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

# Final Audit Report

**Subject:**

## Audit of the Federal Employees Health Benefits Program Operations at AvMed Health Plans

**Report No. 1C-ML-00-11-004**

**Date:** 09/30/11

**-- CAUTION --**

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

# EXECUTIVE SUMMARY

**Federal Employees Health Benefits Program**
**Community-Rated Health Maintenance Organization**
**AvMed Health Plans**
**Contract Number CS 2876 - Plan Code ML**
**Gainesville, Florida**

**Report No. 1C-ML-00-11-004** **Date:** 09/30/11

The Office of the Inspector General performed an audit of the Federal Employees Health Benefits Program (FEHBP) operations at AvMed Health Plans (Plan). The audit covered contract years 2005, 2007, 2009, and 2010 and was conducted at the Plan's office in Gainesville, Florida. Additional field work was performed at our offices in Jacksonville, Florida and Washington, D.C. Based on our audit, we have accepted the Plan's rating of the FEHBP for all years reviewed and have no questioned costs. However, the Plan did not fully comply with the records retention clause of its FEHBP contract for the years covered by this audit.

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

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Inspector General

# AUDIT REPORT

**Federal Employees Health Benefits Program**
**Community-Rated Health Maintenance Organization**
**AvMed Health Plans**
**Contract Number CS 2876 - Plan Code ML**
**Gainesville, Florida**

**Report No. 1C-ML-00-11-004** **Date:** 09/30/11

**Michael R. Esser**
**Assistant Inspector General**
**for Audits**

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# I. INTRODUCTION AND BACKGROUND

## Introduction

We completed an audit of the Federal Employees Health Benefits Program (FEHBP) operations at AvMed Health Plans (Plan) in Gainesville, Florida. The audit covered contract years 2005, 2007, 2009, and 2010. The audit was conducted pursuant to the provisions of Contract CS 2876; 5 U.S.C. Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit was performed by the Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

## Background

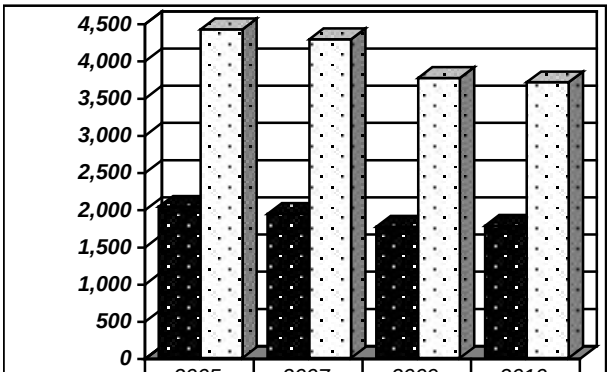
The FEHBP was established by the Federal Employees Health Benefits Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for federal employees, annuitants, and dependents. The FEHBP is administered by OPM's Healthcare and Insurance Office.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

Community-rated carriers participating in the FEHBP are subject to various federal, state and local laws, regulations, and ordinances. While most carriers are subject to state jurisdiction, many are further subject to the Health Maintenance Organization Act of 1973 (Public Law 93-222), as amended (i.e., many community-rated carriers are federally qualified). In addition, participation in the FEHBP subjects the carriers to the Federal Employees Health Benefits Act and implementing regulations promulgated by OPM.

The FEHBP should pay a market price rate, which is defined as the best rate offered to either of the two groups closest in size to the FEHBP. In contracting with community-rated carriers, OPM relies on carrier compliance with appropriate laws and regulations and, consequently, does not negotiate base rates. OPM negotiations relate primarily to the level of coverage and other unique features of the FEHBP.

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

**FEHBP Contracts/Members**
**March 31**




| | 2005 | 2007 | 2009 | 2010 |
|---|---|---|---|---|
| Contracts | 2,033 | 1,936 | 1,765 | 1,776 |
| Members | 4,416 | 4,284 | 3,763 | 3,706 |

The Plan has participated in the FEHBP since 2003 and provides health benefits to FEHBP members in south Florida. The last audit conducted by our office was a limited scope rate reconciliation audit and covered contract year 2008. There were no issues identified during that audit.

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 the preparation of this report and are included, as appropriate, as the Appendix.

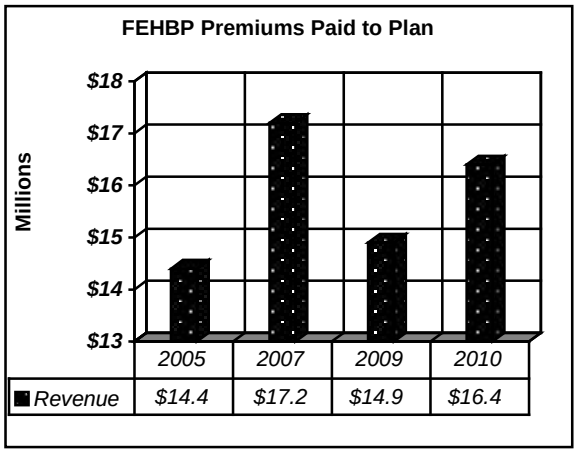
# II. OBJECTIVES, SCOPE, AND METHODOLOGY

## Objectives

The primary objectives of the audit were to verify that the Plan offered market price rates to the FEHBP and to verify that the loadings to the FEHBP rates were reasonable and equitable. Additional tests were performed to determine whether the Plan was in compliance with the provisions of the laws and regulations governing the FEHBP.

## 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 2005, 2007, 2009 and 2010. For these contract years, the FEHBP paid approximately $62.9 million in premiums to the Plan. The premiums paid for each contract year audited are shown on the chart above.

OIG audits of community-rated carriers are designed to test carrier compliance with the FEHBP contract, applicable laws and regulations, and OPM 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. However, the audit included such tests of the Plan's rating system and such other auditing procedures considered necessary under the circumstances. Our review of internal controls was limited to the procedures the Plan has in place to ensure that:

- The appropriate similarly sized subscriber groups (SSSG) were selected;
- the rates charged to the FEHBP were the market price rates (i.e., equivalent to the best rate offered to the SSSGs); and
- the loadings to the FEHBP rates were reasonable and equitable.

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 testing 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.

The audit fieldwork was performed at the Plan's office in Gainesville, Florida, during February 2011. Additional audit work was completed at our field offices in Jacksonville, Florida, and Washington, D.C.

## Methodology

We examined the Plan's federal rate submissions and related documents as a basis for validating the market price rates. Further, we examined claim payments to verify that the cost data used to develop the FEHBP rates was accurate, complete, and valid. In addition, we examined the rate development documentation and billings to other groups, such as the SSSGs, to determine if the market price was actually charged to the FEHBP. Finally, we used the contract, the Federal Employees Health Benefits Acquisition Regulations (FEHBAR), and OPM's Rate Instructions to Community-Rated Carriers to determine the propriety of the FEHBP premiums and the reasonableness and acceptability of the Plan's rating system.

To gain an understanding of the internal controls in the Plan's rating system, we reviewed the Plan's rating system's policies and procedures, interviewed appropriate Plan officials, and performed other auditing procedures necessary to meet our audit objectives.

# III. AUDIT FINDING AND RECOMMENDATIONS

## Premium Rate Review

Based on our audit, we have accepted the Plan's rating of the FEHBP for contract years 2005, 2007, 2009, and 2010 and have no questioned costs. However, we found the following issue that merits corrective action and follow-up:

## Records Retention

During the years covered by this audit, the Plan did not fully comply with the records retention clause of its FEHBP contract. After several requests, the Plan failed to provide sufficient and appropriate documentation supporting the benefit adjustment factors used in the rate development for the FEHBP and SSSGs. Although we ultimately completed sufficient, alternative testing to gain reasonable assurance that the FEHBP received a market price rate, the FEHBP contract requires that the Plan retain and make available all records supporting its rate submission for a period of six years after the end of the contract term to which the records relate.

## Plan's Comments (See Appendix):

The Plan does not agree with our finding or recommendations. The Plan believes the information provided during the review is consistent with the information provided in past audits and supportive of the benefit change factors.

The Plan believes the spreadsheets showing the benefit summaries for each plan design, and the capture of the benefit change factor between the standard benefit plan and the differing benefit plans, is adequate for our purposes. The Plan believes it is "impractical and unnecessary" to supply the granular, or more detailed, information in support of the benefit change factor.

In support of this position, the Plan detailed the following two-step process used to estimate the value of a benefit change.

1) A third party, proprietary actuarial pricing model is used to express the current plan design (medical or drug) relative to a standard benefit whose value is 1.000. For example, if the benefit relativity factor associated with a group's current benefits is 1.0750, the Plan considers this entire benefit plan as approximately 7.5 percent richer than the standard benefit plan.

2) The same actuarial pricing model is used to value the new benefit plan, and it too is expressed relative to the standard plan. Again, if the benefit relativity factor associated with a group's proposed benefit plan is 1.0500, the Plan considers this entire plan as

approximately 5 percent richer than the standard benefit plan. This indicates that the group's new benefit plan represents a small reduction in benefits.

The Plan does not attempt to value each component of a requested benefit change when more than one cost sharing variable or coverage limit is being altered. Instead, the Plan values both the current benefit plan and the proposed benefit plan in their entirety. The Plan believes this approach inherently recognizes any interaction or offsetting effects between simultaneous benefit changes, and an attempt to isolate the value of each component can result in an over/under valuation, creating an inaccurate premium. Each change to plan design should not be considered in a vacuum, but rather as part of a change to an entire plan.

"It is therefore impractical to share support for benefit change factors because deconstructing benefit change factors is not done at the time of quoting and is quite often impossible. In addition, it would likely result in nothing short of sharing an entire software application (certainly a violation of any third-party agreement), which encapsulated all of the actuarial assumptions needed to calculate the value of a benefit plan. Now, and as with prior audits, a complete understanding of the benefit changes and their value is achieved through a quick review of the benefit change factors and summaries. Any other prepared documentation would be superfluous."

**OIG's Response to the Plan's Comments:**

The Plan's response does not adequately address our finding, or provide new information that changes our position. The Plan's comments clearly indicate that the benefit adjustment factor information provided during the audit was at a summary level. The Plan's comments also indicate that the "granular" level support is retained, but that it is "impractical to share" this information. Since the Plan is unwilling to provide sufficient and appropriate documentation supporting the benefit adjustment factors used in the rate development for the FEHBP and SSSGs in all years covered by this audit, we maintain our audit finding and recommendations.

**Recommendation 1**

We recommend that the contracting officer require the Plan to implement a corrective action plan that includes steps to ensure that sufficient and appropriate documentation, including detailed support for benefit adjustment factors, is maintained in its files and available for OIG review during audits, as required in the contract. This corrective action plan should be provided to the contracting officer within 90 days of the date of the final report.

**Recommendation 2**

We recommend that the contracting officer assess the maximum penalty allowed in the contract between OPM and the Plan for its violation of the records retention clause.

In addition, we recommend that the contracting officer inform the Plan that:

- OPM expects it to fully comply with the records retention provisions of the contract and all applicable regulations;

- it should maintain copies of all pertinent rating documents that show the factors and calculations the Plan uses in developing the actual rates for the FEHBP and the groups closest in size to the FEHBP for each unaudited year;

- it should maintain copies of the enrollment reports and other necessary supporting documents for the FEHBP and the groups closest in size to the FEHBP for each unaudited year; and

- the applicable community-rated performance factors described in FEHBAR 1609.7101-2 will be enforced if information requested during audits is not provided.

# IV. MAJOR CONTRIBUTORS TO THIS REPORT

**Community-Rated Audits Group**

[redacted], Auditor-In-Charge

[redacted], Auditor

[redacted], Auditor

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[redacted], Deputy Assistant Inspector General for Audits

[redacted]., Chief

[redacted], Senior Team Leader

Appendix

AvMED HEALTH PLANS

2011 AUG -1 AM 10: 5

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

Dear [redacted]

We are writing in response to Draft Audit Report No. 1C-ML-00-11-004, Dated July 5, 2011.

We do not agree with three areas of Page 1 in the Draft Report:

- The statement: "We noted that the plan provided detailed supporting documentation for the benefit change factors in past audits. However, for the years under review in this audit, the Plan stated that it did not retain the information."
- Recommendation 1
- Recommendation 2

We reach this conclusion by drawing a very important distinction:

**The supporting documentation for a benefit change** consists of the capture of a benefit change factor and the corresponding benefit summaries. We retain this information for all groups, in all years. Further, we supplied these factors and summaries for each of the SSSG and Federal group benefit changes in each audit year.

**The supporting documentation for a benefit change factor** is far more granular. We absolutely retain this information; however it is impractical and unnecessary to supply this information. To understand why involves understanding the two-step process AvMed uses to estimate the value of a benefit change:

1) A third-party, proprietary actuarial pricing model is used to express the current plan design (medical or drug) relative to a standard plan whose value is 1.0000. Let us suppose the benefit relativity factor associated with a group's current plan is 1.0750. In other words we would consider this entire plan to be approximately 7.5% richer than the standard plan in our portfolio.

2) The same actuarial pricing model is used to value the new benefit plan, and it too is expressed relative to the standard plan. Let us suppose the benefit relativity factor associated with a group's proposed plan is 1.0500. In other words we would consider this entire plan to be approximately 5% richer than the standard plan in our



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# Appendix

portfolio - indicating that the group's new plan represents a small reduction in benefits.

Note that AvMed's pricing approach does not attempt to value each component of a requested benefit change when more than one cost sharing variable or coverage limit is being altered. Instead, it values both the current plan and the proposed plan in their entirety. Such an approach inherently recognizes any interaction or offsetting effects between simultaneous benefit changes. For instance, if a deductible and out of pocket maximum are changing at the same time a service is being removed from being subject to the deductible and out of pocket maximum, our approach will capture the value of the entire change, but will not allow one to see how much value is placed on the deductible change versus the other changing components. Indeed, there is no true way of isolating the value of the out of pocket and deductible alterations, because the underlying probability distribution (chosen to match a set of covered services) has changed as a result of one fewer service category now being subject to those components. In fact, an attempt to isolate the value of each component can result in an over/under valuation, creating an inaccurate premium. Each change to a plan design should not be considered in a vacuum, but rather as part of a change to an entire plan.

It is therefore impractical to share support for benefit change factors because deconstructing benefit change factors is not done at the time of quoting and is quite often impossible. In addition, it would likely result in nothing short of sharing an entire software application (certainly a violation of any third-party agreement), which encapsulates all of the actuarial assumptions needed to calculate the value of a benefit plan. Now, and as with prior audits, a complete understanding of the benefit changes and their value is achieved through a quick review of the benefit change factors and summaries. Any other prepared documentation would be superfluous.

Thank you for the opportunity to respond to the Draft Audit Report. Please contact me with any follow-up questions.

Sincerely,

[redacted]

Corporate Actuary
AvMed Health Plans

# Appendix

cc: [redacted] ASA, MAAA
Actuarial Manager
AvMed Health Plans

[redacted]
Director of Commercial Group Underwriting
AvMed Health Plans

[redacted]
VP, Underwriting
AvMed Health Plans