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 AVMED HEALTH PLANS

Report Number 1C-ML-00-14-026
February 27, 2015

EXECUTIVE SUMMARY

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

Report No. 1C-ML-00-14-026 **February 27, 2015**

Why Did We Conduct the Audit?

The primary objective of this performance audit was to determine whether AvMed Health Plans (Plan) was in compliance with the provisions of its contract and the laws and regulations governing the Federal Employees Health Benefits Program (FEHBP). Specifically, we verified if the Plan met the Medical Loss Ratio (MLR) requirements established by the U.S. Office of Personnel Management. Additional tests were performed to determine whether the plan was in compliance with the provisions of the laws and regulations governing the FEHBP.

What Did We Audit?

Under contract CS 2876, the Office of the Inspector General completed a performance audit of the FEHBP operations at the Plan. The audit covered the Plan's 2012 MLR submission, and was conducted in February 2014 at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

During our review of the Plan's MLR submission, we found that the Plan inappropriately included a reinsurance claim totaling $182,000. The Plan's organ transplant reinsurance program provides dollar-one coverage with a zero deductible. Consequently, none of the transplant related claims are processed by the Plan. The Plan pays a transplant reinsurance premium, which like regular reinsurance, should not be included in the MLR calculation.

The U.S. Department of Health and Human Services (HHS) regulations require that claims used in the numerator of the MLR calculation should include only those claims directly paid by a health plan. HHS regulations define direct paid claims as claim payments before ceded reinsurance. In this case, the transplant claim was paid directly by the Plan's reinsurer and should not have been included in the claims total for its MLR calculation. As a result, the FEHBP MLR subsidization penalty account was underpaid by the Plan in the amount of $182,000.

ABBREVIATIONS

ACA	**Affordable Care Act**
ASB	**Administrative Sanctions Branch**
AvMed	**AvMed Health Plans**
CFR	**Code of Federal Regulations**
CPT	**Current Procedural Terminology**
FEHBP	**Federal Employees Health Benefit Program**
FEHBAR	**Federal Employees Health Benefits Acquisition Regulations**
HHS	**Department of Health and Human Services**
MLR	**Medical Loss Ratio**
NPI	**National Provider Identifier**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**AvMed Health Plans**
SSSG	**Similarly Sized Subscriber Group**
TCR	**Traditional Community Rating**
U.S.C.	**United Sates Code**

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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) located in Gainesville, Florida. The audit covered contract year 2012, and was conducted at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida. 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 U.S. 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.

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 FR 19522). MLR is the proportion of FEHBP premiums collected by a carrier that is spent on clinical services and quality health improvements. The MLR for each carrier is calculated by dividing the amount of dollars spent for FEHBP members on clinical services and health care quality improvements by the total amount of FEHBP premiums collected in a calendar year.

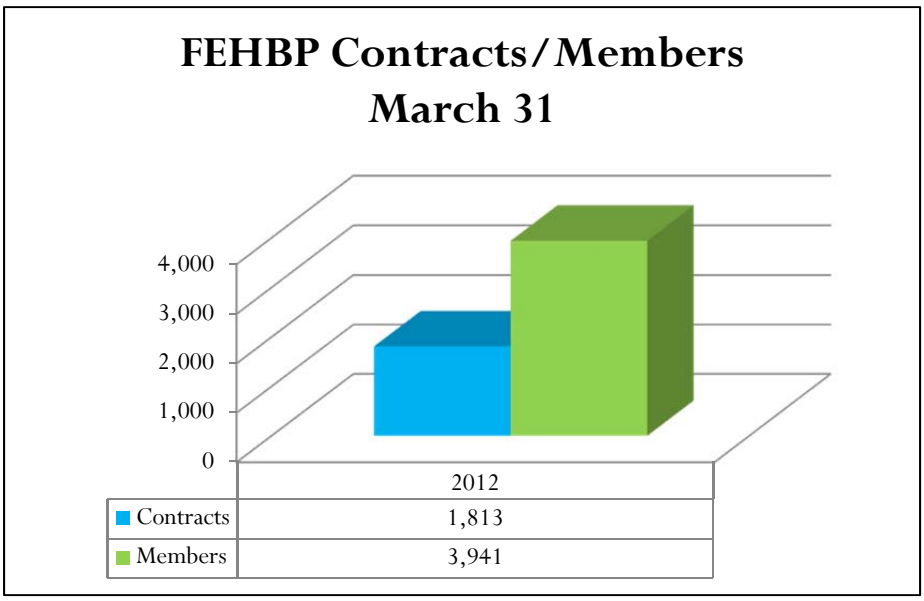
The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act (ACA, P.L. 111-148) and defined by the U.S. Department of Health and Human Services in 45 CFR Part 158. In 2012, community-rated FEHBP carriers could elect to follow the FEHBP-specific MLR requirements,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

Starting with the pilot program in 2012 and for all non-TCR FEHBP carriers in 2013, OPM required the carriers to submit an FEHBP-specific MLR. OPM required that the FEHBP-specific MLR threshold calculation take place after the ACA-required MLR calculation and any rebate amounts due to the FEHBP as a result of the ACA-required calculation be excluded from the FEHBP-specific MLR threshold calculation. Carriers were required 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. This payment would take place via wire transfer.

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 Plan reported 1,813 contracts and 3,941 members as of March 31, 2012, as shown in the chart below.



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 Plan has participated in the FEHBP since 2003 and provides health benefits to FEHBP members in South Florida. A prior audit of the Plan covered contract year 2011. In that audit, we determined that the FEHBP premiums were developed in accordance with applicable laws, regulations and OPM's Rate Instructions to Community-Rated Carriers (rate instructions) for contract year 2011.

The preliminary results of this audit were discussed with the Plan officials at an exit conference and in subsequent correspondence.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

Objective

The primary objective of this performance audit was to determine whether AvMed (the Plan) was in compliance with the provisions of its contract and the laws and regulations governing the FEHBP. Specifically, we verified whether the Plan met the MLR requirements established by OPM and paid the correct amount to the Subsidization Penalty Account, if applicable. We also verified whether the Plan offered a fair premium rate, based on its underwriting guidelines, rating methodology and OPM rules and regulations. 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 year 2012. For this year, the FEHBP paid approximately $22 million in premiums to the Plan.

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 tests of the Plan's FEHBP premium rating system, claims data, quality health expenses, and all other applicable costs considered in the calculation of its FEHBP premiums and MLR. Our review of internal controls was limited to the procedures the Plan has in place to ensure that:

- The rates charged to the FEHBP are developed in accordance with the Plan's standard rating methodology and the claims, factors, trends, and other related adjustments are supported by complete, accurate and current source documentation; and

- The FEHBP MLR calculation is accurate, complete, and valid; claims were processed accurately; appropriate allocation methods for quality health expenses are being used; and, that any other costs associated in its MLR calculation are 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 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.

Based on the survey work performed, we identified a total universe of 69,367 medical claim lines totaling $13,541,293, and 41,554 pharmacy claim lines totaling $2,547,929, from January 1, 2012 through December 31, 2012, and paid through March 31, 2013. The audit universe attributes are the mandatory medical and pharmacy claim field requirements included in FEHB Carrier Letter 2014-01, Audit Requirements for 2012 MLR Pilot Program Carriers.

All audit fieldwork was performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida during February 2014.

Methodology

We examined the Plan's MLR calculation and related documents as a basis for validating the MLR. Further, we examined claim payments and quality health expenses to verify whether the cost data used to develop the MLR was accurate, complete and valid. We also examined the methodology used by the Plan in determining the premium in the MLR calculation. Finally, we used the contract, the Federal Employees Health Benefits Acquisition Regulations (FEHBAR), and rate instructions to determine the propriety of the Plan's MLR calculation.

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

To test whether the Plan accurately processed and paid FEHBP claims for contract year 2012 and complied with its contract, we tested for potential claim errors within the full claims universes of 69,367 medical claim lines and 41,554 pharmacy claim lines; totaling $13,541,293 and $2,547,929, respectively.

During our claim reviews, the samples were not statistically based. Consequently, the results could not be projected to the universe, since it is unlikely that the results are representative of the universe as a whole.

We performed the following procedures that resulted in potential errors which when tested, were found to be processed correctly:

Claims Review

Medical Claims

- We identified a potential coordination of benefits error universe by isolating the medical claims for members over age 65 and paid claim lines over $5,000. We obtained a judgmental sample of 10 claims for 9 members, totaling $228,907, for review in

determining if the claims were coordinated with Medicare properly and accurately processed.

- We identified a potential member enrollment error universe by segregating the medical claims for all claim lines over $30,000, and removing any duplicate claim numbers. We judgmentally selected a sample of 19 claims including 195 claim lines for 17 members, totaling $1,619,385, to determine if the claims were accurately processed.

- We completed a dependent eligibility member review on the medical claims. The universe contained all claims for members over age 26 and excluded all patients identified as a subscriber or spouse. This resulted in a universe of 340 claim lines totaling $61,771. We then removed all duplicate members in the universe and obtained a sample of 19 members. We sent the sample of 19 members to the Plan for review to determine if medical benefits were paid for ineligible dependent members during calendar year 2012.

- We identified a potential bundling/unbundling error universe of 84 claim lines totaling $1,535. The universe contained all claim lines associated with the current procedural terminology (CPT) codes related to the primary panel code 80051, Electrolyte Panel. We sent the entire universe to the Plan for review to determine if the claims were accurately processed for contract year 2012.

Pharmacy Claims

- We identified a potential member enrollment error universe of 76 claim lines for 12 members totaling $265,491 for contract year 2012. The universe contained all claim lines over $2,000. We sent the entire universe of 76 claim lines to the Plan for review to determine if the claims were accurately processed.

- We completed a dependent eligibility member review on the pharmacy claims. The universe contained all claims for members over age 26 and excluded all patients identified as a subscriber. This resulted in a universe of 10,253 claims totaling $601,453. We then removed all duplicate members and further reduced the sample universe by removing members over age 30 in the universe and obtained a sample of 24 members. We sent the sample of 24 members to the Plan for review to determine if pharmacy benefits were paid for ineligible dependent members during calendar year 2012.

- We identified a potential high dollar drug script error universe of 162 claim lines totaling $410,907 for contract year 2012. The universe contained all claim lines over $1,500. We judgmentally selected a sample of 23 claims, totaling $60,878, to determine if the claims were accurately processed.

- We identified a potential high quantity dispensed error universe of 294 claim lines totaling $25,153 for contract year 2012. The universe contained all claim lines with a drug unit measure as EA (for each). We then identified and reviewed the claims with

high quantities that appeared unusual. We judgmentally selected a sample of 4 claim lines totaling $298, to determine if the claims were accurately processed.

- We also performed a quantity dispensed review to determine if there are any unusual trends within the claims data. During our review for unusual trends, we noticed that there were several unusual dispensed quantity scripts related to one member being filled within 30 days for a controlled substance. As a result, we pulled all claims for the identified member and sent a sample of 6 oxycodone claims totaling $736 to the Plan to determine if the claims were properly adjudicated.

We also performed the following procedures that did not result in any potential errors to be tested:

- We completed a duplicate claims review of the medical and pharmacy claim universes (using "best match" criteria) to identify claims that have all the same fields or duplicate claims where only the claim number is different. We chose which fields to match against and the order of precedence. We selected the following fields for medical claims: patient ID number, patient name (first and last), incurred date, covered charges, provider ID, procedure code, diagnosis code, type of service, and provider specialty. For the pharmacy claims, we selected all of the provided fields. We used the sort data function in our statistical software and selected the "keep only one entire duplicate if entirely duplicated" option. This would generate the possible duplicates as a separate run. We then reviewed the results for duplicate claims or any claims that have the same selected fields, but different claim numbers.

- We completed a duplicate claims review of the medical and pharmacy claim universes (using "near match" criteria) to identify claims for which some of the fields are the same or are duplicates but do not exactly match within the medical and pharmacy claim universe. We chose which fields to match against and the order of precedence. We selected the following fields for medical claims: patient ID number, patient name (first and last), incurred date, covered charges, provider ID, procedure code, and procedure modifier code. However, for the pharmacy claims, we selected the member number, subscriber number, and drug code, and the prescription fill dates had to be within five days of each other. We used the sort data function in our statistical software and selected the "keep only one entire duplicate if entirely duplicated" option. This would generate the possible duplicates as a separate run. We then reviewed the results for duplicate claims or any claims that have the same selected fields, but different claim numbers.

- We completed a debarred pharmacist and pharmacies review to determine if the Plan paid any pharmacy claims to debarred pharmacists or pharmacies. We requested a list of debarred pharmacists and pharmacies in the Plan's service area from the OIG Administrative Sanctions Branch (ASB). We ran a query on the claims data to determine if any debarred pharmacists or pharmacies were included in the pharmacy data.

- We completed a review of debarred providers to determine if the Plan paid any medical claims to debarred providers. The review compared the list of debarred providers to the

medical claims data. We requested a list of debarred providers in the Plan's service area from the ASB. We identified the debarred providers and compared each one to the medical claims data. The debarred provider list included the provider names and the provider National Provider Identifier (NPI) numbers, when available. We used the NPI number to query against the medical claims, but used the provider name if the NPI number was unavailable.

- We completed a zero quantity review to determine if any pharmacy claims were paid that had a zero quantity amount. We attempted to identify all pharmacy claims that had zero in the quantity field and a dollar amount in the paid field.

- We completed an ineligible group number review on the medical and pharmacy universes to determine if any claims were paid for non-FEHBP members or for members enrolled in a different employer group. We requested a list of group numbers and group names for both the medical and pharmacy claims data and sorted this data by the group number to identify any exceptions. We used the statistical summary function within our statistical software to determine the universe of group numbers. We compared the universe to the list of group numbers provided by the Plan to determine if there were any results.

- We completed a non-covered benefits review on the medical claims universe. We reviewed the 2012 FEHBP benefit brochure to determine non-covered benefits. We tested the medical claims data to determine if any of the following non-covered benefits were paid in error: elective abortions, sex transformations, reversal of sterilization, radial keratotomy, and eye exercises.

- We completed a deceased member review on the medical and pharmacy universe. We selected a sample from the older population in the claims data. The claims were sorted by member age (over age 85). Claims were extracted from data for the oldest members. We removed any duplicate patient IDs. We obtained a sample of 11 members. The sample was sent to the OIG Office of Investigations to determine if a death record existed for the member.

All samples selected during our audit were not statistically based. Consequently, the results could not be projected to the universe, since it is unlikely that the results are representative of the universe, as a whole.

We also examined the rate build-up of the Plan's Federal rate submissions and related documents as a basis for validating the Plan's standard rating methodology. We verified that the factors, trends, and other related adjustments used to determine the FEHBP premium rate(s) were sufficiently supported by source documentation. Further, we examined claim payments to verify that the cost data used to develop the FEHBP rates was accurate, complete and valid. Finally, we used the contract, the FEHBAR, and the rate instructions 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 policies and procedures and interviewed Plan officials regarding the controls in place to ensure that the appropriate rates were charged. Other auditing procedures were performed as necessary to meet our audit objectives.

In addition, we examined the Plan's financial information and evaluated the Plan's financial condition and ability to continue operations as a viable ongoing business concern.

III. AUDIT FINDING AND RECOMMENDATION

1. MLR Penalty Underpayment **$182,000**

For contract year 2012, AvMed (the Plan) participated in OPM's MLR pilot program. Pilot program carriers were required to meet the OPM-established MLR threshold of 89 percent. Therefore, 89 cents of every health care premium dollar must have been spent on health care expenses. If the MLR was less than 89 percent, the carrier owed a subsidization penalty equal to the difference between the threshold and the carrier's actual MLR.

AvMed calculated an MLR of 76.34 percent and paid a penalty of $2,762,556 to OPM before the deadline of August 31, 2013. However, during our review of the Plan's MLR submission, we found that the Plan inappropriately included a reinsurance claim totaling $182,000. The Plan's organ transplant reinsurance program provides dollar-one coverage with a zero deductible. Consequently, none of the transplant related claims are processed and paid by the Plan. The Plan pays a transplant reinsurance premium, which like regular reinsurance should not be included in the MLR calculation. Based upon guidance provided by a third-party consultant, the Plan inappropriately included estimated transplant claims incurred in its MLR calculation.

HHS regulations require that claims used in the numerator of the MLR calculation should include only those claims directly paid by a health plan. HHS 45 CFR Part 158 Section 158.103, defines direct paid claims as claim payments before ceded reinsurance. Therefore, reinsurance recoveries must also be excluded from the claims total for MLR purposes. Furthermore, the Plan's premiums in the denominator include premiums paid for reinsurance. In this case, the transplant claim was paid directly by the Plan's reinsurer and should not have been included in the claims total for its MLR calculation. As a result, we removed the $182,000 transplant reinsurance claim from the numerator of our audited MLR calculation. We calculated our audited MLR at 75.51 percent and determined that the Plan underpaid its subsidization penalty due to OPM by $182,000 (see Exhibit B).

Plan's Response (see Appendix):

The Plan agrees with our finding.

Recommendation 1

We recommend that the contracting officer require the Plan to pay an additional MLR subsidization penalty of $182,000 for contract year 2012.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

COMMUNITY-RATED AUDITS GROUP

[redacted], Auditor-In-Charge

[redacted], Auditor

[redacted], Senior Team Leader

[redacted], Senior Team Leader

[redacted], Group Chief

EXHIBIT A

AvMed Health Plans
Summary of Questioned Costs

Contract Year 2012

Medical Loss Ratio Questioned Costs	$182,000
Total Questioned Costs	**$182,000**

EXHIBIT B

AvMed Health Plans
MLR Questioned Costs

	Per Audit	Per Plan
2012 FEHBP MLR Target	89%	89%
Claims Expense		
Total Adjusted Incurred Claims	$16,481,322	$16,663,322
Premiums		
Earned Premium	$21,897,080	$21,897,080
Less: Federal and State Taxes and Licensing or Regulatory Fees	$70,250	$70,250
Adjusted Premiums	$21,826,830	$21,826,830
Less: Defective Pricing Finding (Due OPM)	$0	$0
Total Adjusted Premiums (Net of Defective Pricing)	$21,826,830	$21,826,830
Total Adjusted Incurred Claims (MLR Numerator)	$16,481,322	$16,663,322
Total Adjusted Premiums less Defective Pricing (MLR Denominator)	$21,826,830	$21,826,830
FEHB MLR Calculation (rounded)	75.51%	76.34%
MLR Penalty Calculation (see below)	$2,944,556	$2,762,556
MLR Penalty Paid	$2,762,556	$2,762,556
MLR Underpayment Finding (Due OPM)	**$182,000**	**$0**

MLR Penalty Calculation

	Per Audit	Per Plan
2012 FEHBP MLR Target	89%	89%
Less: FEHB MLR Calculation (rounded)	75.51%	76.34%
MLR Difference:	13.49%	12.66%
Multiplied By: Total Adjusted Premium (Net of Defective Pricing)	$21,826,830	$21,826,830
MLR Penalty Calculation	**$2,944,556**	**$2,762,556**

December 10, 2014

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U.S. Office of Personnel Management
Office of the Inspector General
800 Cranberry Woods Drive, Suite 270
Cranberry Township, Pennsylvania 16066

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Enclosed are AvMed Health Plans' responses to the results contained in Report No. 1C-ML-00-14-26, dated September 18, 2014, covering the Deleted by OIG-Not Relevant to Final Report [redacted] Medical Loss Ratio (MLR) submission. As required, we have enclosed both hardcopy and CD format of the information contained below.

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Medical Loss Ratio Review

1. MLR Penalty Underpayment

The Plan inappropriately included a claim totaling $182,000 related to reinsurance expense. In this case, the transplant claim was paid directly by the Plan's reinsurer and should not have been included in the claims total for the MLR calculation.

Plan Response

AvMed agrees that the $182,000 included in the 2012 FEHBP MLR incurred claims for the FEHBP transplant member should be removed from the calculation. Although the cost of

the transplant is a covered benefit, we were given incorrect information from a statutory consultant regarding the admissibility of transplant costs incurred under this contract, in

MLR calculations. All reinsurance is excluded from MLR calculations. AvMed included no costs, nor recoveries, related to transplant reinsurance in the 2013 FEHB calculation. Effective 2014, the transplant benefit became a capitated service provided through a third party intermediary, and is no longer a reinsurance contract.

Please consider AvMed's responses and all relevant material provided in formulation of the final report. If you have any questions or additional information is required, please contact Deleted by OIG-Not Relevant to Final Report

Sincerely,

Deleted by OIG-Not Relevant to Final Report
Vice President, Finance
AvMed Health Plans

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