OFFICE OF THE

CITY AUDITOR

AN AUDIT OF THE CITY OF SAN JOSE EMPLOYEES' HEALTH BENEFITS

– EFFECTIVE HEALTH CARE COST CONTAINMENT COULD SAVE THE CITY, ITS RETIREMENT FUNDS, AND EMPLOYEES $2.9 MILLION OR MORE PER YEAR

A REPORT TO THE

SAN JOSE

CITY COUNCIL

NOVEMBER 1993 93-08

CITY OF SAN JOSÉ, CALIFORNIA

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GERALD A. SILVA
City Auditor

November 5, 1993

Honorable Mayor and Members
of the City Council
801 North First Street, Room 600
San Jose, CA 95110

Transmitted herewith is a report on *An Audit Of The City Of San Jose Employees' Health Benefits.* This report is in accordance with City Charter Section 805.

An Executive Summary is presented on the blue pages in the front of this report while an Administration response is shown on the yellow page before the Appendices.

I will present this report to the Finance Committee at its November 10, 1993, meeting. If you need additional information in the interim, please let me know. The City Auditor staff members who participated in the preparation of this report are Nestor Baula, Bill Hewitt, and Cynthia Newman.

Respectfully submitted,

Gerald A. Silva
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EXECUTIVE SUMMARY

In accordance with the City Auditor's 1993-94 Audit Workplan, we have reviewed the city of San Jose (City) employees' health benefits. We conducted this audit in accordance with generally accepted government auditing standards and limited our work to those areas specified in the Scope and Methodology section of this report.

EFFECTIVE HEALTH CARE COST CONTAINMENT COULD SAVE THE CITY, ITS RETIREMENT FUNDS, AND EMPLOYEES $2.9 MILLION OR MORE PER YEAR

The City offers its current and eligible former employees three health plan options of which two are health maintenance organization (HMO) plans and the third is the City of San Jose Employees' Health Plan (CSJEHP). Those employees enrolled in the CSJEHP can save the City health care costs by using physicians and hospital services within a preferred provider organization (PPO) network. Our review revealed the following:

- Employees enrolled in the CSJEHP could have saved the City, its retirement plans, and themselves about $1.1 million per year by using PPO physicians and hospital services;
- The City has a significantly smaller percentage of employees enrolled in HMOs and requires those employees not enrolled in HMOs to pay smaller annual deductibles, annual out-of-pocket maximums, and coinsurance percentages than the other governmental and quasi-governmental jurisdictions we surveyed; and
- The City is not achieving its premium sharing strategy because of negotiated labor agreements.

As a result, the City, its retirement funds, and employees can save $2.9 million or more per year and better control future cost increases by implementing specific improvements in the health care plan. In addition, our review revealed that an employee Benefits Review Forum (BRF) the Administration established in 1987 to help address issues such as health care cost containment has not been effective. In our opinion, the BRF could be a more effective vehicle for addressing the City's health care issues if (1) the Department of Human Resources (HRD) assumed from the Office of Employee Relations the administrative responsibility for the BRF; (2) the HRD provided the BRF with periodic comparative information on the City's health care programs; and (3) a third-party facilitator was used to moderate the BRF meetings.

RECOMMENDATIONS

We recommend that the City Manager:

Recommendation #1:

Transfer the administrative responsibility for the Benefits Review Forum from the Office of Employee Relations to the Department of Human Resources/Employee Services Division. (Priority 3)

We further recommend that the Office of Employee Relations and the Department of Human Resources:

Recommendation #2:

Request a mid-year budget adjustment to pay for the City's membership in the Joint Powers Agreement for Intergovernmental Employee Relations Service

and continue requesting the Plan Service Analysis reports from the health plan administrator to provide the Benefits Review Forum with periodic information on the City's health care programs. Such information should include (a) a comparison of the City of San Jose Employees' Health Plan annual deductibles and annual out-of-pocket maximums to those of other comparable jurisdictions and the effect inflation has had over the past 20 years on City costs, (b) a comparison of the City of San Jose Employees' Health Plan coinsurance percentages to that of other comparable jurisdictions, and (c) a comparison from year to year of premiums, expenditures, membership, and utilization experiences of the City's various health care plans. (Priority 1)

Recommendation #3:

Request a mid-year budget adjustment for a contract with a third-party facilitator to assist the Benefits Review Forum in (a) identifying long-range goals and objectives, (b) developing a strategy to obtain them, (c) translating the strategy into measurable and operational short-run plans and tactics, and (d) retranslating short-run plans into policies and procedures. (Priority 1)

Recommendation #4:

Annually report to the City Council on the implementation of the City's premium sharing strategy, how it is standardized among the City's bargaining units, the cost implications of not fully implementing the strategy, and any needed changes to the strategy. (Priority 1)

INTRODUCTION

In accordance with the City Auditor's 1993-94 Audit Workplan, we have audited the city of San Jose employees' health benefits. We conducted this audit in accordance with generally accepted government auditing standards and limited our work to those areas specified in the Scope and Methodology section of this report.

The City Auditor's Office thanks those individuals in the Department of Human Resources and the Office of Employee Relations who gave their time, information, insight, and cooperation for this audit. Specifically, we thank the Senior Administrative Officer of the Department of Human Resources -- Benefits Program and his staff for their outstanding responsiveness to our many requests for information.

SCOPE AND METHODOLOGY

This is our second report on the city of San Jose's (City) Employee Benefit Fund Program. This audit reviewed the City's employee health care options, with emphasis on the City of San Jose Employees' Health Plan (CSJEHP).

- Our objectives were
  - To determine whether the City has developed and is following strategies to address its employees' and retirees' health care needs;
  - To determine whether the City is effectively, efficiently, and economically controlling and administering its employees' and retirees' health benefits;
  - To determine whether the City is effectively communicating the health benefit options and cost containment objectives to its employees and retirees; and
  - To identify possible ways to reduce costs to the City and its employees while maintaining its employees' and retirees' health benefits.
- Our methodology included
  - Surveying other governmental and quasi-governmental jurisdictions;
  - Comparing certain provisions in the CSJEHP to other jurisdictions; and
  - Analyzing various management reports.

We performed only limited testing to determine the accuracy and reliability of information in the various computer reports used. Such

testing included observation or a walk-through of the claims processing. We did not review the general and specific application controls for the computer systems used for claims processing.

BACKGROUND

David Osborne and Ted Gaebler, in their book Reinventing Government, make the following observations about government and the health care system:

1. Our governments have abdicated a steering role in health care. Government simply reacts.

2. In an entrepreneurial health care system, government would play a steering role. An entrepreneurial system would encourage competition, particularly through prepaid plans, which allow consumers to shop for the best price. It would measure and publicize results.

3. Customers almost never receive enough information about performance to make informed choices among doctors, hospitals, and insurance plans.

In this report, we discuss certain ways in which the city of San Jose (City) can strengthen its steering role in administering health care for its employees by controlling costs while maintaining the level of health care benefits.

The Cost Of Health Care

The U.S. Department of Commerce estimates that health care spending accounted for more than 14 percent of the gross national product (GNP) in 1992, up from 13.2 percent in the previous year's GNP. The nation's health care bill was $838.5 billion in 1992 and is expected to reach $939.9 billion in 1993.

In the City, health care expenditures for 1992-93 are estimated to be $23.7 million. The City's health care expenditures for 1993-94 are estimated to be $28.3 million, or about 6 percent, of the proposed operating budget amount of $444.1 million. The City has only four departments (Fire, Police, Street and Parks, and Environmental Services) that have budgets exceeding the proposed health expenditure amounts for the 1993-94 fiscal year. The City's problems with skyrocketing health care costs are similar to those faced by other employers in Santa Clara County and throughout the country.

The City's Goals In Providing Health Care

The City's overall goal in providing health care coverage is to ensure that employees, retirees, and their families have access to quality medical care and are protected from unexpected or unaffordable medical expenses.

The City's health care goals are to:

- Provide adequate health care coverage for City employees and their families;
- Provide a reasonable number of plan choices to cover an array of medical and health services; and
- Contain cost.

These three goals are not totally compatible with each other because cost containment of any type of program usually means limiting choices and flexibility. However, the City has made efforts to balance these goals.

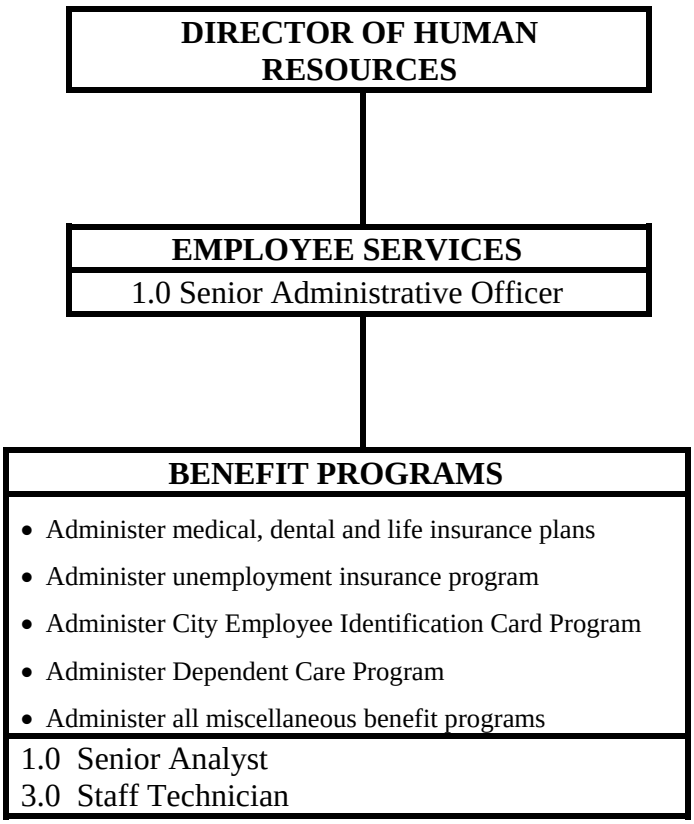
The City's Employee Services Division

The Employee Services Division of the Department of Human Resources (HRD) is responsible for administering the City's benefit plans. Chart I shows the organization of the Employee Services Division of the HRD.

The Division's specific responsibilities include overseeing the City's medical, dental, and life insurance plans; unemployment insurance program; and other miscellaneous benefit programs.

CHART I

ORGANIZATION CHART
FOR THE EMPLOYEE SERVICES DIVISION
OF THE DEPARTMENT OF HUMAN RESOURCES



Funding For Employee Benefits

Health expenditures are paid from the City's employee benefit funds. The City's employee benefit funds consist of the Dental Insurance, Life Insurance, Unemployment Insurance, Employee Benefit, and City of San Jose Health Plan funds. These funds are internal service funds which are used to account for the financing of those services the HRD provides to other City departments and offices on a cost-reimbursement basis.

The total health insurance premium for each specific health plan type is the same for all City employees. The City contributes a certain percentage toward the premium for the employee's health plan. The percentage the City pays and the percentage the employee pays are determined by each employee representation unit's memorandum of agreement (MOA).

City contributions to the cost of medical coverage for employees are negotiated between the City and each employee representation unit and are stated in each MOA. For active employees other than sworn police and fire personnel, the City pays 90 percent of the cost of the lowest cost plan for health coverage. The employee pays 10 percent of the cost of the lowest cost plan (up to a maximum of $25 per month) plus any additional cost for a plan which is not the lowest cost plan. Kaiser is currently the lowest cost plan.

For sworn police and fire personnel, the City pays the full premium for the lowest cost plan; however, employees choosing the lowest cost plan pay $50 annually, plus 10 percent of the 1991 rate increase to a maximum of $8 per month of said increase. For employees electing one of the other

options, the City will contribute the amount it contributed prior to the 1991 rate increases for that option, plus the increase, except that the employee shall pay 10 percent of the increase to a maximum of $8 per month of said increase.

The premium rates for retirees are the same as for active employees for all three of the City's health plans. After retirees become eligible for Medicare at age 65, retirees pay reduced rates with Medicare paying as primary insurer for actual medical costs.

Major Accomplishments Relating
To The City Of San Jose Health Plans

In Appendix B, the HRD informed the City Auditor's Office of its major accomplishments relating to the City's health plans. According to the HRD, the City has made a number of changes to the City of San Jose Employees' Health Plan in its effort to contain costs. These changes included:

1. The establishment of a self-funded indemnity plan initially administered by Blue Cross;

2. The creation of a separate fund to better track the deposit of premiums and payment of claims/administrative costs;

3. Movement from full cost coverage for the lowest cost plan toward a 90/10 cost sharing between the City and enrolled employees;

4. Restructuring of the indemnity plan to move away from unrestricted care toward managed care;

5. Termination of the relationship with Blue Cross and the selection of Foundation Health Preferred Administrators as the third-party administrator;

6. An administrative cost formula based on the number of enrolled employees rather than a percentage of claims costs;

7. The incentive of 100 percent payment for services from physicians and hospitals which have agreed to charge reduced rates (through a preferred provider organization network); and

8. The implementation of an optional on-line claims payment system for prescriptions to reduce administrative costs.

Definition Of Key Terms

In Appendix L, we provide a glossary to define a number of terms relating to health care programs.

FINDING I

EFFECTIVE HEALTH CARE COST CONTAINMENT COULD SAVE THE CITY, ITS RETIREMENT FUNDS, AND EMPLOYEES $2.9 MILLION OR MORE PER YEAR

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Description Of The City's Health Care Plans

The City has three health care plans that are different by design to provide choices for covered employees. Employees may select the plan which fits their own needs and preferences and may change annually during an open enrollment period if they wish.

The three health care plans the City offers to its employees are of two different kinds of health insurance programs: "wellness" and "illness." The "wellness programs" are the Kaiser Permanente and the Lifeguard programs. Both Kaiser Permanente and Lifeguard are HMOs.[1] The "illness program" is the CSJEHP.

Wellness Program

Wellness programs are designed to keep the employee well. They provide regular checkups and immunizations as well as all other medically necessary care and services. There is no paperwork to fill out when the

[1] An HMO is a health care system that provides comprehensive health care services to its members on a prepaid basis. The same membership fee is paid by all members on a prepaid basis regardless of the amount of services used.

employee goes to the doctor or the hospital. The employee may choose either the Kaiser Permanente or the Lifeguard wellness program. Kaiser and Lifeguard are limited choice plans which are administered by the plan providers.

- Kaiser Permanente

Kaiser Permanente offers a clinic-type program. Services are provided at Kaiser Foundation hospitals and medical offices. The City's Kaiser plan covers virtually all recognized medical services and specialty areas, but services must be obtained through a Kaiser facility. The employee may choose a personal doctor from the staff at these facilities. The City does not participate in Kaiser's durable medical equipment coverage. There is no charge for visits to the doctor or for stays in the hospital. Kaiser Permanente is a closed panel HMO.

- Lifeguard

Lifeguard is an open panel HMO. Lifeguard contracts with physicians and other providers who are practicing in the general community and who maintain a non-HMO practice concurrent with their participation in the HMO. Lifeguard provides preventive medicine as well as standard benefits at standard rates with specific contract doctors and hospitals. Treatment by a specialist physician must be at the referral of a primary care physician. Lifeguard has contracts with more than 3,600 private doctors and 50 hospitals in the Bay Area. Employees may select their own primary doctor from the 3,600 private doctors. Lifeguard has 596 private physicians and 8 contracting hospitals in Santa Clara County.

Employees make a small co-payment each time they visit a doctor. The City does not participate in Lifeguard's prescription drug program.

Because premiums for HMOs are fixed for the contract term, the financial risk of the cost of care during the contract term (in excess of the premiums charged) is transferred to the HMO. Consequently, an HMO has an inherent financial incentive to control utilization during the contract term, or else suffer the financial loss.

Illness Program

The City also offers its employees an illness program which is an insurance program that takes care of them when it is medically necessary due to an illness or injury. Unlike the wellness programs, it allows complete freedom of choice of doctor or hospital.

The City joined the Blue Cross indemnity health plan in 1969; however, Blue Cross notified the City early in 1989 that unless the City accepted substantial changes to the disadvantage of the City and its enrolled employees, Blue Cross no longer wished to have the City as a client. The City terminated its contract with Blue Cross on July 31, 1990. On August 1, 1990, the City established the CSJEHP to replace the full-choice plan administered by Blue Cross.

The CSJEHP is a self-funded indemnity health insurance plan administered by Foundation Health Preferred Administrators, a third-party administrator (TPA). The scope of the TPA's services is claims administration, payment of claims, utilization review, and large case management. Benefits are provided for enrollees and their eligible dependents

when medically necessary. Coverage includes illness and certain medical conditions identified in the CSJEHP document. Only medically necessary visits and procedures are covered; preventive medicine is generally not provided.

The CSJEHP allows a full choice of physicians and hospitals; however, the plan has financial incentives for services obtained from a preferred provider organization (PPO), which is a panel of physicians and hospitals, which has agreed to charge reduced rates. Employees have the option to use services of doctors and hospitals that are in the PPO. If medical services are provided by a PPO provider, the plan pays 100 percent of the cost of most services. The plan pays 80 percent of the usual, customary, and reasonable (UCR) charges up to the plan's maximum "out-of-pocket" limits for covered services which are not provided by a PPO provider. Participants are responsible for amounts in excess of UCR charges. There are provisions for claimants who live or work more than 50 miles from a PPO provider and special provisions for emergency services.

The HMO programs are paid on a capitation basis in which the monthly premiums are fixed for each employee and are paid independently of the services provided. The CSJEHP indemnity program is paid on a claims basis in which the City and participating employees pay shares of claims costs as they are incurred per plan specifications. The differences in freedom of choice are reflected in the costs of each program. Indemnity programs typically are more costly than HMO programs, as demonstrated in Table I by the monthly premiums for the 1993-94 fiscal year.

TABLE I

1993-94 MONTHLY HEALTH INSURANCE PREMIUMS

	Kaiser	Lifeguard	CSJEHP
Single	$154.62	$155.42	$175.87
Family	$377.48	$400.70	$434.24

Appendix C presents a comparison of the City's health plan options.

City Health Benefit Enrollment Statistics

The active and retired employees enrolled in the City's health plans as of March 31, 1993, are as shown in Table II.

TABLE II

HEALTH PLAN ENROLLMENTS AS OF MARCH 31, 1993

	Kaiser	Lifeguard	CSJEHP	Total
Single Coverage				
Active	830	209	483	1,522
Retired	199	23	384	606
Family Coverage				
Active	2,210	705	913	3,828
Retired	456	46	632	1,134
Totals	3,695	983	2,412	7,090
Percentage of Total	52	14	34	100
COMPARISON OF ENROLLMENT--ACTIVE VS. RETIRED				
Active	3,040	914	1,396	5,350
Retired	655	69	1,016	1,740
Total	3,695	983	2,412	7,090

CITY OF SAN JOSE TOTAL HEALTH PLAN ENROLLMENT

Active	5,350	75%	Single	2,128	30%	Sworn	2,907	41%
Retired	1,740	25%	Family	4,962	70%	Non-Sworn	4,183	59%
Total	7,090	100%	Total	7,090	100%	Total	7,090	100%

Cost Containment Strategies

Because of the maximum freedom of choice and correspondingly higher costs in the CSJEHP, the City developed the following cost containment strategies to keep the plan affordable:

- Dropping the TPA, Blue Cross, whose administrative fee was a percentage of claims costs, and contracting with a new TPA,

Foundation Health Preferred Administrators, whose administrative fee is based only on the number of enrolled employees;

- Purchasing utilization review services from the new TPA to ensure that only medically necessary procedures are performed and charged by hospital for inpatient care; and

- Moving away from full choice toward managed choice by obtaining discounted hospital and physician rates from a PPO provider.

Appendix D presents a synopsis of the CSJEHP and discusses cost containment provisions more fully.

Employees Enrolled In The CSJEHP Could Have Saved The City, Its Retirement Funds, And Themselves About $1.1 Million Per Year By Using PPO Physicians And Hospital Services

A September 1992 article in The Employee Benefits Journal stated, "*When all is said and done about health care costs, there are only two means to reduce such costs: (1) Pay the health care provider less for service, i.e., reduced or discounted fees; and (2) use less of the health care provider's service--utilization control.*" In this section, we will discuss how CSJEHP members can obtain health care services at reduced or discounted fees and thus save money for themselves and the City.

City employees have two points of choice in which they can control the cost of their health care services: (1) at enrollment--whether to enroll in the CSJEHP or in one of the two less expensive alternative health care plans, Kaiser or Lifeguard, offered by the City, and (2) (for CSJEHP members) at point of service--whether to receive care from a PPO provider or from a provider outside the PPO network of the individual's selection.

Employees enrolled in the CSJEHP can save health care costs for the City, its retirement funds, and themselves by using physicians and hospital services within the PPO network. The PPO network is a group of physicians and hospitals that has contracted with the City to provide employees with services at reduced rates. The City contracted with PPO Alliance[2] to provide the PPO network for the CSJEHP. As the PPO contractor, the PPO Alliance performs the following for the CSJEHP:

- Solicits service providers;
- Negotiates fees for services; and
- Ensures that health care providers are fully qualified and appropriately licensed.

The overall average percentage discount realized through CSJEHP PPO providers is 25 percent. Because of this discount, employees enrolled in the CSJEHP can save the City, its retirement funds, and themselves as much as $1.1 million annually by using physicians and hospitals in the City's PPO network. We estimated the savings based on the Plan Service

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[2] PPO Alliance has 943 physicians in general practice and medical specialties in the CSJEHP throughout the San Jose/Santa Clara County area. The 943 physicians represent approximately 35 percent of the 2,675 physicians in the San Jose/Santa Clara County area. PPO Alliance has over 12,000 physicians throughout California. PPO Alliance has 142 participating hospitals in California. The Santa Clara County hospitals in the alliance are: El Camino, Good Samaritan, O'Connor, South Valley, San Jose Medical Center, Lucile Packard Children's Hospital, and Stanford University Hospital.

Participating doctors and hospitals have agreed to charge significantly less than retail rates for services to plan members. Nearly 70 percent of PPO hospital business in San Jose goes to the Good Samaritan Hospital and the San Jose Medical Center. The City receives discounts approximating 32 percent to 36 percent below normal rates from the Good Samaritan Hospital and the San Jose Medical Center.

On August 1, 1992, PPO Alliance incorporated the services of MEDFOCUS Radiology Network (MRN) into its plan to more effectively control the diagnostic radiology services. MRN has three sites in Santa Clara County.

Analysis reports the City's TPA, Foundation Health Preferred Administrators, prepared. The Plan Service Analysis report summarizes the City's payments for physician services, hospital and facility charges for inpatient and outpatient services, outpatient pharmacy costs, and dental services. In addition, this report breaks down payments by type of vendor, i.e., physicians, hospitals, and pharmacists, who are in the PPO network versus those outside the PPO network. Thus, this report can determine the extent to which the participants are taking advantage of the discounts negotiated by PPO Alliance with the physicians and hospitals.

We reviewed the TPA's Plan Service Analysis reports for (a) the year ending December 31, 1991, (b) the year ending December 31, 1992, and (c) the four months ending April 30, 1993. Table III shows the out-of-network costs for the three periods we reviewed and our estimate of the savings that the City, its retirement funds, and employees would have made had these out-of-network services been provided within the PPO network.[3]

[3] By avoiding the UCR provision, employees also reduce their health care costs when they obtain services from PPO providers. Employees are responsible for 20 percent of UCR charges up to the annual out-of-pocket maximum as well as amounts in excess of UCR charges when services are obtained outside the PPO network. Because information on the amount paid by CSJEHP members in excess of UCR charges is not available, we were unable to quantify the savings that CSJEHP members would have realized from this provision had they obtained their hospital and medical services from PPO providers.

TABLE III

OUT-OF-NETWORK COSTS AND ESTIMATE OF SAVINGS THAT THE CITY, ITS RETIREMENT FUNDS, AND EMPLOYEES WOULD HAVE MADE HAD THE OUT-OF-NETWORK SERVICES BEEN PROVIDED WITHIN THE PPO NETWORK

	Year Ending December 31, 1991			
Services	**Total Costs**	**Costs Outside PPO Network**	**Percentage Of Costs Outside PPO Network**	**Savings Lost At 25%**
Physician	$3,078,313	$1,739,237	57	$434,809
Hospital	3,725,112	1,851,462	50	462,866
Total for 12/31/91	$6,803,425	$3,590,699	53	$897,675

	Year Ending December 31, 1992			
Services	**Total Costs**	**Costs Outside PPO Network**	**Percentage of Costs Outside PPO Network**	**Savings Lost At 25%**
Physician	$3,907,305	$2,208,791	57	$ 552,198
Hospital	4,859,225	2,462,943	51	615,736
Total for 12/31/92	$8,766,530	$4,671,734	53	$1,167,934

	For The Period January 1, 1993 - April 30, 1993			
Services	**Total Costs**	**Costs Outside PPO Network**	**Percentage of Costs Outside PPO Network**	**Savings Lost At 25%**
Physician	$1,479,041	$ 823,465	56	$205,866
Hospital	1,980,926	745,467*	38	186,367
Total for 4/30/93	$3,459,967	$1,568,932	45	$392,233

* This amount includes outpatient pharmacy costs of $158,432. The City's prescription drug program became fully operational in 1993.

TABLE III (CONTINUED)

SUMMARY OF SAVINGS

For The Period Ending	Savings
December 31, 1991	$ 897,675
December 31, 1992	1,167,934
December 31, 1993 (Annualized $392,233 x 3)	1,176,699
Total	$3,242,308
Annual Average (rounded)	$1,081,000

As shown in Table III above, we estimate that the City, its retirement funds, and employees would have saved as much as $1.1 million annually had the CSJEHP members used PPO physicians and hospital services instead of going outside the PPO network.[4] The Council on Education in Management, in its manual entitled Controlling Employee Benefits, states that one of the design changes organizations are making is the reimbursement differentials that are being increased to provide greater financial incentives for individuals to obtain services in the PPO where controls are the greatest. Therefore, it is essential for the City to provide sufficient incentives to encourage employees in the CSJEHP to use PPO physicians and hospitals. Such incentives include the deductible, the out-of-pocket maximums, and coinsurance percentages. Jeffrey D. Mamorsky, in his book The Health Care Handbook, considers the deductible, the out-

[4] It should be noted that certain CSJEHP members, such as retired employees, may reside in geographical areas in which there are no PPO physicians or hospitals. Since such members have no choice but to go outside the PPO network, the PPO savings would not apply to them. Because of the lack of data regarding the medical expenditures of CSJEHP members with no access to the PPO network, we were unable to determine the impact to the potential PPO network savings.

of-pocket maximums, and coinsurance percentages as the greatest incentives for employees to use the PPO network. Starting on page 27 of this report, we will discuss how the City can use these financial incentives to encourage CSJEHP members to use PPO physicians and hospitals.

Survey Of Other Governmental And Quasi-Governmental Jurisdictions

As part of our review, we surveyed other governmental and quasi-governmental jurisdictions in order to compare provisions in the City's health care plans with those of the other jurisdictions. For our survey, we contacted the other jurisdictions directly and also reviewed the results of a survey of monthly medical premiums for 48 other Bay Area jurisdictions. We provided our survey to the City's Office of Employee Relations. Our survey indicated that the City's Kaiser, Lifeguard, and CSJEHP plans charge their members significantly less premiums than comparable health care plans of other jurisdictions.

Based on our surveys, we learned that the following health care premiums were in effect for 1992-93:

MONTHLY PREMIUMS
CITY OF SAN JOSE

Health Insurance	Family Coverage
Kaiser	$363.70
Lifeguard	370.61
CSJEHP	390.85

MONTHLY PREMIUMS
CALIFORNIA PUBLIC EMPLOYEES
RETIREMENT SYSTEM (PERS) MEDICAL[5]

Health Insurance	Three-Party Coverage
Kaiser	$433.11
Lifeguard	427.25
PERSCare*	590.00

* PERSCare is a fee-for-service health plan comparable to the CSJEHP.

Based on the above premiums, the City's monthly Kaiser family premium is $69.41 lower than the PERS three-party Kaiser monthly premium.[6] The City's monthly Lifeguard family premium is $56.64 lower than the PERS three-party Lifeguard monthly premium. The CSJEHP premium is $199.15 less than the PERSCare premium. In discussing the health care premiums with PERS representatives, we learned that the City's premiums are lower than those of PERS because of the following:

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[5] PERS has about 880,000 members (primary enrollees and dependents). PERS is the largest single pool of business for health insurers in the state. PERS pays about $1.1 billion a year to HMOs in California.

PERS medical premiums are significant because 21 Bay Area cities and two local special districts have PERS medical plans. The following local jurisdictions are covered by PERS medical: Cupertino, Los Gatos, Palo Alto, Santa Clara, Sunnyvale, Belmont, Burlingame, Daly City, Foster City, Hillsborough, Menlo Park, Millbrae, Redwood City, San Mateo, Woodside, Alameda, Fremont, Hayward, Oakland, Richmond, Vallejo, Oro Loma Sanitary District, and the Union Sanitary District.

[6] The City's lower rates are the result of a better actual utilization experience relating to basic coverage services. Beginning in 1990, Kaiser Permanente adopted a new system for determining prepaid rates. The new system, called the Adjusted Community Rating (ACR) determines each group's rates for the next year based on the group's actual utilization of basic coverage services by its non-Medicare members in the most recent three-year period for which data are available. We calculated the average monthly cost per member for the 1993-94 Kaiser premium and found it to be $110 for the city of San Jose, as compared to $120 for PERS.

- The percentage of PERS members enrolled in the PERS' self-insured plan, PERSCare, is smaller than the percentage of City members enrolled in the CSJEHP. As a result, premiums are relatively higher for each PERSCare enrollee since the participant pool over which the costs can be distributed is smaller.

- PERS adds an 11 percent administrative charge to the negotiated premium.

- PERS has a three-tier premium structure (one-party, two-party, and three-party), whereas the City has a two-tier premium structure (single and family).

Based on our survey, we found that the City's health plans are able to charge their members significantly less premiums than comparable health care plans of other jurisdictions. The City's health plans are able to charge less because the City does not add an administrative charge to the health care premiums; the City's health plans have a two-tier premium structure rather than a three-tier premium structure like the health plans of other jurisdictions; and the City has a relatively large participant pool in its self-insured indemnity plan.

The City Has A Significantly Smaller Percentage Of Employees Enrolled In HMOs

We also surveyed other jurisdictions in order to compare San Jose's HMO enrollment with those of the other jurisdictions. We found that the City has the second smallest percentage of employees enrolled in HMOs.

Table IV compares San Jose's enrollment of active employees in HMOs to those of other governmental and quasi-governmental jurisdictions.

TABLE IV

ENROLLMENT OF ACTIVE EMPLOYEES IN HMOs

Jurisdiction	Total Active Enrollment	HMO Enrollment	HMO Enrollment As A Percentage Of Active Enrollment
City of Los Angeles	22,800	20,588	90
Bay Area Rapid Transit (BART)	2,797	2,505	90
City of Sunnyvale	788	710	90
County of Los Angeles	70,250	62,284	89
City of Palo Alto	943	799	85
County of Santa Clara	12,755	10,375	81
Santa Clara County Transit	1,397	1,117	80
California Public Employees Retirement System (PERS)	384,000	298,000	78
City of San Jose	5,350	3,954	74
East Bay Regional Park District	406	253	62

As shown above, only the East Bay Regional Park District is lower than San Jose in the percentage of active employees enrolled in HMOs. The audit manager for the East Bay Regional Park District told us that the district has a low enrollment in the HMO and a correspondingly high enrollment in the self-insured plan because the self-insured plan is very generous as compared to similar plans in effect in other jurisdictions.

Our survey indicated that San Jose's active employees' enrollment in HMOs is 4 percent to 16 percent less than the surveyed governmental and quasi-governmental jurisdictions (except the East Bay Regional Park District). The HMO enrollment statistics are significant because they

indicate that the City, its retirement funds, and its employees can realize cost savings if CSJEHP participants transferred to either Kaiser or Lifeguard.

The savings to the City and its retirement funds would result from the reduced premiums and the elimination of the administrative costs. The savings to the employees would result from:

- Reduction in the premium sharing amount;
- Elimination of the deductibles; and
- Elimination of the annual out-of-pocket maximum.

The following are our estimates of the potential savings to the City, its retirement funds, and its employees,[7] based on 1992-93 costs:

- If all CSJEHP participants transferred to Kaiser, the City, its retirement funds, and employees would save $2.8 million.
- If all CSJEHP participants transferred to Lifeguard, the City, its retirement funds, and employees would save $2.6 million.

In our opinion, the City should create financial incentives to encourage a greater percentage of enrollment for both active and retired employees in the HMO health plans offered by the City.

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[7] The projected savings for the employees are conservative because we do not include employee payments for (a) 20 percent of UCR charges up to the annual out-of-pocket maximum and (b) amounts paid in excess of UCR charges when services are obtained outside the PPO network.

The City Requires Its Employees Not Enrolled In HMOs To Pay Smaller Annual Deductibles, Annual Out-of-Pocket Maximums, And Coinsurance Percentages Than Other Governmental Jurisdictions

The City entered into a contract with Blue Cross in 1969. The deductible amounts established in 1969 were $50 per individual and $150 per family. Since the time the deductible amounts were established 23 years ago, the City has not changed the deductible amounts for the self-insured health plan.

The deductible is that portion of covered hospital and medical charges which an insured person must pay before the policy's benefits begin. The purpose of the deductible is to remove from coverage the small medical bills. Such small medical bills are relatively expensive to administer. According to the Health Care Handbook, edited by Jeffrey D. Mamorsky, "*Eliminating these small bills holds down the cost of administration and makes the plan more financially stable.*"

The annual out-of-pocket maximum is the amount the employee is obligated to pay for health care for any one plan year, after which the plan pays 100 percent of any additional covered costs for the year. According to the Council on Education in Management in its manual Controlling Employee Benefits, the trend is to increase this annual out-of-pocket maximum limit.

Coinsurance can mean either the percentage of covered charges that a plan will reimburse an employee or the percentage of covered charges that must be paid by the plan participant. The purpose of coinsurance is to help control the employer's costs by shifting some of the cost to employees. According to the Health Care Handbook, "*Sponsors hope that*

since employees are paying a share of the bill, they will be more interested and concerned about both the utilization of health care services and the level of the charges."

During the transition from Blue Cross to the CSJEHP, the City and all recognized employee representation units formally agreed, as required by "meet and confer," on the plan design. Included in the plan design were the following provisions regarding deductibles:

- The annual deductible would remain at $50 per member, with a three-member cap of $150 per enrolled family, the same as it had been under Blue Cross.

- An annual out-of-pocket maximum for covered hospital expenses in a non-PPO hospital would be established at $1,000 per member.[8] The annual maximum co-payment for non-hospital services from non-PPO providers would remain at $400 per member for the first year (1990),[9] as it had been under the Blue Cross plan.

- Coinsurance percentages the City pays were set at 100 percent for PPO network hospital and physician care, as well as out-of-network emergency care, and 80 percent of UCR charges for out-of-network hospital, physician, and other medical services.

Jonathan E. Fielding, M.D., makes the following comments about deductibles in his book Corporate Health Management: "*In general, the*

[8] Employee organizations agreed to this annual maximum per member to encourage participants to use PPO hospitals which guaranteed discounted rates.

[9] Employee organizations agreed that this maximum would be raised to $500 per member, thereafter, to recognize inflation.

level of deductibles has not been increased regularly to reflect even inflation in the overall economy, let alone the hyper inflation of medical care costs. . . . Many deductibles have not changed in twenty years. To have the same impact as a $100 deductible twenty years ago, the level today would have to be set at $400 to $500." Because the CSJEHP deductible amounts have not been adjusted since they were established 23 years ago, the amounts do not reflect the effects of inflation over the years.

Furthermore, when compared to other jurisdictions,[10] the CSJEHP has smaller annual deductibles, annual out-of-pocket maximums, and coinsurance percentages than the average of the annual deductibles, annual out-of-pocket maximums, and coinsurance percentages of the health care plans of the governmental and quasi-governmental jurisdictions we surveyed. Table V shows the CSJEHP's annual deductibles, the annual out-of-pocket maximums, and coinsurance percentages as compared to the average of the other governmental and quasi-governmental jurisdictions in our survey. Appendix E shows the specific deductibles of the surveyed governmental and quasi-governmental jurisdictions.

[10] We surveyed the following jurisdictions: city and county of San Francisco, city of Palo Alto, city of Mountain View, county of Santa Clara, city of Sunnyvale, county of San Mateo, county of Santa Cruz, East Bay Municipal Utility District, University of California (several plans), city of Los Angeles, county of Alameda, and East Bay Regional Park District.

TABLE V

COMPARISON OF CSJEHP'S ANNUAL DEDUCTIBLES, ANNUAL OUT-OF-POCKET MAXIMUMS, AND COINSURANCE PERCENTAGES TO THOSE OF OTHER JURISDICTIONS

CITY OF SAN JOSE	OTHER CALIFORNIA JURISDICTIONS
Annual Deductibles	***Annual Out-Of-Network Deductibles***
$50 per member	$50 to $500 per member (avg. $190)
$150 per family of 3 or more	$150 to $1000 per family (avg. $440)
Annual Out-Of-Pocket Maximum	***Annual Out-Of-Pocket Maximum***[11]
Hospital Expenses (Out-of-Network):	PPO Network (all types of expenses):
$1,000 per member	$0 to $10,000 per member (avg. $2,100)
$3,000 per family of 3 or more	$2,000 to $8,000 per family (avg. $3,800)
Non-Hospital Expenses (Out-of-Network):	Out-of-Network (all types of expenses):
$500 per member	$500 to $10,000 per member (avg. $3,360)
$1,500 per family of 3 or more	$3,000 to $8,000 per family (avg. $5,800)
[Other plans do not set different maximum for hospital and non-hospital expenses]	
Coinsurance Percentages	***Coinsurance Percentages***
100% PPO network hospital care	80% to 100% (avg. 95%) PPO network hospital
100% PPO network physician care	80% to 100% (avg. 90%) PPO network physician
100% out-of-network emergency care	60% to 100% (avg. 85%) out-of-network emergency
80% of UCR out-of-network hospital care	50% to 90% (avg. 70%) out-of-network hospital
80% of UCR out-of-network physician care	60% to 100% (avg. 70%) out-of-network physician
[All plans pay % shown after deductible up to out-of-pocket maximum, except member always pay amounts above UCR charges]	[Some plans have co-payments for various services and some have maximum allowable amounts]
Specific Lifetime Benefits	***Specific Lifetime Benefits***
$3,500 per year and per member for mental and drug-related disorders.	Many jurisdictions have specific lifetime benefits for mental or nervous disorders, substance abuse, chiropractic services, and physical therapy.

[11] PERSCare, a self-insured health plan funded by the Public Employees' Retirement System and administered by Blue Shield of California, will have an annual out-of-pocket maximum effective January 1, 1994, which is explained as follows, "*If covered services are received from non-Preferred Providers, whether referred by a Preferred Provider or not (there is no implied contract), or from any combination of Preferred and non-Preferred Providers, there is no maximum copayment responsibility per calendar year. In other words, regardless of the amount of copayments paid during a calendar year, the plan will never reimburse covered services in full. In addition, your copayment will be higher if you use non-Preferred Providers, and you will be responsible for any charges that exceed Blue Shield's Allowable Amount.*"

As shown in Table V, the CSJEHP has smaller annual deductibles, annual out-of-pocket maximums, and coinsurance percentages than the average of the annual deductibles, the annual out-of-pocket maximums, and coinsurance percentages of the health care plans of the governmental and quasi-governmental jurisdictions we surveyed.

In an article in the February 1990 issue of Government Finance Review entitled "Milwaukee's Successful Effort to Control Employee Health Care Costs," David R. Riemer states, "*Those city employees who choose to join a very expensive unmanaged health care plan, rather than the taxpayers, ought to bear the extra cost of that plan. . . . To the extent that the plan imposes any costs on employees, . . . it saves costs for the taxpayers.*" By increasing CSJEHP annual deductibles, the annual out-of-pocket maximums, and employee coinsurance percentages, the City, in effect, shifts a larger portion of the cost of the more expensive health care plan, the CSJEHP, to the employees.

For example, if the City increased the CSJEHP deductible from $50 to $200 per member (which would be in line with the practices of the other jurisdictions we surveyed), the City would save about $534,000 annually. Appendix F shows in detail how we estimated these savings. These savings are possible because the City will not have to pay the health care costs to the extent that the CSJEHP members have to pay the increase in deductibles.

With regard to the annual out-of-pocket maximums, the potential for savings is also substantial since the CSJEHP pays 100 percent of health care costs once a member reaches his or her out-of-pocket maximum. The

City's savings would be about $479,000 annually if the City increased the annual out-of-pocket maximum for non-PPO hospital use from $1,000 per member to $3,000[12] per member and the annual out-of-pocket maximum for non-hospital services provided by non-PPO providers from $500 per member to $1,500[13] per member. Appendix F shows in detail how we estimated these savings.

In summary, to reflect the effect of inflation over the years and to be in line with the practices of other jurisdictions, the City should increase the annual deductibles and annual out-of-pocket maximums CSJEHP members pay. Furthermore, in order to encourage CSJEHP members to be prudent in the utilization of health care services and concerned in the level of health care charges, the City should adjust CSJEHP coinsurance percentages so that they are comparable to those in other jurisdictions.

The City Strategy For Premium Sharing Is Being Negated

Prior to 1990-91, the City paid the entire cost of the premium for the lowest cost health care plan offered by the City. The City also paid an equivalent amount towards the premiums of the other plans. Starting in 1990-91, both the City and the employee shared the cost of the lowest cost

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[12] Even if annual current out-of-pocket maximums were tripled, the CSJEHP would still be more generous to its participants than other jurisdictions. For example, the self-insured plan of PERS, PERSCare, will eliminate effective January 1, 1994, the out-of-pocket maximums entirely. In other words, regardless of the amount of co-payments paid during a calendar year, PERSCare will never reimburse covered services in full if covered services are received from non-PPOs. Furthermore, as noted in Appendix J-3, the TPA has recommended that the CSJEHP pay only 80 percent up to $10,000, then 85 percent or 90 percent up to $30,000, then 100 percent thereafter. If the City decides to implement the TPA's suggestion, the City will save more than the $479,000 we are estimating.

[13] Refer to Footnote #12.

plan. The City continued to contribute for the other health plans an amount equivalent to its share in the cost of the lowest cost plan.

In an April 16, 1993, memorandum to the City Council, the HRD stated that the City has implemented a strategy for premium sharing for City employees. According to the memorandum, the City's premium sharing strategy is to pay the equivalent of 90 percent of the lowest cost health care plan the City offers. Each employee would then pay the difference in the cost of the health care plan he or she selects. However, our review of the City's current memorandums of agreement (MOA) and the health care plan premiums indicated that the City's strategy for premium sharing is being negated by the MOAs and the City is actually paying more than the equivalent of 90 percent of the premium for 83 percent of the members enrolled in the lowest cost health care plan. As a result, the City is not sufficiently able to control future cost increases and is paying, based on 1992-93 costs, approximately $805,000 more annually for its employees' health care than it would have to pay had the premium sharing strategy been fully implemented.

Appendices G and H show the 1993-94 health care plan rates and compare the City's portion of the premium to that of the plan members. Appendix I compares the increase or decrease of the employee's share of the premium from the 1992-93 rates. Our review of the City's MOAs and the premium sharing arrangements, as shown in Appendices G through I, indicate that the City's current MOAs negate the City's premium sharing strategy by requiring the City to pay more than 90 percent of the cost of the lowest cost plan as shown in the following provisions:

1. The MOAs for the sworn police and fire units state that effective with the 1991 rate changes, the City will pay the full premium cost for employees electing the plan with the lowest cost on a per annum basis. However, employees choosing the lowest cost plan[14] shall pay $50 on a per annum basis, plus 10 percent of the 1991 rate increase to a maximum of $8 per month of said increase. For sworn police and fire employees electing one of the other options, the City will contribute the amount it contributed prior to the 1991 rate increases for that option, plus any increase, except that the employee shall pay 10 percent of the increase to a maximum of $8 per month of said increase.

2. For bargaining units other than sworn police and fire, the employee pays 10 percent of the lowest cost plan, to a maximum of $25 per month, plus any additional cost for a plan which is not the lowest cost plan.

As a result of the failure to implement the City's stated premium sharing strategy, the City has ended up paying a larger percentage of the health care premiums than would be allowed by the strategy. For example, the City is paying 97 percent of the premium for Kaiser family coverage for the sworn police and fire bargaining units, and 93 percent of the premium for Kaiser family coverage for units other than sworn police and fire. Furthermore, if the Kaiser family coverage premium increases, the City will bear the full increase for units other than sworn police and fire rather than sharing it with Kaiser family enrollees. Because of the cap in the sworn police and fire employees' share of the premium, the City will also bear any increase in excess of the cap for such employees. Provisions

[14] Kaiser Permanente is currently the lowest cost plan.

such as these indicate that the City is moving not towards implementing its 90/10 premium sharing strategy, but rather towards absorbing almost the entire cost of the employees' health care premiums.

Additionally, the lack of uniformity in the current premium sharing arrangement has resulted in the following adverse conditions in the manner that costs are distributed:

1. Premium increases are not shared proportionately by the City and the employees. For example, when we compared the increases in the total CSJEHP premium with the increases in the employee's premium share per pay period for the 1992-93 and the 1993-94 fiscal years for sworn police and fire and all other units, we found the following disproportionate sharing of premium increases:

    - For single CSJEHP coverage for units other than sworn police and fire, the total premium increased $11.42, or 16 percent, per pay period from 1992-93 to 1993-94; however, the employee's share of the premium increased **$8.89, or 110 percent**.

    - For family CSJEHP coverage for units other than sworn police and fire, the premium increased $20.03, or 11 percent, per pay period from 1992-93 to 1993-94; however, the employee's share of the premium increased **$13.66, or 57 percent**.

    - For single CSJEHP coverage for the sworn police and fire units, the total premium increased $11.42, or 16 percent; however, the employee's share of the premium increased only **$1.14, or 13 percent**.

    - For family CSJEHP coverage for the sworn police and fire units, the total premium increased $20.03, or 11 percent;

however, the employee's share of the premium increased only **$2, or 7 percent**.

2. A group of employees is seen to be favored because the employees are being asked to contribute less to the cost for the same health care plan coverage. Specifically,

   - Units other than sworn police and fire pay 2.43 times more for the Lifeguard family coverage than sworn police and fire;
   - Units other than sworn police and fire pay about two times more for the Kaiser coverage than sworn police and fire;
   - The increases in the employee's share of the CSJEHP premiums from 1992-93 to 1993-94 for units other than sworn police and fire were from seven times to nine times more than the increases for the same coverage for sworn police and fire units.[15]

Based on 1992-93 costs for its employees' health care, the City can save approximately $805,000 annually by fully implementing its premium sharing strategy, which is to pay the equivalent of 90 percent of the lowest cost health care plan the City offers. Table VI shows estimated savings by type of coverage and by bargaining unit if the City's premium sharing strategy were implemented.

[15] The annual increases in the employee's share of the CSJEHP premiums from 1992-93 to 1993-94 for units other than sworn police and fire were as follows: single coverage $231.14; family coverage $355.16. The annual increases for the same coverage during the same period for sworn police and fire units were as follows: single coverage $29.64; family coverage $52.

TABLE VI

ESTIMATED SAVINGS BY TYPE OF COVERAGE AND BY TYPE OF PERSONNEL IF THE CITY'S PREMIUM SHARING STRATEGY IS IMPLEMENTED

	Kaiser		*Lifeguard*		*CSJEHP*	
Type of Personnel	**Single**	**Family**	**Single**	**Family**	**Single**	**Family**
Non-sworn	0	$229,154	0	$59,946	0	$107,630
Sworn	36,409	296,918	$8,842	98,649	<10,739>	<22,182>
Subtotal	36,409	$526,072	$8,842	$158,595	<10,739>	$ 85,448
TOTAL SAVINGS OF ➔ $804,627						

Furthermore, the lack of uniformity in the premium sharing arrangement may result in a cycle of escalating costs that may threaten the affordability and viability of the CSJEHP. Based on the various MOAs, the employee's share of the premium for the same health coverage can vary significantly depending on the employee's bargaining unit. An employee represented by the sworn police or fire unit pays a lower premium share than an employee represented by another unit. Because of the premium sharing limits in the sworn police and fire MOAs, the employees in units other than the sworn police and fire units will bear the major portion of future CSJEHP premium increases.

As shown in Table VII, the CSJEHP has 2,412 participants of which 1,271 (53 percent) participants are in bargaining units other than sworn police and fire.

TABLE VII

NUMBER OF SWORN AND NON-SWORN PARTICIPANTS IN THE CSJEHP AS OF MARCH 31, 1993

	Sworn		*Non-Sworn*		
Health Plan	**Active**	**Retiree**	**Active**	**Retiree**	**Total**
CSJEHP					
Single	138	248	345	136	867
Family	430	325	483	307	1,545
Total	568	573	828	443	2,412

The increases in the employee's share of the CSJEHP premium for bargaining units other than sworn police and fire may encourage CSJEHP members represented by units other than the sworn police and fire to convert to an HMO plan that charges a lower premium. Consequently, the City risks having a smaller CSJEHP participant pool over which to spread the cost of expensive claims. When the participant pool shrinks, the City, its employees, or both will need to increase their contributions to cover the cost of expensive claims. Because of the premium sharing limits in the sworn police and fire MOAs (these employees represent 47 percent of CSJEHP participants), the employees in other units will bear the major portion of future CSJEHP premium increases. Thus, the escalating costs will have to be borne mostly by either the City or the diminishing number of employees not represented by the sworn police and fire units. This will then result in another round of escalating costs for the City and the remaining members. This cycle of escalating costs will, over time, seriously erode the affordability and viability of the CSJEHP.

By implementing its premium sharing strategy, the City can improve its control over future cost increases and save, based on 1992-93 costs,

approximately $805,000 annually for its employees' health care. In addition, uniformly implementing the premium sharing strategy will remove the disparity in the premium sharing arrangements among the various bargaining units and preserve the affordability and viability of the plan.

According to the Office of Employee Relations, a major obstacle to uniformly implementing the City's premium sharing strategy among the various bargaining units is binding interest arbitration under which the City has to operate. According to the Office of Employee Relations,

> *By public election, the City of San Jose has been bound by its City Charter to binding interest arbitration with Police and Fire units since 1980. Interest Arbitration, according to the City of San Jose model (Charter Section 1111), provides that if the parties do not reach a voluntary agreement, the dispute proceeds to an arbitration panel for a binding decision. The arbitration panel considers the proposals on an issue-by-issue basis and makes a decision on each issue.*
>
> *Interest arbitration creates difficulty in the negotiating environment for many reasons. The most pressing problem is that the City loses control over the size and configuration of any benefits package. The neutral arbitrator is not bound by economic parameters, nor is the neutral bound to policy, strategy or a Citywide method for standardization of benefits. For this reason, neither the Council nor the Administration has control over maintaining equity between sworn and nonsworn employee groups, which leads to the current state of disparity with employee cost-sharing of health benefits.*

In view of the difficulties in implementing the premium sharing strategy, the City Council should be apprised of the viability of the strategy. Accordingly, the Office of Employee Relations should annually report to the City Council on the implementation of the City's premium sharing strategy, how it is standardized among the City's bargaining units, the cost implications of not fully implementing the strategy, and any needed changes to the strategy.

The City, Its Retirement Funds, And Employees
Can Save $2.9 Million Or More Per Year In Health Care Costs

As discussed in previous sections of this report, our review indicated that the City, its retirement funds, and employees can save $2.9 million or more per year and better control future cost increases by implementing specific improvements in the health care plan. The following summarizes these potential savings:

1. Provide incentives to encourage CSJEHP members to use the PPO network. By using physicians and hospitals in the City's PPO network, employees enrolled in the CSJEHP can take advantage of medical care discounts of 25 percent.
   Potential savings $1,100,000

2. Increase CSJEHP annual out-of-pocket maximums. To reflect the effect of inflation over the years and to be in line with the practices of other jurisdictions, the City should increase the annual out-of-pocket maximum for non-PPO hospital use from $1,000 per member to $3,000 per member and the annual out-of-pocket maximum for non-hospital services provided by non-PPO providers from $500 per member to $1,500 per member.
   Potential savings $ 479,000[16]

3. Increase CSJEHP deductibles. To reflect the effect of inflation over the years and to be in line with the practices of other jurisdictions, the City should increase the annual $50 CSJEHP deductible to $200 per member.
   Potential savings $ 534,000

[16] This is actually a conservative estimate. As explained in Footnote #12 on page 32, the City would save considerably more than $479,000 if it implements the TPA's suggestion described in Appendix J-3. It should be noted that if CSJEHP members increase their utilization of the PPO network, the potential savings for the out-of-pocket maximum may be reduced.

4. Fully implement the City's premium sharing strategy. Based on 1992-93 costs, the City can improve its control over future cost increases and save approximately $805,000 annually by fully implementing its premium sharing strategy, which is to pay the equivalent of 90 percent of the lowest cost health care plan the City offers.

Potential savings	$ 805,000
Total potential savings	$2,918,000

Our review indicated that the City could also save money by providing incentives to encourage its employees to enroll in either of the City's HMO plans--Kaiser Permanente or Lifeguard--rather than the CSJEHP. The following are our estimates of the maximum potential savings to the City, its retirement funds, and its employees, based on 1992-93 costs:

- If all CSJEHP participants transferred to Kaiser, the City, its retirement funds, and employees would save $2.8 million.
- If all CSJEHP participants transferred to Lifeguard, the City, its retirement funds, and employees would save $2.6 million.

As described above, significant savings can be realized, but only with the cooperation of the City's various employee representation units. The City administration has recognized the necessity of labor-management cooperation, and has formed a labor-management committee, the Benefits Review Forum (BRF), to address issues relating to employee health benefits. In the following sections, we describe the BRF in more detail and make recommendations to improve its effectiveness.

The Employee Benefits Review Forum

The BRF is a labor-management committee created by the City Manager in 1987 to help address issues such as health care cost containment. The BRF consists of representatives from all employee union bargaining units, unrepresented management units, the retirees' associations, and City Administration (Office of Employee Relations and HRD). The Office of Employee Relations provides the primary administrative support for the BRF.

The BRF provides a mutual gain bargaining forum for discussion, review, and improvement of all employee benefits. Although the BRF is not strictly a collective bargaining process, one of its goals is to recommend benefit plan changes which can be put into effect without going through separate bargaining with each of the unions as their contracts expire. The City and all voting members of the BRF need to consent before a new benefit is implemented. Generally, only issues needing City-wide implementation are brought to the monthly BRF meetings. Some decisions about program design are subject to the meet and confer process.

In the area of health care benefits, the accomplishments of the BRF includes the selection of a new TPA to replace Blue Cross. Under the new contract, the administrative cost formula is based on the number of enrolled employees rather than a percentage of claims costs.

Despite the above accomplishment, our review revealed that the BRF has not been effective in addressing issues relating to health care cost containment due to its inability to define its mission. For example, in a memorandum dated July 30, 1990, the Director of Employee Relations

informed the City Manager, "... *while all participants in the Benefits Review Forum believe that it is an excellent method for discussing plan changes and improvements, there has been some dissension about the mission of the group, and the City's intentions regarding benefit changes.*" Furthermore, the BRF's minutes of its 1990 and 1991 meetings showed that three years after its formation, it was still spending a significant amount of time trying to define its purpose and policies. When it started to discuss employee benefits, it spent a disproportionate time on dental plan benefits, which comprised only about 16 percent of total funds appropriated for employee health benefits, while virtually ignoring medical benefits, on which the City spent the major portion of employee health care funds.

The City depends on the BRF as the main vehicle for generating concern and concurrence among the City's health care plan participants in ensuring a cost-effective employee and retiree health care system. In an August 22, 1989, memorandum to the BRF, the HRD stated, "*A major key to curtailing rising medical costs lies with the consumers of medical services--our employees. They are the primary contact with the health care industry, and represent the first line of defense against high costs. When our employees understand that the bills they generate directly correspond to the premiums that they pay, they are more likely to make sure that what they select is the most efficient use of their health care dollar*." However, since its creation in 1987, the BRF has not adequately fulfilled its mission of addressing health care cost containment.

Appendix J summarizes our review of BRF activities. As explained in Appendix J, the BRF received suggestions on cost containment strategies from the National Public Employer Labor Relations Association, the HRD,

and the City's TPA for the CSJEHP. To address cost containment issues, such as the ones described in Appendix J was one of the main reasons why the BRF was formed. By not adequately acting on cost containment, the BRF did not, in our opinion, carry out its purpose.

The Employee Benefits Review Forum Could Be A More Effective Vehicle For Addressing The City's Health Care Issues

In our opinion, the BRF could be a more effective vehicle for addressing the City's health care issues if

- The Employee Services Division of HRD assumed from the Office of Employee Relations the administrative responsibility for the BRF;
- The Employee Services Division of HRD provided the BRF with periodic comparative information on the City's health care programs; and
- The City contracted with a third-party facilitator for the BRF.

Transfer The Administrative Responsibility For The Benefits Review Forum To The Employee Services Division

Currently, the Office of Employee Relations in the City Manager's Office has the primary administrative support responsibility for the BRF. The Office of Employee Relations has the following program purposes:

- To provide services that ensure the City's compensation program attracts and retains a highly qualified workforce and
- To promote positive management-employee relationships which contribute to employee productivity.

The Office of Employee Relations has collective bargaining responsibilities and commensurable performance measures. The following three performance measures of the Office of Employee Relations are some of its responsibilities and reflect that collective bargaining can be an adversarial process:

- Negotiate new contracts or schedule interest arbitration prior to expiration of existing contract;
- Percentage of grievances resolved before arbitration; and
- Percentage of favorable decisions on arbitrated grievances.

Thus, the tendency of a committee, such as the BRF, that is comprised mostly of labor representatives would be to view any guidance or suggestions from the Office of Employee Relations with skepticism or reservations.

In contrast, the Employee Services Division in the HRD is responsible for administering and managing all benefit programs for the City, the employees, retirees, and their families. The staff in the benefit funds program manages such programs as New Employee Orientation, Police & Fire Retirement, Federated Retirement, Dental Insurance, Deferred Compensation, Life Insurance, Unemployment Insurance, San Jose Employees' Health Fund, and Employee Medical Services. The staff provides all customer services related to these programs, administers contracts, develops and distributes marketing information, and regularly generates all program reports.

In our opinion, cooperation between the City and its employee organizations will be more natural and forthcoming if the Employee Services Division of HRD assumed administrative responsibility over the

BRF in view of the customer service orientation of the Employee Services Division in contrast to the Office of Employee Relations' inherent adversarial orientation.

Provide Periodic Comparative Information On Health Care Programs

The BRF could also be a more effective vehicle for addressing the City's health care issues if the Employee Services Division of HRD provided BRF with periodic comparative information on the City's health care programs. Such periodic comparative information should be requested from the health care plan administrator and through surveys of other jurisdictions in order to enable the labor-management committee to analyze the health care plans and determine possible cost containment approaches. The information could include

- Complete description of health plans offered;
- Complete description of ancillary benefits offered, such as dental and prescription drugs;
- Enrollment in each plan, including HMOs, showing the number of employees with family and single coverage;
- Last year, current year, and projected monthly rates with comparisons to the rates of other jurisdictions;
- Employer and employee contribution to each plan and method of determination (percentage of cost or flat dollar);
- Financing information on each plan;
- Experience statements;
- Information on any cost containment efforts to date and any identified savings;

- Utilization data on each plan (including inpatient, outpatient, professional, major medical, and prescription drugs);
- Employer practice for continuing coverage to retirees;
- Copies of any consultant's reports; and
- Labor or management proposals.

In previous years, the City cooperated with Santa Clara County and other local jurisdictions in the Joint Powers Agreement for Intergovernmental Employee Relations Service. The information and research which this service provided included comparative surveys of local jurisdictions, bargaining settlements, and trends of labor litigation, legislation, and arbitration. The City's annual membership fee was based on the number of City employees and was about $24,000 for 1992-93. Because of the 1993-94 budget reductions, the City terminated its participation in this service.

In our opinion, the information and research the Employee Relations Service provides, along with the Plan Service Analysis reports the CSJEHP administrator provides, is critical to the BRF's success in addressing the City's health care plan issues. Accordingly, the City should again participate in the Employee Relations Service and continue requesting the Plan Service Analysis reports from the CSJEHP administrator and provide such information to the BRF to facilitate it accomplishing its cost containment objectives. The Office of Employee Relations and the HRD should request a mid-year budget adjustment to pay for the City's membership in the Joint Powers Agreement for Intergovernmental Employee Relations Service and continue requesting the Plan Service Analysis reports from the CSJEHP administrator to provide the BRF with

periodic information on the City's health care programs. Such information should include (a) a comparison of the CSJEHP annual deductibles and annual out-of-pocket maximums to those of other comparable jurisdictions and the effect inflation has had over the past 20 years on City costs, (b) a comparison of the CSJEHP coinsurance percentages to that of other comparable jurisdictions, and (c) a comparison from year to year of premiums, expenditures, membership, and utilization experiences of the City's various health care plans.

Contract With A Third-Party Facilitator

A third-party facilitator could also help the BRF become the guiding force of a labor-management cooperative process to address health care cost containment for the City. In our opinion, many changes to the City's health plan are possible, but a cooperative approach is needed to accomplish the needed changes. A third-party facilitator can help labor and management in exploring how to effectively control costs and maintain adequate levels of benefits. Authoritative literature shows that joint labor-management cooperation has been successfully used in the public sector in such jurisdictions as the state of Minnesota, state of Oregon, Chicago public schools, the city of Peoria, and, locally, the county of San Mateo. Considering the extent of the savings possible, we think it is prudent for the City to budget for a third-party facilitator to take advantage of the win-win cost savings opportunities available.

Patrick McMahon, in his article for the American Management Association entitled "Health Care Cost Containment: A Labor-Management Issue," observes that labor and management must work

together to meet the challenge of escalating health care costs. Labor and management must stop being passive payees of health care costs and become active partners in the formation of new health plans and strategies. The author recommends using a third-party facilitator as a strategy for health care cost containment. Mr. McMahon says at least 90 percent of the changes necessary for health care cost containment can be made outside the collective bargaining agreement where labor and management come together, compare lists, and begin the process of building trust and cooperation. Steering committees become the guiding force of the labor-management cooperative process.

Appendix K describes an example of a health care cost containment action plan using a third-party facilitator. In our opinion, the BRF could be a more effective vehicle for addressing the City's health care issues if the City contracted with a third-party facilitator to assist the BRF in (a) identifying long-range goals and objectives, (b) developing a strategy to obtain them, (c) translating the strategy into measurable and operational short-run plans or tactics, and (d) retranslating short-run plans into policies and procedures.

Much of the history of labor and management relations has involved resolving disputes, solving problems, and making decisions through adversarial means. All too often this means conflict resolution at contract negotiation time. The position that the adversarial process puts labor and management in makes it difficult, if not impossible, to find a common basis for ongoing communication outside the collective bargaining agreement's scope of influence. Both parties must have absolute trust in the third party's motives and objectivity. The third-party facilitator acts as

the catalyst that makes this interaction possible. He or she is an unbiased outsider who initially facilitates a cooperative atmosphere and acts as a resource for ideas and methods.

CONCLUSION

Our audit of employee benefits indicated that City employees enrolled in the City of San Jose Employees' Health Plan (CSJEHP) can save the City health care costs by using physicians and hospital services within a preferred provider organization (PPO) network. Our survey of other governmental and quasi-governmental jurisdictions disclosed that the City (1) has a significantly smaller percentage of employees enrolled in health management organizations (HMOs), and (2) requires its employees not enrolled in HMOs to pay smaller annual deductibles, annual out-of-pocket maximums, and coinsurance percentages. In addition, the City strategy for premium sharing is being negated because negotiated labor agreements prevent the City from achieving its cost containment objectives. As a result, the City, its retirement funds, and employees can save $2.9 million or more per year and better control future cost increases by implementing specific improvements in the health care plan.

In 1987, the Administration established an employee Benefits Review Forum (BRF) to help address issues such as health care cost containment. However, our review revealed the BRF has not been effective. In our opinion, the BRF could be a more effective vehicle for addressing the City's health care issues if (1) the Department of Human Resources (HRD) assumed from the Office of Employee Relations the administrative responsibility for the BRF, (2) the HRD provided the BRF

with periodic comparative information on the City's health care programs, and (3) a third-party facilitator was used to facilitate BRF meetings.

RECOMMENDATIONS

We recommend that the City Manager:

Recommendation #1:

Transfer the administrative responsibility for the Benefits Review Forum from the Office of Employee Relations to the Department of Human Resources/Employee Services Division. (Priority 3)

We further recommend that the Office of Employee Relations and the Department of Human Resources:

Recommendation #2:

Request a mid-year budget adjustment to pay for the City's membership in the Joint Powers Agreement for Intergovernmental Employee Relations Service and continue requesting the Plan Service Analysis reports from the health plan administrator to provide the Benefits Review Forum with periodic information on the City's health care programs. Such information should include (a) a comparison of the City of San Jose Employees' Health Plan annual deductibles and annual out-of-pocket maximums to those of other comparable jurisdictions and the effect inflation has had over the past 20 years on City costs, (b) a comparison of the City of San Jose Employees' Health Plan coinsurance percentages to that of other comparable jurisdictions, and (c) a comparison from year to

year of premiums, expenditures, membership, and utilization experiences of the City's various health care plans. (Priority 1)

Recommendation #3:

Request a mid-year budget adjustment for a contract with a third-party facilitator to assist the Benefits Review Forum in (a) identifying long-range goals and objectives, (b) developing a strategy to obtain them, (c) translating the strategy into measurable and operational short-run plans and tactics, and (d) retranslating short-run plans into policies and procedures. (Priority 1)

Recommendation #4:

Annually report to the City Council on the implementation of the City's premium sharing strategy, how it is standardized among the City's bargaining units, the cost implications of not fully implementing the strategy, and any needed changes to the strategy. (Priority 1)

OTHER PERTINENT INFORMATION

President Clinton's Proposal for National Health Care

On September 21, 1993, President Clinton published his proposal for national health care reform. Under his health plan, every American would be covered by a basic benefit package. It is interesting to note that the city of San Jose's health plans are significantly more generous to the employee than the President's proposed national health plan. According to the San Jose Mercury News, the proposed national health plan and its costs would be as follows:

Basic Plans

Three basic plan options would be offered:

- **Low-Cost Sharing:** HMO-style. Patient pays $10 co-payments for outpatient services; no co-payment for hospital stay.
- **High-Cost Sharing:** Fee-for-service style. Patient pays $200 individual/$400 family deductible; insurance pays 80% of medical bills.
- **Combination:** Patient pays only $20 co-payment if in-network providers are used; insurance covers 80% of bill if other providers are used.

Basic Benefits

- Treatment by doctors and other health professionals
- Emergency services
- Mental health services
- Pregnancy-related services and family planning
- Home health care as an alternative to hospitalization
- Prescription drugs
- Vision and hearing care

- Hospital stays
- Preventive care, such as checkups, immunizations, pap smears, cholesterol tests, and mammograms.
- Treatment for drug and alcohol abuse
- Hospice care for the terminally ill
- Ambulance services
- Extended care in nursing homes or rehabilitation facilities
- Preventive dental services for children

Items Not Covered

- Services not medically necessary
- Hearing aids
- Adult eyeglasses and contact lenses
- Private duty nursing
- Cosmetic surgery
- In vitro fertilization
- Sex change surgery
- Private hospital rooms

How System Would Work

- Individuals would receive a national health security card to guarantee their access to services.
- Most individuals would be assigned by their states to a regional health alliance.
- Regional health alliances would negotiate with various insurers to obtain coverage for their members.
- Individuals would select a health plan from those offered in their alliance.

The Costs[17]

- For individuals, the cost would be a maximum out-of-pocket of $1,500 per year plus the employee share of the average annual premium of $360.
- For families, the cost would be a maximum out-of-pocket of $3,000 per year plus the employee share of the average annual premium of $840.

How Insurance Costs Would be Shared[18]

– Those enrolled in cheaper plan options would pay lower premiums than those shown above because workers/individuals pay the difference between the employer contribution and the price of the plan they select.

– Employers pay at least 80 percent of the cost of an average premium in a region. Total average premium for individuals, about $1,800; for families, about $4,200. Average share for an individual, $360; for a family, $840.

– People with low incomes now in Medicaid would be included in the regional health alliances. The government would pay the premiums.

– Unemployed and self-employed would pay the total premium, but it would be tax-deductible.

[17] Actual amount will vary from region to region.

[18] Refer to Footnote #17.

LIST OF ABBREVIATIONS

BRF	Benefits Review Forum
City	City of San Jose
CSJEHP	City of San Jose Employee's Health Plan
GNP	Gross National Product
HRD	Department of Human Resources
HMO	Health Maintenance Organization
MOA	Memorandum of Agreement
PERS	Public Employees Retirement System (California)
PPO	Preferred Provider Organization
TPA	Third-Party Administrator
UCR	Usual, Customary, and Reasonable Fees

CITY OF SAN JOSE - MEMORANDUM

TO:	Finance Committee	FROM:	Nona Tobin, Acting Director Human Resource Department
SUBJECT:	AUDIT RESPONSE: EMPLOYEES' HEALTH BENEFITS	DATE:	November 4, 1993

APPROVED: *[signature]* DATE: 11/4/93

The Human Resources Department and Office of Employee Relations have reviewed the *Audit of the City of San Jose Employees' Health Benefits* and support its finding and recommendations. Human Resources and Employee Relations agree that the majority of the strategies require the agreement of employee groups through meet and confer. Human Resources and Employee Relations also agree that we should improve the effectiveness of the Benefits Review Forum.

FINDING: COST CONTAINMENT COULD SAVE THE CITY, ITS RETIREMENT FUNDS AND EMPLOYEES $2.9 MILLION OR MORE PER YEAR

RESPONSE: The Human Resources Department agrees with this finding, and would like to caution the Finance Committee regarding the usability of the $2.9 million.

The Auditor correctly notes the total savings would be shared between the City, the retirement funds and the enrollees. This is because expenditure savings are realized through reduced contributions into the health funds. Since contributions are shared in accordance with negotiated formulas between the City and its employees and the retirement funds and retirees, all expenditure savings would be realized by all contributors accordingly. In the case of non-sworn employees and retirees whose cost-sharing formula is based on the lowest priced plan (currently Kaiser), reductions in contributions to either Lifeguard or the City of San Jose Employees' Health Plan (CSJEHP) will be realized by the employees and retirees first. The City and retirement funds would begin to realize savings once the cost of the lowest priced plan is reduced.

The Auditor also correctly notes that the $2.9 million represents a maximum potential savings that would be realized under a number of ideal conditions as described below. Human Resources advises that the ideal conditions are not likely to occur in full, and, consequently, it is unlikely that the full $2.9 million savings will be achieved.

TOTAL POTENTIAL SAVINGS ESTIMATE

Use of Preferred Providers	$ 1.1 million
Increase CSJEHP Deductibles	$ 0.5 million
Increase CSJEHP Out-of-Pocket Maximums	$ 0.5 million
Fully Implement Premium Sharing Strategy	$ 0.8 million
TOTAL POTENTIAL SAVINGS	$ 2.9 million

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Use of Preferred Providers—The $1.1 million savings estimate requires that all enrollees obtain services through preferred providers. This is not likely because of certain geographic limitations (primarily retirees who live outside the Bay Area) and since many CSJEHP plan participants desire the freedom to choose specific physicians who may or may not be preferred providers. However, improvements to the existing incentive structures (deductibles, co-payments and out-of-pocket maximums) are likely to significantly increase the use of preferred providers. These changes are subject to meet and confer.

Increase CSJEHP Deductibles—The $0.5 million savings estimate assumes that all enrollees that met the current $50 deductible would have met a $200 deductible. A larger barrier to realizing these savings is that the deductible is subject to meet and confer, and consequently requires agreement from all bargaining units.

Increase CSJEHP Out-of-Pocket Maximums—The $0.5 million savings estimate assumes that all enrollees that met the current $1,000 out-of-pocket maximum would have met a $3,000 out-of-pocket maximum. Again, a larger barrier to realizing these savings is that the out-of-pocket maximum is subject to meet and confer, and requires agreement from all bargaining units.

Fully Implement Premium Sharing Strategy—As with the two items above, a true 90%/10% cost-sharing formula is subject to meet and confer. The $0.8 million savings is dependent upon agreement from all bargaining units.

This particular savings strategy is critical to generating savings for the City and retirement funds. As noted earlier, the City and retirement funds realize savings only when the cost of the lowest priced plan is reduced. Of the four strategies identified by the Auditor, this is the only one that directly addresses the lowest priced plan.

RECOMMENDATION #1: TRANSFER THE ADMINISTRATIVE RESPONSIBILITY FOR THE BENEFITS REVIEW FORUM FROM THE OFFICE OF EMPLOYEE RELATIONS TO THE HUMAN RESOURCES DEPARTMENT

RESPONSE: Both offices agree with this recommendation. Human Resources will provide leadership and technical expertise. The Office of Employee Relations will continue to participate and handle meet and confer as required. The administrative transfer will be effective in February 1994.

RECOMMENDATION #2: PROVIDE THE BENEFITS REVIEW FORUM WITH PERIODIC INFORMATION ON THE CITY'S HEALTH CARE PROGRAMS

RESPONSE: Human Resources and Employee Relations agree with this recommendation. It is consistent with an existing work plan to provide enrollees with quality benefits information.

Note that this particular recommendation, as proposed by the Auditor's Office, would restore the City's membership to the Joint Powers Agreement for Intergovernmental Employee Relations Service (through the County of Santa Clara), which was eliminated in the 1993-94 Adopted Budget. This item will be reviewed in either the Mid-Year Budget Review or the 1994-95 budget process. Also, preliminary discussions will be held with the County regarding an enhancement of services.

RECOMMENDATION #3: REQUEST A MID-YEAR BUDGET ADJUSTMENT FOR A CONTRACT WITH A THIRD-PARTY FACILITATOR

RESPONSE: Human Resources and Employee Relations agree with this recommendation. It is consistent with an existing work plan to ensure the quality and appropriateness of the City's benefits programs. Preliminary discussions with potential consultants indicate an ongoing cost of approximately $30,000 plus a one-time start-up cost of $20,000.

RECOMMENDATION #4: ANNUALLY REPORT TO THE CITY COUNCIL ON THE IMPLEMENTATION OF THE CITY'S PREMIUM SHARING STRATEGY

RESPONSE: The Human Resources Department and the Office of Employee Relations agree with this recommendation. The first such report will be presented to the Council in September 1994.

CONCLUSION: The Human Resources Department appreciates the opportunity to work with the Office of the City Auditor to improve the operational and cost effectiveness of the City's health benefits programs. Human Resources agrees with the audit's finding, and, accordingly, has developed work plans for satisfying the recommendations.

Prior to this audit, Human Resources already had developed a strategic plan for the Employee Benefits program that includes the long-range benefits plan and the third-party facilitator recommended by the City Auditor. We have defined the products and processes, and look forward to proceeding on the work plans with the assistance of the third-party facilitator.

Additionally, the Finance Committee should note that the City's entire health benefits program could be drastically affected by the President's National Health Care Reform proposal. City staff will continue to monitor the proposal as it moves and changes through the legislative process. The staff will inform the Finance Committee and the City Council of significant impacts as they begin to finalize in the legislation.

Nona Tobin, Acting Director
Human Resources Department

cc: Les White, City Manager
Regina V.K. Williams, Assistant City Manager
Joan Gallo, City Attorney
Larry D. Lisenbee, Budget Director
John Guthrie, Director of Finance
Mary Egan, Employee Relations Officer

APPENDIX A

DEFINITIONS OF PRIORITY 1, 2, AND 3
AUDIT RECOMMENDATIONS

The City of San Jose's City Policy Manual (6.1.2) defines the classification scheme applicable to audit recommendations and the appropriate corrective actions as follows:

Priority Class[1]	Description	Implementation Category	Implementation Action[3]
1	Fraud or serious violations are being committed, significant fiscal or equivalent non-fiscal losses are occurring.[2]	Priority	Immediate
2	A potential for incurring significant fiscal or equivalent fiscal or equivalent non-fiscal losses exists.[2]	Priority	Within 60 days
3	Operation or administrative process will be improved.	General	60 days to one year

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1 The City Auditor is responsible for assigning audit recommendation priority class numbers. A recommendation which clearly fits the description for more than one priority class shall be assigned the higher number. **(CAM 196.4)**

2 For an audit recommendation to be considered related to a significant fiscal loss, it will usually be necessary for an actual loss of $25,000 or more to be involved or for a potential loss (including unrealized revenue increases) of $50,000 to be involved. Equivalent non-fiscal losses would include, but not be limited to, omission or commission of acts by or on behalf of the City which would be likely to expose the City to adverse criticism in the eyes of its citizens. **(CAM 196.4)**

3 The implementation time frame indicated for each priority class is intended as a guideline for establishing implementation target dates. While prioritizing recommendations is the responsibility of the City Auditor, determining implementation dates is the responsibility of the City Administration. **(CAM 196.4)**

APPENDIX B

CITY OF SAN JOSE - MEMORANDUM

To:	Gerald A. Silva City Auditor	From:	Nona Tobin
Subject:	EMPLOYEE HEALTH CARE PLANS	Date:	September 8, 1993
Approved:		Date:	

As input for the audit of the City of San Jose Employees' Health Plan (CSJEHP), this memo provides information regarding major program accomplishments relative to the City's health benefits programs.

BACKGROUND

The City's overall goal in providing medical care coverage is to ensure that employees, retirees and their families have access to quality medical care and are protected from unexpected or unaffordable medical expenses.

A number of considerations have influenced the design of San Jose's Employee Health Care Program. These include: premium costs, which have risen much faster than inflation and which accompany overall health care cost increases; the general increase in the use of medical services and "high tech" treatment, particularly among those who have health care coverage; a goal of medical care which is accessible, free of fraud, and of consistently high quality; and a commitment to provide a choice from among major plan types to meet varying individual and family needs.

To achieve its employee health program objectives, the City of San Jose offers three health care plans that are different by design to provide choices for covered employees. Employees may select the plan which fits their own needs and preferences. Their choices include a closed panel health maintenance organization plan through Kaiser Foundation, an individual practice health maintenance organization through Lifeguard, and a modified managed care program which allows free choice of physicians and hospitals through the City of San Jose Employees' Health Plan.

The City of San Jose has been struggling with the issue of rising health care costs for over 15 years. Premium costs increased by nearly 15% per year from 1980 until 1992. Increases from 1991–92 to the current fiscal year have averaged only 6 to 7%.

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ACCOMPLISHMENTS

In its effort to contain costs, the City has made a number of changes in recent years to what is now the City Employees' Health Plan. These have included:

- The establishment of a self-funded indemnity plan, initially administered by Blue Cross;
- The creation of a separate fund to better track the deposit of premiums and payment of claims/administrative costs;
- Movement from full cost coverage for the lowest cost plan toward a 90/10 cost sharing between the City and enrolled employees;
- Restructuring of the indemnity plan to move away from unrestricted care toward managed care;
- Termination of the relationship with Blue Cross and the selection of Foundation Health Preferred Administrators as the third party administrator;
- An administrative cost formula based on the number of enrolled employees rather than a percentage of claims costs;
- The incentive of 100% payment for services from physicians and hospitals which have agreed to charge reduced rates (through a Preferred Provider Network); and
- The implementation of an optional on-line claims payment system for prescriptions to reduce administrative costs.

CONCLUSION

All three of the health care plans offered by the City of San Jose are identified in current agreements between the City and its employee organizations, and changes are subject to the meet and confer process. A partnership between City administration and its various employee groups, through the Benefits Review Forum, was formed specifically to develop and maintain workable, quality, affordable medical care plans.

The overall objective of the City's health care program continues to be to provide quality health care as economically as possible. City administration, with the Benefits Review Forum, will continue to explore improvements to the City of San Jose Employees' Health Plan which meet this objective.

Nona Tobin, Acting Director
Human Resources Department

APPENDIX C

HEALTH PLAN OPTIONS

City of San Jose

SERVICE	LIFEGUARD	KAISER	CSJEHP
GENERAL	Lifeguard Plan is a prepaid direct service health care system allowing you to choose physician services from over 3,600 private physicians and 50 contracting hospitals throughout Santa Clara, Contra Costa, Alameda and Solano Counties. All hospitalization must be approved by the Lifeguard Managed Care Dept. All services must be by member providers.	Kaiser Plan is a prepaid direct service health care system. Services are provided ONLY at Kaiser Foundation Hospitals and Medical Offices. You may choose a personal physician from the staff for you and your family.	The City of San Jose Employees' Health Plan (CSJEHP) is an indemnity health plan which allows the freedom to choose a physician or hsopital. The Plan covers medically necessary services only. There is an annual deductible of $50 per eligible person from covered medical expense charges (limited to 3 deductibles per family). All hospitalization must be reviewed by Preferred Administrators.
HOSPITAL ROOM & EXTRAS	Covered when certified and coordinated in advance by the Lifeguard Managed Care Dept.	Unlimited days full coverage. Special care units when determined medically necessary by physician.	120 days full coverage in room of 2 or more beds or special care units when determined medically necessary by physician. Pays 100% of hospital charges if you use a panel provider; 80% if you do not. All hospital stays are subject to advance review.
OUTPATIENT EMERGENCY ROOM	A $25 charge is made for ER charges for sudden onset of illness or due to an accident.	No Charge.	Pays in full for emergency treatment. Pays 100% for follow-up treatment if you use a panel provider; 80% if you do not.
AMBULANCE	No charge if medically necessary.	No charge if authorized and medically necessary.	Pays up to $200 toward ambulence fees for hospital benefits as bed patient. Pays 80% of UCR charges in excess of $200.
SURGEONS, ASSISTANTS, ANESTHETISTS	Precertification by Lifeguard is required. All physicians must be contracting physicians	No charge.	Pays 100% for services provided by panel providers; 80% of UCR charges for non-panel providers. All surgical procedures are subject to advance review.
PHYSICIAN VISITS: • OFFICE • IN HOME • IN HOSPITAL	 • $4 co-payment per visit • $5 co-payment per visit • No charge, but must be pre-certified by Lifeguard	 • No charge; no limit • $5 per family member • No charge	Covers only medically necessary visits. Pays 100% if you use a panel provider; 80% of UCR if you do not.
MATERNITY	Covered, with $25 co-payment for 1st exam and $4 co-payment each visit thereafter.	Complete care without charge to member for hospital physician services.	Provides normal hospital & surgical benefits for employee and spouse only. Pays 100% if you use a panel provider; 80% of UCR if you do not. All hospital stays are subject to advance review.
OUTPATIENT X-RAY AND LABORATORY	No charge when ordered by & obtained at contracting provider.	No charge; no limit to number of visits.	Pays 100% at a hospital or laboratory; 80% in a physician's office.
OUTPATIENT DRUGS	Not covered.	$1 charge per prescription at Kaiser pharmacy.	Pays 80% of UCR charges.
ROUTINE ANNUAL EXAMS	Charge ranges from $5 to $25, depending on age of patient. Limited to 1 exam per patient every 366 days	No charge.	Not covered.

SERVICE	LIFEGUARD	KAISER	CSJEHP
WELL BABY CARE	Fully covered from birth to age 2.	No charge; no limit to visits.	Not covered.
ALLERGY TESTS	$4 co-payment per office visit.	No charge; no limit to visits.	Pays under Laboratory provisions.
ACUTE ALCOHOLISM/ DRUG ADDICTION	Inpatient: Limited in member hospital for detox only. Rehab is not covered. Outpatient: Crisis intervention only. 20 visits per 366 days with 50% co-payment. Counseling and rehab are not covered.	In hospital: Detox only. In office: No charge.	In hospital: Pays up to 15 days each calendar year for direct care and treatment when hospitalized. In patient: Pays up to 15 physician hospital visits each calendar year when eligible for hospital benefits. Pays 100% if you use a panel provider; 80% if you do not. Maximum benefit is $3,500 each calendar year. All hospital stays are subject to advance review.
PSYCHOTHERAPY FOR DIRECT CARE FOR ACUTE PHASE OF MENTAL CONDITION	Inpatient: Crisis intervention only. 30 days precertified hospital coverage per 366 days with 1 physician visit daily. Outpatient: Crisis intervention only. 20 visits per 366 days with 50% co-payment charge. Counseling is not covered.	In hospital: Up to 45 days per calendar year at no charge. In office: Up to 20 visits per calendar year at no charge for short-term psychiatric care.	In hospital: Pays up to 30 days each calendar year for room & services. In patient: Pays up to 30 physician hospital visits each calendar year when eligible for hospital benefits. Pays 100% if you use panel provider(s); 80% if you do not. All hospital stays are subject to advance review. Outpatient: Not covered.
PHYSICAL THERAPY & CHIROPRACTIC	Short term physical therapy for accute conditions is covered. Chiropractic is not covered.	Short term physical therapy for acute conditions is covered. Chiropractic is not covered.	Physical therapy and chiropractic treatment is covered for approved medically necessary conditions. Pays 100% if you use a panel provider; 80% if you do not.
CORRECTIVE APPLIANCES & ARTIFICIAL AIDS	50% charge. Must be prescribed by plan physician.	Not covered.	Pays 80% of UCR charges.
OUT-OF-AREA COVERAGE	Coverage for bona fide emergency care for treatment of illness or accident while temporarily out of Lifeguard service area. Patient pays $25 per visit. The Lifeguard Managed Care Dept. must be notified the next working day.	Full coverage for emergency services required before member's medical condition permits travel or transfer to nearest Kaiser facility for care. Full coverage within service area if transporting member to Kaiser facility would have caused delay likely to result in death, serious disability, etc.	Benefits provided for care received anywhere in the world. Pays 80% of UCR for non-emergency treatment. Pays in full for emergency treatment.
COORDINATION OF BENEFITS	Yes.	No.	Yes.
ELIGIBLE FAMILY MEMBERS	Legal spouse. Unmarried children under age 19, or to age 24 if FULL-TIME student and qualified as dependent under IRS Codes; or incapable of self-support due to mental retardation or physical handicap.	Legal spouse. Unmarried children under age 24 and supported by you; or unmarried children incapable of self-support due to mental retardation or physical handicap.	Legal spouse. Unmarried children to age 23 if FULL-TIME student and qualified as dependent under IRS Codes; or unmarried children incapable of self-support due to mental retardation or physical handicap (must be so certified before 19th birthday).
SUBROGATION	Yes.	Yes.	Yes.

APPENDIX D

CITY OF SAN JOSE EMPLOYEES' HEALTH PLAN

The City of San Jose Employees' Health Plan is a self-funded indemnity health insurance plan established in 1970. The Plan is administered by Preferred Administrators. Their address is:

Preferred Administrators Insurance Services
P. O. Box 10009
Palo Alto, CA 94303-0901

Their telephone numbers are:

(415) 967-5219 Locally
(800) 331-5301 (inside CA)
(800) 654-6701 (outside CA)

The main group numbers are: 10021 - Active
10022 - Council, Redevelopment, MECU, COBRA
10023 - Retirees

Your subgroup number is the same as your bargaining unit, (e.g., MEF - Unit 05 is subgroup 05.)

Benefits are provided for enrollees and their eligible dependents when medically necessary. Coverage includes illness, injury, and certain medical conditions identified in the Plan document.

Maximum Benefit: One million dollars per lifetime per enrollee.

Deductible: $50.00 per year, per family member, maximum three (3) family members.

The Plan pays for covered services at the following rate:

Hospital

Services by a **panel provider**	100%
Services by a non-panel provider	80% of UCR
Except that the following exceptions are are paid at:	
* Emergency Services	100%
* Services in a hospital when you live and work more than 50 miles from a panel hospital	90% of UCR
* Services which are only available at specialized hospitals	100%
Maximum out-of-pocket on UCR charges is $1000	

Non-Hospital

Services by a panel provider	100%
Services by a non-panel provider	80% of UCR
Except that:	
* Emergency services	100%
* Services from a physician when you live and work more than 50 miles from a panel physician	90% UCR
*Drugs/Durable Medical Equipment, etc.	80% of UCR
* Maximum out-of-pocket on UCR charges is $500	

Panel Provider - A doctor, hospital, or other healthcare provider who has agreed to accept a certain fee as payment in full and who has agreed not to bill the patient for any fees above and beyond those paid by the Plan. The name of our panel is PPO Alliance.

Review: All hospitalizations (inpatient and outpatient) must be reviewed. If the hospitalization is an emergency, call Preferred at (800) 344-5877 within 48 hours (or the next business day if later.) If it is an elective surgery, call at least 10 days in advance. The call can be made by you, your physician, your physicians' office, or the hospital. The number to call is on your card. If you do not have your hospitalization reviewed, the Plan will pay 20% less than it otherwise would have paid.

Large Case Management is a service available to employees and their families who are facing very expensive medical treatment (typically cancer, AIDS, head or spinal column injuries, intensive neo-natal treatment, or other similar cases.) The Plan provides a nurse who can act as coordinator for medical services and claims payments and, in some cases, authorize special benefits in order to obtain medically appropriate care in a more economical and cost-effective manner. This service is available if requested. It is not mandatory.

CITY OF SAN JOSE EMPLOYEES' HEALTH PLAN

GENERAL	The City Plan is an indemnity health plan which allows the freedom to choose a physician or hospital. The Plan is a "sickness" type plan which provides coverage for medically necessary services only. Medical payments start after satisfaction of an annual out-of-pocket deductible of $50 per eligible person from covered medical expense charges. Maximum deductible limitation of no more THREE (3) deductibles per family.
HOSPITAL ROOM & EXTRAS	120 days full coverage in room of two or more beds or special care units when determined medically necessary by a physician. Pays 100% of hospital charges if you use a panel provider or 80% if you do not. All hospital stays are subject to review. See your card for the telephone number.
OUTPATIENT EMERGENCY ROOM	Pays in full for treatment. Pays 100% for follow up treatment if you use a panel provider or 80% if you do not.
AMBULANCE	Pays up to $200 toward ambulance fees for hospital benefits as bed patient. Pays 80% UCR charges in excess of the $200.
SURGEONS, ASSISTANTS ANESTHETISTS	Pays in full for services provided by Panel providers. Pays 80% of UCR charges for non-panel providers.
PHYSICIAN (OFFICE VISIT, HOME VISIT, HOSPITAL	Covers only medically necessary visits. Pays 100% if you use a panel provider, 80% for a non-panel provider.
MATERNITY	Provides normal hospital and surgical benefits for employee and spouse only. Pays 100% if you use a panel provider; 80% of UCR if you a non-panel provider.

CITY OF SAN JOSE EMPLOYEES' HEALTH PLAN	
OUTPATIENT X-RAY AND LABORATORY	Pays 100% at a hospital; 80% in a physician's office or Laboratory.
OUTPATIENT DRUGS	Pays 80% of UCR charges.
ROUTINE ANNUAL EXAMS	Not covered.
WELL BABY CARE	Not covered.
ALLERGY TESTS	Pays under LAB provision.
PSYCHOTHERAPY FOR DIRECT CARE FOR ACTIVE PHASE OF MENTAL CONDITION	IN HOSPITAL: Pays up to 30 days each calendar year for room and services. INPATIENT: Pays up to 30 physician hospital visits each calendar year when eligible for hospital benefit. Pays 80% or 100% (depending on use of panel providers) for hospital room and service until payments total $3,500 each calendar year.
ACUTE ALCOHOLISM AND DRUG ADDICTION	IN HOSPITAL: Pays up to 15 days each calendar year for direct care and treatment when hospitalized. INPATIENT: Pays up to 15 physician hospital visits each calendar year when eligible for hospital benefit. Pays 100% if you use a panel provider, 80% if you use a non-panel provider.
CORRECTIVE APPLIANCES & ARTIFICIAL AIDS	Pays 80% of UCR charges.
COVERAGE	Benefits are provided for care received anywhere in the world.
COORDINATION OF BENEFITS	Yes.
+LIGIBLE FAMILY MEMBERS	Legal Spouse. Unmarried children under age 19; or unmarried children to age 23 if full-time student and meet IRS determination of dependent; or unmarried children incapable of self support due to mental retardation or physical handicap (must be certified prior to 19th birthday.)
SUBROGATION	Yes.

APPENDIX E

COMPARISON OF THE CITY OF SAN JOSE'S DEDUCTIBLES TO OTHER GOVERNMENTAL AND QUASI-GOVERNMENTAL JURISDICTIONS

	Amount In PPO Network		Out-of-Network	
Jurisdiction	**Individual**	**Family**	**Individual**	**Family**
City of San Jose	$ 50	$150	$ 50	$150
City and County of San Francisco	250	500	250	500
City of Palo Alto	200	400	200	400
City of Mountain View	0	0	150	450
County of Santa Clara	150	450	150	450
City of Sunnyvale	200	400	200	400
County of San Mateo	50	150	50	150
County of Santa Cruz	100	300	100	300
East Bay Municipal Utility District	200	600	200	600
UC, Pru Net Plan	50	150	200	400
UC High Option Plan	200	400	200	400
UC Care Plan	150	450	150	450
City of Los Angeles	0	0	500	1,000
County of Monterey	250	500	250	500

APPENDIX F

COMPUTATION OF POTENTIAL SAVINGS RESULTING FROM INCREASE IN CSJEHP DEDUCTIBLE AND OUT-OF-POCKET MAXIMUMS

Our survey of other jurisdictions, as summarized in Table V, shows that the CSJEHP deductibles and out-of-pocket maximums are significantly more generous than those of the health care plans of other jurisdictions. In our opinion, increasing the CSJEHP deductibles and out-of-pocket maximums will provide strong incentives for employees to use the PPO network, as well as make the CSJEHP deductibles and out-of-pocket maximums comparable to those of the health care plans of other jurisdictions. In this analysis, we show the potential savings for the City if it increased the CSJEHP deductibles and out-of-pocket maximums.

To the extent that the employee deductibles and out-of-pocket maximums are increased, the City's costs will be decreased. Thus, to estimate the City's savings, we took the average number of CSJEHP members who met their deductibles and out-of-pocket maximums in 1991 and 1992, computed the value of the deductibles and out-of-pocket maximums they paid, and compared the amounts to the amounts they would pay if each member's deductible and out-of-pocket maximums were increased.

	Number Of Members Who Met Their Deductibles	
1991	3,689	
1992	3,435	
Average	3,562	
Current value of deductibles (3,562 x $50)		$178,100
Value of deductibles after increase from $50 to $200 per member (3,562 x $200)		712,400
Potential savings to the City if each member's deductible were increased		$534,300

	Number Of Members Who Met Their Out-Of-Pocket Maximums:	
	Non-PPO Hospital Use	**Non-Hospital Services From Non-PPO Providers**
1991	88	322
1992	81	295
Average	85	309
Current out-of-pocket maximums	$1,000	$500
Current value of out-of-pocket maximums	$ 85,000 (85 x $1,000)	$154,500 (309 x $500)
Value of out-of-pocket maximums after increase	$255,000 (85 x $3,000)	$463,500 (309 x $1,500)
Difference	$170,000	$309,000
Potential savings to the City if out-of-pocket maximums were increased		$479,000

1993-94 Health Plan Rates per Payperiod

Full-Time Employees

	CSJ Health Plan Single (26 ppds)	CSJ Health Plan Family (26 ppds)	Kaiser Single (24 ppds)	Kaiser Family (24 ppds)	Lifeguard Single (26 ppds)	Lifeguard Family (26 ppds)
Police and Fire						
Employee Contribution	10.26	32.44	3.86	6.31	3.60	9.16
City Contribution	70.91	167.98	73.45	182.43	68.13	175.78
Total	81.17	200.42	77.31	188.74	71.73	184.94
All Other Units						
Employee Contribution	16.94	37.73	7.73	12.50	7.50	22.25
City Contribution	64.23	162.69	69.58	176.24	64.23	162.69
Total	81.17	200.42	77.31	188.74	71.73	184.94

Part-Time Benefitted Employees (All Except Police and Fire)

	CSJ Health Plan Single	CSJ Health Plan Family	Kaiser Single	Kaiser Family	Lifeguard Single	Lifeguard Family
B-Benefit 30-39.9 Hrs (75%)						
Employee Contribution	33.00	78.40	25.12	56.56	23.56	62.92
City Contribution	48.17	122.02	52.19	132.18	48.17	122.02
Total	81.17	200.42	77.31	188.74	71.73	184.94
C-Benefit 25-29.9 Hrs (62.5%)						
Employee Contribution	41.03	98.74	33.82	78.59	31.59	83.26
City Contribution	40.14	101.68	43.49	110.15	40.14	101.68
Total	81.17	200.42	77.31	188.74	71.73	184.94
D-Benefit 20-24.9 Hrs (50%)						
Employee Contribution	49.05	119.07	42.52	100.62	39.61	103.59
City Contribution	32.12	81.35	34.79	88.12	32.12	81.35
Total	81.17	200.42	77.31	188.74	71.73	184.94

Dental Rates for Part-Time Employees Only

Part-Time Dental Rates	B-Benefitted	C-Benefitted	D-Benefitted
Employee Contribution	6.62	9.94	13.25
City Contribution	19.88	16.56	13.25
Total	26.50	26.50	26.50

Printed 6/22/93

APPENDIX H

CITY AND EMPLOYEE SHARE OF 1993-94 ANNUAL HEALTH PREMIUM COST

SWORN POLICE AND FIRE

Single Coverage	Annual Premium Cost	City Share	City Percentage	Employee Share	Employee Percentage
Kaiser	$1,855.44	$1,762.80	95	$ 92.64	5
Lifeguard	$1,864.98	$1,771.38	95	$ 93.60	5
CSJEHP	$2,110.42	$1,843.66	87	$266.76	13

Family Coverage	Annual Premium Cost	City Share	City Percentage	Employee Share	Employee Percentage
Kaiser	$4,529.76	$4,378.32	97	$151.44	3
Lifeguard	$4,808.44	$4,570.28	95	$238.16	5
CSJEHP	$5,210.92	$4,367.48	84	$843.44	16

FULL-TIME EMPLOYEES EXCEPT SWORN POLICE AND FIRE

Single Coverage	Annual Premium Cost	City Share	City Percentage	Employee Share	Employee Percentage
Kaiser	$1,855.44	$1,669.92	90	$185.52	10
Lifeguard	$1,864.98	$1,669.98	90	$195.00	10
CSJEHP	$2,110.42	$1,669.98	79	$440.44	21

Family Coverage	Annual Premium Cost	City Share	City Percentage	Employee Share	Employee Percentage
Kaiser	$4,529.76	$4,229.76	93	$300.00	7
Lifeguard	$4,808.44	$4,229.94	88	$578.50	12
CSJEHP	$5,210.92	$4,229.94	81	$980.98	19

APPENDIX I

COMPARISON OF ANNUAL HEALTH PREMIUM COST TO EMPLOYEES FOR 1992-93 AND 1993-94

SWORN POLICE/FIRE

	1992-93	1993-94	Increase/ Decrease
Single Coverage			
Kaiser	$85.44	$ 92.64	$ 7.20
Lifeguard	87.36	93.60	6.24
CSJEHP	237.12	266.76	29.64
Family Coverage			
Kaiser	$134.88	$151.44	$16.56
Lifeguard	202.02	238.16	36.14
CSJEHP	791.44	843.44	52.00

OTHER THAN SWORN POLICE/FIRE

	1992-93	1993-94	Increase/ Decrease
Single Coverage			
Kaiser	$178.32	$185.52	$7.20
Lifeguard	200.72	195.00	(5.72)
CSJEHP	209.30	440.44	231.14
Family Coverage			
Kaiser	$300.00	$300.00	$ 0
Lifeguard	382.98	578.50	195.52
CSJEHP	625.82	980.98	355.16

APPENDIX J

REVIEW OF THE BENEFITS REVIEW FORUM ACTIVITIES

We reviewed the activities of the Benefits Review Forum (BRF) from March 1988 to April 1993. Our review indicated that the BRF has not adequately addressed the health care plan cost containment issues that have been brought to its attention. The following are examples of the issues that, in our opinion, the BRF did not adequately address or resolve:

1. In 1986, the Office of Employee Relations of the Department of Human Resources (HRD) received a suggested action plan from the National Public Employer Labor Relations Association through its manual entitled The Labor-Management Guide To Health Care Cost Containment for establishing a labor-management committee to focus on implementing cost containment strategies. The suggested action plan includes the following steps:

   Step 1. Select the members of the labor-management committee.

   Step 2. Develop a statement of goals and objectives.

   Step 3. Train the committee in communications, problem solving, data analysis, and health care cost containment strategies and practices.

   Step 4. Conduct an intensive examination of the jurisdiction's health care program, including its utilization by employees and cost.

   Step 5. Determine which areas of the health care program are best suited for immediate cost containment efforts.

   Step 6. Establish priorities for implementing those changes that have been agreed upon.

   Step 7. Develop an "implementation plan" with time targets.

   Step 8. Proceed to make changes, giving appropriate attention to employee education and the requirements of the collective bargaining agreement.

   Step 9. Monitor results.

   Although the City formed the BRF as a labor-management committee, the BRF was unable to implement significant cost containment strategies, such as those described in items 2 and 3 below.

2. In 1989, HRD recommended to the BRF a number of cost containment techniques and strategies including plan redesign, the use of PPOs, tighter administrative controls, utilization reviews, and employee communication and education programs. The HRD recommendations were contained in a memorandum dated August 22, 1989, in which HRD informed the BRF that the City's health benefit costs have increased 15 percent per year and health care costs nationwide were climbing at a higher rate than other goods and services. HRD said that the City increases were occurring despite the CSJEHP's cost containment features. HRD suggested that as the BRF was considering replacing Blue Cross, it would be an appropriate time to review the City's cost containment efforts and see where improvements could be implemented. HRD stated there are a number of cost containment approaches, some of which have proven successful in reducing health costs and others which have somewhat uncertain results. The most common methods include the following:

    a. Plan redesign, including mandatory outpatient surgery, incentive for outpatient surgery, and separate specialized retiree program;

    b. Hospital utilization review, including silent review, mandatory pre-admission review, and mandatory second surgical opinion;

    c. Alternative delivery systems, including large case management, and use of hospices, home health care, and mail order and generic drugs;

    d. Administrative and claims controls, including patient invoice audits;

    e. Cost sharing, including coordination of benefits, subrogation, increased co-payments, and increased deductibles; and

    f. Employee communication and education programs, including wellness programs and employee assistance programs.

    HRD explained that cost containment techniques worked by limiting hospital stays; redirecting employees toward equally beneficial but less expensive forms of treatment; reviewing all services, fees, and invoices; and helping employees become better consumers of services through education and cost sharing.

3. In 1990, the City contracted with Foundation Health Preferred Administrators to replace Blue Cross as the third-party administrator (TPA) for the CSJEHP. On September 23, 1991, HRD sent a memorandum to the BRF summarizing the TPA's suggested changes. The TPA recommended that about 40 specific services and supplies be excluded from the coverage. In addition, the TPA suggested ways to improve the contract and reduce costs. The following were some of the TPA's suggestions:

a. The plan should not pay 100 percent of any service. A modest co-payment of $5 for physician and emergency services would help prevent overuse. Since the deductible is so small, perhaps there should be a trade-off of the deductible for the co-payment.

b. The $1,000 cap for covered services in a non-PPO hospital is too low. The TPA suggested that the City pay 80 percent up to $10,000, then 85 percent or 90 percent up to $30,000, and 100 percent thereafter.

c. On dental care, the City should exclude jaw surgery except for traumatic fracture or malignancy. The TPA stated that if the City allowed any surgery on the TM Joint (orthognatics), it should have a maximum of $1,000 or $2,500. The TPA noted that this surgery is seldom successful and has horrible complications.

d. On diagnostic radiology or laboratory services, the City should pay 100 percent for outpatient laboratory or PPO provider and only 80 percent for such services at any hospital or non-PPO provider.

e. The City should limit physical therapy and chiropractic treatments to 24 annual visits or $750 to $1,000 per year.

f. The City should have some eligibility exclusion for pre-existing conditions. The TPA suggested that a time limit be specified and that the City exclude dependents of new enrollees who are totally disabled and medicare/medicaid eligible.

To address cost containment techniques, such as those that the National Public Employer Labor Relations Association, the HRD, and the TPA proposed, was one of the main reasons that the BRF was formed. In not adequately acting on such suggestions, the BRF failed to carry out its purpose.

APPENDIX K

EXAMPLE OF A HEALTH CARE COST CONTAINMENT ACTION PLAN USING A THIRD-PARTY FACILITATOR

The Health Research Institute (HRI) in Walnut Creek, California, is a non-profit, research-based organization providing health care cost containment and health improvement policy planning and implementation assistance, research, health education, data collection and analysis, and communication services to major private and public employers, labor-management committees, and coalitions. The HRI suggests four possible phases in which a third-party facilitator helps the labor-mangement committee to identify, implement, and monitor health care plan and cost control changes.

Phase I--Education and Awareness Building

During this first phase, the third-party facilitator helps build awareness among the labor and management representatives on the importance of controlling employee health care costs and the various means to accomplish the cost containment objectives. Without a clear sense of direction and a good understanding of the forces driving medical care costs, decisions are often made in a patchwork or piecemeal way which causes highly ineffective results. HRI says both labor and management need to know what works and what does not work to effectively control short-, medium-, and long-term health care costs.

Phase II--Analyze Data And Prepare A Finding Report.

The HRI says this step is extremely valuable because all members of the labor-management committee need specific information about the current plan's operations, costs, and usage. The third-party facilitator will usually coordinate the preparation of the findings report. Such a report can show how the plan design features may be resulting in unintended cost-increasing effects and how cost-saving measures may be performing inadequately. The findings report will help the committee in its policy decisions.

Jonathan Fielding, M.D., corroborates the need for management information in his book, Corporate Health Handbook, by suggesting that organizations "*invest in collecting and carefully analyzing accurate data on health status, health risks, health care costs and utilization,...and have a system, either internal or external, that can provide timely and accurate information to identify problems and help assess the success of health care management activities.*"

Phase III--Goal-Setting

During this phase, the third-party facilitator guides the labor-management committee in preparing goals and objectives which address issues such as the following:

- At the most fundamental level, what are the purposes served by sponsoring a group health plan?
- What are the short-, medium-, and long-term health cost control targets?
- What are the components of cost which should be affected by the committee's efforts?
- What is the timeframe within which the labor management committee should accomplish the goals?
- Are the City and unions willing to influence the behavior of employees, retirees, and dependents?
- What forms of cost control efforts are not acceptable to the committee?
- What role(s) should measurement and monitoring play?

Phase IV--Plan Implementation

In this final phase, the facilitator assists the labor-management committee in (1) determining which actions will best meet the committee's stated short-, medium-, and long-term goals; (2) determining an implementation timetable; and (3) determining implementation responsibilites and accountabilities.

According to the HRI, the most significant barrier to adopting cost controls in organizations where at least some employees are represented is a lack of awareness that working together is more effective than working separately to control health care costs. By using a third-party facilitator, parties which normally deal with one another in an adversarial fashion will have an impartial catalyst to help them realize the importance of cooperation and to guide them in planning and implementing mutually beneficial strategies.

APPENDIX L

GLOSSARY

To provide clarity and understanding to readers of this report, definition of several key items is essential. Significant terms relating to health care programs are defined in this glossary.

Capitation -- A fixed, predetermined amount paid to a provider for each person served without regard to the actual number or nature of services provided to each person in a set period of time, usually a year. Capitation is the payment method used by health maintenance organizations (**HMO**) but is unusual for non-HMO health services.

Closed Panel -- A system in which plan participants may receive services only at specified facilities or through a limited number of providers.

Coinsurance -- A policy provision, frequently found in major medical insurance, where both the covered person and the plan share in a specified ratio (e.g., 80%/20%) the costs of the hospital and medical expenses resulting from an illness or injury.

Cost Containment -- Efforts aimed at holding down the cost of medical care or reducing its rate of increase.

Cost Sharing -- Arrangements where consumers (employees or their dependents) pay a portion of the cost of health services, sharing costs with employers. Deductibles, coinsurance, and payroll deductions are forms of cost sharing.

Deductible -- That portion of covered hospital and medical charges which an insured person must pay before the policy's benefits begin.

Dependents -- Generally, the spouse and children of a covered individual as defined in a plan. Under some plans, parents or other members of the family may be dependents.

Experience Rating -- A method of adjusting the insurance premium for a risk based on actual past loss experience for that particular group as opposed to loss experience for a total community.

Family Deductible -- A deductible that is satisfied by the combined expenses of all covered family members. For example, a plan with a $100 deductible may limit its application to a maximum of three deductibles ($300) for the family, regardless of the number of family members. An aggregate family deductible may be met by one or several family members. See **Deductible**.

Fee-For-Service -- Method of billing for health services under which a physician or other practitioner charges separately for each patient encounter or service rendered. This is the usual method of billing by the majority of the country's physicians. Under a fee-

for-service payment system, expenditures increase if the fees increase, if more units of service are charged, or if more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita, or prepayment systems where the physician is not charged with the number of services actually rendered.

Health Maintenance Organizations (HMO) -- A health maintenance organization is a health care system that provides comprehensive health care services to its members on a prepaid basis. The same membership fee is paid by all members on a prepaid basis regardless of the amount of services used. Because of the fixed fee, the HMO has an incentive to cut costs and reduce hospitalization whenever possible. HMOs provide comprehensive health care services with an emphasis on preventive health care. They encourage patients to utilize their services by eliminating deductibles or coinsurance payments, although some HMOs do assess a minimal charge for certain services or for medications. One drawback to HMOs is that many provide only limited levels of care for the treatment of mental and nervous disorders and treatment of alcoholism and substance abuse.

Hospital Benefits -- Hospital benefits provide coverage for hospital charges for either inpatient or outpatient service. Charges made by physicians who are not members of the hospital staff are not considered hospital charges. There are two general components to hospital benefits--coverage for "room and board" and coverage for other "miscellaneous" costs.

In Network -- A doctor, hospital or other healthcare provider who has agreed to accept a certain fee as payment in full and who has agreed not to bill the patient for any fees above and beyond those paid by the Plan. See **Preferred Provider Organization (PPO)**

Inpatient -- A person who occupies a hospital bed, crib, or bassinet and is under observation, care, diagnosis, or treatment for at least 24 hours.

Open enrollment -- A specified period of time occurring annually during which employees may opt in or out of benefit plans (for themselves and dependents).

Outpatient -- A person who visits a clinic, emergency room, or health facility and receives health care without being admitted as an overnight patient.

Paid Claims -- The dollar value of all claims paid (hospital, medical, surgical, etc.) during the plan year, regardless of the date(s) that the services were performed.

Preferred Provider Organization (PPO) -- A PPO is an administrative organization that maintains a series of contractual relationships with a network of providers and is designed to be coupled with a benefit plan design that encourages employers to channel their health care to a preferred network of providers. The PPO is a variation of the traditional fee-for-service care arrangement representing a group of physicians, dentists, or hospitals or other practitioners that contract with employers, insurance companies, unions, or third party administrators (TPA) to provide employees with services at

reduced rates. There are many different PPO arrangements now being developed, but most have the following features:

- Panel of participating providers. A limited number of health care providers participate in the PPO.
- Negotiated fee schedule. A lower-than-standard or discounted charge will be made for all professional services.
- Utilization control guarantees. All providers agree to operate within the framework of the plan's cost controls, e.g., pre-certification on hospital admissions.
- Incentives for members to select the preferred providers. Patients retain the right to use other than the participating providers, but co-payments are required for health care services from other than participating providers.
- Reimbursement mechanisms. In exchange for participation in the PPO, the provider is guaranteed prompt payment.

Premium -- The amount of money a policyholder agrees to pay an insurance company for an insurance policy in consideration for which the insurance company guarantees the payment of specified benefits.

Prescription Drug Plans -- The employee pays the pharmacy a nominal deductible amount with the plan covering the remainder of the cost. The actual cost of a drug program is based on the allowance that is paid to the pharmacy plus the administrative charges. Most plans use a participating pharmacy arrangement where the plan agrees to reimburse on the basis of the acquisition cost of the drug, plus a negotiated dispensing fee, less the amount of the employee deductible. The plan administration costs may be per claim cost or a flat monthly charge per participant.

Self-Funding or Self-Insurance -- A method of financing a benefit plan without insurance. The employer assumes direct financial responsibility for reimbursing all claims liabilities. Some self-funded employers purchase stop-loss insurance protection.

Third-Party Administrator (TPA) -- The party to an employee benefit plan that may collect contributions, pay claims, and/or provide administrative services.

Usual, Customary, and Reasonable (UCR) fees -- **Usual Fee**: That fee usually charged for a given service by an individual provider to his or her private patient, that is, the provider's own usual fee. **Customary Fee:** A fee in the range of usual fees charged by providers of similar training and experience in an area. **Reasonable Fee:** A fee that meets the two previous criteria or, in the opinion of the review committee, is justifiable considering the special circumstances of the case in question.

> ***Note:*** UCRs are maintained by insurance companies and TPAs and may vary considerably among carriers.

Utilization -- Use of health care facilities, labor force, services, and equipment.

Utilization Review -- A method of systematically reviewing the necessity and appropriateness of an institution providing treatment, nature and scope of treatment, and timeliness and appropriateness of discharge.