning on January 1, 2025. For these individuals, eligibility for enrollment or coverage in FEHBP health plans ended on December 31, 2024, and enrollment and coverage will only be offered by the Postal Service Health Benefits (PSHB) health plans. Subject to limited exceptions, Postal Service annuitants who retire and become Medicare-eligible after December 31, 2024, and their Medicare-eligible[1] family members, must enroll in Medicare Part B[2] as a condition of eligibility to enroll in the PSHBP. The first open season for the PSHBP began on November 11, 2024, and ran through December 13, 2024.

[1] Medicare is generally for people 65 or older, but may also include people with disabilities, end-stage renal disease, or amyotrophic lateral sclerosis, commonly known as ALS.

[2] Medicare Part B helps cover medical services like doctors' services, outpatient care.

The first contract year began January 1, 2025.

Section 101 of the PSRA added a new section, 8903c, to title 5 United States Code (U.S.C.) chapter 89, which directs OPM to establish the PSHBP. The PSHBP was authorized under the title I Postal Service Financial Reforms provisions in the PSRA in furtherance of Congress's objective to "improve the financial position of the Postal Service while increasing transparency and accountability of the Postal Service's operations, finances, and performance." OPM issued a final rule on May 6, 2024, to set forth standards to implement section 101 of the PSRA to establish the PSHBP.

Our oversight of OPM's implementation of the PSHBP was ongoing, with periodic audit reports throughout the program's implementation. During this reporting period, we issued a flash report for the PSHBP on critical resource issues.

Flash Report: Postal Service Health Benefits Program: Critical Resource Issues

July 2, 2025 | 2025-PSHB-091

During our review of PSHB operations, we identified critical resource issues in OPM's administration of the PSHBP and issued a flash report to communicate the issues to stakeholders. Specifically, we reported concerns that OPM may not have the appropriate resources in place to ensure that the systems implemented for the PSHBP will remain fully staffed, supported, and funded during OPM's workforce optimization initiative.

For staffing, we reported on our concerns that after recent reductions, OPM lacks sufficient resources, specifically skilled personnel, to administer and support the Health Benefits Data Platform, which is a crucial component of OPM's administration of the PSHBP. The data platform interfaces Postal Service and partner data at various intervals with numerous agencies, partners, and systems. The loss of critical staff, in conjunction with the ongoing hiring freeze, risked operational failure of the data platform.

Without skilled personnel, the data platform is at risk of ceasing to operate effectively, which would cause other system failures and limit the functionality of implemented PSHBP processes and systems. The effects of data platform operational failure include, but are not limited to, the loss of functionality for the electronic centralized enrollment process (CEP). Loss of the CEP's functionality is of significant concern since it provides OPM with an authoritative source of PSHBP enrollment data and future FEHBP enrollment data.

We also noted in our report that OPM does not have the necessary appropriated funds to administer and support the PSHBP, nor does it have a contingency plan to ensure continuity of operations for the PSHBP in the absence of securing funding. The Full-Year Continuing Appropriations and Extensions Act, 2025, ultimately did not include an anomaly of $24 million in administrative expenses for the purpose of implementing the PSHBP. At the time of reporting, OPM did not provide a

contingency plan to make up for this potential funding not being available.

Without this funding source, and with no funding contingency plan, the PSHBP faces an increased risk of failure. Specifically, if the CEP fails, 1.7 million Postal Service enrollees could potentially be unable to compare, select, and enroll in the PSHBP online. Additionally, the loss of the CEP will hinder OPM's intended future use of the system for the approximately 6.5 million federal employees, annuitants, and eligible family members enrolled in the FEHBP.

OPM agreed with the OIG that sustained funding is critical to long-term success of the PSHBP. Additional responses provided from OPM for the recommendations included narrative corrective actions and plans undertaken by OPM. No evidence was provided in the response to support these statements that they are working towards allocating both personnel and funds as necessary to ensure the PSHBP will operate as intended. Additionally, OPM noted that the OIG and OPM previously collaborated on a legislative proposal, the FEHB Protection Act of 2025 (H.R. 2193), which was cleared by the House Committee on Oversight and Government Reform in March 2025. This demonstrated congressional interest in establishing a centralized enrollment mechanism to reduce improper payments in the FEHBP and PSHBP. The proposal, however, was not incorporated into the enacted version of the FEHB Protection Act, Pub. L. 119–21, Title IX § 90101 (2025). We acknowledge that OPM has demonstrated an intent to engage in planning for a functional CEP, though further concrete steps are needed to translate this commitment into measurable outcomes, including a contingency plan in the short term.

Information Systems Audits

OPM manages a wide portfolio of information systems to help fulfill its mission. OPM systems and applications support retirement claims and multiple governmentwide human resources services. Private carriers participating in the FEHBP rely on information systems and applications to administer health benefits to millions of current and former federal employees and their dependents. And although the Defense Counterintelligence and Security Agency owns the background investigations program, OPM continues to provide support to the legacy background investigations systems.

The ever-increasing frequency and sophistication of cyberattacks on both the private and public sectors make the continual maturation and enhancement of cybersecurity programs a critical need for OPM and its contractors. Information technology audits identify the challenges in responding to the escalating threats to cybersecurity and provide tangible strategies and action plans to rectify and/or mitigate the challenges. The specific audits conducted each year are based on a risk assessment model that considers various factors, including the size of the carrier, the sensitivity of the information in the system, the time elapsed since the last audit, and our previous audit results.

Our audit universe encompasses all 55 OPM-owned information systems as well as the 64 information systems used by private sector entities that contract with OPM to process federal data.

We issued one information systems audit report and one flash report during the reporting period.

Audit of the Information Systems General and Application Controls at Excellus BlueCross BlueShield

June 30, 2025 | 2024-ISAG-020

Our information technology (IT) audit focused on the claims processing applications used to adjudicate FEHBP claims for Excellus BlueCross BlueShield members, as well as the various processes and IT systems used to support these applications. Our audit of Excellus's IT security controls determined, among other things, that Excellus conducts routine information security risk assessments, has implemented adequate access and environmental controls, and has sufficient policies and procedures to facilitate system backups.

We made one recommendation related to network security.

Flash Report for the Audit of the U.S. Office of Personnel Management's Government-Wide Email System

September 24, 2025 | 2025-ISAG-018

The primary objective of this report was to communicate our concerns regarding the OPM Office of the Chief Information Officer's (OCIO) rollout of the Government-Wide Email System (GWES). Other objectives of this audit were to determine how the GWES was developed and implemented, determine its impact on OPM's cybersecurity posture, and address congressional inquiries in accordance with applicable laws and regulations such as the Federal Information Security Modernization Act of 2014 (Public Law 113–283). While the audit is not complete, we became aware of issues that should be addressed promptly. This report does not represent the final conclusions of the audit. Our work will continue, and a final report, which may include further findings, will be issued at the conclusion of the audit. We found issues in the OCIO's rollout of the GWES, including the reintroduction of significant information security risks into OPM's control environment. Specifically, our audit identified the following:

- OPM senior management overrode established information technology security and privacy controls.
- OPM failed to establish protocols for handling sensitive data received through the GWES.

After our communication of these issues to the agency, the decision was made by OPM to decommission GWES. As part of our ongoing audit work, we will be reviewing the decommissioning process.

Internal Audits

Our internal audits focus on improving the efficiency and effectiveness of OPM's operations and their corresponding internal controls. We conduct comprehensive

performance audits and special reviews of OPM programs, operations, and contractors and conduct and oversee certain statutorily required projects for improper payments and charge card reporting. In addition, we oversee OPM's annual financial statement audit, perform risk assessments of OPM programs and operations, and work with program offices to resolve and close internal audit recommendations.

We issued one internal audit report during this reporting period.

Audit of OPM's Compliance with the Payment Integrity Information Act of 2019

May 23, 2025 | 2025-IAG-003

The Payment Integrity Information Act of 2019 (PIIA) aims to improve efforts to identify and reduce governmentwide improper payments. Agencies are required to identify and review all programs and activities they administer that may be susceptible to significant improper payments based on guidance provided by the Office of Management and Budget (OMB). OMB Circular A-123, Appendix C, Memorandum M-21-19, Requirements for Payment Integrity Improvement, dated March 5, 2021, includes guidance for agency programs with annual outlays over $10,000,000 for all program or activity payments reported. Two of OPM's earned benefit programs, Retirement Services and the FEHBP, met OMB's statutory threshold.

Payment integrity requirements are published with the agency's annual financial statement in accordance with payment integrity guidance in OMB Circular A-136. The agency must also publish any applicable payment integrity information in the materials which accompany the annual financial statements. The most common materials which accompany the annual financial statement are the payment integrity information published on paymentaccuracy.gov. Agency inspectors general are to review payment integrity reporting for compliance and issue an annual report.

The objective of this audit was to determine whether OPM complied with PIIA for fiscal year (FY) 2024. We determined that OPM was not in compliance with PIIA for FY 2024. OPM did not meet 4 of the 10 PIIA requirements for the FEHBP. Specifically, they did not do the following:

- publish improper payment and unknown payment estimates
- publish corrective action plans
- demonstrate improvements to payment integrity or reach a tolerable improper payment and unknown payment rate
- report an improper payment and unknown payment estimate of less than 10 percent

We could not determine whether Retirement Services created reclamations for five retired annuitants that received duplicate check payments, or chargebacks, in the amount of $17,522; and we were unable to verify data in Retirement Services' Centenarian Project master spreadsheet.

In addition, there are six outstanding audit findings from prior years' audits. One of the

recommendations involves Retirement Services' improper payments rate being virtually stagnant and has remained open since first identified in FY 2017.

Special Audits

In addition to health insurance and retirement programs, we audit various other benefit programs administered by OPM for federal employees, annuitants, and their eligible dependents. These include the Federal Employees' Group Life Insurance Program, Federal Flexible Spending Account Program, Federal Long Term Care Insurance Program, and Federal Employees Dental and Vision Insurance Program.

Our office also conducts audits of Pharmacy Benefit Managers (PBM) that administer pharmacy benefits for the FEHBP carriers. The objective of these audits is to ensure costs charged and services provided to federal subscribers are in accordance with the contracts and applicable federal regulations.

Our audits of the Combined Federal Campaign ensure monies donated by federal employees and annuitants are properly handled and disbursed to charities according to the designations of contributing employees and annuitants.

We did not issue any special audits during this reporting period.

Evaluation Activities

OIG evaluations provide an alternative method for conducting independent, credible, and thorough reviews of OPM's programs and operations to prevent waste, fraud, and abuse. Evaluations quickly analyze OPM concerns or issues that need immediate attention by using a variety of review methods and evaluation techniques and are completed in accordance with the Quality Standards for Inspection and Evaluation (known as the Blue Book), published by the Council of the Inspectors General on Integrity and Efficiency (CIGIE). Evaluation reports provide OPM management with findings and recommendations that assist in enhancing program operations, efficiency, effectiveness, and compliance with applicable policies and procedures.

We issued one evaluation report and one data brief during this reporting period.

Evaluation of the U.S. Office of Personnel Management's Oversight of Its Telework and Remote Work Programs

June 16, 2025 | 2024-OEI-001

We completed an evaluation of OPM's oversight of its telework and remote work program, which was initiated in response to a congressional request, dated August 28, 2023. The Telework Enhancement Act of 2010, Public Law 111–292 and 5 Code of Federal Regulations 531.605, established guidance related to telework and remote work across the federal government. OPM leveraged telework and remote work to meet its human capital needs and to improve mission delivery. As a result, we sought to assess whether OPM effectively oversees its telework and remote work programs.

The scope and corresponding results of our evaluation were based on telework and remote work–related data and activity during FY 2024 and did not include any policy or program changes that occurred starting in January 2025. During our evaluation we determined that OPM used a multilevel approach to perform its oversight of the telework and remote work programs consisting of supervisors, telework coordinators within program offices, and corporate-level oversight from OPM Human Resources (HR). However, there were opportunities for improving internal controls to strengthen OPM's oversight of these programs. Specifically, we found the following:

- 11 of the 37 (29.7 percent) teleworkers we sampled had lapsed telework agreements
- 6 of the 39 (15.4 percent) remote workers we sampled did not have an approved agreement on file
- 19 of the 90 (21.1 percent) discrepancies related to telework agreements identified by OPM HR and sent to program offices were unresolved by the end of a 4-month period
- 3 of the 37 (8.1 percent) employee timesheets we sampled were not

compliant with OPM's in-office telework policy, as the badging data did not support the minimum number of in-office days reported on timesheets for 18 of the 31 (58.1 percent) teleworkers sampled that reported in-office days

We made one recommendation to OPM HR to develop written procedures detailing their internal controls to ensure compliance with telework and remote work program requirements. OPM HR concurred with our recommendation and implemented corrective action to address our concerns. Based on our analysis of the corrective action taken, we consider the recommendation closed.

Evaluation of Top Federal Employees Health Benefits Program Medical Conditions by Premium Expenditure During Contract Years 2019 Through 2021

August 5, 2025 | 2023-CAAG-026

We evaluated the top medical and pharmacy categories on which the FEHBP spent the most from 2019 to 2021, using claims data from carriers covering about 77 percent of individuals enrolled in the FEHBP. Our analysis found that the highest costs were for cancer, endocrine/metabolic diseases, immunological agents, health status factors, musculoskeletal disorders, and circulatory system diseases. These categories significantly contributed to the $131 billion spent on medical care during this period.

Specifically, the spending breakdown is as follows:

- Cancer: $13.2 billion (10 percent of total spending)
- Endocrine/Metabolic Diseases: $11.8 billion (9 percent)
- Immunological Agents: $11.8 billion (9 percent)
- Factors Influencing Health Status: $11 billion (8 percent)
- Musculoskeletal Systems Disorders: $10.9 billion (8 percent)
- Diseases of the Circulatory System: $10.6 billion (8 percent)

In addition to sharing this information with our stakeholders via this data brief, we will also utilize the insights gleaned from our analysis to focus future evaluation efforts around the quality of care being afforded to FEHBP members and ensure that premium dollars are properly spent to provide that care.

Enforcement Activities

The OIG's criminal, civil, and administrative investigations provide oversight of OPM programs and operations. Through our work to protect the agency's health care and retirement operations, we protect public safety and taxpayer dollars.

Our health care investigations stop harmful or unscrupulous medical providers and companies that steal from or endanger the American people. Through our investigations and debarment actions, we pursue medical professionals who perform unnecessary procedures, do not provide the medical services they bill patients for, or otherwise cheat the health care system and the FEHBP. We prioritize investigations into large-dollar schemes or allegations of patient harm.

Our retirement investigations ensure that the benefits OPM pays through its retirement programs goes to the intended retired annuitants and survivor annuitants, not to fraudsters. Whether we end tens of thousands of dollars of improper payments going to an unentitled person or stop an elder abuse scheme that diverts money from the rightful annuitant, our work provides essential oversight of OPM programs and operations. These investigations resolve years of fraud, waste, or abuse.

We also conduct investigations into OPM personnel or contractors related to allegations of misconduct or fraud, waste, and abuse in OPM programs.

The oversight work described in this report is a subset of the vital enforcement activities the OIG conducts to ensure the integrity and safety of OPM programs and program participants. Unless the subject of an investigation has been convicted by a jury or pleaded guilty, they are considered innocent until proven guilty in a court of law; these narratives are allegations of wrongdoing based on our investigations.

Health Care Fraud Investigations

The OIG investigates health care fraud allegations that annually cost the American taxpayer hundreds of millions of dollars. Our investigations also pursue offenders who act dangerously and without the best interest of their patients in mind.

The OIG's nationwide investigative force conducts complex investigations into health care fraud that affects the FEHBP and PSHBP. Investigative analysts and forensic auditors analyze millions of health care claims and records related to our data-driven operations. Our criminal investigators conduct interviews, surveillance, and search and arrest warrants to protect OPM health care programs and its members. OIG staff are part of multiagency taskforces and other governmentwide law enforcement initiatives. With our partners in Offices of the U.S. Attorneys nationwide, our investigations bring to justice those who harm FEHBP members or the program.

The following are case summaries of our investigations that occurred during this reporting period.

Falsified Claims of Behavioral Analysis Treatment Leads to Guilty Plea

In November 2020, we received a case referral from a state law enforcement partner about an Applied Behavioral Analysis treatment center fraudulently billing for services performed by a board-certified behavioral analyst that were not performed by board-certified staff.

Our criminal investigators found notes falsified to claim that the board-certified behavioral analyst performed the services to increase reimbursement from the FEHBP carriers. Some session notes to support billing were prefilled or inaccurate. FEHBP carriers paid $66,851 in fraudulent claims.

In our interviews during the investigation, one source suggested that this fraud potentially negatively affected the patients treated at the center by delaying crucial early childhood interventions for children with autism or other developmental disorders.

On August 11, 2025, one individual pleaded guilty in the U.S. District Court for the District of Alaska to health care fraud. Sentencing in this case is pending.

Three Coconspirators Indicted for Alleged False Hearing Aid Scheme

In April 2018, we received information from a law enforcement partner about a provider who billed for digital hearing aids and sensorineural hearing loss when providing firearm hearing protection. The OIG has observed a trend and investigated similar fraud schemes, as we reported in previous semiannual reports.[3] On May 28, 2025, three coconspirators were indicted by a grand jury in the U.S. District Court for the Northern District of Texas on charges of conspiracy to commit health care fraud.

These individuals specifically marketed to federal law enforcement and claimed that they were selling hearing protection covered by insurance that was free or provided at no cost. To receive payment from insurance companies, the coconspirators submitted insurance claims for hearing aids. There was no medical necessity. Some (but not all) beneficiaries received cursory hearing screening, but none of the individuals indicted in this scheme had active licenses as hearing professionals.

Per the indictment, the coconspirators allegedly made a stamp of a hearing specialist's signature that they could use on patient records and appeal letters without the individual's knowledge. They sent these materially false and misleading patient records and documents to FEHBP carriers to receive reimbursement. This fraud continued even after at least one insurance

[3] Semiannual Report to Congress (OIG-SAR-67), September 2022, page 23, and Semiannual Report to Congress (OIG-SAR-69), September 2023, page 22.

plan put the provider on prepayment review.

The brazenness of the scheme is remarkable: the coconspirators in this case—based on alleged false information and half-truths—requested members of Congress write letters to OPM so that OPM would encourage the FEHBP carrier to approve and pay for claims submitted by the coconspirators.

In all, the FEHBP paid $834,154 for these claims.

The individuals were arrested in June 2025. Their court cases are pending. The OIG notes that these individuals are innocent until proven guilty in a court of law.

COVID-19 Fraud Investigations

The OIG forecasted in previous semiannual reports that fraudsters taking advantage of the COVID-19 pandemic for their own financial gain would target and harm the FEHBP. In this semiannual report, we summarize several investigations of schemes to defraud the government by misrepresenting services related to COVID-19 testing or treatment.

Illinois Individual Receives Added Time to Prison Sentence for COVID Testing Fraud

Multiple qui tam complaints alleged that a laboratory was double-billing COVID-19 tests to both the state of Illinois and private insurers, including FEHBP carriers. The laboratory also allegedly billed for services that were never performed.

FEHBP carriers paid $357,985 for the claims double billed to both the state and FEHBP carriers. However, when the laboratory was placed in a receivership in 2022, money was refunded to the state of Illinois. The FEHBP carriers were billed for the tests performed. FEHBP carriers also paid $6,336 for the health care services that were never performed.

In June 2024, a grand jury in the U.S. District Court for the Central District of Illinois indicted the laboratory owner on six counts of health care fraud, one count of mail fraud, and three counts of wire fraud.

On April 23, 2025, the laboratory owner pleaded guilty to one count of health care fraud and one count of wire fraud. He was sentenced by the court to an additional 37 months in prison—as he is already in prison for other offenses—and 36 months of probation after his release. In lieu of paying monetary restitution, the laboratory owner forfeited a luxury RV valued at $1 million.

OIG Participates in National Health Care Fraud Takedown: Operation Gold Rush

OIG criminal investigators participated in the 2025 National Health Care Fraud Takedown as part of Operation Gold Rush. This operation resulted in the largest loss amount ever charged in a health care fraud case brought by the DOJ.

Because of this scheme, the FEHBP paid $2.37 million to a medical group and related entities for COVID-19 tests that allegedly never occurred.

A criminal complaint was filed against two individuals in the U.S District Court for the Northern District of Illinois, charging them with money laundering and health care fraud. These two individuals were arrested at the airport before they could take one-way international flights, potentially fleeing beyond the reach of American law enforcement. Further events related to this case are upcoming. The OIG notes that these individuals are innocent until proven guilty in a court of law.

Two Individuals Arrested on 58 Counts of COVID-Related Health Care Fraud

In 2023, an FEHBP member complained to their insurance company that they were billed for COVID-19 testing services that never occurred. Our investigation found reasonable allegations that a laboratory misrepresented and overbilled the types of test kits it sent to members as well as sent and billed for unrequested test kits.

The OIG led this investigation in the U.S. District Court for the Southern District of New York until it merged with an ongoing multiagency investigation. In the scheme, the laboratory allegedly provided "no-cost" COVID-19 testing kits via mail but collected insurance information and submitted claims that were inflated using high-reimbursement procedural codes as if the tests were observed and performed in a laboratory. After successfully billing for a patient's first batch of tests, the laboratory would at intervals bill for more tests—without the knowledge or consent of the patient.

Between seven different FEHBP carriers, the program had paid this laboratory $1.21 million for claims related to COVID testing and other claims. Our criminal investigators helped prepare and issue more than 100 grand jury subpoenas as part of this investigation. We also conducted search warrants and other law enforcement operations related to this fraud.

On July 22, 2025, two individuals were indicted in the U.S. District Court for the Eastern District of Michigan on 58 counts of health care fraud and conspiracy to commit health care fraud.[4]

These two individuals were arrested in a multistate, multiagency operation in July 2025. One of the individuals is currently being held in prison because he is considered a flight risk by the court. Further events related to this case are forthcoming. The OIG notes that these individuals are innocent until proven guilty in a court of law.

Opioid Fraud Investigations

The opioid crisis is an ongoing Public Health Emergency. The OIG has reported successful investigations of doctors and health professionals who inappropriately prescribe opioids. In this report, we describe our investigative participation in one of the government's most significant civil

[4] Press Release, U.S. Department of Justice, CEO and Medical Director Charged in $500M COVID-19 Test Billing Fraud (July 31, 2025).

settlements with a nationwide pharmacy chain that wantonly filled opioid prescriptions despite patients' risks of addiction, harm, and overdose.

National Pharmacy Chain Settles Allegations of Violating the False Claims Act Related to Opioid Prescriptions

We received several allegations that a nationwide pharmacy chain knowingly violated the False Claims Act and the Controlled Substances Act. According to the allegations, the pharmacy dispensed or pressured its employees to fill and dispense opioid prescriptions that should have been rejected.

The allegations identified three general categories where the pharmacy chain should have refused to fill the risky or dangerous prescriptions but did not:

- prescriptions with high morphine milligram equivalent doses (a measurement of how strong the medication is)
- polypharmacy prescriptions for so-called "Holy Trinity" combinations (typically a short-acting opioid, a benzodiazepine, and a muscle relaxant)
- often/early refills for Schedule II prescription drugs

These types of prescriptions increased the risk of patients developing addictions and substance abuse disorders or overdosing.

Investigative analysis of FEHBP claims found approximately $8.2 million worth of claims paid by FEHBP carriers. This involved analyzing 30,000 plan codes associated with the global claims data set to find FEHBP carrier claims to determine the harm to the FEHBP. We also interviewed former pharmacists who attested to being pressured to fill questionable prescriptions.

On April 21, 2025, the pharmacy chain settled to resolve the allegations that it violated the False Claims Act and Controlled Substances Act. The pharmacy chain agreed to pay $300 million, including $150 million for the alleged violations of the False Claims Act. From that, the FEHBP received $5,060,722. Additionally, the FEHBP is set to receive an additional $818,150 based on a contingency payment in the settlement.

The Anti-Kickback Statute's Exclusion of the FEHBP

The Anti-Kickback Statute is one of the most important statutory tools the government uses to protect Americans from unscrupulous providers in the health care system. However, since the law's passage, OPM's health care programs have been explicitly excluded. This prevents the OPM OIG from using this law to protect the FEHBP and PSHBP.

The OIG has raised our concerns about how this exemption weakens the program administration of OPM and oversight by the OIG. OPM and the OIG will continue to work together to inform Congress of this vulnerability. In this semiannual report, we have one example of a case where we did not pursue investigative action because of the DOJ's determination that the allegations

focused on violations of the Anti-Kickback Statute.

OPM OIG Blocked from Joint Investigation Because of Anti-Kickback Statute Exclusion

In January 2025, we received a case notification from an FEHBP carrier after that carrier received a request for information related to an ongoing investigation. The request was related to a health care group that, according to our initial analysis, had billed the FEHBP for more than $16 million over the past 5 years. Our investigators learned from DOJ that the case was related to kickbacks and alleged violations of the Anti-Kickback Statute. Because we cannot pursue violations of the Anti-Kickback Statute, we closed our investigation and did not participate in the case with our federal law enforcement partners.

Retirement Fraud Investigations

The OIG investigates allegations of fraud, waste, and abuse affecting OPM's retirement programs. These programs (FERS and CSRS) are particularly vulnerable to annuity payments stolen after the death of a retired annuitant or survivor annuitant.

Many of our investigations into retirement cases reveal annuities stolen or paid improperly for years. Our cooperative efforts with OPM Retirement Services are important to ending these schemes. We receive referrals from the agency or develop proactive leads and conduct investigations to find ongoing waste, fraud, or abuse. Our criminal investigators analyze retirement files and bank information, evaluate potentially forged documents, and untangle identity theft plots as part of our oversight of the programs.

Seven Years of Improper Annuity Payments Recovered from Bank

In November 2024, the Retirement Services Fraud Unit provided us an investigative lead when one of their Centenarian Project letters, addressed to a survivor annuitant, resulted in the receipt of a death certificate copy. The individual, who was both an annuitant and survivor annuitant, had died in April 2017.

OPM paid $142,878 in survivor annuity payments until September 2024—more than 7 years after the annuitant's death. Their bank returned $12,789 through the reclamation process.

Our investigation initially focused on the children of the decedent and suspicious financial transactions made from the bank accounts. Our criminal investigator reviewed the details of eight different financial accounts and multiple transfers and transactions used to potentially conceal the original source of funds. This led to our identification of the decedent's annuity for their federal service in addition to the survivor annuity under investigation.

We contacted OPM's Fraud Branch regarding the multiple annuities. An error by OPM Retirement Services when adjudicating the survivor annuity had allowed the payments to continue and resulted in the overpayment.

Multiple interviews with the child of the decedent and further investigation, including the use of grand jury subpoenas, revealed that the death was reported to OPM and the bank that received the annuity payments knew the survivor annuitant had died. The bank did not notify the government as required under title 31 Code of Federal Regulations part 210.10(a), which requires a financial institution to immediately notify the relevant agency if it learns of the death of an annuitant.

On June 16, 2025, the U.S. Treasury performed a debit action and transferred $130,088 to OPM. Based on the cooperative efforts of OIG investigators and the Retirement Services Fraud Branch, OPM recovered the entire overpayment.

Administrative Sanctions of FEHBP Health Care Providers

Under the FEHBP administrative sanctions authority (5 U.S.C. § 8902a), we suspend or debar health care providers whose actions demonstrate insufficient professional responsibility to participate in the FEHBP. At the end of the reporting period, there were a total of 40,352 active suspensions and debarments which prevented health care providers from participating in the FEHBP.

Debarment disqualifies a health care provider from receiving payment of FEHBP funds for a stated time period. The FEHBP has 18 bases for debarment. The most frequently cited provisions are for criminal convictions or professional licensure restrictions/revocations. Before debarring a provider, our office gives the provider notice and the opportunity to contest the sanction in an administrative proceeding.

Suspension has the same effect as a debarment, but it becomes effective upon issuance without prior notice and remains in effect for a limited time. The FEHBP sanctions law authorizes suspension only in cases where adequate evidence indicates that a provider represents an immediate risk to the health and safety of FEHBP enrollees.

During the reporting period, we issued 498 administrative sanctions (including both suspensions and debarments) of health care providers who committed violations impacting the FEHBP and its enrollees. In addition, we addressed 1,936 sanctions-related inquiries and correspondence.

We develop our administrative sanctions caseload from a variety of sources, including the following:

- administrative actions issued against health care providers by other federal agencies
- cases referred by the OIG Office of Investigations
- cases identified by the OIG Administrative Sanctions Group through systematic research and analysis of electronically available information about health care providers
- referrals from other sources, including FEHBP carriers, state regulatory entities, and federal law enforcement agencies

Administrative sanctions serve two important functions. First, they protect the financial integrity of the FEHBP. Second,

they protect the health and safety of federal employees and annuitants and their eligible family members who obtain their health insurance coverage through the FEHBP.

The following cases handled during the reporting period highlight the importance of our proactive work.

Debarment of Two Pennsylvania Medical Practices Owned/Controlled by Debarred Physician

In July 2019, our office debarred a Pennsylvania physician based on his exclusion by the U.S. Department of Health and Human Services (HHS) for a felony-controlled substance abuse conviction, which carries a minimum 5-year exclusion period. His OPM debarment runs concurrently with the term of his HHS exclusion. As of September 2025, the OPM debarment and HHS exclusion remain in effect.

In August 2024, the BCBSA notified us that they received a prescription claim from an FEHBP enrollee written by a debarred provider. An investigation revealed that the pharmacy incorrectly listed the debarred physician as the prescribing provider, causing his name to appear in BCBSA's claims data. Based on the initial report that the debarred provider submitted a prescription claim, research was conducted into the entities affiliated with the debarred physician. The investigation revealed that the debarred physician was the principal and vice president of two medical practices.

Under 5 U.S.C. § 8902a(c)(2)(d), the OPM has the authority to debar an entity that is owned or controlled by a sanctioned provider. Additionally, 5 CFR § 890.1011(b) provides the OPM authority to debar an entity that is owned or controlled by an individual who is currently debarred, suspended, or otherwise excluded from any procurement or non-procurement activity. The OPM regulations at 5 CFR § 890.1003 define "control" as the direct or indirect ownership of 5 percent or more of an entity, or serving as an officer, director, agent, or an employee of an entity.

The debarred physician's actions and affiliation with the medical practices posed a risk to both FEHBP enrollees and the financial integrity of the program. Therefore, in July 2025, we issued notices proposing the debarment of the two practices. The debarments of the medical practices went into effect September 2025 and will coincide with the debarment terms of the debarred physician.

Debarment of a Florida Medical Practice Owned or Controlled by Debarred Physician

In July 2023, our office debarred a Florida physician based on his exclusion by HHS for a felony health care fraud conviction, which carries a minimum 5-year exclusion period. His debarment runs concurrently with the term of his HHS exclusion. As of September 2025, the OPM debarment and HHS exclusion remain in effect.

The physician, along with three other parties, conspired to defraud health care benefit programs such as Medicare, Medicaid, and the FEHBP. The physician and

co-conspirators received substantial sums of money by submitting fraudulent claims for payment for prescriptions to PBMs, who paid the claims on behalf of the health care programs. The physician was convicted on one count of conspiracy to commit health care fraud and sentenced to 14 years imprisonment, to be followed by 3 years of supervised probation.

Information obtained by our office revealed that the debarred physician owned or controlled a medical practice. The debarred physician's actions and affiliation with the medical practice posed a risk to FEHBP enrollees and the financial integrity of the program. Therefore, in March 2025, we issued a notice proposing the debarment of the medical practice.

The debarment of the medical practice took effect in April 2025 and will coincide with the debarment terms of the debarred physician.

Statistical Summary of Enforcement Activities

Investigative Actions and Recoveries

Indictments and Criminal Informations	18
Arrests	13
Convictions	6
Criminal Complaints/Pre-Trial Diversion	4
Subjects Presented for Prosecution	22
Federal Venue	22
Criminal	17
Civil	5
Dollars Submitted by FEHBP Carriers as Potential Fraud, Waste, or Abuse	$601,093,155
Dollars Presented to the U.S. Department of Justice	$3,446,551,999
Expected Recovery Amount to OPM Programs	$6,278,819
Civil Judgments and Settlements	$6,016,941
Criminal Judgements and Restitution	$131,790
Administrative Recoveries	$130,088
Expected Recovery Amount for All Programs and Victims[5]	$355,569,642

Investigative Administrative Actions

FY 2025 Investigative Reports Issued[6]	174
Issued between April 1, 2025, and September 30, 2025	55
Whistleblower Retaliation Allegations Substantiated	0
Cases Referred for Suspension and Debarment	0
Personnel Suspensions, Terminations, or Resignations	0
Referrals to the OIG Office of Audits	0
Referrals to an OPM Program Office	1

[5] Expected Recovery Amount for All Programs and Victims is the amount of criminal fines/penalties and civil judgments/settlements returned not to OPM, but to the general fund of the Treasury. It also includes asset forfeitures, court assessments, and/or fees resulting from criminal investigations conducted by our office. Many of these criminal investigations were conducted jointly with other Federal agencies who share credit for the fines, penalties, assessments, and forfeitures.

[6] The total number of investigative reports issued during the reporting period includes reports of investigations and summative investigative reports.

Administrative Sanctions Activities

FEHBP Debarments and Suspensions Issued	498
FEHBP Provider Debarment and Suspension Inquiries	1,936
FEHBP Debarments and Suspensions in Effect at the End of the Reporting Period	40,352

Table 1: Enforcement Activities

	OPM Healthcare & Insurance Office	OPM Retirement Services Office	Other OPM Program Offices	External/ Internal Matters	Total
Cases Opened					
Investigations[7]	9	1	0	0	10
Preliminary Investigations[8]	18	2	0	0	20
FEHBP Carrier Notifications/Program Office	748	4	0	0	752
Complaints – All Other Sources/Proactive[9]	199	6	0	12	217
Cases Closed					
Investigations	40	5	0	2	47
Preliminary Investigations	10	1	0	2	13
FEHBP Carrier Notifications/ Program Office	181	5	0	0	186
Complaints – All Other Sources/Proactive	127	1	0	4	132
Cases In Progress[10]					
Investigations	90	13	3	0	106
Preliminary Investigations	22	4	2	0	28
FEHBP Carrier Notifications/ Program Office	754	6	0	0	760
Complaints – All Other Sources/Proactive	84	6	0	14	104

[7] This includes preliminary investigations from this reporting period and previous reporting periods converted to investigations during this reporting period.
[8] This includes complaints or carrier notifications from this reporting period and previous reporting periods converted to preliminary investigations during this reporting period.
[9] This excludes allegations received via the OIG Hotline, which are reported separately in this report.
[10] Cases in progress may have been opened in a previous reporting period.

OIG Hotline Complaint Activities

OIG Hotline Complaints Received	**1,753**
Sources of OIG Hotline Cases Received	
Website	1,158
Telephone	362
Letter	148
Email	84
In-Person	1
OPM Program Office	
Healthcare and Insurance	364
Customer Service	55
Health Care Fraud, Waste, and Abuse Complaint	152
Other Health Care and Insurance Issues	157
Retirement Services	550
Customer Service	121
Retirement Fraud, Waste, and Abuse Complaint	92
Other Retirement Services Issue	337
Other OPM Program Offices/Internal Matter	26
Customer Service	7
Other OPM Program Fraud, Waste, and Abuse Complaint	2
Other OPM Program Issue[11]	17
External Agency Issue (Unrelated to OPM)	771
Unknown	42
OIG Hotline Cases Reviewed and Closed/Converted[12]	**2,256**
Outcome of OIG Hotline Complaints Closed	
Referred to External Agency	10
Referred to OPM Program Office	242
Retirement Services	46
Healthcare and Insurance	121
Other OPM Programs/Internal Matter	75
Referred to FEHBP Carrier	113

[11] During this reporting period, the OPM OIG received many hotline contacts about Administration initiatives such as the Deferred Resignation Program. The OPM OIG evaluated these hotline contacts based on their relevancy to OPM programs and operations.

[12] Includes hotline cases that may have been received in a previous reporting period.

No Further Action	1,891
Converted to Case	0

OIG Hotline Complaints Pending[13]	**224**
By OPM Program Office	
Healthcare and Insurance	40
Retirement Services	169
Other OPM Program Offices/Internal Matters	10
External Agency Issue (unrelated to OPM)	5

[13] Includes hotline cases pending an OIG internal review or an agency response to a referral.

Legal and Legislative Activities

Under the Inspector General Act of 1978, as amended (5 U.S.C. §§ 401–424), OIGs are required to obtain legal advice from a counsel reporting directly to an inspector general (IG). This reporting relationship ensures that the OIG receives independent and objective legal advice. The OIG Office of Legal and Legislative Affairs (OLLA) discharges this statutory responsibility in several ways, including by providing advice to the IG and OIG office components on a variety of legal issues, tracking and commenting on legislative matters affecting the work of the OIG, and advancing legislative proposals that address waste, fraud, and abuse against and within OPM programs.

During this reporting period, OLLA advised the Deputy IG Performing the Duties of the IG and other OIG components on many legal and regulatory matters. OLLA also evaluated and provided comments to Congress and the CIGIE Legislation Committee on proposed and draft legislation related to OPM and the OIG's programs and operations.

Congressional Engagements

OLLA coordinated 23 congressional engagements since our last semiannual report. In collaboration with other OIG components, we provided information and facilitated meetings to address specific congressional requests and inquiries that covered a range of topics, including OPM and OIG workforce capacity and reductions, telework, whistleblower protections, and constituent requests. We also organized bipartisan briefings with congressional staff to discuss the status or results of ongoing OIG oversight.

In addition, we reengaged with staff from the House Committee on Oversight and Government Reform on the FEHB Protection Act of 2025, legislation which includes reforms intended to promote accountability, reduce improper payments, and increase efficiency in the FEHBP.[14] We also shared technical assistance with the Senate Committee on Homeland Security and Governmental Affairs staff and expressed the OIG's support for adopting legislative language for the bill as included in the House-passed reconciliation package.[15]

Enhancing the Integrity of OPM's Health Benefits Programs Through Modernization and Oversight

As noted above, the OIG has continued to engage with congressional stakeholders in both the House and Senate on the FEHB Protection Act of 2025. The bill, as introduced, required OPM to conduct an audit of covered family members as well as

[14] H.R. 2193 – 119th Congress (2025-2026): FEHB Protection Act of 2025 (Ordered to be reported as amended by the House Committee on Oversight and Government Reform Mar. 25, 2025).
[15] H.R. 1 – 119th Congress (2025-2026): One Big Beautiful Bill Act § 90004 (Engrossed in House May 22, 2025).

implement processes to verify family member eligibility and disenroll those found to be ineligible for FEHB coverage.

The bill also included a legislative proposal that OPM and the OIG jointly presented to congressional stakeholders in the last congressional session. This proposal would enable access to funding for OPM to modernize PSHBP and FEHBP enrollment processes and for the OIG to conduct program oversight. Based on our technical assistance, the House Committee on Oversight and Government Reform also incorporated provisions for records retention and investigative referrals into a version of the bill that was included in the House-passed reconciliation package. However, neither our technical assistance nor the joint OPM/OIG legislative proposal was included in the reconciliation package that was passed by the Senate and ultimately signed into law by the President.[16]

Overall, the OIG applauds the passage of the FEHB Improvements provisions in the final reconciliation bill (Pub. L. No. 119-21) that aim to bolster the integrity of the FEHBP by requiring OPM to review family member eligibility in the program and develop processes for ongoing eligibility verification and disenrollment of ineligible members. The OIG has previously reported that member eligibility self-certification without a verification process could expose the program to significant overcharges and contribute to an estimated $3 billion-dollar loss annually.[17] Verifying ineligible members and ultimately disenrolling them from the program is a crucial step towards addressing this longstanding OIG concern.

However, the decentralized nature of FEHBP enrollment remains unaddressed. This is the underlying issue that has allowed member ineligibility to persist in the program. For several years, through various reports and engagements with congressional staff, the OIG has emphasized that centralized enrollment is critical to reducing and preventing ineligible members in the FEHBP. OPM has developed a CEP for the PSHBP as part of its implementation of the new health benefits program. As highlighted in a recent OIG report, the ongoing operation of that functionality and its proposed expansion to the FEHBP is in jeopardy without adequate, consistent funding.[18]

The FEHB Protection Act of 2025, cleared by the House Committee on Oversight and Government Reform in March 2025 (H.R. 2193), included provisions that would allow access to a capped amount of mandatory funding from the Employees Health Benefits Fund for OPM to maintain a centralized enrollment system that it developed for the PSHBP and eventually expand it to the broader FEHBP. The bill also included

[16] Pub. L. No. 119-21, July 4, 2025.
[17] Final Audit Report, Audit of the U.S. Office of Personnel Management's Administration of Federal Employee Insurance Programs (4A-HI-00-19-007), October 30, 2020.
[18] Flash Report, The U.S. Office of Personnel Management's Postal Service Health Benefits Program: Critical Resource Issues (2025-PSHB-091), July 2, 2025.

resources to conduct real-time oversight of OPM's efforts, ensuring effective and efficient development and implementation of the system. While funding was not included in the version of the legislation enacted in July 2025 (Pub. L. 119–21, Title IX § 90101), the OIG continues to support consideration of this proposal to invest in OPM's enrollment modernization and independent OIG oversight. Centralized enrollment, together with OIG oversight, is essential to preventing fraud and improper payments, strengthening accountability, and improving long-term efficiency in the FEHBP.

Appendix I-A: Final Reports Issued With Questioned Costs for OPM Insurance Programs

Subject	Number of Reports	Questioned Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	15	$292,031,550
B. Reports issued during the reporting period with questioned costs	3	$70,490,820
Subtotals (A+B)	18	$362,522,370
C. Reports for which a management decision was made during the reporting period	5	$30,264,030
1. Net disallowed costs	N/A	$14,610,708
Disallowed costs during the reporting period	N/A	$14,927,429[1]
Less: costs originally disallowed but subsequently allowed during the reporting period	N/A	$316,721[2]
2. Net allowed costs	N/A	$15,653,322
Allowed costs during the reporting period	N/A	$15,336,601[3]
Plus: costs originally disallowed but subsequently allowed during the reporting period	N/A	$316,721[2]
D. Reports for which no management decision has been made by the end of the reporting period	13	$332,258,340
E. Reports for which no management decision has been made within 6 months of issuance	11	$273,945,352

[1] Represents the management decision to support questioned costs and establish a receivable during the reporting period.
[2] Represents questioned costs which were determined by management to be allowable charges per the contract, subsequent to an initial management decision to disallow and establish a receivable.
[3] Represents questioned costs (overpayments) which management allowed and for which no receivable was established. This figure also includes the allowance of underpayments to be returned to the carrier.

Appendix I-B: Final Reports Issued With Questioned Costs for All Other Audited Entities

Subject	Number of Reports	Questioned Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	0	$0
B. Reports issued during the reporting period with questioned costs	0	$0
Subtotals (A+B)	0	$0
C. Reports for which a management decision was made during the reporting period	0	$0
1. Net disallowed costs	N/A	$0
2. Net allowed costs	N/A	$0
D. Reports for which no management decision has been made by the end of the reporting period	0	$0
E. Reports for which no management decision has been made within 6 months of issuance	0	$0

Appendix II: Resolution of Questioned Costs in Final Reports for OPM Insurance Programs

Subject	Questioned Costs
A. Value of open recommendations at the beginning of the reporting period	$292,031,550
B. Value of new audit recommendations issued during the reporting period	$70,490,820
Subtotals (A+B)	$362,522,370
C. Amounts recovered during the reporting period	$14,610,708
D. Amounts allowed during the reporting period	$15,653,322
E. Other adjustments	$0
Subtotals (C+D+E)	$30,264,030
F. Value of open recommendations at the end of the reporting period	$332,258,340

Appendix III: Final Reports Issued With Recommendations for Better Use of Funds

Subject	Number of Reports	Questioned Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	0	$0
B. Reports issued during the reporting period with questioned better use of funds amounts	0	$0
Subtotals (A+B)	0	$0
C. Reports for which a management decision was made during the reporting period	0	$0
D. Reports for which no management decision has been made by the end of the reporting period	0	$0
E. Reports for which no management decision has been made within 6 months of issuance	0	$0

Appendix IV: Reports Issued

Report Number	Subject	Date Issued	Questioned Costs
2025-IAG-003	The U.S. Office of Personnel Management's Compliance with the Payment Integrity Information Act of 2019 for Fiscal Year 2024 in Washington, D.C.	May 23, 2025	—
2024-OEI-001	Evaluation of the U.S. Office of Personnel Management's Oversight of Its Telework and Remote Work Programs in Washington, D.C.	June 16, 2025	—
2024-ISAG-020	Information Systems General and Application Controls at Excellus BlueCross BlueShield in Rochester, New York	June 30, 2025	—
2025-PSHB-091	U.S. Office of Personnel Management's Postal Service Health Benefits Program: Critical Resource Issues in Washington, D.C.	July 2, 2025	—
2023-CAAG-026	Evaluation of Top Federal Employees Health Benefits Program Medical Conditions by Premium Expenditure During Contract Years 2019 Through 2021 in Washington, D.C.	August 5, 2025	—
2024-CAAG-023	Claims Processing and Payment Operations as Administered by Horizon Blue Cross and Blue Shield of New Jersey for Contract Years 2021 Through 2023 in Newark, New Jersey	September 9, 2025	$124,606
2025-ERAG-004	Blue Cross and Blue Shield of Alabama in Birmingham, Alabama	September 15, 2025	$580,794
2024-ERAG-003	Anthem Blue Cross and Blue Shield in Mason, Ohio	September 18, 2025	$69,785,420
2025-ISAG-018	U.S. Office of Personnel Management's Government-Wide Email System in Washington, D.C.	September 24, 2025	—
		TOTAL	$70,490,820

Appendix V: Priority Open Recommendations

The OPM OIG identifies its three highest priority open recommendations on Oversight.gov. These priority recommendations merit special attention from OPM leadership because their implementation could significantly improve program management and payment integrity. All three of our current priority recommendations focus on strengthening the FEHBP to reduce costs and provide better services to federal employees and their families.

Report Number	Subject	Date Issued	Rec #	Recommendation
2022-SAG-029	Audit of the American Postal Workers Union Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc., for Contract Years 2016 through 2021	March 29, 2024	3	We recommend that OPM's Contracting Officer require the PBM and Carrier to return $12,484,472 to the FEHBP for its portion of retail pharmacy pricing discounts not received from the PBM for CYs 2016 through 2021.
1C-59-00-20-043	Audit of the Federal Employees Health Benefits Program Operations at Kaiser Foundation Health Plan, Inc.	August 16, 2022	1	We recommend that OPM revise or replace the FEHBP MLR requirements to provide a reliable measure of the premium dollars spent on the FEHBP program, including the impact of carrier corporate structure and the current community-rated product market.
4A-HI-00-18-026	FEHB Program Integrity Risks Due to Contractual Vulnerabilities	April 1, 2021	7	We recommend that OPM modify Section 2.3(g) and 2.3(g)(ii) to provide expectations for how carriers are to proactively identify overpayments and to define what it means by egregious errors.

Appendix VI: Summary of Reports More Than 6 Months Old Pending Corrective Action

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total Issued
4A-CF-00-08-025	The U.S. Office of Personnel Management's Fiscal Year 2008 Consolidated Financial Statements in Washington, D.C.	November 14, 2008	1	0	6
4A-CF-00-09-037	The U.S. Office of Personnel Management's Fiscal Year 2009 Consolidated Financial Statements in Washington, D.C.	November 13, 2009	1	0	5
4A-CF-00-10-015	The U.S. Office of Personnel Management's Fiscal Year 2010 Consolidated Financial Statements in Washington, D.C.	November 10, 2010	2	0	7
4A-CF-00-11-050	The U.S. Office of Personnel Management's Fiscal Year 2011 Consolidated Financial Statements in Washington, D.C.	November 14, 2011	1	0	7
4A-CF-00-12-039	The U.S. Office of Personnel Management's Fiscal Year 2012 Consolidated Financial Statements in Washington, D.C.	November 15, 2012	1	0	3
4A-CF-00-13-034	The U.S. Office of Personnel Management's Fiscal Year 2013 Consolidated Financial Statements in Washington, D.C.	December 13, 2013	1	0	1
4A-CF-00-14-039	The U.S. Office of Personnel Management's Fiscal Year 2014 Consolidated Financial Statements in Washington, D.C.	November 10, 2014	2	0	4

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total Issued
4A-CF-00-15-027	The U.S. Office of Personnel Management's Fiscal Year 2015 Consolidated Financial Statements in Washington, D.C.	November 13, 2015	2	0	5
4A-CF-00-16-030	The U.S. Office of Personnel Management's Fiscal Year 2016 Consolidated Financial Statements in Washington, D.C.	November 14, 2016	7	0	19
4A-CF-00-17-028	The U.S. Office of Personnel Management's Fiscal Year 2017 Consolidated Financial Statements in Washington, D.C.	November 13, 2017	9	0	18
L-2018-1	Management Advisory Report - Review of the U.S. Office of Personnel Management's Non-Public Decision to Prospectively and Retroactively Re-Apportion Annuity Supplements in Washington, D.C.	February 5, 2018	3	0	3
4A-CF-00-18-012	The U.S. Office of Personnel Management's Fiscal Year 2017 Improper Payments Reporting in Washington, D.C.	May 10, 2018	1	0	2
4A-CF-00-18-024	The U.S. Office of Personnel Management's Fiscal Year 2018 Consolidated Financial Statements in Washington, D.C.	November 15, 2018	9	0	23
4A-CI-00-18-037	The U.S. Office of Personnel Management's Compliance with the Federal Information Technology Acquisition Reform Act in Washington, D.C.	April 25, 2019	1	0	5

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total Issued
4A-CF-00-19-012	The U.S. Office of Personnel Management's Fiscal Year 2018 Improper Payments Reporting in Washington, D.C.	June 3, 2019	1	0	4
4A-CI-00-19-008	The U.S. Office of Personnel Management's Compliance with the Data Center Optimization Initiative in Washington, D.C.	October 23, 2019	3	0	23
4A-CF-00-19-022	The U.S. Office of Personnel Management's Fiscal Year 2019 Consolidated Financial Statements in Washington, D.C.	November 18, 2019	9	0	20
1H-01-00-18-039	Management Advisory Report - Federal Employees Health Benefits Program Prescription Drug Benefit Costs in Washington, D.C.	February 27, 2020 Reissued March 31, 2020	0	1	2
4A-RS-00-18-035	The U.S. Office of Personnel Management's Federal Employees Health Benefits Program and Retirement Services Improper Payments Rate Methodologies in Washington, D.C.	April 2, 2020	3	3	12
4A-CF-00-20-014	The U.S. Office of Personnel Management's Fiscal Year 2019 Improper Payments Reporting in Washington, D.C.	May 14, 2020	1	0	3
1H-07-00-19-017	CareFirst BlueChoice's Federal Employees Health Benefits Program Pharmacy Operations as Administered by CVS Caremark for Contract Years 2014 through 2017 in Scottsdale, Arizona	July 20, 2020	3	0	8

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total Issued
4A-HI-00-19-007	The U.S. Office of Personnel Management's Administration of Federal Employee Insurance Programs in Washington, D.C.	October 30, 2020	5	1	24
4A-RS-00-19-038	The U.S. Office of Personnel Management's Retirement Services Disability Process in Washington, D.C.	October 30, 2020	0	5	8
4A-CF-00-20-024	The U.S. Office of Personnel Management's Fiscal Year 2020 Consolidated Financial Statements in Washington, D.C.	November 13, 2020	9	0	21
4A-HI-00-18-026	Management Advisory Report - FEHB Program Integrity Risks Due to Contractual Vulnerabilities in Washington, D.C.	April 1, 2021	11	0	11
4A-CF-00-21-008	The U.S. Office of Personnel Management's Fiscal Year 2020 Improper Payments Reporting in Washington, D.C.	May 17, 2021	1	0	4
1H-99-00-20-016	Reasonableness of Selected FEHBP Carriers' Pharmacy Benefit Contracts in Washington, D.C.	July 29, 2021	2	0	3
4A-CF-00-21-027	The U.S. Office of Personnel Management's Fiscal Year 2021 Consolidated Financial Statements in Washington, D.C.	November 12, 2021	9	0	20
1A-10-17-21-018	Health Care Service Corporation for Contract Years 2018 through 2020 in Chicago, Illinois	February 23, 2022 Reissued March 16, 2022	0	4	18

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total Issued
2022-IAG-002	The U.S. Office of Personnel Management's Compliance with the Payment Integrity Information Act of 2019 in Washington, D.C.	June 23, 2022	1	0	6
1C-59-00-20-043	Kaiser Foundation Health Plan, Inc., in Oakland, California	August 16, 2022	0	1	16
1A-10-15-21-023	BlueCross BlueShield of Tennessee in Chattanooga, Tennessee	August 25, 2022	1	0	11
2022-IAG-003	The U.S. Office of Personnel Management's Fiscal Year 2022 Consolidated Financial Statements in Washington, D.C.	November 14, 2022	9	0	15
2022-CRAG-0010	The Federal Employees Health Benefits Program Termination Process at Health Plan of Nevada, Inc., in Las Vegas, Nevada	February 15, 2023	3	1	20
1H-08-00-21-015	Group Health Incorporated's Federal Employees Health Benefits Program Pharmacy Operations as Administered by Express Scripts, Inc., for Contract Years 2015 through 2019 in St. Louis, Missouri	February 16, 2023	10	0	12
2022-CAAG-0023	Claims Processing and Payment Operations at Blue Cross and Blue Shield of North Carolina for Contract Years 2018 through 2020 in Durham, North Carolina	March 3, 2023	1	0	5
2022-CAAG-0014	Evaluation of COVID-19's Impact on FEHBP Telehealth Services and Utilization in Washington, D.C.	March 6, 2023	3	2	5

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total Issued
2023-IAG-002	The U.S. Office of Personnel Management's Compliance with the Payment Integrity Information Act of 2019 in Washington, D.C.	May 22, 2023	1	0	2
2022-IAG-0019	The U.S. Office of Personnel Management's Retirement Services' Settlement Process in Washington, D.C.	June 15, 2023	0	2	5
2022-CAAG-035	Claims Processed in Accordance with the Omnibus Budget Reconciliation Acts of 1990 and 1993 at All Blue Cross and Blue Shield Plans for Contract Years 2019 through 2021 in Washington, D.C.	June 27, 2023	6	2	11
2023-CAAG-001	Claims Processing and Payment Operations at Select Anthem Blue Cross and Blue Shield Plan Sites for Contract Years 2019 through 2021 in Washington, D.C.	November 6, 2023	1	0	7
2023-IAG-017	The U.S. Office of Personnel Management's Fiscal Year 2023 Consolidated Financial Statements in Washington, D.C.	November 13, 2023	8	0	15
2023-OEI-001	Evaluation of the U.S. Office of Personnel Management's Processing of Initial Retirement Claim Applications in Washington, D.C.	November 15, 2023	1	2	5
2022-CAAG-001	The Office of Personnel Management's Disputed Claims Process for years 2018 through 2020 in Washington, D.C.	December 20, 2023	15	0	15

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total Issued
2023-CAAG-009	Claims Processing and Payment Operations at all Blue Cross and Blue Shield Plans as Related to Provider Network Status for Contract Years 2019 through 2021 in Washington, D.C.	February 15, 2024	1	0	3
2022-SAG-029	American Postal Workers Union Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc., for Contract Years 2016 through 2021 in Glenn Burnie, Maryland	March 29, 2024	7	0	17
2024-IAG-010	The U.S. Office of Personnel Management's Compliance with the Payment Integrity Information Act of 2019 in Washington, D.C.	May 29, 2024	1	1	5
2024-CRAG-006	Final Audit Research Results: OPM's Subscription Income Process in Washington, D.C.	June 17, 2024	3	0	3
2023-ISAG-024	Information Systems General and Application Controls at Group Health Cooperative of South Central Wisconsin in Madison, Wisconsin	July 15, 2024	0	2	16
2024-ISAG-009	Information Technology Security Controls of the U.S. Office of Personnel Management's White House Fellows System in Washington, D.C.	August 8, 2024	1	0	1
2023-OEI-002	Evaluation of the U.S. Office of Personnel Management's Property Management Process in Washington, D.C.	August 28, 2024	0	3	3

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total Issued
PSHB-088	The U.S. Office of Personnel Management's Implementation of the Postal Service Health Benefits Program: Collection of Members' Eligibility Documentation in Washington, D.C.	September 13, 2024	3	0	3
2024-ISAG-008	Federal Information Security Modernization Act Audit - Fiscal Year 2024 in Washington, D.C.	October 30, 2024	2	0	4
2023-SAG-019	Compass Rose Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc., for Contract Years 2017 through 2022 in St. Louis, Missouri	November 14, 2024	9	0	11
2024-IAG-017	The U.S. Office of Personnel Management's Fiscal Year 2024 Consolidated Financial Statements in Washington, D.C.	November 15, 2024	4	0	4
2023-IAG-021	The U.S. Office of Personnel Management's Audit Resolution Process Group in Washington, D.C.	November 26, 2024	8	1	18
2024-ERAG-002	Florida Blue in Jacksonville, Florida	January 8, 2025	3	0	22
2024-ERAG-004	HMO Missouri, Inc., in Mason, Ohio	March 25, 2025	1	0	8
		TOTAL	201	31	557

[1] As defined in OMB Circular No. A-50, a recommendation is considered "resolved" when the audit organization and agency management have agreed on the action to be taken on reported findings and recommendations, regardless of whether corrective action has been implemented. Outstanding and unimplemented (open) recommendations listed in this appendix that have not yet been resolved are not in compliance with the OMB Circular No. A-50 requirement that recommendations be resolved within 6 months after the issuance of a final report.

Appendix VII: Most Recent Peer Review Results

We do not have any open recommendations to report from our peer reviews.

Subject	Date of Report	Result
System Review Report on the U.S. Office of Personnel Management Office of the Inspector General Audit Organization (Issued by the Office of Inspector General, U.S. Department of Labor)	September 4, 2024	Pass[1]
System Review Report on the U.S. Department of State Office of Inspector General Audit Organization (Issued by the Office of the Inspector General, U.S. Office of Personnel Management)	January 30, 2025	Pass
External Quality Assessment Review of the Office of the Inspector General for the U.S. Office of Personnel Management Investigative Operations (Issued by the Tennessee Valley Authority Office of the Inspector General)	January 19, 2023	Compliant[2]
Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the U.S. Railroad Retirement Board (Issued by the Office of the Inspector General, U.S. Office of Personnel Management)	March 28, 2024	Compliant
External Peer Review Report for the U.S. Office of Personnel Management Office of the Inspector General (Issued by the U.S. National Science Foundation Office of Inspector General)	September 16, 2025	Pass
External Peer Review Report on the Office of the Inspector General for the Library of Congress (Issued by the Office of the Inspector General, U.S. Office of Personnel Management)	July 22, 2021	Compliant[3]

[1] A peer review rating of pass is issued when the reviewing OIG concludes that the system of quality control for the reviewed OIG has been suitably designed and complied with to provide the audit organization with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. The Peer Review does not contain any deficiencies or significant deficiencies.
[2] A rating of compliant conveys that the reviewed OIG has adequate internal safeguards and management procedures to ensure that the Council of the Inspectors General on Integrity and Efficiency standards are followed and that law enforcement powers conferred by the 2002 amendments to the IG Act are properly exercised.
[3] A rating of compliant conveys that the reviewed OIG has adequate internal safeguards and management procedures to ensure that the Council of the Inspectors General on Integrity and Efficiency standards for inspections and evaluations are followed.

Appendix VIII: Investigative Recoveries

Investigative Recovery Area	Sum of Total Recovery Amount	Sum of OPM Recovery Net
Administrative Action	$130,088	$130,088
Retirement Services	$130,088	$130,088
CSRS & FERS	$130,088	$130,088
Administrative Debt Recovery	$130,088	$130,088
Civil Action	$352,819,102	$6,016,941
Healthcare and Insurance	$352,819,102	$6,016,941
FEHBP	$352,819,102	$6,016,941
Retirement Services	$0	$0
CSRS & FERS	$0	$0
Criminal Action	$2,620,452	$131,790
Healthcare and Insurance	$2,620,452	$131,790
FEHBP	$2,620,452	$131,790
Retirement Services	$0	$0
CSRS & FERS	$0	$0
TOTAL (Administrative + Civil + Criminal Actions)	$355,569,642	$6,278,819

Reporting Requirements in the Inspector General Act of 1978, As Amended

Requirement	Location
Review of legislation and regulations	Legal and Legislative Activities
Significant problems, abuses, and deficiencies as well as the associated reports and recommendations for corrective action	Audit Activities, Evaluation Activities
Recommendations made before the reporting period, for which corrective action has not been completed	Appendix VI
Significant investigations closed during the reporting period	Statistical Summary of Enforcement Activities
Number of convictions closed during the reporting period resulting from investigations	Statistical Summary of Enforcement Activities
Audit, inspection and evaluation reports issued during the reporting period, including information regarding the value of questioned costs and recommendations for funds put to better use	Appendix IV
Management decisions made during the reporting period with respect to audits, inspections, and evaluations issued during a previous reporting period	Summary of Reports More Than 6 Months Old Pending Corrective Action
Reportable information under section 804(b) of the Federal Financial Management Improvement Act of 1996	Information Systems Audits, Internal Audits
Information pertaining to peer review by other OIGs	Most Recent Peer Review Results
Statistical tables showing the number of investigative reports issued, persons referred for criminal prosecution, and indictments and criminal informations during the reporting period	Statistical Summary of Enforcement Activities, OIG Hotline Complaint Activity, Investigative Recoveries
Metrics used for developing the data for the table showing investigative reports, persons referred for criminal prosecution, and indictments and criminal informations	Statistical Summary of Enforcement Activities, OIG Hotline Complaint Activity
Reports on investigations involving substantiated misconduct by senior government employees or officials	No activity
Descriptions of whistleblower retaliation, including implicated individuals and any consequences imposed	No activity
Agency attempts to interfere with OIG independence	No activity
Closed investigations, audits, and evaluations not disclosed to the public	Statistical Summary of Enforcement Activities, OIG Hotline Complaint Activity
Closed investigations involving senior government employees, not disclosed to the public	No activity

See James M. Inhofe National Defense Authorization Act for Fiscal Year 2023, H.R. 7776, 117th Cong. § 5273 (2022).

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