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

Final Audit Report

AUDIT OF THE FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM OPERATIONS AT BLUE CARE NETWORK OF MICHIGAN

Report Number 2023-CRAG-010
March 12, 2024

EXECUTIVE SUMMARY

Audit of the Federal Employees Health Benefits Program Operations at Blue Care Network of Michigan

Report No. 2023-CRAG-010 **March 12, 2024**

Why Did We Conduct the Audit?

The primary objective of the audit was to determine whether Blue Care Network of Michigan complied with the provisions of its contract and the laws and regulations governing the Federal Employees Health Benefits Program (FEHBP). To accomplish this objective, we verified whether the FEHBP premium rates were developed in accordance with contract regulations and rating instructions established by the U.S. Office of Personnel Management (OPM).

What Did We Audit?

Under Contract CS 2011, the Office of the Inspector General completed a performance audit of the FEHBP premium rate developments for contract years 2020 through 2022. We conducted our audit fieldwork remotely from March 6, 2023, through October 30, 2023.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

We found that portions of the 2020 through 2022 FEHBP premium rate developments were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM. Specifically, the Plan misstated the 2022 medical base rates and 2020 through 2022 vision base rates, resulting in errors in the FEHBP premium rates in 2020 through 2022. However, these issues were classified as procedural as they were immaterial to the overall premium rate calculations and had no related questioned costs.

- The 2022 premium rate development included improperly calculated medical and vision base rates.
- The 2020 through 2021 premium rate developments included improperly calculated vision base rates.
- The Plan did not maintain adequate supporting documentation for overage dependents as required by applicable criteria.

Our audit did not disclose any findings related to the following review areas: medical claims overview, pharmacy claims overview, capitations, contract compliance, corporate and financial structure, and medical claims pricing review.

ABBREVIATIONS

ACR	**Adjusted Community Rate**
BCN	**Blue Care Network of Michigan**
CFR	**Code of Federal Regulations**
Contract	**OPM Contract CS 2011**
DIFS	**Michigan Department of Insurance and Financial Services**
EDI	**Electronic Data Interface**
FEHB	**Federal Employees Health Benefits**
FEHBAR	**Federal Employees Health Benefits Acquisition Regulations**
FEHBP	**Federal Employees Health Benefits Program**
MLR	**Medical Loss Ratio**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**Blue Care Network**
PMPM	**Per Member Per Month**

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I. BACKGROUND

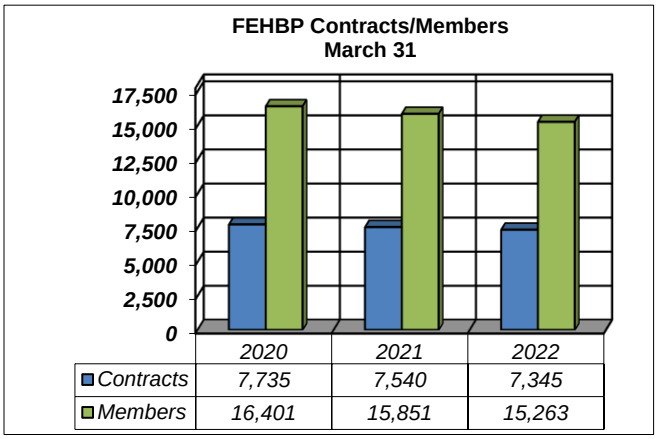
This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at Blue Care Network (BCN) (Plan), plan codes LX and K5. The audit was conducted pursuant to the provisions of Contracts CS 2011 (Contract); 5 United States Code Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract years 2020 through 2022 and was conducted remotely by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG) staff.

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

In April 2012, OPM issued a final rule establishing an FEHBP-specific Medical Loss Ratio (MLR) requirement to replace the similarly-sized subscriber group comparison requirement for most community-rated FEHBP carriers (77 Federal Register 19522). The premium rates charged to the FEHBP under the MLR methodology should be developed in accordance with OPM Rules and Regulations and the Plan's state-filed standard rating methodology (or if the rating method does not require state filing, the Plan's documented and established rating methodology). All FEHBP pricing data is to 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. Further, an independent professional must be able to follow the carriers' 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 OPM 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 promulgated by OPM.

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



	2020	2021	2022
Contracts	7,735	7,540	7,345
Members	16,401	15,851	15,263

The Plan has participated in the FEHBP since 1984 and provides health benefits to FEHBP members in the East and Southeast Michigan service area.

The most recent audit of plan code LX was an MLR audit. The audit covered contract years 2013 through 2016 and identified overstated MLR credits for contract years 2013 through 2015. There were recommendations to reduce the Plan's 2013 through 2015 MLR credits. Although the report identified issues in contract year 2016, it did not result in a penalty due to OPM or a credit due to the Plan. Specifically, the Plan included claims for ineligible non-disabled dependents in 2013 through 2016 and terminated coverage early for eligible nondisabled dependents in 2013 through 2016. The final report was issued in June of 2019, and all issues were resolved by OPM. However, the last full scope audit of the Plan's premium rates covered contract years 2010 through 2011. The results of our audit showed that the rating of the FEHBP was in accordance with the applicable laws, regulations, and the Office of Personnel Management's rating instructions for the years audited.

For plan code K5, the most recent audit was a rate reconciliation audit for 2008. The purpose of the audit was to determine if the proposed 2008 rate reconciliation is acceptable as a basis to set a fair and reasonable contract price adjustment. Based on the results of the audit, we recommended acceptance of the proposed reconciliation.

Some of the preliminary results of this audit were communicated to Plan officials during the Notice of Finding and Recommendations process. The Plan's comments were considered in the preparation of this report and are included, as appropriate, in the report. Additionally, we discussed the issues outlined in this report with Plan officials during the Exit Conference and subsequent meetings.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

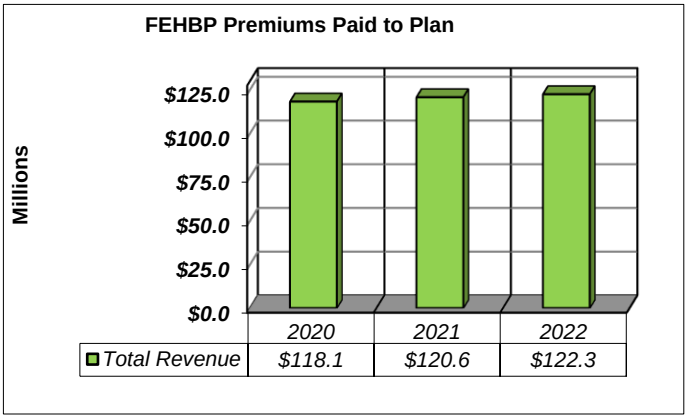
OBJECTIVES

The primary objective of this performance audit was to determine whether the Plan complied with the provisions of its Contract and the laws and regulations governing the FEHBP. Specifically, we verified whether the Plan developed its FEHBP premium rates in accordance with the applicable regulations and rating instructions established by OPM.

SCOPE

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

This performance audit covered contract years 2020 through 2022. For these years, the FEHBP paid approximately $361 million in premiums to the Plan.



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

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

- the premium rate calculations were accurate, complete, and valid;
- medical claims were processed accurately; and
- any other costs associated with its premium rate calculations were appropriate.

In conducting the audit, we relied to varying degrees on computer-generated billing, enrollment, and claims data provided by the Plan. We did not verify the reliability of the data generated by

the various information systems involved. However, nothing came to our attention during our audit utilizing the computer-generated data to cause us to doubt its reliability. We believe that the available data was sufficient to achieve our audit objectives. Except as noted above, the audit was conducted in accordance with generally accepted government auditing standards, issued by the Comptroller General of the United States.

We remotely conducted our audit fieldwork from March 6, 2023, through October 30, 2023.

METHODOLOGY

We examined the Plan's premium rate calculations and related documents as a basis for validating the premium rates. Further, we examined medical claim payments, capitations, pharmacy rebates, completion factors, benefit factors, trends, administrative expenses, and any other applicable expenses considered in the calculation of the premium rates to verify that the cost data used was accurate, complete, and valid. Finally, we used the Contract, the Federal Employees Health Benefits Acquisition Regulations (FEHBAR), the OPM rate instructions, and applicable Federal regulations to determine the propriety of the Plan's premium rate calculations.

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

We conducted meetings with Plan representatives and discussed the Plan's policies and procedures over the capitations process, including the methodology for the capitations included in the premium rate submissions.

We interviewed the Plan personnel and discussed the Plan's policies and procedures for enrollment and discussed the enrollment as it relates to the development of FEHBP premium rates.

We also interviewed Plan officials and reviewed the Plan's policies and procedures associated with its internal controls over the Fraud, Waste, and Abuse, debarment, and offshore contracting programs.

We reviewed the Plan's organization charts and determined which corporate entities the FEHBP plan codes fell under. Also, we verified the financial relationships between the plan and its parent company or other related parties, if applicable. We reviewed the Plan's financial statements for potential impacts or audit leads and any internal audit reports provided and documented the audit findings.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. PREMIUM RATE REVIEW

Carriers proposing rates to OPM are required to submit a Certificate of Accurate Pricing certifying that the cost or pricing data submitted in support of the FEHBP premium rates were developed in accordance with the requirements of 48 CFR, Chapter 16 and the FEHBP Contract CS 2011 (Contract). We determined that the Plan's 2020 through 2022 Certificates of Accurate Pricing for plan codes LX and K5 were defective. Specifically, the Plan misstated the 2022 medical base rates and 2020 through 2022 vision base rates, resulting in errors in the FEHBP premium rates in 2020 through 2022. However, these issues were classified as procedural as they were immaterial to the overall premium rate calculations and had no related questioned costs.

1. Medical and Vision Base Rate Errors — Procedural

While preparing responses to our information requests during our audit of the 2020 through 2022 FEHBP premium rates, the Plan identified errors in the data that was used to calculate the 2022 medical base rate and the 2020 through 2022 vision base rates.

The Plan self-reported errors in the data that was used to calculate the 2022 medical base rate and the 2020 through 2022 vision base rates.

The certificate of accurate pricing states, " the cost or pricing data submitted (or, if not submitted, maintained and identified by the carrier as supporting documentation) to the Contracting Officer or the Contracting Officer's representative or designee in support of the [FEHBP rates] were developed in accordance with the requirements of 48 CFR Chapter 16 and the FEHB contract and are accurate, complete, and current as of the date this certificate is executed … ."

Contract Section 2.2(a) states, "The Carrier shall provide the Benefits as described in the agreed upon brochure text ... ."

Contract Section 5.64(c)(2)(ii)(A) of the Contract states that the Contractor's internal control system will at a minimum provide for "Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the ... internal control system." The contract further states at Section 5.64(c)(2)(ii)(C)(1), (2) and (3) that the Contractor's internal control system should provide "Periodic reviews of company business practices, procedures, policies, and internal controls for compliance with … the special requirements of government contracting … ."

According to the Plan, some benefits cannot be entered directly into the product pricing model and require manual entry of actuarial cost estimates. The actuarial cost estimates impact the following benefits: hearing aids, temporomandibular joint disfunction, skilled nursing facility, telehealth online visits, weight reduction coinsurance, inpatient and outpatient mental health and substance use disorder, and postnatal visits. Therefore, the Plan used "flat impacts" for these benefits. The Plan defined two different types of flat impacts:

- "Flat impacts for benefits that cannot be valued in the model. These impacts are developed by the actuarial team and filed with the Michigan Department of Insurance and Financial Services (DIFS)."
- "Flat impacts for benefits that cannot be entered on the model input tab but that can be developed from the model through actuarial analysis based on the model data and assumptions. These flat impacts are not shown directly in the rate filing since they are developed from the model but are used in the development of base rates filed with DIFS for plans."

As previously mentioned, the cost estimates for several of these benefits were not appropriately updated to use the applicable 2022 actuarial estimates. Specifically, the cost estimate errors were included in the Flexible Plan-by-Plan Dollar Impact and Flexible Plan-by-Plan Percentage Impact components of the medical base rate. The original Flexible Plan-by-Plan Dollar Impact was $3.25, and the Flexible Plan-by-Plan Percentage Impact was -.59 percent. The correct impact values should have been $3.40 and -.05 percent, respectively.

The Plan input incorrect benefits into its vision rate model that impacted the 2020 through 2022 vision base rates[1].

After correcting the errors, the Plan provided the correct medical base rate for 2022 and vision base rates for 2020 through 2022.

The chart on the following page shows the original and corrected per month per month base rates for the medical and vision benefits.

[1] The impacted vision benefits included the following: copays for lens and contacts, benefit allowances, frames every 12 months, out of network allowance, and photochromatic coverage.

Contract Year	Base Rate	Original Base Rate PMPMs	Corrected Base Rate PMPMs
2022	Medical	$198.40	$199.54
2020	Vision	Regular: $6.35 Comp: $5.14	Regular: $4.32 Comp: $3.50
2021	Vision	Regular: $6.47 Comp: $5.24	Regular: $4.20 Comp: $3.40
2022	Vision	Regular: $6.47 Comp: $5.24	Regular: $4.20 Comp: $3.40

The Plan stated that the vision base rate error only impacted the FEHBP premium rate and did not impact the processing of the vision claims or copays collected. The FEHBP enrollees' claims were paid per plan design for 2020 through 2022. The audit team reviewed the LX vision claims for 2020 through 2022 and confirmed that the appropriate copays of $5.00 or $7.50 were collected for exams and contacts/lenses. Based on this review, we were able to confirm that the claims processing and copay collections were not impacted by the vision base rate error. Based on the errors noted above, only the premium rates were inaccurate for 2020 through 2022. However, when we applied the adjustments to our audited rates for contract years 2020 through 2022, the overall impact was immaterial to the overall premium rate calculations.

The Plan has documented review policies and procedures in place over the process to calculate the medical and vision base rates, and these procedures include reviews of the data that is used at various levels. Unfortunately, despite the Plan's review process, the errors in the base rate calculations were missed. As a result, incorrect cost estimates were applied to the medical base rate in 2022 and incorrect vision benefits were applied to the calculation of the 2020 through 2022 vision base rates. However, as a part of self-reporting the issue, the Plan provided documentation to show they have implemented additional monitoring and training to ensure the review processes are followed by all responsible parties.

The Plan has already implemented additional monitoring and training to ensure the review processes. Therefore, no further action is required.

Plan's Response:

The Plan agrees with the finding.

OIG Comment:

We appreciate the Plan for promptly disclosing and addressing the issue found in the medical and vision base rates. We will review the effectiveness of the Plan's additional monitoring and training during a future audit.

B. INTERNAL CONTROLS REVIEW

1. Overage Dependent Eligibility — Procedural

The Plan did not maintain adequate documentation to support that 15 dependents were disabled and incapable of self-support prior to turning age 26 during the 2022 Adjusted Community Rating (ACR) claims experience period. Therefore, we cannot verify whether these dependents were eligible for continued Federal Employees Health Benefits (FEHB) coverage beyond age 26.

The Plan did not maintain adequate documentation to support that 15 dependents were disabled and incapable of self-support prior to turning age 26.

The 2020 and 2021 FEHB benefit brochures state that dependent children aged 26 or older may continue coverage if they are disabled and incapable of self-support prior to age 26.

FEHB Carrier Letter 2020-16 provides guidance on verifying family member eligibility on existing enrollments. As outlined in the letter, FEHB carriers have the ability "to request proof of family member eligibility from an enrollee at any time for existing enrollments" in accordance with the regulation published at 83 FR 3059. The letter further notes that "An FEHB Carrier should implement these procedures when there are questions or concerns about a family member's eligibility."

Per FEHB Carrier Letter 2021-7, Attachment A, "Pursuant to contract clause 3.4, Contractor Records Retention (FEHBAR 1652.204-70), OPM requires all carriers to maintain documentation to support all calculations and statements pertaining to the reconciliation." The referenced contract clause requires a six-year record retention policy. The largest components of the reconciliation are the medical and pharmacy claims incurred during the experience periods that are used to develop the FEHBP premium rates. Claims should only be included in the experience period for the rate submissions if they were actual Federal claims paid. Additionally, under the FEHB brochure, benefits should only be provided (i.e., paid) for eligible enrollees.

We selected a random sample of 25 dependents aged 26 or older from the 2020 and 2021 medical ACR claims data used in the 2022 FEHBP premium rate development to verify the dependent's eligibility. Of these, 12 dependents were considered disabled and incapable of self-support within the Plan's claims system. However, the Plan was unable to provide documentation from federal employing offices to support that six of the dependents were certified as disabled and incapable of self-support. For one of the six dependents, the Plan was relying on Medicare status as support for the permanent disability status and provided a screenshot of system notes to support the determination status. However, the Plan did not provide the actual documentation from the MARx system[2], or the determination letter referenced in the system notes. For the five remaining members, the Plan could not provide the supporting documentation because its existing records retention policy only requires the documentation to be maintained for 10 years. Because some of the records supporting the members' disabled classification exceeded 10 years, the documentation was no longer available for our review based on the Plan's policy. Without the documentation that the Plan used to validate the enrollees' eligibility for coverage, we could not confirm the six overage dependents in our review were eligible for FEHB coverage during the 2022 experience period nor confirm that claims for these enrollees were allowable.

As a result of our review, we expanded our sample of dependents aged 26 or older and identified 21 additional dependent enrollees whose eligibility may be unsupported. During our expanded review, we analyzed the support provided by the Plan for the 21 additional overage dependents to determine if the Plan appropriately maintained documentation certifying that the dependents over age 26 were disabled and incapable of self-support. We determined that 9 of the additional 21 sampled dependents did not have sufficient documentation to support their overage dependent eligibility status, bringing the total to 15.

The Plan again cited its record retention policy as the reason why eligibility documentation was not maintained for overage dependents in over half the cases. However, the Plan did not adhere to its own policy because it did not maintain eligibility documentation for three of the nine dependents that were reportedly certified as disabled within its 10-year retention period. The Plan also noted that four of the nine members' eligibility was sent via the Electronic Data Interface 834 files from the federal employing offices and no certification was submitted by the payroll office on the Electronic Data Interface 834 file. Therefore, without documentation from federal employing offices to support that the enrollees were certified as disabled and incapable of self-support prior to age 26, these enrollees do not appear to be

[2] The Medicare Advantage Prescription Drug System (MARx) stores Medicare Advantage Organization (MAO), Part C and Part D Sponsor, Part D enrollment, payment, and premium information and calculates monthly Part C/D payments and adjustments for each Plan. Via MARx, MAOs and Part D sponsors are able to submit batch data files, view information on the User Interface (UI), and download reports.

eligible to receive coverage based on the Plan's system information. As such, their claims should not be included in the experience periods used for premium rating.

In summary, a combined total of 46 enrollees were reviewed as dependents aged 26 or older from the 2020 and 2021 medical ACR claims data used in the 2022 FEHB premium rate development. Per our review, the Plan did not have adequate documentation to support 15 of the overage dependents in our reviews were eligible for continued FEHB coverage beyond age 26.

Recommendation 1

In accordance with FEHB Carrier Letter 2020-16, we recommend that the Plan verify that the 15 unsupported overage dependents identified during our review are still eligible for FEHB coverage and update its claims and enrollment systems accordingly.

Recommendation 2

We recommend that the Plan retain supporting documentation from the responsible employing offices for designated FEHBP overage dependents indefinitely to properly support all calculations and statements pertaining to the FEHB rate reconciliations.

Recommendation 3

We recommend that the Plan update its written policies and procedures to align its retention of FEHB overage dependent disability certification documentation with requirements in FEHB Carrier Letter 2021-7, Attachment A, to maintain documentation that supports all calculations and statements pertaining to the reconciliation.

Plan's Response:

The Plan has "reached out to the payroll offices but obtaining responses from the payroll offices has been difficult and time-consuming. To date, BCN has received documentation for 10 of the overage dependent samples. BCN will continue to reach out to the payroll offices in effort to obtain the supporting documentation on the remaining samples."

The Plan stated that "the payroll offices frequently use the 834 process for enrollments, and BCN is required to accept such enrollments as the source of truth. There is no way to attach a document specific to a member to an outbound 834 file, so the payroll office

is unable to send a disability letter with the 834 file. The payroll office should instead send the enrollment manually including the supporting documentation to be enrolled.

Regarding directly contacting the enrollee to verify disability status, [the Plan] believes the payroll office is the more appropriate party to do this reach-out to the remaining sample of overage dependents pursuant to regulatory guidance and given that some of the overage dependents were deemed disabled prior to enrolling in BCN coverage. The preamble to the final rule cited in OPM's summary above at 83 FR 3059 ('Final Rule') expressly states that 'the employing offices will be responsible for collecting documentation and determining proof of eligibility status and that the information will be sent to FEHB Program Carriers.' Furthermore, the Final Rule states that an FEHB carrier 'may' request verification of eligibility from the enrollee but does not use the word 'shall' or 'must.' See 5 CFR 890.308(e). This interpretation is consistent with the U.S. Government Accountability Office's position in a December 2022 report on OPM's efforts to ensure only eligible family members are enrolled in FEHBP coverage. … Additionally, the sample letter to request family member eligibility verification from the enrollee is directed toward the employing office."

In response to recommendation 2, the Plan stated that "Neither the FEHBP contract nor FEHBP regulations require carriers to retain records indefinitely. Section 3.4 of the FEHB contract and FEHBAR 1652.204-70 require a carrier to retain documentation supporting their rate submission for the applicable contract year for a period of six years after the end of the contract year to which the records relate. As an example, if a manual enrollment was initially submitted with a disability certification for a March 1, 2017, enrollment, the carrier would be required to retain such certification through the end of 2023 (i.e., six years from the end of the 2017 contract year when the certification was submitted). The OIG auditors have cited no regulatory or sub-regulatory guidance that the six year requirement is a rolling timeframe other than to make a conclusory statement that BCN's example 'does not reflect the intention of that requirement.' Furthermore, the OIG auditors failed to acknowledge that whether BCN was able to produce the disability certification would not have impacted any of the overage dependents' eligibility status for the years following the determination as BCN does not make initial disability determination. BCN must accept the payroll office's decision on a family member's eligibility."

In response to recommendation 3, "BCN believes its record retention policies are compliant with Section 3.4 of the FEHB contract and FEHBAR 1652.204-70. Carrier Letter 2021-7 Attachment A does not specify a retention timeframe for documentation

that supports all calculations and statements pertaining to a reconciliation. Rather, the Letter references Section 3.4 of the FEHB contract for the timeframe."

OIG Comment:

We recognize and appreciate the Plan's continued efforts to obtain support for the disability status of the questioned sampled dependents. We also acknowledge the issues and difficulties experienced by the Plan in obtaining the supporting documentation from the applicable payroll offices. However, we recommend that the carrier continue to work with the applicable payroll offices to obtain the required documentation. Additionally, we plan to address the issues and difficulties experienced by the Plan with the applicable payroll offices with OPM officials.

We agree that the Plan is required to accept the 834 to process enrollments and the reports do not include the supporting certification documentation from the payroll offices. But this does not prohibit the Plan from requesting supporting certification documentation from the applicable payroll offices.

Further, we understand the Plan's position that the payroll offices are the more appropriate parties to do the outreach to the remaining overage enrollees in question. However, none of the guidance or reasons cited by the Plan prohibits or restricts them from reaching out directly to the overage dependents in question. All parties in the enrollment process have a responsibility to ensure that the enrollment files are correct and accurate. FEHB Carrier Letter 2020-16 specifically states that "Both FEHB Carriers and employing offices have a shared responsibility to verify and confirm family member eligibility, recognizing that ineligible family members can result in the FEHB Program paying erroneous or even fraudulent claims." We continue to recommend that the Plan pursue all available means to obtain support for the enrollees' disability status and note that the FEHB Carrier Letter 2020-16, Section I.A., offers directions to carriers on requesting appropriate documentation through a letter to the enrollee, with a copy to the applicable employing office.

The Plan correctly noted that the Contract and associated FEHBAR reference do not require a Carrier to retain documentation supporting disability status indefinitely. Our findings and recommendation are intended to provide clarity on the requirement captured in FEHB Carrier Letter 2021-7, Attachment A. The Plan uses claims data in the experience period that is used to develop its FEHBP premium rates each year. That data includes the claims incurred by the overage dependents we identified in our review. In this case, as long as any of the overage dependents have claims that are used to develop a premium rate in any given year, the documentation of their disability certification that confirms their eligibility to incur those

claims is relevant to the contract year to which that premium rate relates, plus six years. The documentation should be accessible to various Plan officials and oversight personnel in order to ensure the enrollee is eligible for coverage and claims payment. To avoid experiencing this possible issue in subsequent audit inquires, we continue to recommend that the Plan retain support for these enrollees indefinitely, i.e., as long as the enrollees incur claims that are used in the FEHBP premium rate developments. Further, even though the Plan did not make the initial disability determination, the Plan is required to provide supporting certification documentation for overage dependents.

Lastly, the Plan believes its record policies and procedures are compliant with Section 3.4 of the FEHB contract and FEHBAR 1652.204-70 and that the Carrier Letter 2021-7 Attachment A references Section 3.4 of the FEHB contract for the timeframe. However, as previously noted above, the Plan is not currently maintaining support that overage dependents who incur claims used in the FEHBP premium rates are certified as disabled and, therefore, eligible to incur those claims. This documentation should be retained through any contract year that includes claims for these enrollees, plus six years, per the Contract and referenced FEHBAR sections. As such, we continue to recommend that the Plan updates its policies to reflect retention of documentation for this unique circumstance.

C. Other Areas of Review

During our audit, we reviewed the following areas, for which no issues requiring corrective actions were identified.

1. Medical and Pharmacy Claims Processing

During our review, we found that the Plan has adequate controls to assure the FEHBP medical and pharmacy claims are being adjudicated properly in accordance with the contract, regulations, and internal policies and procedures.

2. Capitations

Our review determined that the Plan has policies and procedures over its capitation process. The Plan was able to provide the capitation information used in the development of the FEHBP rate calculations.

3. Enrollment

Our review determined that the Plan has policies and procedures for its enrollment process and the enrollment information used in the development of the FEHBP rate calculations.

4. Contract Compliance

The contract compliance review included the areas of fraud, waste, and abuse; debarment; and offshore contracting. We noted the following results:

a. Fraud, Waste, and Abuse

Our review of the fraud, waste, and abuse documents maintained by the Plan determined that it has sufficient policies and procedures in place, in accordance with the FEHBP Carrier Letters.

b. Debarment

Per Contract Sections 2.7 and 5.47, the Plan must meet contractual requirements related to providers debarred by the OPM OIG FEHBP Debarring Official. Based on our review, we concluded the Plan has processes and procedures in place to meet the requirements outlined in the contract.

c. Offshore Contracting

Our review determined that the Plan has appropriate processes and procedures in place to meet the requirements of FEHB Carrier Letter 2012-23 and provided adequate oversight of offshore contracting activities.

5. Corporate and Financial Review

Our limited review of the Plan's corporate structure, financial statements, and internal audits did not result in any potential audit leads or findings.

6. Medical Claims Pricing

During our review, we determined that the Plan accurately priced and paid allowable medical benefits for eligible enrollees in accordance with the FEHB benefit brochure, its contract with OPM, and the Plan's contract with its providers.

Exhibit A

Blue Care Network of Michigan
Medical Claims Sample Selection Criteria and Methodology

Universe Criteria	Universe of Unique Claims (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Number	Sample (Dollars)	Results Projected to the Universe?
Incurred Medical Claims from 1/1/2020 through 1/31/2021 used in the 2022 Claims Experience	206,648	$72,578,398	Judgmental/Random - utilized SAS EG[3] to select 20 random claims greater than $20,000.	20	$613,437	No
Dependents that Incurred ACR Claims from 1/1/2020 through 1/31/2021 used in the 2022 Claims Experience	89 Dependents, Age > = 26	N/A	Random - utilized SAS EG to select 25 random dependents, age > = 26	25	N/A	No

[3] SAS Enterprise Guide is a software used to analyze data allowing users to access and manipulate data quickly.

APPENDIX

Received: December 27, 2023

Deleted by OIG – Not Relevant to the Final Report

A. PREMIUM RATE REVIEW

Deleted by OIG – Not Relevant to the Final Report

1. **Deleted by OIG – Not Relevant to the Final Report**

Recommendation 2

We recommend that the Plan include additional measures related to its calculation of the medical and vision base rates to ensure that process is being followed by all responsible parties.

Plan's Response

Deleted by OIG – Not Relevant to the Final Report. The Plan agreed with recommendation 2.

BCN Comments

BCN agrees with recommendation 2 as noted.

2. **Deleted by OIG – Not Relevant to the Final Report**

B. INTERNAL CONTROLS REVIEW

Deleted by OIG – Not Relevant to the Final Report

1. **Overage Dependent Eligibility**

Deleted by OIG – Not Relevant to the Final Report

Recommendation 4

In accordance with FEHB Program Carrier Letter 2020-16, we recommend that the Plan verify that the 15 unsupported overage dependents identified during our review are still eligible for FEHB coverage and update its claims and enrollment systems accordingly.

APPENDIX

BCN Comments

In alignment with direction from the OIG auditors, BCN reached out to the payroll offices but obtaining responses from the payroll offices has been difficult and time-consuming. To date, BCN received documentation for 10 of the overage dependent samples. BCN will continue to reach out to the payroll offices in effort to obtain the supporting documentation on the remaining samples.

As acknowledged in the OIG auditor comments below, the payroll offices frequently use the 834 process for enrollments, and BCN is required to accept such enrollments as the source of truth. There is no way to attach a document specific to a member to an outbound 834 file, so the payroll office is unable to send a disability letter with the 834 file. The payroll office should instead send the enrollment manually including the supporting documentation to be enrolled.

Regarding directly contacting the enrollee to verify disability status, BCN believes the payroll office is the more appropriate party to do this reach-out to the remaining sample of overage dependents pursuant to regulatory guidance and given that some of the overage dependents were deemed disabled prior to enrolling in BCN coverage. The preamble to the final rule cited in OPM's summary above at 83 FR 3059 ("Final Rule") expressly states that "the employing offices will be responsible for collecting documentation and determining proof of eligibility status and that the information will be sent to FEHB Program Carriers." Furthermore, the Final Rule states that an FEHB carrier "may" request verification of eligibility from the enrollee but does not use the word "shall" or "must." See 5 CFR 890.308(e). This interpretation is consistent with the U.S. Government Accountability Office's position in a December 2022 report on OPM's efforts to ensure only eligible family members are enrolled in FEHBP coverage.

> **Amended regulations.** In 2018, OPM published amended regulations stating that proof of family member eligibility must be provided to the FEHB health insurance carrier, employing office, or OPM upon request. These regulations also establish a process for the removal of individuals who are not found to be eligible. Pursuant to these regulations, employing offices and FEHB carriers may – but are not required to – request proof of family member eligibility at any time for exisiting participants.

Additionally, the sample letter to request family member eligibility verification from the enrollee is directed toward the employing office.

Attachment 1: Agency/Tribal Employer Request for Verification of Family Member Eligibility

For Employing Office/Tribal Employer Use

Recommendation 5

We recommend that the Plan retain supporting documentation from the responsible employing offices for designated FEHBP overage dependents indefinitely to properly support all calculations and statements pertaining to the FEHB rate reconciliations.

BCN Comments

Neither the FEHBP contract nor FEHBP regulations require carriers to retain records indefinitely. Section 3.4 of the FEHB contract and FEHBAR 1652.204-70 require a carrier to retain documentation supporting their rate submission for the applicable contract year for a period of six years after the end of the contract year to which the records relate. As an example, if a manual enrollment was initially submitted with a disability certification for a

March 1, 2017, enrollment, the carrier would be required to retain such certification through the end of 2023 (i.e., six years from the end of the 2017 contract year when the certification was submitted).

The OIG auditors have cited no regulatory or sub-regulatory guidance that the six year requirement is a rolling timeframe other than to make a conclusory statement that BCN's example "does not reflect the intention of that requirement." Furthermore, the OIG auditors failed to acknowledge that whether BCN was able to produce the disability certification would not have impacted any of the overage dependents' eligibility status for the years following the determination as BCN does not make initial disability determination. BCN must accept the payroll office's decision on a family member's eligibility.

Recommendation 6

We recommend that the Plan update its written policies and procedures to align its retention of FEHB overage dependent disability certification documentation with requirements in Carrier Letter 2021-7 Attachment A to maintain documentation that supports all calculations and statements pertaining to the reconciliation.

APPENDIX

BCN Comments

BCN believes its record retention policies are compliant with Section 3.4 of the FEHB contract and FEHBAR 1652.204-70. Carrier Letter 2021-7 Attachment A does not specify a retention timeframe for documentation that supports all calculations and statements pertaining to a reconciliation. Rather, the Letter references Section 3.4 of the FEHB contract for the timeframe.

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