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

Data Brief

Downward Trends in FEHBP Members' Use of Preventive Care Services Caused by the COVID-19 Pandemic

Report Number 1K-99-00-20-046
Original Issue Date: December 21, 2020
Corrected Report Issue Date: January 6, 2021

Errata page

The U.S. Office of Personnel Management
Office of the Inspector General
Office of Audits

Data Brief on the Downward Trends in FEHBP Members' Use of Preventive Care Services Caused by the COVID-19 Pandemic

On page 17 we incorrectly cited that there were 80 fee-for-service carrier contracts within the Federal Employees Health Benefits Program (FEHBP). It was brought to our attention that the 80 carrier contracts include both fee-for-service and community-rated contracts.

Our original text on page 17 was as follows: "While the carriers selected for this analysis represent a large share of the FEHBP population, they are only 2 of the more than 80 fee-for-service carrier contracts in the FEHBP."

The page 17 text was changed to read: "While the carriers selected for this analysis represent a large share of the FEHBP population, they are only 2 of the more than 80 carrier contracts in the FEHBP."

The corrections made to the paragraph on page 17 do not alter the recommendations made in the final data brief.

EXECUTIVE SUMMARY

Downward Trends in FEHBP Members' Use of Preventive Care Services Caused by the COVID-19 Pandemic

Report No. 1K-99-00-20-046 **January 6, 2021**

Key Takeaways

- Federal Employees Health Benefit Program (FEHBP) members' utilization of preventive care services has significantly decreased during the COVID-19 pandemic.
  - Annual Wellness Visits fell 18.6%
  - Colonoscopies fell 32.2%
  - Mammograms fell 23.8%
  - Pediatric Immunizations fell 16.2%
  - Prostate Exams fell 16.8%
  - Women's Preventive Exams fell 36.2%

- This significant decrease in preventive care services could have potential cost and participant health ramifications for the program should these trends not recover in the coming months.

Purpose of this Data Brief:

In this Data Brief, we present concerns with downward trends related to preventive care services utilized by a selected section of FEHBP participants during the Coronavirus Disease 2019 (COVID-19) pandemic. Specifically, this brief focuses on claims incurred and paid during the period of January through August of 2020 and compares this data to the same time period in 2019.

The Data Brief offers the U.S. Office of Personnel Management (OPM) and the FEHBP participating health insurance carriers insight into how COVID-19 is impacting a large portion of the FEHBP population and will, hopefully, encourage discussions regarding actions that may need to be considered to offset the potential impact to the program and its members.

Our objective was to analyze trends in the health insurance claims data for the FEHBP over time throughout the COVID-19 pandemic.

Michael R. Esser
Assistant Inspector General for Audits

ABBREVIATIONS

CDC	**Centers for Disease Control and Prevention**
COVID-19	**Coronavirus Disease 2019**
CPT	**Current Procedural Terminology**
DTaP	**Diphtheria, Tetanus, and Pertussis**
FEHBP	**Federal Employees Health Benefits Program**
HepA	**Hepatitis A**
HepB	**Hepatitis B**
Hib	**Haemophilus influenzae type B**
HPV	**Human Papillomavirus**
JAMA	**Journal of the American Medical Association**
MMR	**Measles, Mumps, and Rubella**
MMRV	**Measles, Mumps, Rubella, and Varicella**
OPM	**U.S. Office of Personnel Management**
STI	**Sexually Transmitted Infection**
TDaP	**Tetanus, Diphtheria, and Pertussis**

TABLE OF CONTENTS

I. BACKGROUND

Use of preventive care benefits has been proven to avert unnecessary illnesses and diseases and has helped to mitigate health care costs. For example, a 2014 article by the Centers for Disease Control and Prevention (CDC) reported, "Among…children born during 1994-2013, routine childhood immunizations were estimated to prevent 322 million illnesses (averaging 4.1 illnesses per child) and 21 million hospitalizations (0.27 per child) over the course of their lifetimes." These vaccinations also averted an estimated 732,000 premature deaths from vaccine-preventable illnesses.[1] Additionally, the U.S. Department of Health and Human Services estimates that childhood immunizations save 33,000 lives and result in a total estimated cost savings of $43.3 billion each year.[2] Similar benefits can also be attained for other types of preventive care.

As the largest employer-sponsored group health insurance program in the world, with over 8 million enrollees, the FEHBP provides coverage for a wide range of preventive care services, at no cost share for the enrollee, for both adults (22 years of age and over) and children (under 22 years of age). Preventive services for adults include physical/well visits, colonoscopies, Prostate Specific Antigen tests, screening mammograms, cervical exams, and Sexually Transmitted Infection (STI) screenings, among others. Some of the preventive services covered for children include healthy newborn visits and screenings, hearing and vision screenings, STI screenings, and cervical exams. The program also covers a wide array of vaccinations for both adults and children, including:

- Hepatitis A and B
- Varicella
- Human Papillomavirus (HPV)
- Influenza
- Measles, Mumps, and Rubella (MMR)
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, and Pertussis (TDaP)

In addition, Shingles is covered for adults only, while Haemophilus influenzae type B (Hib), Poliovirus, and Rotavirus are covered for children only. The following table shows the utilization of mammograms, prostate exams, and childhood immunizations by FEHBP members and their total cost to the program during contract years (January 1 – December 31) 2017 through 2019.

[1] Whitney CG, Zhou F, Singleton J, et al. Benefits from Immunization During the Vaccines for Children Program Era – United States, 1994-2013 --- April 25, 2014. Weekly; 63(16):352-355, https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6316a4.htm.

[2] Office of Disease Prevention and Promotion, Immunization and Infectious Disease, https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases.

Table 1: FEHBP Preventive Care Utilization 2017-2019 [3]

Year	Mammograms	Prostate Exams	Childhood Immunizations	Total Cost to the Program
2017	763,392	51,795	1,147,357	$190,548,987
2018	771,547	52,859	1,123,411	$198,041,311
2019	782,622	49,346	1,141,306	$212,355,452

As evidenced by the above chart, FEHBP members understand the importance of these benefits and are taking advantage of them.

[3] The figures in this chart include only the two carriers selected for this evaluation and do not encompass the entire FEHBP.

II. SCOPE AND METHODOLOGY

SCOPE

On a monthly basis, we receive health insurance claims data from several FEHBP carriers. For the purposes of this Data Brief, data from two of the larger fee-for-service carriers was determined to be most reliable. The below table shows the total people enrolled, the number of claims incurred, and the total cost to the program for each of these carriers during contract years 2017 to 2019 and through August 31, 2020.

Table 2: Plan #1 Participation in the FEHBP from 2017-2020

Year	Number of Individuals Enrolled	Total Number of Claims Incurred	Cost to Program
2017	5,407,958	219,827,226	$24,028,377,511
2018	5,362,263	223,697,771	$25,321,931,916
2019	5,432,782	226,877,813	$26,773,014,419
2020*	5,522,559	125,510,716	$15,334,389,207

Table 3: Plan #2 Participation in the FEHBP from 2017-2020

Year	Number of Individuals Enrolled	Total Number of Claims Incurred	Cost to Program
2017	677,369	23,650,445	$1,031,762,244
2018	710,986	25,211,606	$1,117,805,707
2019	709,810	24,939,552	$1,149,080,192
2020*	714,436	13,246,470	$627,153,505

We also selected the time period of January 1, 2017, to August 31, 2020, for analysis purposes. Using this timeframe allowed us to see utilization patterns for a three-year time period and allowed us to compare these patterns to the utilization we observed during the pandemic. Based on our initial analysis of preventive care trends during the January 1, 2017, through the December 31, 2019, time period, we established that the calendar year 2019 claims data could be used as a baseline to compare against the utilization patterns identified in the January 1st through August 31, 2020, claims data. The figures on the following pages outline the results of these comparisons.

* The 2020 data for claims incurred and costs in Tables 2&3 only covers the period from January 1st through August 31, 2020.

METHODOLOGY

We conducted this evaluation in accordance with the 2012 Quality Standards for Inspection and Evaluation, also known as the Council of the Inspectors General on Integrity and Efficiency (CIGIE) Blue Book.

For the purposes of this brief, our claims universe was comprised of claims from the following preventive care services.

- Annual Wellness Exams
- Colonoscopies
- Routine (Non-Diagnostic) Mammograms
- Pediatric Vaccines
- Prostate Exams
- Women's Preventive Exams

All claims for the above preventive care services between January 1, 2017, and August 31, 2020, (by date the service was incurred) were selected using the Current Procedural Terminology (CPT) codes in the table below.

Table 4: Current Procedural Terminology Codes used in Data Queries

Procedure Type	Procedure Subtype	CPT Code(s) Used
Annual Wellness Exams		99381-99387
Colonoscopies		45378-45382, 45384-45387, 45388-45393, 45398, G0105, G0121
Mammograms		77067, G0202
Pediatric Vaccines	Diphtheria, Tetanus, and Pertussis	90696-90698, 90700, 90702, 90723
	Hepatitis A	90633
	Hepatitis B	90740, 90743-90744, 90746-90747
	Hib	90647-90648
	Human Papillomavirus	90651
	Measles, Mumps, and Rubella	90707
	Measles, Mumps, Rubella, and Varicella	90710
	Meningococcal	90619-90621, 90734
	Pneumococcal	90670, 90732
	Poliovirus	90713
	Rotavirus	90680-90681
	Tetanus, Diphtheria, and Pertussis	90714-90715
	Varicella	90716
Prostate Exams		G0102, G0103
Women's Preventive Exams		G0101, Q0091

III. DATA ANALYSIS RESULTS

A. Reductions in Utilization of Preventive Care During COVID-19

Figure 1 below shows the number of preventive care services provided during the months of January to August for contract years 2017 through 2020. As evidenced by this figure, we observed steep declines in preventive health care across a range of services in March and April 2020. While the claims for these services rebounded somewhat starting in May 2020, our most recent data available shows preventive services trending down beginning in July and continuing into August. It is too early to tell how a potential surge in COVID-19 cases heading into autumn and winter may affect future utilization, but the current direction is concerning.

Figure 1: Overall Preventive Care Trend January – August, 2017 - 2020

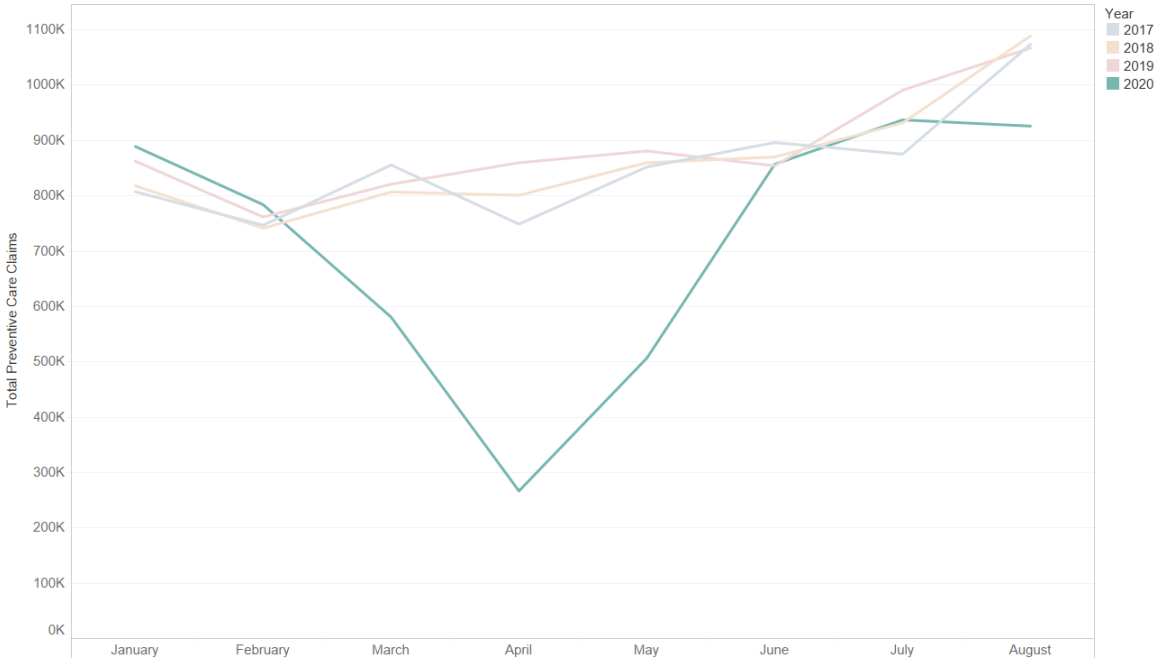
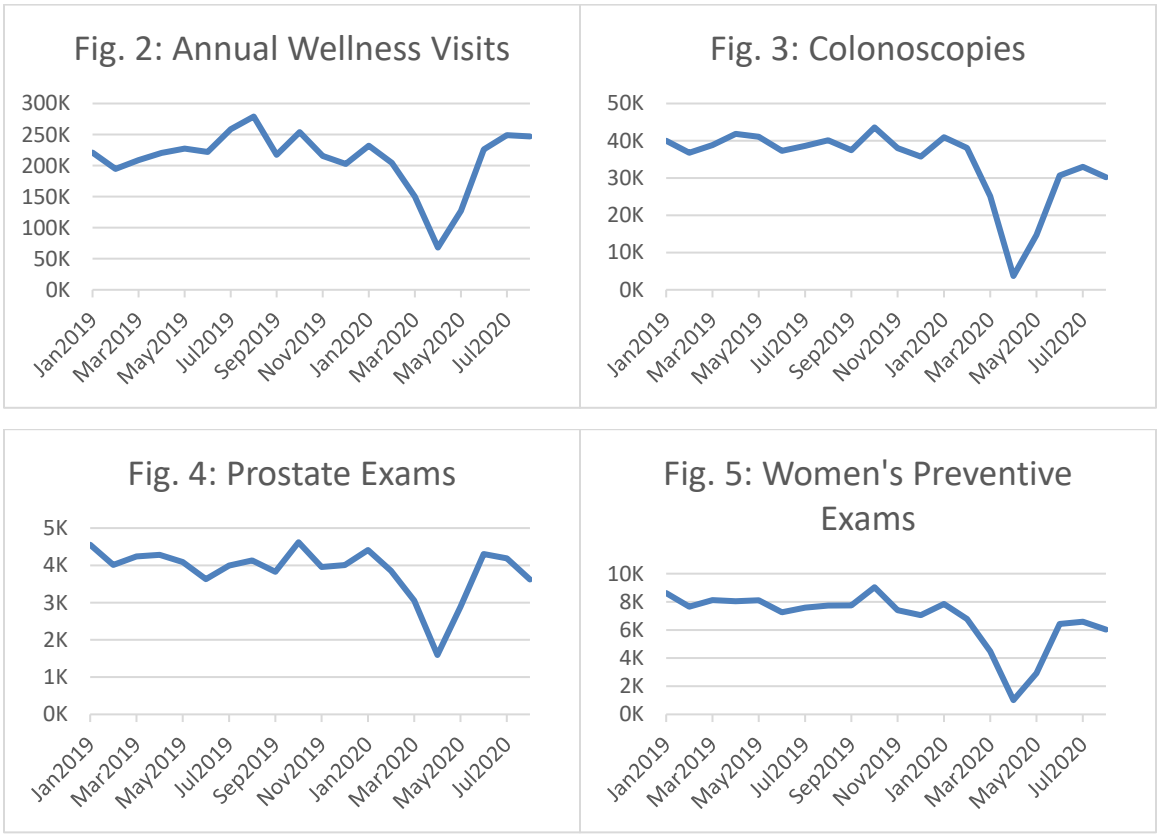


Figure 1: Overall Preventive Care Trend January to August, 2017-2020. In this line graph, the lines show the overall preventive care trend from January to August. Each line represents a single year, from 2017 to 2020. The lines for 2017, 2018, and 2019 follow similar trends, increasing mildly over time from January to August. The line for 2020, however, drops sharply starting in February until April. The 2020 line begins rising again in May and is close to being on trend with the 2017-2019 lines from May to July, but drops slightly again in August. As of August, the 2020 rate of preventive care utilization remains well below the prior years.

For a more detailed view of these trends, we selected four preventive service types covering the period of January 1, 2019, to August 31, 2020 (see Figures 2-5 on the next page).

Figures 2-5: Preventive Care Trends Detailed by Procedure Type



Our analysis also identified downward trends in mammograms. Based on the enrollment totals shown in Tables 2 and 3 on page 3 above, for the plans we analyzed, the number of covered individuals increased by 1.54 percent from 2019 to 2020. While the increase in specific procedures will depend on the demographics of the subscribers from year to year, procedures should generally increase in line with the increase in subscribers. However, this was not the case for mammograms, which saw an average decrease of 23 percent per month in 2020, as opposed to the 1-2 percent increase that would be expected (see Figure 6 on the next page).

Figure 6: Percent Increase/Decrease in Mammograms per Month from 2019 to 2020

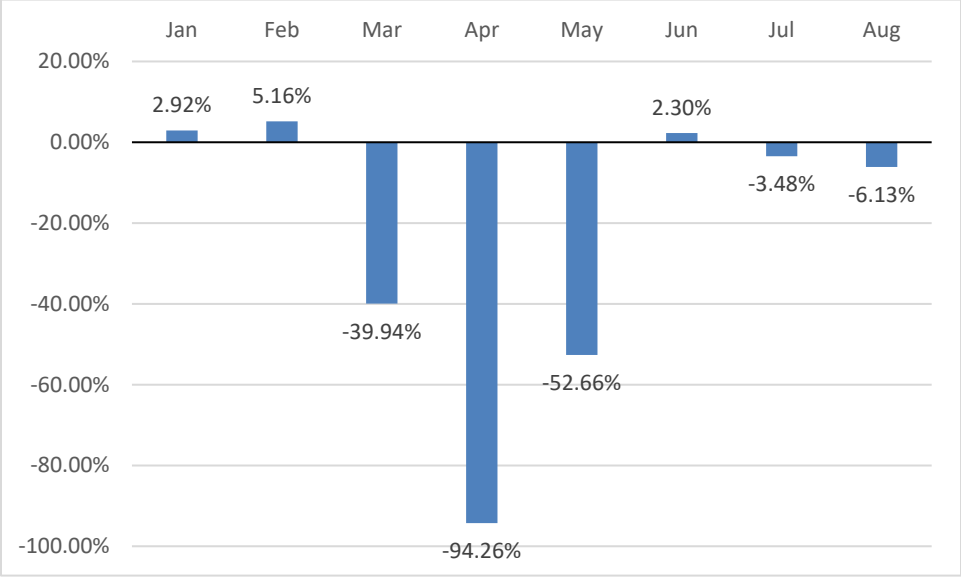
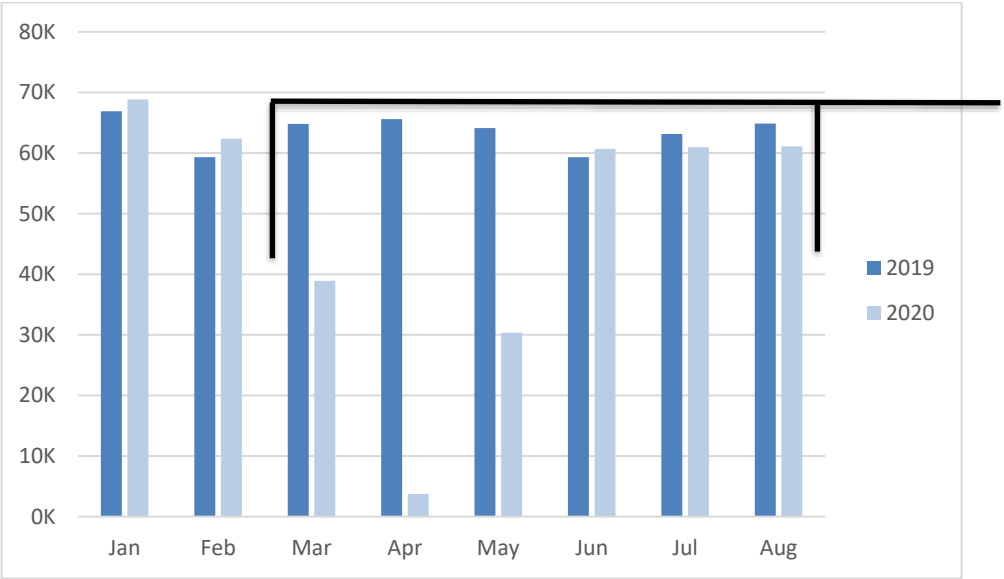


Figure 7: Mammograms per Month, 2019 versus 2020



When compared to 2019, a total of 126,074 fewer mammograms were performed from March through August of 2020.

In summary, the two carriers analyzed have seen a total reduction of 126,074 mammograms performed from March through August 2020 compared to the same time period in 2019. A well-recognized, 29-year study has found that one life can be saved for every 1,677 mammographic examinations performed.[4] Given the decrease in mammograms performed

[4] Tabar L, Vitak B, Hsiu-Hsi Chen T, et al. Swedish Two-County Trial: Impact of Mammographic Screening on Breast Cancer Mortality during 3 Decades – September 1, 2011. Radiology. DOI: https://doi.org/10.1148/radiol.11110469

The decrease in mammograms performed could lead to a minimum of 75 additional breast cancer-related deaths.

through August for these two carriers alone, the FEHBP could see an increased mortality of about 75 individuals, and this number could increase even more if these trends do not change.

Even putting aside potential increased mortalities, studies have shown that early cancer detection via mammograms allows for treatment with less aggressive therapies. Patients whose breast cancer is detected by mammogram rather than by physical examination have smaller tumors, are less likely to have metastases in the lymphnodes, and are less likely to require chemotherapy or mastectomy.[5,6] Chemotherapy alone can have devastating side effects, including alopecia (hair loss), vomiting, neutropenia (low white blood cell count), and sepsis.[7] Furthermore, studies have shown that breast cancer patients treated with chemotherapy are affected by both short and long term deficits in memory and learning that can persist for up to a decade after treatment is completed.[8] It is clear that there are enormous benefits to receiving regular mammograms and it is for this reason that we are greatly concerned with the impact this downward trend could potentially have on the Federal population.

Additionally, we have seen reductions in the number of childhood immunizations performed during the pandemic. The charts on pages 9 and 10 show the rate of immunizations for individuals under 22 years of age for the years 2017 – 2020. While the rate has been rising again since April, it still has not met the average rate for August from the past three years, despite a greater number of enrolled individuals.

[5] Barth R, Gibson GR, Carney, PA et al. Detection of Breast Cancer on Screening Mammography Allows Patients to be Treated with Less-Toxic Therapy. American Journal of Roentgenology; 2005; 184:324-329, DOI: 10.2214/ajr.184.1.01840324

[6] Ahn S, Wooster M, Valente C, et al. Impact of Screening Mammography on Treatment in Women Diagnosed with Breast Cancer. Annals of Surgical Oncology; 2018; 25:2979-2986; DOI: 10.1245/s10434-018-6646-8

[7] Fisher B, Anderson S, Tan-Chiu E, et al. Tamoxifen and chemotherapy for axillary node-negative, estrogen receptor-negative breast cancer: findings from National Surgical Adjuvant Breast and Bowel Project B-23. J Clin Oncol 2001; 19:931-942, DOI: 10.2214/ajr.184.1.01840324

[8] Ahles TA, Saykin AJ, Furstenberg CT, et al. Neuropsychologic impact of standard-dose systemic chemotherapy in long-term survivors of breast cancer and lymphoma. J Clin Oncol 2002; 20:485-493, DOI: 10.1200/JCO.2002.20.2.485

Figure 8: Pediatric Vaccination Rate, January to August 2017-2020

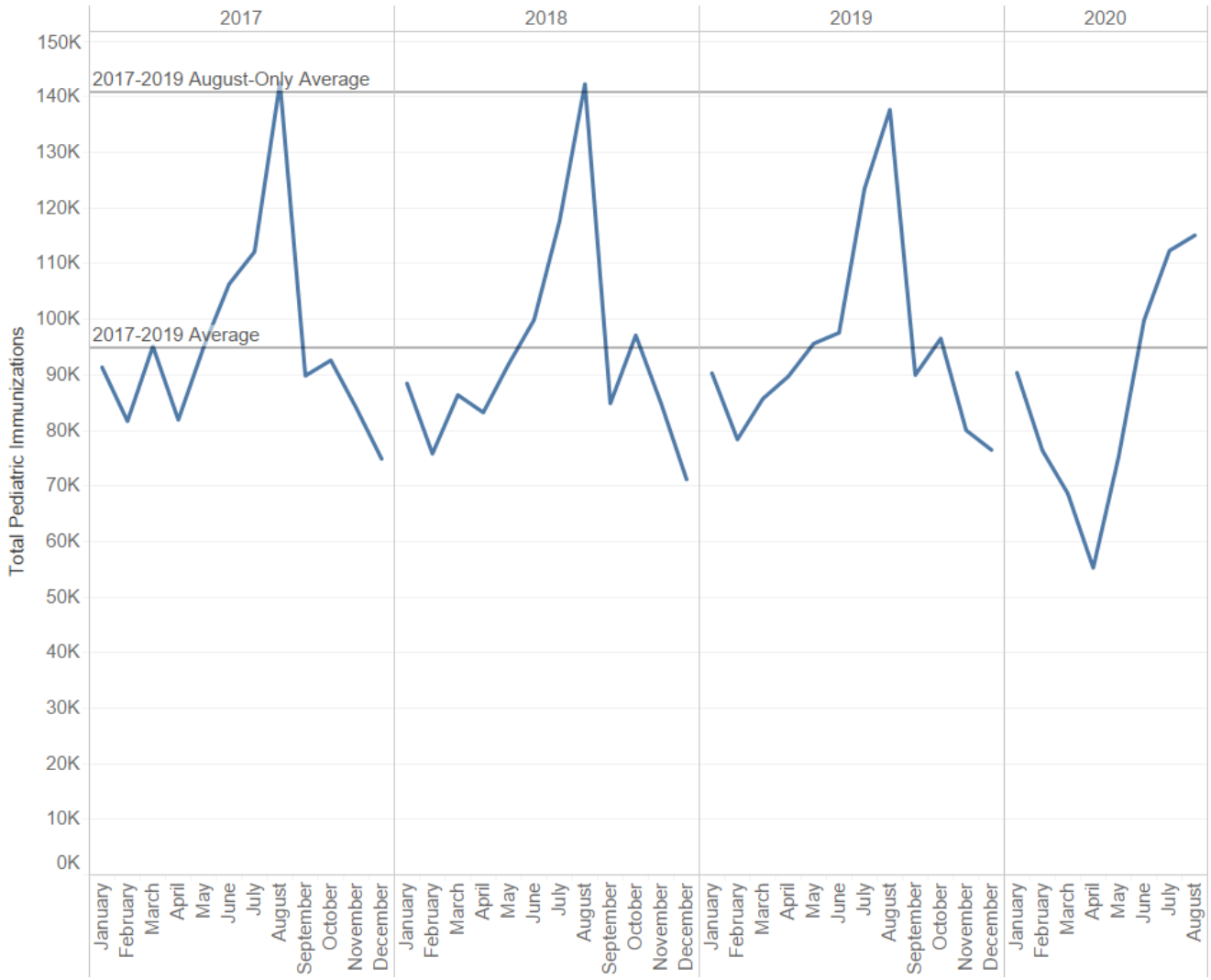


Figure 8: Pediatric Vaccination Rate, January to August 2017-2020. In this line graph, the lines show the trend of pediatric vaccination rates from January 2017 through August 2020. The lines for years 2017 to 2019 show the same general trend, peaking drastically in July. These years do have variations from month to month, but do not have any very drastic drops. The line for 2020, on the other hand, shows a drastic drop from February to April. The 2020 line does begin to pick back up in May, continuing through August. The chart also shows two horizontal average lines: one for the overall 2017 to 2019 average and one for the 2017 to 2019 August-only average. The lowest point on the 2020 line is about twice the distance from the overall average line and is the lowest point of any of the prior three years. While the 2020 line does begin to increase after April, as previously mentioned, it does not come close to reaching the 2017 to 2019 August average line. The 2020 August mark is lower than the 2017 to 2019 August average by about 28 thousand.

Figure 9: Percent Change in Pediatric Vaccination Rates, January to August 2019-2020

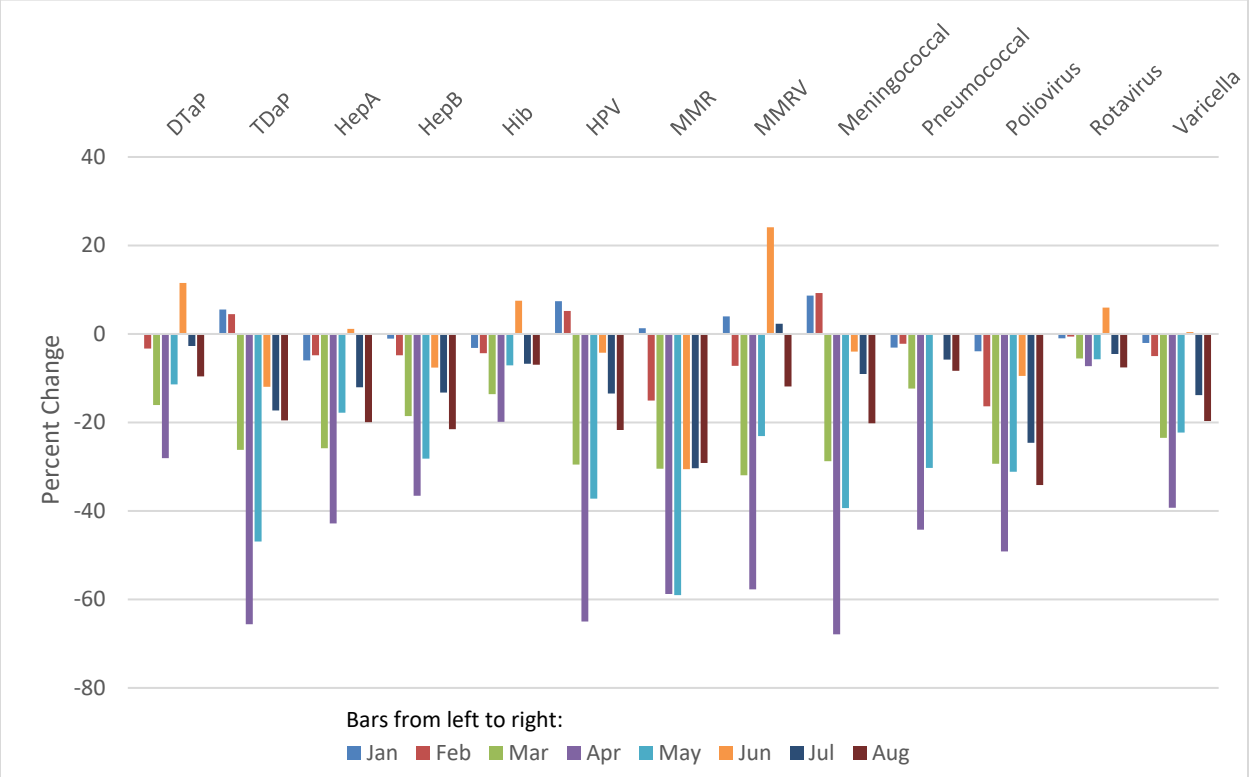


Figure 9: Percent Change in Pediatric Vaccination Rates, January to August 2019-2020. Pediatric vaccinations include DTaP, TDaP, HepA, HepB, Hib, HPV, MMR, MMRV, Meningococcal, Pneumococcal, Poliovirus, Rotavirus, and Varicella. In this bar graph, for each vaccination, the bars show the percentage change between 2019 and 2020. Each bar represents a single month. Most bars are below the zero line, representing declines in vaccination rates. The graph shows a steep decline in April and May for each vaccination, rebounding somewhat in June and July, with DTaP, Hib, MMRV, and Rotavirus climbing above the zero line. A downward trend begins again in August for all vaccinations except Hib and MMR. The most significant declines in April and May 2020 were for TDaP, HPV, MMR, MMRV, and Meningococcal vaccinations. Also for these vaccinations, the data for August 2020 shows the most concerning downward trend after vaccination rates rebounded somewhat in June and July 2020. For all types of vaccinations, the vaccination rate in 2020 remains below the same period in 2019.

Furthermore, as evidenced by the below charts, some vaccinations are not returning to normal rates as quickly as others. Pneumococcal, Hib, and MMRV vaccinations appear to be nearing the same rates as this time last year (see Figures 10-12). Each of these vaccines experienced only a 12 percent drop or less in administration in August of 2020 as compared to August of 2019. However, HPV, Hep B, Poliovirus, Meningococcal, and MMR rates are still well below the threshold from last year (see Figures 13-17). Each of these vaccines experienced a 20 percent drop or greater in administration when comparing August of 2020 to August of 2019.

Figure 10: Pneumococcal immunizations appear to be returning to rates close to those seen in 2019, with only an 8% drop in August.

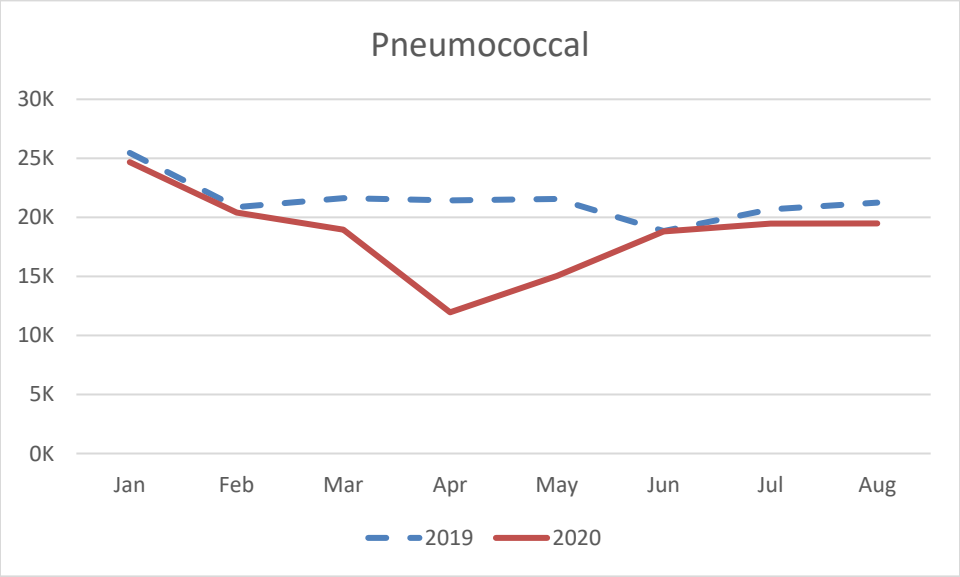


Figure 11: Hib immunizations appear to be returning to rates close to those seen in 2019, with only a 7% drop in August.

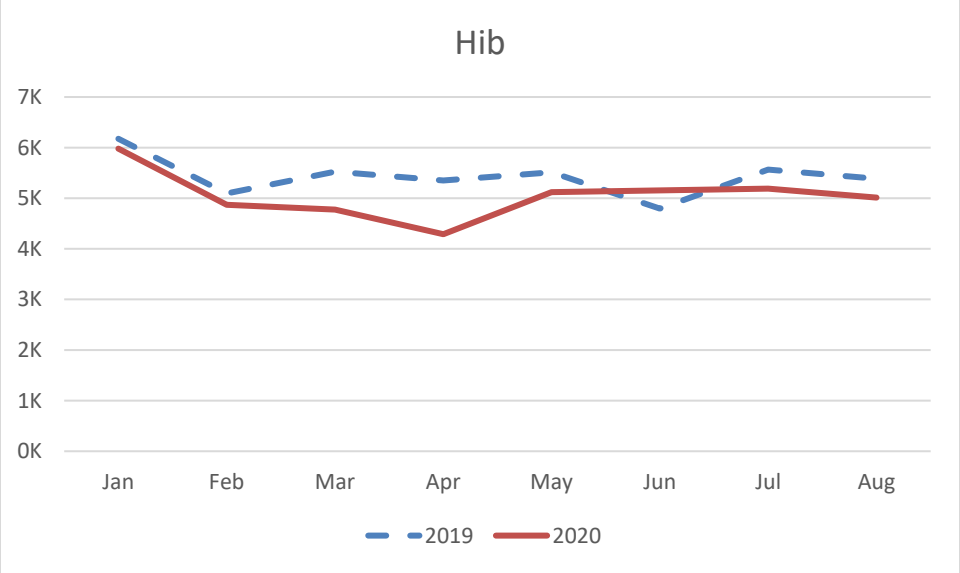


Figure 12: MMRV immunizations appear to be returning to rates close to those seen in 2019, with only a 12% drop in August.

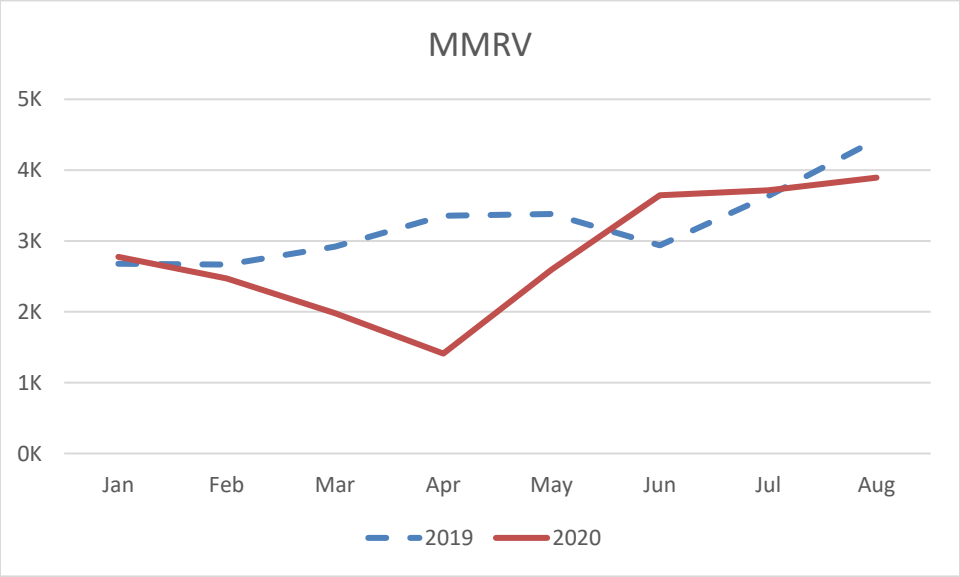


Figure 13: HPV vaccinations do *not* appear to be returning to rates close to those seen in 2019, experiencing a 22% drop in August.

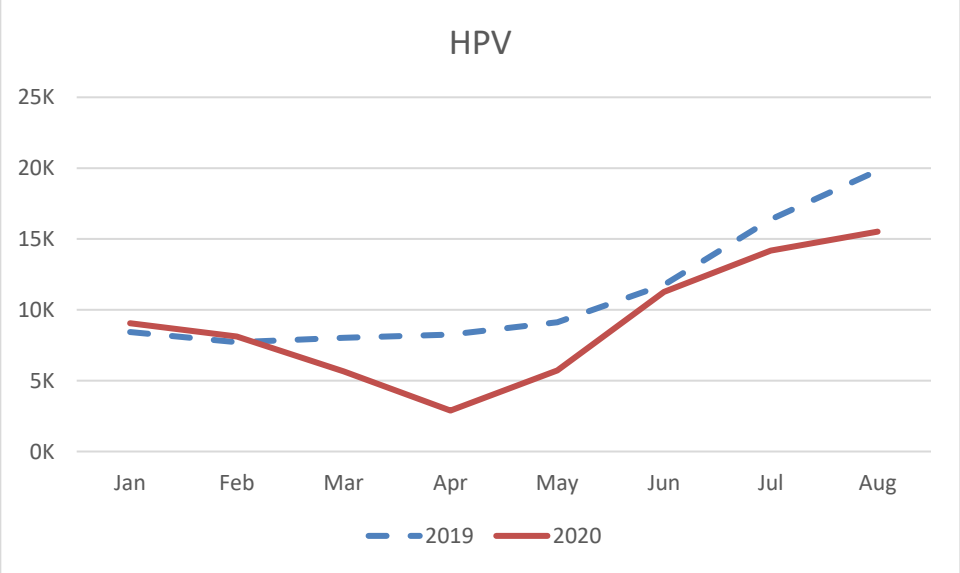


Figure 14: Hepatitis B vaccinations do *not* appear to be returning to rates close to those seen in 2019, experiencing a 22% drop in August.

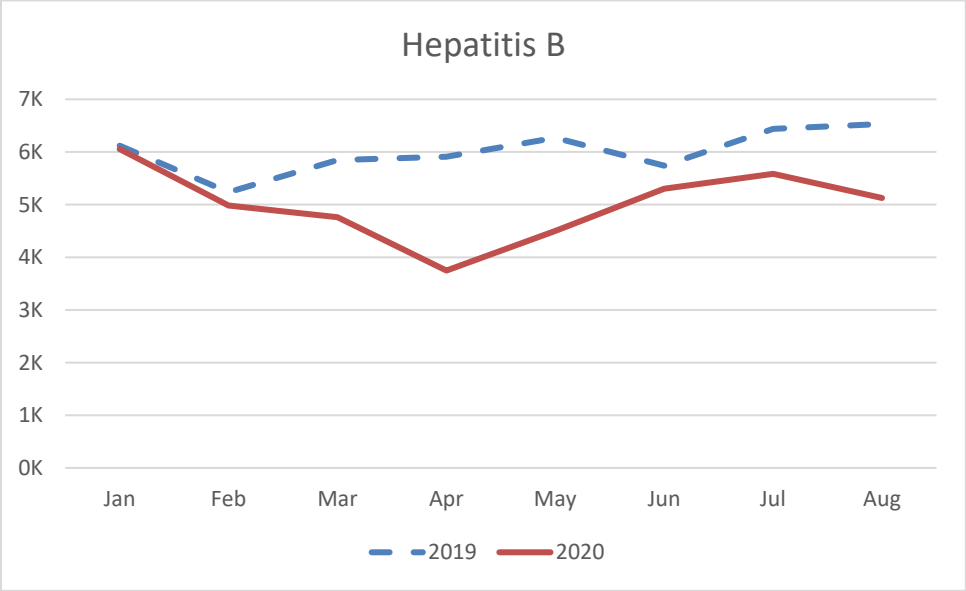


Figure 15: Poliovirus vaccinations do *not* appear to be returning to rates close to those seen in 2019, experiencing a 34% drop in August.

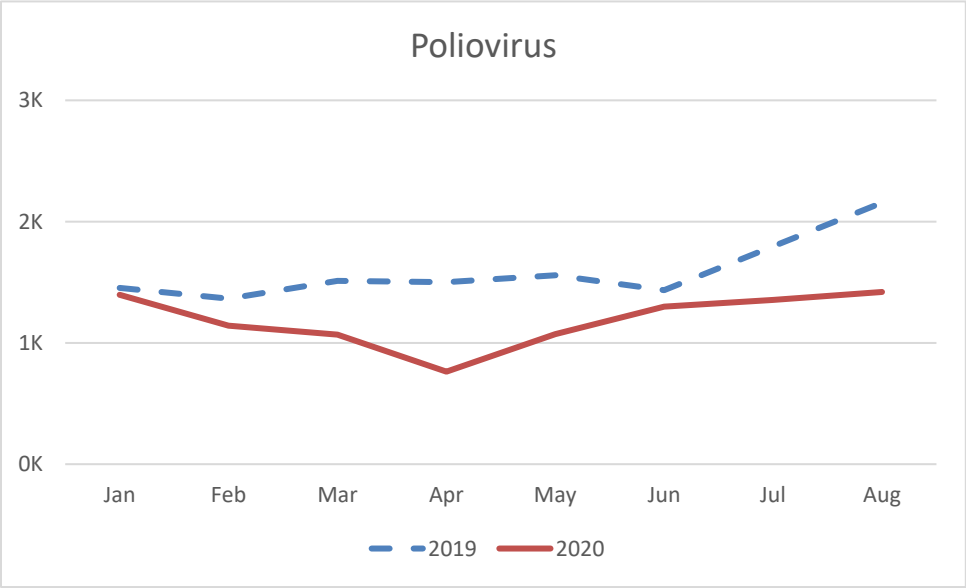


Figure 16: Meningococcal vaccinations do *not* appear to be returning to rates close to those seen in 2019, experiencing a 20% drop in August.

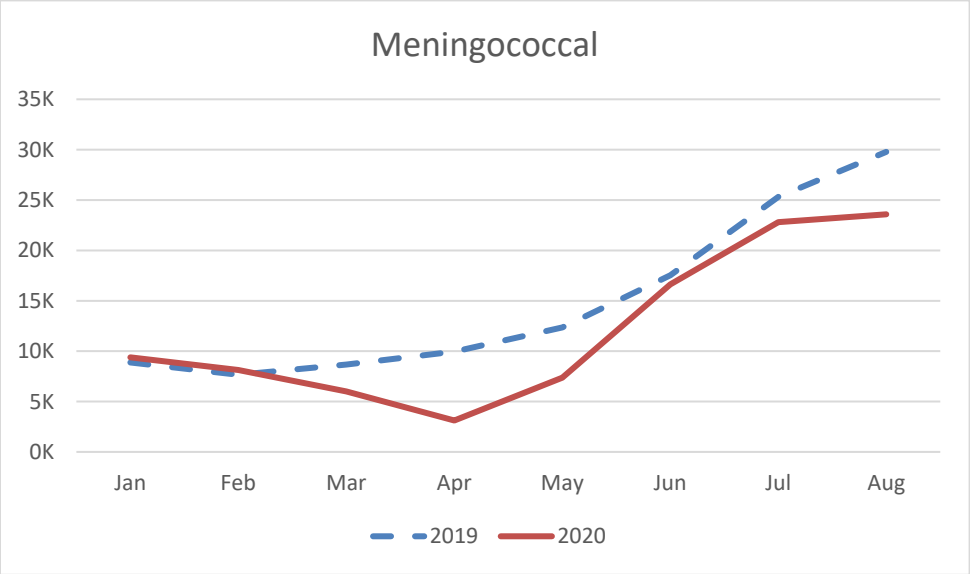
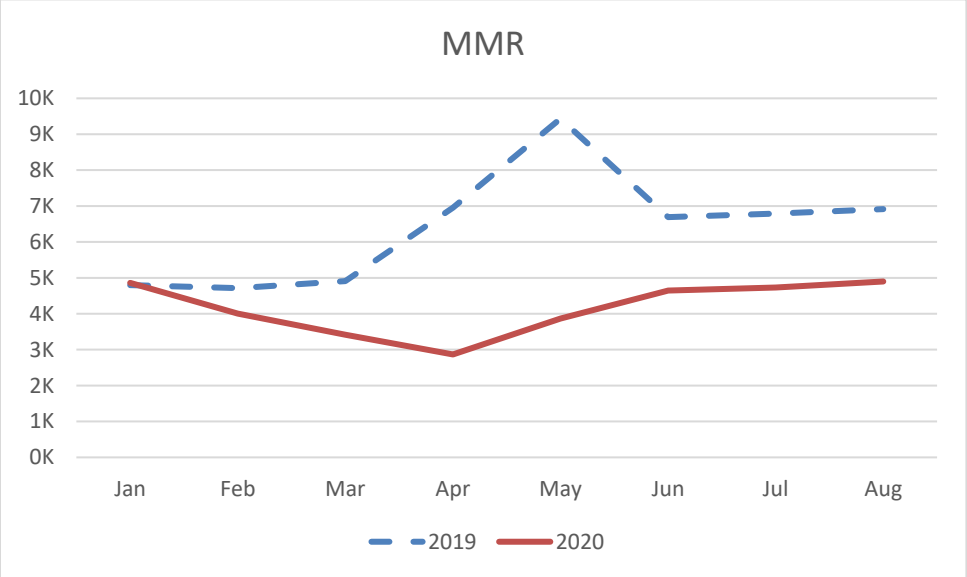


Figure 17: MMR vaccinations do *not* appear to be returning to rates close to those seen in 2019, experiencing a 29% drop in August.



Even if childhood vaccinations return to levels seen in 2019 for the remainder of this year, it is important to remember that because of the significant drops in the spring, we would need to be seeing drastically higher rates of vaccinations in the second half of the year to make up for those missed earlier in the year.

Finally, organizations such as the CDC are highlighting the importance of getting a flu shot this year.[9] Reducing the rates of flu infection throughout the country will help lessen the burden on the health care system this winter, while flu season occurs during the ongoing COVID-19 pandemic. The influenza vaccination of course still carries all of its usual benefits: reducing the risk of contracting the flu, reducing the severity of the illness if one does get the flu, and reducing the risk of hospitalization from a flu infection. Recent studies have shown that there may be additional health benefits to receiving the flu vaccine this year. According to an August 20, 2020, article in the Journal of the American Medical Association (JAMA), a study performed in Wuhan, China, found that coinfection of COVID-19 and influenza was a significant risk factor for prolonged hospital stays. Patients who were infected with both influenza and COVID-19 stayed in the hospital an average of 5 days longer than those infected with COVID-19 only.[10] The CDC has posted communication strategies for maximizing flu vaccinations, especially amongst vulnerable populations.[11]

In addition to employing strategies to maximize flu vaccinations this year, it is also important for health insurance carriers and providers to ensure availability of COVID-19 and influenza tests. According to the above mentioned JAMA article, studies are showing that the treatments for COVID-19 and for influenza vary. Mistakenly treating patients for the wrong virus can not only be wasteful, but potentially harmful.[10] Coincidentally, the guidance for isolation in case of influenza infection has never been as strict as the guidance for isolation in case of COVID-19 infection. Given that the symptoms of the two viruses can be similar, some experts worry that patients may mistake their COVID-19 symptoms for the flu and may not isolate properly, thus furthering the spread of the coronavirus.[11]

The U.S. Food and Drug Administration has granted an Emergency Use Authorization for a new test, which can check for A and B type influenza and SARS CoV-2 simultaneously.[12] The CDC explains that the use of this test is important to allow laboratories time to process more tests in a given period as well as to conserve important testing materials in short supply.[13]

---

[9] Centers for Disease Control and Prevention, Influenza (Flu) What You Need to Know for 2020-21, Updated October 20, 2020. https://www.cdc.gov/flu/season/faq-flu-season-2020-2021.htm.
[10] Rubin, R. What Happens When COVID-19 Collides with Flu Season? August 20, 2020. The Journal of the American Medical Association; 2020; 324(10):923-925, DOI: 10.1001/jama.2020.15260
[11] Centers for Disease Control and Prevention, Influenza (Flu) What You Need to Know for 2020-21, Updated October20, 2020. https://www.cdc.gov/flu/season/faq-flu-season-2020-2021.htm.
[12] Redfield, R. Influenza SARS-CoV-2 (Flu SC2) Multiplex Assay. United States Food and Drug Administration. July 2, 2020, https://www.fda.gov/media/139744/download
[13] Centers for Disease Control and Prevention, Multiplex Assay for Flu and COVID-19 & Supplies. Updated October 25, 2020, https://www.cdc.gov/coronavirus/2019-ncov/lab/multiplex.html

IV. CONCLUSION

As can be seen from our claims analysis results, FEHBP members' utilization of preventive care services has significantly decreased throughout the COVID-19 pandemic. Though utilization for some of these services appears to be rebounding since June, utilization rates have not returned to levels seen in previous years for many types of services and are not close to the utilization levels that would be needed to make up for the services missed earlier in the year. Given the many benefits of regular preventive care, we have concerns about the effect of these trends on the health of the FEHBP population, as well as on the health care system as a whole. As stated in our Executive Summary, it is hoped that this brief will encourage discussions between OPM and the program's participating carriers regarding actions that may need to be considered to offset the potential impact to the program and its members.

Recommendation 1

We recommend that OPM engage with its FEHBP carrier partners to assess the potential impact of the trends outlined in this brief on each of their member populations and, with due diligence, formulate recommendations and a plan for agency action based on the best interests of the Government, the FEHBP, and its enrollees.

Recommendation 2

We recommend that OPM work with FEHBP carriers to develop and implement creative solutions that will encourage FEHBP members to safely make use of preventive care services, including but not limited to those mentioned in this brief.

Recommendation 3

We recommend that OPM work with FEHBP carriers to develop plans to help mitigate potential long-term effects of these trends on future premium rates.

OPM's Response:

"Impacts of the pandemic have been felt in almost every segment of society and the FEHB is no exception. As some physician offices closed and some hospitals limited elective care, it was no surprise to see preventive claims and utilization decrease."

In response to these trends, FEHB Carriers have initiated reminders to members on the importance of resuming and maintaining key health screenings and treatments. Various OPM program offices and the Carriers themselves have also been actively engaged in surveying, analyzing, monitoring, communicating, and planning appropriate actions. "Work continues in this rapidly changing environment and will necessitate flexible solutions based on many factors, which could recharacterize or even render moot formally documented…plans."

While we recognize OIG's thoughtful research and value their partnership, we would like OIG to expand its analysis to other carriers. While the carriers selected for this analysis represent a large share of the FEHBP population, they are only 2 of the more than 80 carrier contracts in the FEHBP. We also seek the opportunity to review the data behind OIG's analysis to help direct the Contracting Office's future actions in providing access to relevant benefits and protecting FEHBP members.

Finally, while OPM is acting in each area covered by the above recommendations, their broad nature does not lend themselves to formal responses. As stated above, potential actions are fluid based upon fluctuating circumstances. Upon issuance of the Final Data Brief, OPM's Healthcare and Insurance office will provide periodic oral updates on the agency's efforts as OIG has agreed would be appropriate in response to this evaluation.

"OPM is fully committed to positioning the FEHB Program to help members combat COVID-19 with information and access to treatments as they become available."

OIG Comments:

The OIG appreciates OPM's willingness to partner with us in an effort to anticipate and take action on potential program impacts resulting from the pandemic. We look forward to continuing our collaborative efforts with them to address these concerns.

While we are open to expanding our analysis to other carriers, we do want to note that the two carriers chosen for this brief are the two largest, nationwide carriers in the FEHBP, covering 76 percent of the FEHBP population. We have no reason to believe that member behavior in the remaining 24 percent of the population will differ greatly and we therefore believe our analysis is very likely to be representative of the overall FEHBP population.

APPENDIX

Healthcare and Insurance

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
1900 E Street, NW, Washington, DC 20415

DATE: December 14, 2020

MEMORANDUM FOR MICHAEL R. ESSER
Assistant Inspector General for Audits

FROM: LAURIE E. BODENHEIMER
Acting Director, Healthcare and Insurance

THROUGH: EDWARD M. DEHARDE
Assistance Director, Contracting Officer, Federal Employee Insurance Operations

SUBJECT: OPM's Response to Draft Data Brief to Downward Trends in the Federal Employees Health Benefits (FEHB) Program Members' Use of Preventive Care Services Caused by the COVID-19 Pandemic, Report Number 1K-99-00-20-046 November 17, 2020

Thank you for the opportunity to respond to the Office of the Inspector General's (OIG) Draft Data Brief, Report Number 1K-99-00-20-046. The Draft Data Brief provides an OIG analysis of preventive care trends in the FEHB Program from the sample of overall FEHB Program claims that the OIG has in its possession. The data brief shows a decrease in the utilization of preventive services during a period within the first several months of the COVID-19 pandemic. Impacts of the pandemic have been felt in almost every segment of society and the FEHB Program is no exception. As some physician offices closed and some hospitals limited elective care, it was no surprise to see preventive claims and utilization decrease.

As noted in the data brief, preventive care utilization returned to pre-COVID-19 levels in many categories within the eight-month period and continues to fluctuate as the COVID-19 risk rises and falls. In response, FEHB Carriers have initiated awareness reminders to members on the importance of resuming and maintaining key health screenings and treatments. This includes a focus on controlling high blood pressure, immunization adherence, medication adherence and monitoring the use of antibiotics.

The Draft Data Brief contains three recommendations, seeking engagement from the agency and Carriers to assess the potential impact of the trends noted in the brief, to propose creative solutions to encourage FEHB members to use preventive services and to develop plans to

mitigate the potential long-term effects of these trends on future premiums. HI's contracting officials, Chief Medical Officer, Program Analysis and Development, Office of the Actuaries and the Carriers themselves have been actively engaged in surveying, analyzing, monitoring, communicating and planning appropriate actions throughout OPM's benefit and rate negotiations, Open Season preparations, contract closeouts and preparations of the 2021 Call Letter. Work continues in this rapidly changing environment and will necessitate flexible solutions based on many factors, which could recharacterize or even render moot formally documented (preliminary and sensitive) plans.

We recognize OIG's thoughtful research and we value OIG's partnership. We would like OIG to expand its analysis to additional carriers. While the carriers selected represent a large share of the FEHB Program population, they are just two of the more than 80 carrier-contracts in the FEHB Program. We further seek the opportunity to review the data behind OIG's analysis to help inform the Contracting Office's future actions to provide greater access to relevant benefits and protection from the virus to FEHB Program members.

Recommendation 1
We recommend that OPM engage with its FEHB carrier partners to assess the potential impact of the trends outlined in this brief on each of their member populations and, with due diligence, formulate recommendations and a plan for agency action based on the best interests of the government, the FEHBP, and its enrollees.

Recommendation 2
We recommend that OPM work with FEHB carriers to develop and implement creative solutions that will encourage FEHBP members to safely make use of preventive care services, including but not limited to those mentioned in this brief.

Recommendation 3
We recommend that OPM work with FEHB carriers to develop plans to help mitigate potential long-term effects of these trends on future premium rates.

While OPM is acting in each area, the broadly written recommendations do not lend themselves to formal responses. Potential actions are fluid based upon fluctuating circumstances. Upon release of the Final Data Brief, HI will provide periodic oral updates on the agency's efforts as OIG has agreed would be appropriate in response to this evaluation.

OPM is fully committed to positioning the FEHB Program to help members combat COVID-19 with information and access to treatments as they become available.

If you have any questions regarding our response to Draft report number 1K-99-00-20-046 please contact [redacted], Chief, Audit Resolution & Compliance at [redacted]@opm.gov.

cc: Barnes, Butler, [redacted], DeHarde, [redacted]

Report Fraud, Waste, and Mismanagement

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

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

By Phone:

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

By Mail:

Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, NW
Room 6400
Washington, DC 20415-1100