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

Final Audit Report

AUDIT OF THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM OPERATIONS AT CAPITAL HEALTH PLAN

Report Number 1C-EA-00-19-024
May 13, 2020

EXECUTIVE SUMMARY

Audit of the Federal Employees Health Benefits Program Operations at Capital Health Plan

Report No. 1C-EA-00-19-024 **May 13, 2020**

Why Did We Conduct The Audit?

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

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

What Did We Audit?

Under Contract CS 2034, the Office of the Inspector General (OIG) completed a performance audit of the FEHBP MLR submissions to OPM for contract years 2014 through 2016. We conducted our audit fieldwork from July 22, 2019, through November 26, 2019, at the Plan's offices in Tallahassee, Florida, and in our OIG offices.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

We determined that portions of the MLR calculations were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM for contract years 2014 through 2016. This resulted in overstated MLR credits of $222,141 for 2014, $175,997 for 2015, and $82,045 for 2016. Specifically, our audit identified the following:

- The Plan did not accurately report its adjusted incurred claims in contract years 2014 through 2016.
- The Plan improperly processed claims for diabetic test strips and lancets under the durable medical equipment benefit instead of the pharmacy benefit.
- The Plan did not use an acceptable count method to calculate its FEHBP Transitional Reinsurance Fee (TRF) for contract years 2014 through 2016.
- The Plan reported an incorrect TRF in its 2014 MLR filing due to its Medicare primary membership.

The Plan did not have adequate written policies and procedures to govern its MLR process and did not maintain documentation in accordance with its Contract with OPM.

ABBREVIATIONS

CFR	**Code of Federal Regulations**
CMS	**Centers for Medicare & Medicaid Services**
Contract	**Contract CS 2034**
DME	**Durable Medical Equipment**
FEHBP	**Federal Employees Health Benefits Program**
IBNR	**Incurred But Not Reported**
MLR	**Medical Loss Ratio**
OIG	**Office of the Inspector General**
OPM	**Office of Personnel Management**
Plan	**Capital Health Plan**
SSSG	**Similarly-Sized Subscriber Group**
TRF	**Transitional Reinsurance Fee**
U.S.C.	**United States Code**

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I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at Capital Health Plan (Plan). The audit was conducted pursuant to the provisions of Contract CS 2034 (Contract); 5 United States Code (U.S.C.) Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract years 2014 through 2016, and was conducted at the Plan's offices in Tallahassee, Florida.

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

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

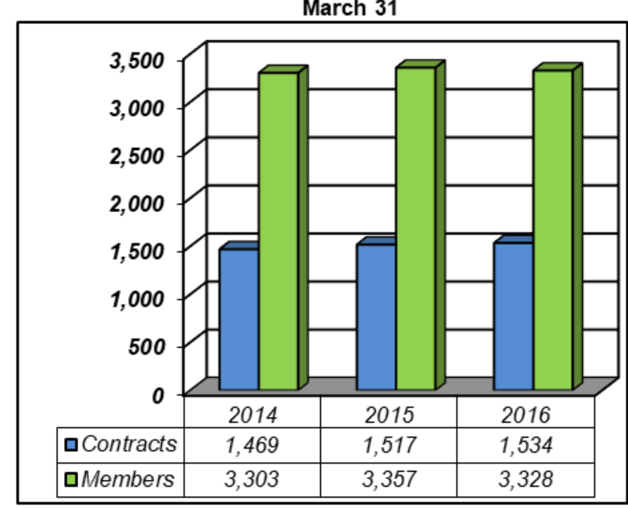
The MLR was established to ensure that health plans are meeting specified thresholds for spending on medical care and health care quality improvement measures, and thus limiting spending on administrative costs, such as executive salaries, overhead, and marketing of the health plan. However, in our opinion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

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

Starting with the pilot program in 2012 and for all non-traditional community-rated FEHBP carriers in 2013, OPM required the carriers to submit an FEHBP-specific MLR. This FEHBP-specific MLR calculation required carriers to report information related to earned premiums and expenditures in various categories, including reimbursement for clinical services provided to enrollees, activities that improve health care quality, and all other non-claims costs. If a carrier fails to meet the FEHBP-specific MLR threshold, it must make a subsidization penalty payment to OPM within 60 days of notification of amounts due.

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

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



The Plan has participated in the FEHBP since 1986 and provides health benefits to FEHBP members in Tallahassee, Florida. A prior FEHBP audit of the Plan covered contract year 2012. The audit did not identify any findings or questioned costs, and no corrective action was necessary.

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

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

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

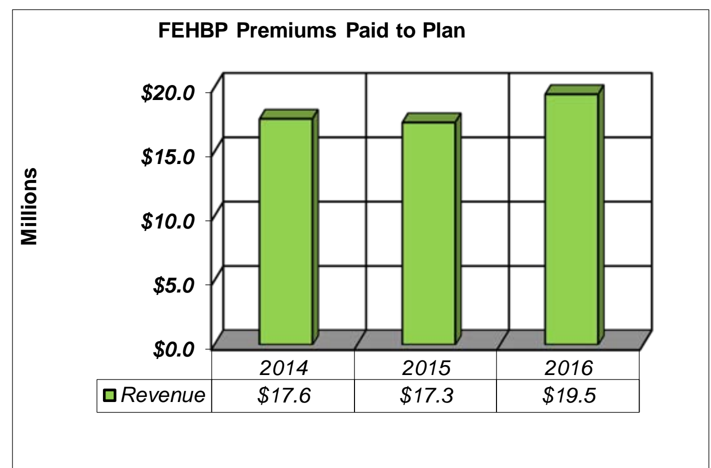
Our audits of the MLR submission filed with OPM are completed in accordance with the criteria expressed in OPM's rating instructions. The MLR audit evaluation includes an assessment of key components of the MLR calculation, including allowable claims, capitations, health care expenses, and quality health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

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

SCOPE

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

This performance audit covered contract years 2014 through 2016. For these years, the FEHBP paid approximately $54.4 million in premiums to the Plan.



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

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

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

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

We conducted our audit fieldwork from July 22, 2019, through November 26, 2019, at the Plan's offices in Tallahassee, Florida, as well as in our offices in Cranberry Township, Pennsylvania; Jacksonville, Florida; and Washington, D.C.

METHODOLOGY

We examined the Plan's MLR calculations and related documents as a basis for validating the MLR. Further, we examined medical claim payments, quality health expenses, taxes and

regulatory fees, premium income, and any other applicable costs to verify that the cost data used to develop the MLR was accurate, complete, and valid. Finally, we used the Contract, the OPM rate instructions, and applicable Federal regulations to determine the propriety of the Plan's MLR calculations.

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

The tests performed for medical claims, along with the methodology, are detailed in Exhibit E at the end of this report. Due to current contract limitations, our review of the Pharmacy claims was limited to the Plan's policies and procedures and did not include an evaluation of the contract pricing of pharmacy claims or benefits received.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. MEDICAL LOSS RATIO REVIEW

The Certificates of Accurate MLR that the Plan signed for contract years 2014 through 2016 were defective. The Certificate of Accurate MLR states that the FEHBP specific MLR is accurate, complete, and consistent with the methodology in Section 1615.402(c)(3)(ii). In accordance with Federal regulations and the OPM Community Rating Guidelines, our audit identified the following issues:

1. Overstated MLR Credits $480,183

During the 2014 through 2016 MLR filing periods, the Plan calculated MLR ratios that exceeded OPM's upper threshold of 89 percent and resulted in credits to the Plan. During our review of the FEHBP MLR filings, we identified issues that resulted in lower audited MLRs than those that were calculated by the Plan. Discussion of the specific issues that led to the overstated credits, listed in Table I below, are discussed beginning in section A.2 of this report.

	Table I – Overstated MLR Credits				
Year	**Plan's MLR Ratio**	**Audited MLR Ratio**	**Plan's Current Credit**	**Audited Credit**	**Credit Adjustment Due to OPM**
2014	106.88%	105.55%	$3,065,760	$2,843,619	$222,141
2015	110.26%	109.22%	$3,598,772	$3,422,775	$175,997
2016	98.09%	97.66%	$1,743,700	$1,661,655	$82,045
Total Credit Amount Due to OPM					**$480,183**

2. MLR Claims Data

a. Inaccurately Reported Incurred Claims

The Plan did not accurately report its 2014 through 2016 adjusted incurred claims.

The 2014 through 2016 OPM rating instructions required that Carriers "maintain all MLR documentation ... to fully support all claim values." Contract Section 1.11(b) further requires insurance carriers to maintain all records relating to the Contract and to make these records available for a period of time specified by the Federal Employees Health Benefits Acquisition Regulation 1652.204-70. The referenced clause is also incorporated in Section 3.4, which requires the carrier to maintain

individual enrollee and/or patient claim records "for six years after the end of the contract term to which the claim records relate."

Further, the OPM Carrier Letter 2015-1 and 2013-11 Rate Instructions state that no completion factor should be applied or included in the MLR claims totals. The estimated incurred but not reported (IBNR) totals are calculated by using completion factors and therefore should not be allowed in the MLR claims totals.

Based on our review of 2014 through 2016 FEHBP MLR Form Line 2.1(b) adjusted claims, we identified variances that the Plan was unable to explain. The Plan stated that it did not maintain its transactional level detail at the time of its original MLR filings for 2014 through 2016. As a result, it had to refresh several reports in order to provide the required audit documentation, which caused the variances in the 2014 through 2016 audited adjusted incurred claims totals. Additionally, the Plan erroneously included an estimated IBNR in its original 2014 MLR filing.

We identified variances in each year of our review, as shown in Table II below. As a result, the Plan overstated its 2014 through 2016 MLR numerators, which caused its credits to be overstated.

Table II – Claim Variances	
Contract Year	**Variance**
2014	$181,596
2015	$159,643
2016	$66,018

b. Diabetic Supply Claims

The Plan improperly processed claims for diabetic test strips and lancets under the durable medical equipment (DME) benefit instead of the pharmacy benefit. The 2014 FEHBP benefit brochure required diabetic test strip and lancet claims to be processed as pharmacy benefits. We reviewed a sample of 75 medical claims for contract year 2014 and determined that the Plan improperly processed claims for diabetic test strips and lancets. The Plan had agreements with two suppliers during the audit scope to process specific brands of diabetic supplies as DME benefits. The Plan stated that the diabetic supplies provided through the DME benefit were delivered at a lower cost per unit when used in tandem with the pharmacy benefit. This did not comply with the FEHBP benefit brochure.

As a result, we removed the improperly processed claims for the two suppliers from the 2014 through 2016 MLR calculations, as illustrated in Table III.

Table III - Diabetic Test Strips and Lancets		
Contract Year	**Number of Claims**	**Amount Removed**
2014	369	$12,496
2015	457	$16,353
2016	359	$16,027
Totals	**1,185**	**$44,876**

3. Transitional Reinsurance Fees

We reviewed the Transitional Reinsurance Fees (TRF) for contract years 2014 through 2016. Based on our review, we determined (a) the Plan used an unacceptable method to count the number of covered lives and (b) the TRF was overcharged. Although these issues are noteworthy, we do not have recommendations related to the TRF because it ended in 2017 and is no longer part of the MLR calculation.

Section 1341 of the Affordable Care Act established a transitional reinsurance program. It was established to help stabilize premiums in the individual market inside and outside of the Marketplaces during the 2014 through 2016 benefit years. It collects contributions from contributing entities to fund reinsurance payments to issuers of non-grandfathered reinsurance-eligible individual market plans, the administrative costs of operating the reinsurance program, and the General Fund of the U.S. Treasury.

a. Membership Count Method

The Plan did not use an acceptable count method to calculate the FEHBP TRF for contract years 2014 through 2016.

The Centers for Medicare & Medicaid Services (CMS) used the annual enrollment count to calculate a contributing entity's reinsurance contribution amount due for the applicable benefit year. In order to calculate the number of covered lives of reinsurance contribution enrollees for a benefit year, CMS set forth certain permitted counting methods in 45 CFR 153.405. The permitted counting method depends on

whether the contributing entity is a health insurance issuer or a self-insured group health plan, and whether, in the case of a group health plan that is a contributing entity, the plan offers more than one coverage option.

The Plan calculated its TRF by totaling members for each month of the calendar year and dividing by 12 months. This method is not one of the CMS approved counting methods for the FEHBP TRF calculations for 2014 through 2016. Based on the Plan's calculation, the average membership was overstated for 2014 and 2016 and understated for 2015. The overall impact on the TRF and MLR calculations was immaterial for contract years 2014 through 2016.

b. 2014 Medicare Primary Membership

The Plan reported an incorrect TRF in its 2014 MLR filing due to its Medicare primary membership.

Per OPM Carrier Letter 2013-15 - Transitional Reinsurance Program Fee, carriers are not required to make fee payments for individuals who are enrolled in any part of Medicare if Medicare is the primary payer of services for those individuals. A carrier's loading must be adjusted to recognize that the fee is not applicable for those FEHB members where Medicare coverage (Part A, Part B, or both) is primary.

According to 45 CFR 153.400(a)(1)(iv), members covered as Primary under Medicare Secondary Payor rules are excluded.

The TRF generally applies to major medical coverage, including grandfathered plans. However, certain types of coverage are specifically excluded from the fee, including Medicare. During our audit, it was determined that the Plan erroneously included Medicare primary members in the TRF calculation. As a result, the TRF was overstated by $31,516, which caused the 2014 MLR denominator to be understated.

Conclusion

We recalculated the Plan's 2014 through 2016 FEHBP MLRs, incorporating the above-mentioned adjustments. A comparison of our audited MLR calculations to those submitted by the Plan showed overstated FEHBP MLR credit amounts of $222,141, $175,997, and $82,045 in contract years 2014 through 2016, respectively.

Recommendation 1

We recommend that the contracting officer reduce the MLR credit in contract year 2014 by $221,141.

Recommendation 2

We recommend that the contracting officer reduce the MLR credit in contract year 2015 by $175,997.

Recommendation 3

We recommend that the contracting officer reduce the MLR credit in contract year 2016 by $82,045.

Plan Response

The Plan agrees with Recommendations 1, 2 and 3, regarding the adjustments necessary to the credit carry forward balances for the contract years 2014 through 2016.

Recommendation 4

We recommend that the Plan ensure completion factors are not used for the claims in its MLR filings.

Plan Response

The Plan agrees to this finding and has implemented a process to ensure completions factors are not used in future MLR filings.

Recommendation 5

We recommend that the Plan ensure all claims are processed in accordance with the FEHBP benefit brochure.

Plan Response

The Plan agrees to this finding and is…making the necessary changes as it relates to processing diabetic test strips and lancets claims under the pharmacy benefits.

B. INTERNAL CONTROLS

The Plan did not have adequate written policies and procedures to govern its MLR process and did not maintain documentation in accordance with its 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."

Additionally, Contract Section 1.11(b) requires insurance carriers to maintain all records relating to the Contract and to make these records available for a period of time specified by the Federal Employees Health Benefits Acquisition Regulations 1652.204-70. The referenced clause is incorporated into the contracts at Section 3.4, which requires the carrier to maintain "all records applicable to a contract term ... for a period of six years after the end of the contract term to which the claim records relate."

The Plan did not comply with the Contract's records retention requirements and was unable to provide all of the necessary supporting documentation during the audit. We also noted that allocation ratios were either not supported or varied from the support provided by the Plan. A lack of internal controls over the MLR review process resulted in discrepancies in the MLR filings reviewed for contract years 2014 through 2016.

Recommendation 6

We recommend that the Plan maintain all records and MLR documentation for the time period specified in its Contract.

Plan Response

The Plan agrees to this finding and has implemented a process to retain all records need to support the MLR report for the duration of time required by its Contract under Section 1.11 (b).

Recommendation 7

We recommend that the Plan institute a more stringent FEHBP MLR review process to identify reporting errors prior to submitting the FEHBP MLR to OPM.

Plan Response

The Plan agrees to this finding and has implemented a process to improve the review process going forward. Policies and procedures will be enhanced to include these additional steps going forward.

EXHIBIT A

Capital Health Plan
Summary of MLR Credit Adjustments

2014 Overstated MLR Credit	$222,141
2015 Overstated MLR Credit	$175,997
2016 Overstated MLR Credit	$82,045
Total Overstated MLR Credit	**$480,183**

EXHIBIT B

Capital Health Plan
2014 MLR Credit Adjustment

	Plan	Audited
2014 FEHBP MLR Lower Thresholds (a)	85%	85%
2014 FEHBP MLR Upper Thresholds (b)	89%	89%
Claims Expense		
Medical & Pharmacy Claims	$18,200,525	$18,200,525
Less: Diabetic Supply Claims	$0	$12,496
Less: Inaccurately Reported Incurred Claims	$0	$181,596
Adjusted Incurred Claims	**$18,200,525**	**$18,006,433**
Plus: Quality Health Improvement Expenses	$125,191	$125,191
Total MLR Numerator	**$18,325,716**	**$18,131,624**
Premium Income	$17,556,692	$17,556,692
Less: Taxes and Regulatory Fees	$410,674	$410,674
Plus: Inaccurate Transitional Reinsurance Fee	$0	$31,516
Total MLR Denominator (c)	**$17,146,018**	**$17,177,534**
FEHBP Medical Loss Ratio (d)	106.88%	105.55%
Credit Calculation (If (d) is greater than (b), ((d-b)*c)	$3,065,760	$2,843,619
Total Credit Adjustment Due To OPM		**$222,141**

EXHIBIT C

Capital Health Plan
2015 MLR Credit Adjustment

	Plan	Audited
2015 FEHBP MLR Lower Thresholds (a)	85%	85%
2015 FEHBP MLR Upper Thresholds (b)	89%	89%
Claims Expense		
Medical & Pharmacy Claims	$18,573,089	$18,573,089
Less: Diabetic Supply Claims	$0	$16,353
Less: Inaccurately Reported Incurred Claims	$0	$159,643
Adjusted Incurred Claims	**$18,573,089**	**$18,397,093**
Plus: Quality Health Improvement Expenses	$93,986	$93,986
Total MLR Numerator	**$18,667,075**	**$18,491,079**
Premium Income	$17,272,035	$17,272,035
Less: Taxes and Regulatory Fees	$341,357	$341,357
Total MLR Denominator (c)	**$16,930,678**	**$16,930,678**
FEHBP Medical Loss Ratio (d)	110.26%	109.22%
Credit Calculation (If (d) is greater than (b), ((d-b)*c)	$3,598,772	$3,422,775[1]
Total Credit Adjustment Due To OPM		**$175,997[1]**

[1] Due to rounding the Audited MLR percentage, the totals may not mathematically tie.

EXHIBIT D

Capital Health Plan
2016 MLR Credit Adjustment

	Plan	Audited
2016 FEHBP MLR Lower Thresholds (a)	85%	85%
2016 FEHBP MLR Upper Thresholds (b)	89%	89%
Claims Expense		
Medical & Pharmacy Claims	$18,723,923	$18,723,923
Less: Diabetic Supply Claims	$0	$16,027
Less: Inaccurately Reported Incurred Claims	$0	$66,018
Adjusted Incurred Claims	**$18,723,923**	**$18,641,878**
Plus: Quality Health Improvement Expenses	$92,987	$92,987
Total MLR Numerator	**$18,816,910**	**$18,734,865**
Premium Income	$19,466,353	$19,466,353
Less: Taxes and Regulatory Fees	$282,971	$282,971
Total MLR Denominator (c)	**$19,183,382**	**$19,183,382**
FEHBP Medical Loss Ratio (d)	98.09%	97.66%
Credit Calculation (If (d) is greater than (b), ((d-b)*c)	$1,743,700	$1,661,655
Total Credit Adjustment Due To OPM		**$82,045**

EXHIBIT E

Claims Sample Selection Criteria/Methodology

Medical Claims Sample

Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Medical claims incurred from 1/1/2014 through 12/31/2014	114,075 claims	$6,659,977	Utilized RAT-STATS (90% Confidence Level 50% Anticipated Rate of Occurrence and 20% Desired Precision Range), which generated a sample size of 75. Then utilized SAS to randomly select 75 incurred, unadjusted medical claims.	Statistical	No

APPENDIX

January 21, 2020

[redacted]
Chief, Community-Rated Audits Group
U.S. Office of Personnel Management
1900 E Street, NW
Room 6400
Washington, D.C. 20415-1100

Dear Mr. [redacted]

Your letter to Capital Health Plan (Plan) dated December 13, 2019, communicates the findings, conclusions and recommendations from the Capital Health Plan Draft Audit Report 1C-EA-00-19-024. The Plan appreciates the opportunity to respond to the audit findings.
The Plan's comments concerning the finding in the report are as follows:

A. Medical Loss Ratio Review:

Recommendation 1
We recommend that the contracting officer reduce the MLR credit in contract year 2014 by $222,141.

Recommendation 2
We recommend that the contracting officer reduce the MLR credit in contract year 2015 by $175,997.

Recommendation 3
We recommend that the contracting officer reduce the MLR credit in contract year 2016 by $82,045.

Plan Response (1-3):
The Plan agrees with Recommendations 1, 2 and 3, regarding the adjustments necessary to the credit carry forward balances for the contract years 2014 through 2016.

Deleted by the OIG – Not Relevant to the Final Report

Recommendation 5
We recommend that the Plan ensure completion factors are not used for the claims in its MLR filings.

Plan Response:
The Plan agrees to this finding and has implemented a process to ensure completions factors are not used in future MLR filings.

Recommendation 6
We recommend that the Plan ensure all claims are processed in accordance with the FEHBP benefit brochure.

Plan Response:
The Plan agrees to this finding and is **Deleted by the OIG – Not Relevant to the Final Report** making the necessary changes as it relates to processing diabetic test strips and lancets claims under the pharmacy benefits **Deleted by the OIG – Not Relevant to the Final Report** .

B. Internal Controls:

Recommendation 5
We recommend that the Plan maintain all records and MLR documentation for the time period specified in its Contract.

Plan Response:
The Plan agrees to this finding and has implemented a process to retain all records need to support the MLR report for the duration of time required by its Contract under Section 1.11 (b).

Recommendation 6
We recommend that the Plan institute a more stringent FEHBP MLR review process to identify reporting errors prior to submitting the FEHBP MLR to OPM.

Plan Response:
The Plan agrees to this finding and has implemented a process to improve the review process going forward. Policies and procedures will be enhanced to include these additional steps going forward.

Please let us know if you have any questions or if there is any additional support that we can provide to assist you.

Respectfully,

Paul A. Bawek
Controller
(850-383-[redacted]
[redacted]@chp.org

Report Fraud, Waste, and Mismanagement

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