



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

Final Audit Report

**Audit of the Federal Employees
Dental and Vision Insurance Program Operations
As Administered by Aetna Dental
For Contract Years 2010 through 2013**

**Report Number 1J-0D-00-15-037
February 16, 2016**

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EXECUTIVE SUMMARY

Audit of the Federal Employees Dental and Vision Insurance Program Operations as Administered by Aetna Dental

Report No. 1J-0D-00-15-037

February 16, 2016

Why Did We Conduct the Audit?

The main objective of the audit was to determine if the costs charged and services provided to the Federal Employees Dental and Vision Insurance Program members were in accordance with the terms of Contract Number OPM-06-00060-1 and Federal regulations.

What Did We Audit?

The Office of the Inspector General has completed a performance audit that included a review of Aetna Dental's (Plan) annual accounting statements, claims processing, fraud and abuse program, and rate proposals for contract years 2010 through 2013. Our audit was conducted from May 4 through 8, 2015, at the Plan's offices in Blue Bell, Pennsylvania. Additional audit work was completed at our offices in Washington, D.C. and Cranberry Township, Pennsylvania.

What Did We Find?

We determined that the Plan needs to strengthen its procedures and controls related to the coordination of benefits and preparing the annual rate proposals.

Specifically, our audit identified two areas requiring improvement.

1. The Plan did not properly coordinate the payment of benefits for 4 out of 102 claims that we reviewed from contract year 2013.
2. The Plan misreported numerous pricing assumptions in its 2010 through 2013 premium rate proposals.



Michael R. Esser
*Assistant Inspector General
for Audits*

ABBREVIATIONS

ACT	Federal Employee Dental and Vision Benefits Enhancement Act of 2004
CBS	Claim Benefit Specialist
COB	Coordination of Benefits
Contract	Contract OPM-06-00060-1
CY	Contract Year
EOB	Explanation of Benefits
FEDVIP	Federal Employees Dental and Vision Insurance Program
FEHBP	Federal Employees Health Benefits Program
FOIA	Freedom of Information Act
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
Plan	Aetna Dental

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I. BACKGROUND

This report details the results of our audit of the Federal Employees Dental and Vision Insurance Program (FEDVIP) operations as administered by Aetna Dental (Plan) for contract years (CY) 2010 through 2013. The audit was performed by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as authorized by the Inspector General Act of 1978, as amended.

The FEDVIP was created on December 23, 2004 by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004 (Act). The Act provided for the establishment of programs under which supplemental dental and vision benefits are made available to Federal employees, retirees, and their dependents.

OPM has overall responsibility to maintain the FEDVIP website, act as a liaison and facilitate the promotion of the FEDVIP through Federal agencies, be responsive on a timely basis to the carriers' requests for information and assistance, and perform functions typically associated with insurance commissions such as the review and approval of rates, forms, and education materials.

OPM's Contracting Office contracts with Aetna Life Insurance Company to provide dental coverage to Federal beneficiaries enrolled in the Aetna Plan under the FEDVIP. The Plan's responsibilities under Contract Number OPM-06-00060-1 (Contract) are carried out at its offices located in Blue Bell, Pennsylvania. Section I.11 of the Contract includes a provision, Inspection of Services – Fixed Price, which allows for audits of the program's operations. It is the responsibility of the Plan's management to establish and maintain a system of internal controls and comply with applicable FEDVIP laws and regulations.

This was the OIG's first audit of the Plan. The initial results of this audit were discussed with Plan officials during an exit conference on June 24, 2015. A draft report was provided to the Plan on August 28, 2015 for its review and comment. The Plan's response to the draft report was considered in preparation of this final report and is included as an Appendix.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

Objective

The main objective of the audit was to determine if the costs charged and services provided to the FEDVIP members were in accordance with the terms of the Contract and Federal regulations.

Specifically, our audit objectives were:

Annual Accounting Statement Review

- To determine if the Plan's 2010 through 2013 Annual Accounting Statements were accurately reported to OPM.

Claims Processing Review

- To determine if the Plan paid claims in accordance with the terms of the Contract, its annual benefit brochures, and its internal policies and procedures.
- To determine if the Plan recovered claim overpayments in accordance with the terms of the Contract, its annual benefit brochures, and its internal policies and procedures.

Fraud and Abuse Review

- To determine if the Plan's fraud and abuse program is sufficient and if potential fraud cases are being reported to OPM.

Rate Proposal Review

- To determine if the Plan accurately developed its 2010 through 2013 premium rates.

Scope and Methodology

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

This performance audit included reviews of the Plan's annual accounting statements, claims processing, fraud and abuse program, and rate proposals for CYs 2010 through 2013. The audit fieldwork was conducted at the Plan's office in Blue Bell, Pennsylvania, from May 4 through 8, 2015. Additional audit work was completed at our Cranberry Township, Pennsylvania and Washington, D.C. offices.

The Plan reported the following premium income earned, claims incurred, expenses paid, and profit received for CYs 2010 through 2013:

Contract Year	Earned Premiums	Claims Incurred	Expenses	Profit
2010				
2011				
2012				
2013				
Total				

In planning and conducting the audit, we obtained an understanding of the Plan’s internal control structure to help determine the nature, timing, and extent of our auditing procedures. This was determined to be the most effective approach to select areas of audit. For those areas selected, we primarily relied on substantive tests of transactions and not tests of controls. Additionally, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Plan’s system of internal controls taken as a whole.

We also conducted tests of accounting records and other auditing procedures as we considered necessary to determine compliance with the Contract and 5 CFR 894. Exceptions noted in the areas reviewed are set forth in the “Audit Findings and Recommendations” section of this report. With respect to the items not tested, nothing came to our attention that caused us to believe that the Plan had not complied, in all material respects, with those provisions.

In conducting the audit, we relied to varying degrees on computer-generated data provided by the Plan. Due to the time constraints, we did not verify the reliability of the data generated by the various information systems involved. However, while utilizing the computer-generated data during our audit, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

To determine whether the costs charged and services provided to the FEDVIP members were in accordance with the terms of the Contract and Federal regulations, we performed the following audit steps:

Annual Accounting Statement Review

- We traced the data reported by the Plan in its 2010 through 2013 Annual Accounting Statements back to supporting documentation and identified any material variances.

Claims Processing Review

- For CY 2013, we reviewed all 52 paid dental claims over \$2,000 and selected an additional random sample of 50 claims (totaling 102 claims for \$117,619 out of a universe of 694,839 claims totaling \$96,251,934¹) to ensure that they were properly supported and accurately processed.
- From the same universe of CY 2013 claims, we selected all negative claim amounts over \$700 (for a total of 25 claim recoveries in the amount of \$22,815) to determine if the overpayments were accurately identified and credited back to the FEDVIP.

Fraud and Abuse Review

- We met with the Plan's Special Investigations Unit to gain an understanding of its fraud and abuse program, and we traced the information reported in the Plan's 2013 Fraud and Abuse Savings Data Report back to supporting documentation to identify any material variances and ensure that potential fraud cases were being reported to OPM.

Rate Proposal Review

- We traced the data used to develop the Plan's 2010 through 2013 annual rate proposals back to supporting documentation and identified any material variances.

The samples mentioned above, that were selected and reviewed in performing the audit, were not statistically based. Consequently, the results could not be projected to the universe since it is unlikely that the results are representative of the universe taken as a whole.

¹ Actual paid claims differ from what was reported in the annual accounting statement due to retroactive claim adjustments.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. ANNUAL ACCOUNTING STATEMENT REVIEW

The results of our review showed that the Plan had sufficient policies and procedures in place to ensure that its annual accounting statements reported to OPM were accurate.

B. CLAIMS PROCESSING REVIEW

1. Coordination of Benefits (COB) Errors

Procedural

The Plan did not properly coordinate the payment of benefits for 4 out of 102 claims that we reviewed from CY 2013.

Section C(II) of the Contract states, “Carriers under the new dental and vision program will be secondary payors and will be responsible for coordination of benefits with Federal Employees Health Benefits Program [FEHBP] plans, which will provide primary benefits.”

Additionally, section C(III)(M) of the Contract states, “OPM expects plans that are chosen to participate in the Federal Employees Dental and Vision Insurance Program [FEDVIP] to provide coverage at the point of service. The plans, not the enrollees, should be responsible for coordinating benefits with the primary payor.”

For CY 2013, we reviewed a sample of 102 dental claims to determine if the Plan paid the claims in accordance with the terms of the Contract, its annual benefit brochures, and its

We identified a four percent error rate among the claims tested for COB accuracy.

policies and procedures. As part of our review, we tested the effectiveness of the Plan’s internal controls related to the COB to determine whether claims requiring COB were processed in compliance with the terms of the Contract.

Our review identified four claims with the following COB errors:

- Two claims were not processed for COB because the Plan did not coordinate benefits with the affected members’ FEHBP plans, specifically the Foreign Service Benefit Plan and the Compass Rose Health Plan. The Plan stated that it only coordinates benefits with Blue Cross and Blue Shield, Rural Carriers, and Mail Handlers. COB for all other FEHBP plans are bypassed unless there is a valid explanation of benefits (EOB) attached to the claim.

- One claim requiring COB was not recognized by the claims system or forwarded to a claims specialist due to a system error. The Plan reported that the error came from BENEFEDS not identifying the member's primary FEHBP plan, but our records from BENEFEDS did show the member's primary FEHBP plan as Blue Cross and Blue Shield.
- One claim's COB was miscalculated by a claims specialist. The Plan stated that the error was due to a delay by the member's primary FEHBP plan in updating to a new procedure code and allowable benefit. An adjustment to this claim was made after we identified the error during our audit.

While the claim overpayments in our sample were immaterial, the errors show that there are weaknesses in the claims system related to COB that need to be corrected to help reduce improper claim payments.

Recommendation 1

We recommend that the contracting officer require the Plan to amend its existing policies and procedures to ensure that it processes COB for **all** FEHBP plans. Dental benefits provided by FEHBP plans are published in annual plan brochures found on OPM's website. The Plan should review these brochures on an annual basis to identify which plans and benefits require COB and program its claims system accordingly.

Recommendation 2

We recommend that the contracting officer require the Plan to review its claims system to determine the cause of the system error that failed to identify a claim requiring manual COB processing, and take corrective action to resolve this issue.

Recommendation 3

We recommend that the contracting officer direct the Plan to perform a review of its paid claims on a routine basis (i.e., monthly, quarterly, and/or annually) to verify the accuracy of its COB processing. The Plan's methodology for selecting claims to review should include consideration of those claims most likely to require COB (e.g., basic Class A services that include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.). The results of these reviews should be shared with OPM to identify error rates, causes of errors, performance improvements, and agreed-upon solutions to resolve problems.

Plan's Response:

The Plan agrees with the errors identified in this finding and will have its claim benefit specialists complete refresher training. Its current COB process relies on the provider or BENEFEDS to identify the member's primary insurance carrier. Its claim benefit specialists also attempt two calls to the provider to identify the member's primary insurance. If primary coverage is not identified then it pays the claim as the primary carrier.

Although Aetna did not provide justification for why it's not coordinating benefits with the Foreign Service Benefit Plan and the Compass Rose Health Plan, it did insist that BENEFEDS failed to identify the member's primary insurance coverage, which we considered a system error as listed in the second bullet above. It also stated that it has a Stratified Quality Audit Program that reviews a sample of claims every quarter.

OIG Comments:

As shown in this finding, the Plan's current COB workflow falls short of identifying all FEHBP plans that offer dental benefits. Relying on BENEFEDS or the provider to identify the member's primary insurance coverage is only one small component of coordinating benefits with other carriers. The Plan should establish policies and procedures that ensure all COB is pursued by identifying **all** FEHBP plans that have dental benefits and coordinating each member's claim according to their FEHBP dental benefit.

For the claims system error that failed to identify the member's primary coverage, we again point out that the file we received from BENEFEDS showed that member's primary coverage, which lead us to the finding. The Plan's claim that BENEFEDS did not identify the member's primary coverage is insufficient, and it should continue to review its claims system to identify the error that failed to process COB for this member.

Regarding the Plan's Stratified Quality Audit Program, we did not test or verify this program, but our own limited review showed a four percent error rate for COB. Based on our results, the Plan needs to perform additional reviews that focus on the accuracy of COB as stated in recommendation 3.

C. FRAUD AND ABUSE REVIEW

The results of our review showed that the Plan had sufficient policies and procedures in place to ensure that its fraud and abuse oversight activities and results reported to OPM were accurate.

D. RATE PROPOSAL REVIEW

1. Misreported Premium Rates

Procedural

The Plan misreported numerous pricing assumptions in its 2010 through 2013 premium rate proposals.

Section I.6(d)(1) of the Contract states, “The Carrier shall submit ... proposed premiums for the next succeeding period, and ... An estimate and breakdown of the costs for dental and vision coverage in a format on which the parties may agree; ... Sufficient data to support the accuracy and reliability of this estimate; [and] ... An explanation of the differences between this estimate and the original (or last preceding) estimate for the same insurance coverage”

Section I.6(e) of the Contract states, “Upon the Contracting Officer’s receipt of the data required by ... [the] above, the Contracting Officer and the carrier will promptly negotiate to redetermine fair and reasonable premiums for insurance coverage to be provided in the period following the effective date of price redetermination.”

Additionally, Section L.14.3.1 of the Contract states, “The proposed premium shall include all costs associated with providing dental and or vision insurance services, including adjudicating claims and reimbursing providers or enrollees. The premium shall include all associated administrative costs, including but not limited to beneficiary and enrollee services, communications and education, network building and provider services, appeals, program integrity, OPM administrative fee, and all other costs.”

Finally, Section L.14.3.2 of the Contract states, “The proposed biweekly premium shall be based on the required benefit ... and the offeror’s actuarial assumptions underlying its development”

As part of the FEDVIP, OPM invites dental carriers to renegotiate their premium rates annually by submitting rate proposals to justify changes in costs and benefits. These rate proposals are used by OPM as the basis for negotiation and for collecting data to assist in its oversight of the FEDVIP.

For each year of our scope, we redeveloped the Plan’s premium rates to determine if accurate pricing assumptions were used based on supporting documentation. During our review, we identified six errors in the rate development process and two instances in which the Plan lacked documentation to support actuarial assumptions.

Rate Development Errors

- The Plan used the wrong annual trend in its 2010 through 2013 rate proposals;
- The Plan did not use a consistent methodology to calculate additional administrative fees in its 2010 through 2013 rate proposals;
- The Plan used the wrong benefit adjustment factor in its 2013 rate proposal;
- The Plan used the wrong standard administrative fee² in its 2013 rate proposal;
- The Plan did not apply a six percent credit for unallowable expenses in its 2010 rate proposal; and
- The Plan applied the wrong 2009 benefit change factor in its 2010 rate proposal.

These rate development errors had both positive and negative effects on the rates. The Plan stated that the first three bulleted items were strategic changes implemented to maintain competitive rates by using lower pricing assumptions and the last three bulleted items were errors as a result of oversight.

Lack of Documentation to Support Pricing Assumptions

- The Plan did not provide sufficient and appropriate documentation to support its decision to provide a six percent credit for unallowable expenses in its 2010 through 2013 rate proposals; and
- The Plan did not provide sufficient and appropriate documentation to support its decision to load three percent to its standard administrative expenses in its 2010 through 2012 rate proposals.

The Plan proposed premium rates using inaccurate and unsupported pricing information.

The Plan stated that the six percent credit for unallowable expenses was the result of a study it performed on its FEHBP operations in 2004, which we considered outdated and irrelevant to FEDVIP operations. The Plan also stated that it was unsure why it applied a three percent loading to standard administrative expenses as this assumption was not supported by any internal documentation.

While completing our review, we determined that the net effect of the rating errors and unsupported pricing assumptions did not amount to an overcharge of premium for 2010 through 2013 since the Plan provided a greater competitive discount each year.

² The Plan incorporates two administrative expense loadings in developing its premium rates: 1) A standard administrative fee charged to all of its commercial dental insurance lines of business based on enrollment and 2) An additional administrative fee for FEDVIP specific charges.

Regardless, we determined that there is a risk that enrollees may be overcharged in future years by the Plan as it changes its pricing strategies and assumptions over time without correcting rate development errors and unsupported pricing assumptions. Additionally, there is a risk that OPM is relying on the Plan's misreported pricing assumptions during its annual negotiations with the Plan, and it's likely incorporating erroneous data provided by the Plan in its administration of the FEDVIP.

Recommendation 4

We recommend that the contracting officer require the Plan to implement policies and procedures to ensure that its premium rate proposal development and reporting processes are sufficiently and adequately documented. The Plan's policies and procedures should clearly document requirements for using accurate data, maintaining supporting documentation, and supervisory review before submission to OPM.

Plan's Response:

The Plan agrees with our finding and recommendation.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Special Audits Group

[REDACTED], Auditor-In-Charge

[REDACTED], Auditor

[REDACTED], Auditor

[REDACTED], Group Chief (former), [REDACTED]

[REDACTED], Group Chief, [REDACTED]

[REDACTED], Senior Team Leader

aetna

980 Jolly Road
Blue Bell, PA 19422

[REDACTED]
Executive Director
FEHBP Underwriting
Tel: [REDACTED]
Email: [REDACTED]@aetna.com

October 6, 2015

[REDACTED]
Group Chief, Special Audits Group
U.S. Office of Personnel Management
Office of the Inspector General
800 Cranberry Woods Drive, Suite 270
Cranberry Township, PA 16066

Re: FEDVIP Aetna Dental Audit
Contract Number OPM-06-00060-1
Report No.1J-0D-00-15-037

Dear [REDACTED]:

Thank you for the opportunity to respond to the draft audit report dated August 28, 2015. After careful review of the draft report, we agree with all of the draft report's findings pertaining to Aetna's Federal Employees Dental and Vision Insurance Program (FEDVIP). In the attached response, we will address each finding and recommendation in more detail.

Please let me know if you have any questions.

Sincerely,

[REDACTED]

[REDACTED]
Executive Director

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Claims Processing Review

1. Coordination of Benefits Errors

Aetna agrees that 4 of the 102 claims that were reviewed from contract year 2013 were not coordinated properly. We have responded to OIG's recommendations using the specific claims samples in question (samples 65, 80, 82 and 90).

Recommendation 1: We recommend that the contracting officer direct the Plan to amend its existing policies and procedures to ensure that it processes COB for all FEHBP plans.

Samples 80 & 82: Aetna agrees to the COB procedural error. Aetna's COB workflow instructs the claim benefit specialists (CBS) first attempt two calls to the provider to inquire if a copy of the primary carrier EOB can be sent to Aetna in order to coordinate benefits as the secondary carrier. If after the second attempt Aetna is unable to obtain the copy of the primary carrier's EOB, then Aetna must act as the primary carrier when processing the claim. Aetna's EOB includes a remark stating we will reconsider the claim as the secondary carrier upon receipt of the primary carrier's explanation of benefits.

All FEDVIP claim benefit specialists will complete refresher training on the FEDVIP COB workflow and procedures.

Recommendation 2: We recommend that the contracting officer direct the Plan to test its claims system to determine the cause of the system error that failed to identify a claim requiring manual COB processing and implement corrective action to resolve this issue.

Sample 65: Aetna agrees that this claim was not paid correctly due to a system error that did not identify primary FEHBP coverage.

When primary FEHBP coverage is reported, the member's file is updated accordingly, allowing the claim system to identify claims that require manual COB processing and directs those claims to a CBS for manual COB intervention. When BENEFEDS does not report that there is primary coverage under an FEHBP plan, then the appropriate coding is not added under the FEDVIP member's plan that would indicate COB is required. Thus, the FEDVIP plan pays as the primary carrier.

All FEDVIP claim benefit specialists will complete refresher training on the FEDVIP COB workflow and procedures.

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Recommendation 3: We recommend that the contracting officer direct the Plan to perform a review of its paid claims on a routine basis (i.e. monthly, quarterly, and/or annually) to verify the accuracy of its COB processing. The Plan's methodology for selecting claims to review should include consideration of those claims most likely to require COB (e.g. procedure codes for Class A services). The results of these reviews should be shared with OPM to identify error rates, causes of errors, performance improvements, and agreed-upon solutions to resolve problems.

Aetna Response: Aetna is open to discussion with FEDVIP regarding the accuracy of the COB claim processing.

Aetna's stratified quality audit program includes all claims processed, including COB claims. Any claim considered is eligible for audit.

Stratified Quality Audit: Using an industry accepted, statistically valid stratified audit methodology, populations of processed claims are segregated into dollar categories (strata) based upon the amount paid. A sampling of 300 claims quarterly (100 claims monthly) is randomly selected from within 7 strata (including a zero pay). Results are extrapolated over the respective populations based upon the weight of each strata relative to the given populations. Sampling levels are such that an industry acceptable typical precision level of + 1% is achieved.

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Rate Proposal Review

1. Misreported Premium Rates

Aetna agrees that there were misreported pricing assumptions in the 2010 through 2013 premium rate proposals.

Recommendation 4: We recommend that OPM direct the Plan to implement policies and procedures to ensure that its premium rate proposal development and reporting processes are sufficiently and adequately documented. The Plan's policies and procedures should clearly

document requirements for using accurate data, maintaining supporting documentation, and supervisor review before submission to OPM.

Aetna Response: The Plan agrees to implement a more efficient system for documenting specific pricing guidelines and to improve the supervisory review prior to submitting to OPM going forward.

Specifically regarding the credit for unallowable expenses, the Plan will conduct a high level analysis of Aetna Inc.'s corporate general and administrative expenses to determine what is allowable in accordance with FAR -- Part 31 Contract Cost Principles and Procedures. An appropriate unallowable expense percentage will be determined using this analysis.

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