OFFICE OF THE

CITY AUDITOR

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

– THE CITY OF SAN JOSE CAN IMPROVE ITS HEALTH CARE PLAN, REDUCE ITS EMPLOYEES' AND RETIREES' MEDICAL COSTS BY MORE THAN $1 MILLION A YEAR, AND POTENTIALLY RECOVER AN ADDITIONAL $905,000 IN PRIOR YEARS' OVERPAYMENTS

A REPORT TO THE

SAN JOSE

CITY COUNCIL

MARCH 1995

95-01

CITY OF SAN JOSÉ, CALIFORNIA

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GERALD A. SILVA
City Auditor

March 15, 1995

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 Plan.* 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(s) before the Appendices.

I will present this report to the Finance Committee at its March 22, 1995, meeting. If you need additional information in the interim, please let me know. The City Auditor's staff members who participated in the preparation of this report are Bill Hewitt and Nestor Baula.

Respectfully submitted,

Gerald A. Silva
City Auditor

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EXECUTIVE SUMMARY

In accordance with the City Auditor's 1994-95 Audit Workplan, we have audited the City of San Jose Employees' Health Plan. 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 OF SAN JOSE CAN IMPROVE ITS HEALTH CARE PLAN, REDUCE ITS EMPLOYEES' AND RETIREES' MEDICAL COSTS BY MORE THAN $1 MILLION A YEAR, AND POTENTIALLY RECOVER AN ADDITIONAL $905,000 IN PRIOR YEARS' OVERPAYMENTS

The city of San Jose (City) offers its employees three health care plans of which one is the City of San Jose Employees' Health Plan (CSJEHP). The City contracts with PPO Alliance to administer a series of contractual arrangements with a network of physicians, hospitals, and other medical service providers. The medical service providers with which PPO Alliance contracts are the City's preferred provider organization (PPO). As such, it is in the best interest of the City and its employees that PPO Alliance contract with as many medical service providers as possible and that it negotiate the best possible price for specific medical procedures. In addition, the City contracts with a third-party administrator--Foundation Health Preferred Administrators (FHPA)--to pay and administer medical claims that medical service providers submit for payment for services to those employees in the CSJEHP. As such, it is in the best interest of the City and its employees that the FHPA pay claims in a timely manner and take advantage of all negotiated or available medical service discounts.

Our review of the City's contractual arrangement with PPO Alliance and FHPA and their performance under the City's contract revealed the following:

- At the recommendation of the Benefits Review Forum, the City awarded a contract to PPO Alliance without going through a competitive bidding process, and documented evidence does not support the City's decision to award a contract to FHPA;

- FHPA was unable to provide us with documentation for 33 of the 242 claims selected for our review;

- FHPA has not paid medical service claims in a timely manner;

- FHPA has not taken advantage of negotiated or available medical service discounts. As a result, the City's employees and retirees paid $890,000 unnecessarily over the last four years; and

- FHPA paid about $15,000 for ineligible claims during the last four years.

The Santa Clara County PPO option for its employees is the Preferred 100 Plan. Comparing Santa Clara County's Preferred 100 Plan to the CSJEHP revealed the following:

- PPO Alliance has not provided the City or its employees with a number of medical service providers in its PPO comparable to the County's and

- PPO Alliance has not negotiated discount rates with medical service providers in its PPO comparable to the County's PPO.

Our review also revealed that the City has an opportunity to consolidate with Santa Clara County for a PPO and that by so doing the City will be able to

- Reduce premium costs for both its employees and retirees;

- Obtain better price discounts for medical services;

- Obtain fast-payment discounts;

- Implement additional concurrent utilization reviews of medical service bills; and

- Increase employee use of the PPO.

By forming a medical services purchasing coalition with Santa Clara County, we estimate that the City will save its employees and retirees more than $1 million a year in medical service costs and health insurance premiums. In addition, the City should pursue reimbursement of $905,000 in prior years' overpayments.

RECOMMENDATIONS

We recommend that the Human Resources Department:

Recommendation #1:

Require PPO Alliance and Foundation Health Preferred Administrators to provide relative unit values for all applicable medical services and procedures. (Priority 1)

Recommendation #2:

Require Foundation Health Preferred Administrators immediately to apply the already-negotiated and available discounts described in the PPO Alliance's Physician Reimbursement Schedule. (Priority 1)

Recommendation #3:

Set a deadline for Foundation Health Preferred Administrators (FHPA) to provide the documentation that was requested during the audit. If FHPA fails to provide the documentation, disallow the amounts paid for undocumented medical claims. (Priority 1)

Recommendation #4:

Require Foundation Health Preferred Administrators to provide the City with a payment report from August 1, 1990, to April 30, 1992, and a separate report from May 1, 1992, to the present for all PPO procedures which were paid as billed because there were no relative values to compute a discount. Each report should show (1) the claim number, (2) date of service, (3) the procedure code number and description, (4) the billed and paid amount, and (5) billed and paid totals for the two report periods. After determining the dollar value of 10 percent and 20 percent discounts not taken, request the City Attorney to initiate actions to recover any overpayments. (Priority 1)

Recommendation #5:

Develop and implement procedures to ensure that the current eligibility files for the City of San Jose Employees' Health Plan are complete and accurate. (Priority 3)

Recommendation #6:

Develop and implement procedures to monitor the continuing eligibility of the employees and their dependents for the City of San Jose Employees' Health Plan. Such procedures could include requesting the third-party administrator to periodically produce an exception report of potential ineligible dependents as a basis for monitoring eligibility. (Priority 3)

Recommendation #7:

Consult with the City Attorney regarding possible City recourse to recover amounts paid on ineligible dependent claims between August 1, 1990, and February 28, 1994. (Priority 3)

In addition, we recommend that the Human Resources Department and Benefits Review Forum:

Recommendation #8:

Request funding for a full-time analyst to monitor the City of San Jose Employees' Health Plan. (Priority 2)

Finally, we recommend that the Human Resources Department:

Recommendation #9:

Solicit a proposal from Santa Clara County in the next scheduled City of San Jose Employees' Health Plan request for proposal process for the selection of the claims administrator and the preferred provider organization. (Priority 1)

Recommendation Requiring Budget Action

Of the preceding recommendations, #8 may not be able to be implemented absent additional funding. Accordingly, the City Manager should request during the 1995-96 budget process that the City Council appropriate an amount sufficient to implement recommendation #8.

INTRODUCTION

In accordance with the City Auditor's 1994-95 Audit Workplan, we have audited the City of San Jose Employees' Health Plan. 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 Human Resources Department who gave their time, information, insight, and cooperation for this audit. Specifically, we thank the Senior Administrative Officer of the Human Resources Department--Benefits Program and his staff for their outstanding responsiveness to our many requests for information.

SCOPE AND METHODOLOGY

Our audit objectives were to:

- Determine opportunities for cost savings;
- Evaluate the effectiveness of the city of San Jose's (City) preferred provider organization;
- Determine whether the third-party administrator is processing claims in accordance with plan provisions and related documents;
- Determine whether claims are paid in the proper amount;
- Determine that documentation was on file for claims paid and such documents submitted were adequately completed with all data necessary to process the claim;
- Evaluate the effectiveness of the computer controls for claims processing and payment;
- Determine whether the turnaround time for processing claims was within acceptable industry standards; and
- Determine whether proper safeguards exist to prevent the City from being charged for expenses of ineligible persons.

We performed only limited testing to determine the accuracy and reliability of the various computer reports used. Such testing included observation or a walk-through of the claims processing, a review of the system documentation, and a statistical sample of the claims processed. We analyzed the processed claims data for a 28-month period. We did not review the general controls for the computer systems used for claims processing.

In reviewing the timeliness and validity of payments, we selected the month of April 1994 for our statistical sample of the claims processed. During

April 1994, Foundation Health Preferred Administrators (FHPA) paid 4,946 City of San Jose Employees' Health Plan (CSJEHP) claims totaling $1,114,601. We stratified these claims into the following categories:

1. Claims of $1,000 or greater
2. Claims of $200 or greater but less than $1,000
3. Claims less than $200

Category 1 claims totaled $618,322 and comprised 55.5 percent of total claims payment amounts in April 1994; category 2 claims totaled $250,495 and comprised 22.5 percent of total claims payment amounts in April 1994. We reviewed all 171 claims in category 1, a random sample of 71 of the claims in category 2, and 319 of the claims in category 3. The results of our tests are discussed on page 27 of this report.

The Bank of America keeps the cancelled checks for the CSJEHP claims paid. We did not review the cancelled checks for the claims in our audit samples.

BACKGROUND

The Cost Of Health Care

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

The city of San Jose's (City) health care expenditures for 1994-95 are expected to be $27.4 million, or about 6 percent, of the proposed General Fund's $489.6 million operating budget. The City has only four departments (Fire, Police, Streets and Parks, and Environmental Services) with budgets that exceed the City's proposed expenditure for health care in 1994-95. Like other employers in Santa Clara County and throughout the country, the City is faced with skyrocketing health care costs.

The City's Goals In Providing Health Care Coverage

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 care services; and
- Contain costs.

These three goals are not totally compatible with each other. For example, cost containment usually means limiting choices and flexibility. The City, however, has made efforts to balance these goals.

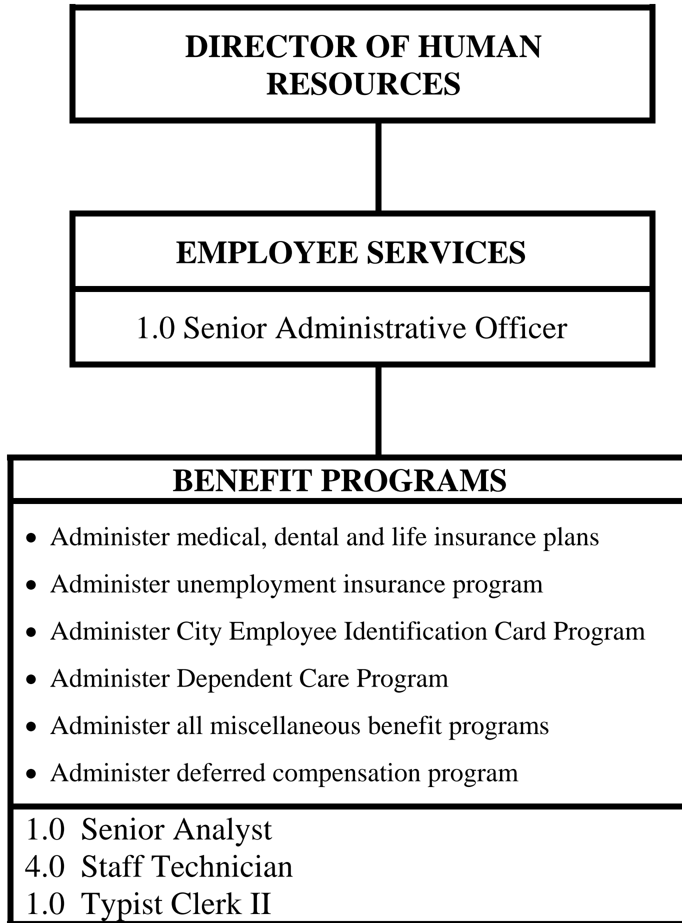
The City's Employee Services Division

The Employee Services Division of the Human Resources Department (HRD) is responsible for administering the City's benefit programs. 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 HUMAN RESOURCES DEPARTMENT



Funding For Employee Benefits

Employee benefit funds pay for the City's health care expenditures. These funds are the Dental Insurance, Life Insurance, Unemployment Insurance, Employee Benefit, and City of San Jose Employees' Health Plan (CSJEHP) funds. These funds are internal service funds which are used to (1) receive transfers from other City funds, (2) make payments on health care expenditures,

and (3) account for the financing of HRD services to other City departments and offices on a cost-reimbursement basis.

The total health insurance premium for each specific health care plan type is the same for all City employees. The City contributes a certain percentage toward the premium for the employee's health care plan. The percentage the City and the employee pay is determined by each employee representation unit's memorandum of agreement (MOA). For active employees, the City pays 90 percent of the cost of the lowest cost plan for health care 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 Permanente is currently the lowest cost plan.

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

Major Accomplishments Relating
To The City Of San Jose Employees' Health Plan (CSJEHP)

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

- The establishment of a self-insured 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 self-insured 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 percent 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.

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

FINDING I

THE CITY OF SAN JOSE CAN IMPROVE ITS HEALTH CARE PLAN, REDUCE ITS EMPLOYEES' AND RETIREES' MEDICAL COSTS BY MORE THAN $1 MILLION A YEAR, AND POTENTIALLY RECOVER AN ADDITIONAL $905,000 IN PRIOR YEARS' OVERPAYMENTS

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- FHPA paid about $15,000 for ineligible claims during the last four years.

The Santa Clara County PPO option for its employees is the Preferred 100 Plan. Comparing the County's Preferred 100 Plan to the CSJEHP revealed the following:

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- Obtain better price discounts for medical services;
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- Implement additional concurrent utilization reviews of medical service bills; and
- Increase employee use of the PPO.

By forming a medical services purchasing coalition with Santa Clara County, we estimate that the City will save its employees and retirees more than $1 million a year in medical service costs and health insurance premiums. In

addition, the City should pursue reimbursement of $905,000 in prior years' overpayments.

CITY OF SAN JOSE 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 health maintenance organizations (HMO).

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 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 the plan providers administer.

The essential elements of the Kaiser and Lifeguard plan options are summarized in Chart II.

CHART II

ESSENTIAL ELEMENTS OF THE KAISER AND LIFEGUARD PLAN OPTIONS

Kaiser Permanente	Lifeguard
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 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 copayment each time they visit a doctor. The City does not participate in Lifeguard's prescription drug program.

Illness Program

The City also offers its employees an illness program which is an insurance program that pays for an employee's medical costs which are the result of an illness or injury. Unlike the wellness programs, the illness program allows the employee to use any doctor or hospital he or she chooses.

The City joined the Blue Cross indemnity health care plan in 1969. However, in 1989 Blue Cross notified the City that unless the City accepted substantial changes to the plan, Blue Cross no longer wished to have the City as a client. The City found the proposed changes to be unacceptable and terminated its contract with Blue Cross on July 31, 1990. On August 1, 1990, the City established the CSJEHP to replace the full-choice Blue Cross plan.

The City and all recognized employee organizations formally agreed on the plan design for the CSJEHP. The plan design included the following provisions:

- The annual deductible would remain at $50 per member, the same as it had been under Blue Cross, with a three-member cap of $150 per enrolled family;
- An annual out-of-pocket maximum for covered hospital expenses in a non-PPO hospital was established at $1,000 per member. Employee organizations reluctantly agreed to this annual maximum per member to encourage participants to use PPO hospitals which guaranteed discounted rates; and
- For the first year (1990), the annual maximum copayment for non-hospital services from non-PPO providers remained at $400 per member. This was the same as the Blue Cross plan for non-Blue Cross doctors/providers. Employee organizations agreed that this maximum would be raised to $500 per member after 1990 to recognize inflation.

HMO vs. Self-Insured Health Care Plan

The CSJEHP is a self-insured health care plan. The plan provides benefits for enrollees and their eligible dependents when medically necessary. The plan covers those illnesses and medical conditions identified in the CSJEHP document. The plan generally covers only medically necessary visits and procedures but not preventive medicine or procedures.

Premiums for HMOs are fixed for the contract term; therefore, 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. While the CSJEHP allows full choice of physicians and hospitals, it also has financial incentives to encourage employees to use the

services of a PPO. A PPO is an administrative organization that maintains a series of contractual relationships with a network of providers. The PPO contracts with employers, insurance companies, unions, or third-party administrators (TPA) to provide services at reduced rates to those employees that use the PPO. There are many different PPO arrangements, but most have the following features:

- A panel of participating medical service providers. A limited number of medical service providers participate in the PPO;
- A 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, such as pre-certification on hospital admissions;
- Incentives for members to select the participating providers. Patients retain the right to use other than the participating providers, but often copayments are required for medical services from other than participating providers; and
- Reimbursement mechanisms. In exchange for participation in the PPO, the provider is guaranteed prompt payment.

Members in the CSJEHP have the option to use the services of those doctors and hospitals that are in the PPO. Generally, when a PPO provider provides medical services to a covered employee, the plan pays 100 percent of the cost. When a non-PPO provider provides services to a covered employee, the plan pays 80 percent of the usual, customary, and reasonable (UCR) fees up to the plan's maximum "out-of-pocket" limits. Plan participants are responsible for those amounts in excess of the UCR fees. Included in the plan are provisions

for those claimants who live or work more than 50 miles from a PPO provider and for emergency services.

The City pays Kaiser and Lifeguard on a capitation basis. Under this arrangement, monthly premiums are a fixed amount per employee regardless of the type or extent of medical services provided. Conversely, the CSJEHP self-insured program pays providers on a claims basis. Both the City and participating employees pay shares of claims costs as they are incurred per plan specifications.

An employee that chooses to use the CSJEHP has an additional choice of whether to receive care from a PPO provider or from a non-PPO provider.

The Council on Education in Management in its publication, Controlling Employee Benefits, says a PPO has these principal risks:

1. Unlike an HMO, the PPO assumes no risk regarding the cost of medical services. Medical service providers are paid on a fee-for-service basis at an agreed discount. As a result, PPO providers are paid regardless of the cost of care or utilization rates.

2. The non-PPO charge to the employee may not be sufficiently large to direct members to PPO providers.

City Health Care Plan Enrollment Statistics

The active and retired employees enrolled in the City's health care plans as of September 1994 are shown in Table I.

TABLE I

CITY OF SAN JOSE
HEALTH CARE PLAN ENROLLMENTS AS OF SEPTEMBER 1994

	Kaiser	Lifeguard	CSJEHP	Total
Single Coverage				
Active*	798	195	452	1,445
Retired	240	52	417	709
Subtotal	1,038	249	869	2,154
Family Coverage				
Active	2,100	690	862	3,652
Retired	497	30	655	1,182
Subtotal	2,597	720	1,517	4,834
Totals	3,635	967	2,386	6,988
Percentage of Total	52	14	34	100
Comparison of Enrollment--Active vs. Retired				
Active*	2,898	885	1,314	5,097
Retired	737	82	1,072	1,891
Total	3,635	967	2,386	6,988

Total Health Care Plan Enrollments

	Enrollments	Percentage Of Enrollment
Active	5,097	73
Retired	1,891	27
Total	6,988	100
Single	2,154	31
Family	4,834	69
Total	6,988	100

* Active enrollment amounts exclude COBRA employees as well as employees on leaves of absence.

Contract With PPO Alliance

The City has a contract with PPO Alliance. This organization does the following for the CSJEHP:

- Solicits PPO providers;
- Negotiates fees for services;[1] and
- Ensures that medical service providers are fully qualified and appropriately licensed.

PPO Alliance is a statewide PPO established in late 1983 by two of the largest multi-hospital systems in the western United States: UniHealth America and Adventist Health System/West. The company began marketing its services in spring 1984. During the next two years, another 57 facilities joined the PPO. Between 1991 and 1992, PPO Alliance added an additional 79 facilities, focusing on network expansion in the northern portion of California. As hospitals were added, individual physicians, medical groups, and independent practice associations (IPA) affiliated with PPO hospitals were recruited for membership in the PPO. Today, the statewide PPO consists of 240 facilities and nearly 19,300 practitioners. The corporate office for PPO Alliance is in Woodland Hills, California.

PPO Alliance recruits providers following a sequential process that begins with the incorporation of hospitals into the PPO. The following guidelines determine eligibility for hospital PPO membership:

- The hospital must be accredited by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO);

[1] See Appendix D for potential hospital and physician savings as described in the PPO Alliance Plus Directory for Northern California 1993-94.

- There must be a minimum of 85 percent board-certified or board-eligible physicians on active staff;
- The hospital must be a market leader and must possess community prestige and institutional reputation;
- The hospital must offer a full range of services;
- The hospital's location must be in proximity to other participating hospitals;
- The hospital must have a demonstrated ability to achieve reasonable participation of medical staff; and
- The hospital must show a commitment to managed care and successful participation in risk contracting.

Once the hospitals are enrolled, PPO Alliance recruits its physician staff members. PPO Alliance's preferred method is to develop relationships with hospital-sponsored, or designated, IPAs or medical groups. If none are available, PPO Alliance solicits individual staff physicians with active privileges. In addition, PPO Alliance recruits physicians where specific specialty and geographic coverage is needed.

To ensure that the physicians joining the PPO Alliance network practice at the highest standards, PPO Alliance has developed a two-pronged approach to verifying physician credentials. First, PPO Alliance relies on the contracting hospitals, IPAs, and organized medical groups to perform a large part of the quality assurance screening of providers. As a result, PPO Alliance has set two major requirements for membership. Each member must have:

- Active admitting privileges at a participating hospital and

- Professional liability coverage in amounts consistent with community standards (usually amounts in excess of $500,000 per incident and $1,000,000 in the aggregate).

Inherent in these requirements are additional criteria or standards that must be met. For example, since the JCAHO accredits PPO Alliance acute care facilities, each provider must meet and maintain certain JCAHO-set minimum medical staff criteria. Specific requirements include appropriate licensure, relevant training and/or expertise, and current competence in the physician's field of practice. When reviewing an applicant, the hospital may verify that the applicant has adequate professional liability insurance and determine if the applicant (1) is involved in any professional liability action, (2) has had challenges made to his or her license or registration, and (3) has previously lost medical staff membership.

All PPO Alliance hospitals are committed to providing high quality services. The majority of PPO Alliance physicians are board-certified or board-eligible in their respective specialties and must have staff privileges at one or more of the medical facilities.

Contract With Foundation Health Preferred Administrators (FHPA)

FHPA is the City's third-party administrator (TPA) for the City's self-insured health care plan (CSJEHP). FHPA, a subsidiary of Foundation Health Corporation, is a full-service TPA for claims and referral management. The subsidiary covers approximately 150,000 participants. Clients include physician groups and employers with self-insured health care programs. FHPA originated as Preferred Administrators Insurance Services located in Palo Alto, California, and became operational on January 1, 1986.

FHPA's parent company, Foundation Health Corporation, is one of the largest statewide HMOs in California. Foundation Health Corporation operates several businesses, with most stemming from its core HMO. The company initially concentrated operations in the Central Valley of California, notably the Sacramento area, and maintained this core presence after plans outside the state were divested. The company gradually expanded into the San Francisco Bay Area and became one of the largest HMOs in northern California. Foundation Health Corporation provides managed health care services to approximately 3.4 million eligible individuals, primarily in California, through its HMO, government contracting, and specialty managed care subsidiaries. In July 1993, the Department of Defense notified Foundation Health Corporation that it was not selected to continue as the contractor for the CHAMPUS Reform Initiative (CRI) in California and Hawaii, a program which provided over 40 percent of the company's revenues in 1993. Foundation Health Corporation was the prime contractor pursuant to the CRI under one of the largest government health care contracts in the United States, covering about 860,000 eligible military-related beneficiaries in California and Hawaii. The Department of Defense instead awarded its $3.5 billion Pentagon contract to provide medical care for these military retirees and their dependents to the San Diego-based unit of Aetna Life & Casualty Company.

The scope of FHPA's services for the CSJEHP is claims administration, payment of claims, utilization review, and large case management.[2] Benefits are provided for enrollees and their eligible dependents when medically necessary. Coverage includes illness and certain medical conditions identified in the

[2] For detailed description of scope of services in the contract between the City and FHPA, see Appendix E.

CSJEHP document. Only medically necessary visits and procedures are covered; preventive medicine is generally not provided.

The City compensates FHPA at a fixed amount per enrollee per month for claims administration and a fixed amount per enrollee per month for utilization review services. In addition, the City pays FHPA at an hourly rate for large case management services performed in accordance with the terms and conditions of the agreement.

FHPA paid the following number of CSJEHP claims for 1991, 1992, and 1993:

Calendar Year	**Number of Claims**
1991	42,722
1992	56,320
1993	63,470

The CSJEHP payment of claims amounts were as follows for the last three fiscal years:

Fiscal Year Ended	**Payment Of Claims Amount**
June 30, 1992	$10,701,001
June 30, 1993	$9,527,622
June 30, 1994	$9,614,445

Appendix F shows FHPA's claims processing flow chart.

At The Recommendation Of The Benefits Review Forum, The City Awarded A Contract To PPO Alliance Without Going Through A Competitive Bidding Process, And Documented Evidence Does Not Support The City's Decision <u>To Award A Contract To FHPA</u>

The City did not select PPO Alliance through a request for proposal (RFP) process when it decided to no longer have Blue Cross process claims. According to the Human Resources Department (HRD) personnel, FHPA gave the City three PPO options from which to choose. Of the three options, the Benefits Review Forum recommended PPO Alliance because the City was looking for both a PPO and a TPA and FHPA already had the PPO Alliance Plus network on its computer system.

We also noted the following anomalies in the City files for the selection of the TPA and the PPO in 1990:

1. There were seven companies that submitted proposals. Their quotations for the costs of administration varied from a low of $9.40 per employee per month to a high of $15.18 per employee per month. Thus, there was a variance of $5.78 or 61 percent. We saw no analysis of this variance, and the TPA the City did select had a quoted price of $9.84 per employee, which was 4.7 percent higher than the lowest quoted price. In addition, the City did not require the companies to itemize the components of the administration costs, such as, claims administration, eligibility, subrogation, and basic management reports. In our opinion, the City's specifications were too general. This contributed to the unexplained wide variation in the price quotations and caused the resultant contractual provisions that were based on the RFP to lack sufficient specificity.

2. The TPA selected had the least experience.

3. The TPA selected had the smallest number of clients in California.

4. The City did not request how often the UCR fees would be updated.

5. When proposals were requested, the City's health care plan had an enrollment of 1,650 active employees (65 percent) and 870 retirees (35 percent). The City placed more emphasis on a quality statewide PPO which would tend to benefit retirees, rather than an effective PPO in the immediate area which would tend to benefit active employees.

6. Of the seven companies submitting proposals, two had more than three times the number of physicians in Santa Clara County in their PPOs than the company the City selected.

7. Of the seven companies submitting proposals, four had more hospitals in Santa Clara County in their PPOs than the company the City selected.

8. Of the seven companies submitting proposals, four had a larger number of physicians statewide in their PPOs than the company selected.

9. The City did on-site visits for only two of the seven companies submitting proposals to evaluate the computer systems for claims processing.

On February 20, 1990, the Director of HRD sent a memorandum to the City Manager which provided an update on the process of selecting a TPA to replace Blue Cross. The role of the TPA was to pay claims, monitor eligibility, coordinate hospital review services and PPO provider discounts, and provide a variety of utilization reports. The HRD was coordinating the selection of the TPA in conjunction with the Benefits Review Forum. In her memorandum, the Director of HRD said the selection criteria included experience, organizational structure, computerization, reporting capability, references, review services organization, and the extensiveness of the PPOs.

Request For Proposal Process

The ideal time to check to make sure that key players and decision-makers understand the business ramifications of selecting a medical vendor is during the process of preparing an RFP.

Linda F. Jones and Jorge A. Font, in the article entitled "Meeting Employer Needs In The Managed Care Request For Proposal Process," Health Care Financing, Winter 1992, made the following comments:

> *Managed care has become an important vehicle for employers in implementing cost containment efforts. . . . As managed care has gained acceptance, there has been a surge of competition among managed care vendors . . . .*
>
> *Over the past few years, employers have also become more sophisticated in their understanding of managed care and are rightfully demanding services that ensure cost savings, quality standards of care, and performance guarantees that satisfy employee needs and organizational goals. It is no wonder that vendor relationships based on historical agreements are being challenged. Increased competition and demands on accountability have made the request for proposal (RFP) process a more critical step in ensuring that the right vendor is selected to deliver quality, affordable services that meet the organization's expectations.* [Emphasis added]
>
> *Implementing a managed care RFP process is one that should not be performed hastily. Employers should initiate the process by defining basic service requirements demanded from a managed care program. Definition of these specifications, written into the RFP, serves an essential role in facilitating the vendor evaluation and selection process. Ideal candidates are those who meet or exceed minimum capabilities, as well as offer creative approaches in customizing their services to meet organizational needs.*
>
> *The RFP process is systematic by design. The following discussion outlines the sequence of steps typically followed to facilitate vendor evaluation and selection to ensure that the best vendor is* [selected] *to address an organization's needs.*
>
> ***Step 1. Development of a managed care strategy***
> *The building block of the RFP process is the development of the organization's managed care strategy, both short-term and long-term. This*

strategy statement is instrumental in assuring that the development of a managed care system is consistent with the company's overall health care philosophy, strategy, and objectives on a year-by-year basis.

Step 2. Assess the existing benefit plan

Step 3. Determine the timing for implementation of managed care programs
Implementation of different managed care programs typically does not occur simultaneously, but is phased-in to allow timely, successful integration into the existing health benefits structure.

Step 4. Prepare an RFP questionnaire to collect relevant data

Step 5. Analyze vendor RFP responses and quantify findings

Step 6. Summarize findings and identify finalists

Step 7. Conduct interviews with finalists

Step 8. Check references

Step 9. Formal presentation of findings and recommendations

Step 10. Workplan for implementation

With rampant changes occurring in the health care environment and the overriding concern with rising costs, employers must be deliberate in their design of managed care programs. A well-designed RFP questionnaire and systematic process can ensure that the employer has achieved the vendor selection that optimally meets organizational goals, objectives, and employee needs.

The above process is designed to permit the vendors to best address the soliciting entity's needs. Some authorities say that if an organization needs help in the RFP process, it should retain a consultant. Discussion with HRD personnel indicated that in 1989 the City had not formulated a long-term managed care strategy before implementing the RFP process to select a TPA.

Test Of Medical Claims

In reviewing the timeliness and validity of payments, we selected the month of April 1994 for our statistical sample of claims processed. In April, FHPA paid 4,946 CSJEHP claims totaling $1,114,601. We stratified these claims into the following categories:

1. ***Claims of $1,000 or greater***. During April 1994, FHPA paid 171 CSJEHP claims of $1,000 or greater. Although these 171 claims were only 3.5 percent of the total number of claims, the payments for these claims were $618,322, or 55.5 percent of the total claims payment amounts. We included in our test all 171 claims of $1,000 or greater. FHPA was unable to provide to us the documentation for 23 of the 171 claims (see page 27). However, we were able to review for timeliness all 171 payments in this category.

2. ***Claims of $200 or greater but less than $1,000***. During April 1994, FHPA paid 634 CSJEHP claims of $200 or greater but less than $1,000. These 634 claims were only 12.8 percent of the total number of claims but represented $250,495, or 22.5 percent of the total claims payment amounts. For our audit sample, we randomly selected 71 claims from this category. FHPA was unable to provide to us the documentation for 10 of the 71 claims selected (see page 27). However, we were able to review for timeliness all 71 payments in this category.

3. ***Claims less than $200***. During April 1994, FHPA paid 4,141 CSJEHP claims less than $200. We performed limited tests on these claims because although they represent a large percentage (83.7 percent) of the total number of claims paid for the month, they represent only a small share of total claims payment amounts (22.1 percent). Our testing of claims less than $200 was limited to reviewing 319 claims for timeliness of processing.

FHPA Was Unable To Provide Us With Documentation
For 33 Of The 242 Claims Selected For Our Review

As mentioned above, we selected for our review all 171 claims in category 1. Additionally, we selected a random sample of 71 claims in category 2. We initially requested the documentation for these claims on June 5, 1994. FHPA was unable to provide us documentation for 23 of the 171 category 1 claims and 10 of the 71 category 2 claims. Despite repeated requests in July, August, and September 1994, including requests made directly to the FHPA vice president of Operations, FHPA still failed to provide us with the requested documentation. Consequently, we were unable to determine the validity of 23 category 1 claims (which totaled $56,300) and 10 category 2 claims (which totaled $5,048).

Except for the 33 claims for which documentation was not made available to us, we were satisfied that the categories 1 and 2 claims we selected for review were valid medical payments in accordance with the CSJEHP agreement.
Because of the relatively small dollar amount represented by category 3 claims, we did not review these claims for validity.

In our opinion, the HRD should set a deadline for FHPA to provide the documentation that we requested during our audit. If FHPA fails to provide the documentation, the HRD should disallow the amounts paid for undocumented medical claims.

FHPA Has Not Paid Medical Claims In A Timely Manner

We summarized the claims turnaround times for the 242 claims in our sample. FHPA calculates claims turnaround time as the number of days required to process a claim after FHPA receives it. Our sample indicated FHPA was not meeting its own claims turnaround target of processing 80 percent of the claims

within 10 business days and 97 percent within 28 business days.[3] Our tests showed that FHPA processed only 34.57 percent of the claims within 10.7 business days and only 88.89 percent of the claims within 28 business days.

Table II summarizes our results:

TABLE II

SUMMARY OF CLAIMS TURNAROUND TIMES
FOR CATEGORIES 1 AND 2 CLAIMS

Business Days	Sample Claims Processed	Sample Claims Paid	Percentage Processed	Percentage Paid	FHPA's Claims Processing Targets
7.14	17	4	7.00	1.65	
10					80%
10.71	84	10	34.57	4.13	
14.28	179	38	73.66	15.70	
17.85	200	90	82.30	37.19	
21.42	209	130	86.01	53.72	
25	211	148	86.83	61.15	
28	216	156	88.89	64.47	97%
32.14	222	166	91.36	68.60	
35.71	230	187	94.65	77.27	
Over 35.71	242	242	100.00	100.00	100%

Based on the results of the above sample, we conducted additional tests to verify the claims turnaround time for the 4,141 claims less than $200 that the TPA paid in April 1994. We randomly sampled 319 of these 4,141 claims to

[3] Generally, 5 business days equal 7 calendar days; thus, for example, 10 business days are equal to 14 calendar days.

assess the claims turnaround time. Our tests showed that FHPA was not meeting its own internal standard of processing 80 percent of the claims within 10 business days. Specifically, FHPA had processed only 39.18 percent[4] of the claims after 10.71 business days.

Table III shows the results of our tests.

TABLE III

SUMMARY OF CLAIMS TURNAROUND TIMES
FOR CATEGORY 3 CLAIMS

Business Days	Sample Claims Processed	Sample Claims Paid	Percentage Processed	Percentage Paid	FHPA's Claims Processing Target
7.14	12	10	3.76	3.13	
10					80%
10.71	125	21	39.18	6.58	
14.28	267	101	83.70	31.66	
17.85	291	209	91.22	65.52	
21.42	296	261	92.79	81.82	
25	302	271	94.67	84.95	
28	308	274	96.55	85.89	97%
32.14	309	280	96.87	87.77	
35.71	313	284	98.12	89.03	
Over 35.71	319	319	100.00	100.00	100%

[4] Our total audit sample size of 561 claims for our review of timeliness of claims payment was initially designed to produce a confidence level of 90 percent with a precision of plus or minus 2 percent, based on an expected error rate not exceeding 5 percent. However, because the sample disclosed an error rate of 60 percent instead of 5 percent or less, the revised precision associated with our sample is estimated at plus or minus 7 percent.

In addition, we compared FHPA's internal standards of performance for claims processing to industry standards and another TPA's standards for claims processing. The results of our comparison are shown below:

FHPA Performance Standard	Industry Performance Standard	Surveyed TPA
80% within 10 business days & 97% within 28 business days	90% within 10 business days	95% within 10.71 business days

Source: Industry performance standard provided by Deloitte & Touche.

As is shown above, FHPA is not processing claims within its own standards and those standards are significantly lower than industry and another TPA's standards.

When FHPA submitted its proposal to the City in 1990, it said its maximum claims paid turnaround objective was 7 to 14 calendar days. Further, FHPA told the City that historically it met or exceeded its 7- to 14-calendar day objectives.

In June 1994, FHPA sent a letter to CSJEHP members which said:

> *Effective June 27, 1994, Foundation Health Preferred Administrators (FHPA) will consolidate their Claims Processing and Utilization Management operations resulting in the relocation of these services from Palo Alto to the Sacramento area. There will be no interruption to FHPA's service resulting from the office relocation. This move is expected to provide overall enhanced service to the plans administered by FHPA.*

According to HRD personnel, FHPA's claims processing turnaround time significantly deteriorated after FHPA relocated to the Sacramento area in June 1994. As was noted above, our testing of FHPA claims processing was for the month of April 1994--two months before FHPA's relocation.

PPO Alliance physician contracts state the following about the payor's (FHPA) responsibility to pay claims on time:

> *Pay Practitioner, to the extent Payor is financially responsible as the primary payor under applicable coordination of benefit rules for Covered Services, within thirty (30) days of receipt of a complete and proper claim for services rendered by PRACTITIONER to a Participant, or within such sooner period as may be required by law; or notify PRACTITIONER within thirty (30) days of receipt of a claim which is not complete or proper, together with a description of the manner in which the claim is deficient. Upon failure by a Payor to make payment or otherwise respond hereunder within sixty (60) days of the Payor's receipt of a claim, PRACTITIONER may bill the Participant for such services at PRACTITIONER'S usual and customary charges for the services; provided, however, that in no event shall PRACTITIONER thereby be deemed to have waived any right to proceed against the Payor for payment for Covered Services; and provided, further, that PRACTITIONER'S rights hereunder are in addition to and not in lieu of any other rights that PRACTITIONER may have at law, including, without limitation, any rights under Section 1371 of the California Health & Safety Code and Sections 10123.13 and 11512.180 of the California Insurance Code.* [Emphasis added]

As noted above, FHPA's failure to make payments or notify practitioners of improper claims within 60 days can result in the City and its employees paying higher (UCR) fees. In June 1994, we reviewed the results of our audit tests with HRD. HRD subsequently included in its contract with the TPA effective June 1994 the following provision:

> *PAYMENT OF CLAIMS*
>
> *CONSULTANT shall take all reasonable steps necessary to process claims and disburse Benefit payments to persons entitled to such payments under the Plan. The CONSULTANT agrees to maintain an inventory of unprocessed claims of no more than 10 calendar days.*

FHPA Has Not Taken Advantage Of Negotiated Or Available Medical Service Discounts, And As A Result Cost The City's Employees And Retirees About $890,000 Over The Last Four Years

The American Medical Association (AMA) has prepared a systematic listing and coding of physician procedures and services. This listing is called the Physicians' Current Procedural Terminology (CPT). Each procedure or service is identified by a five-digit code. Currently, there are approximately 8,650 CPT codes. The use of CPT codes simplifies the reporting of services. This coding and recording system allows for accurate descriptions and identification of physician procedures or services.

PPO Alliance negotiates physician reimbursement rates for various geographical locations for medicine, surgery, radiology, pathology, and anesthesia categories. These negotiated physician reimbursement rates are used to determine the payment to a PPO physician. The payment to a PPO physician is determined by multiplying the appropriate negotiated rate by the California relative value for each CPT code. The Conversion Manual for the California Relative Value Studies (CRVS) says the following:

> *The Relative Value Studies is a reflection of the practice of medicine in California. It is a coded listing of physician services with unit values to indicate the relativity within each individual section of median charges by physicians for these services. Since the unit values reflect medians of charges by California physicians, they do not necessarily reflect the charges of any individual physician nor the pattern of charges in any specific area of California.*

Our review disclosed that FHPA's computer system did not have relative values for a significant number of CPT codes. From November 12, 1992, to June 2, 1994, FHPA's CPT dictionary had 8,219 CPT codes in use. Of these, FHPA's computer system had no relative value for 4,470 (54.39 percent) of the

CPT codes. As of June 3, 1994, FHPA's CPT dictionary had 8,658 CPT codes in use. Of these, FHPA's system had no relative value for 1,473 (17.01 percent) of the CPT codes.[5] For those codes with no relative unit values, the City cannot take advantage of the PPO physician discounts.

Table IV summarizes our count.

TABLE IV

PERCENTAGE CALCULATION OF CPT CODES WITH NO RELATIVE VALUE FROM NOVEMBER 12, 1992, TO JUNE 2, 1994, AND AS OF JUNE 3, 1994

	November 12, 1992, To June 2, 1994	As Of June 3, 1994
Number of pages	329	347
Range of CPT codes	00100-99499	00100-99499
Number of CPT codes	8,219	8,658
Number of CPT codes with no relative value	4,470	1,473
Percentage with no relative value	54.39	17.01

For those PPO medical services and procedures (CPT codes) that had no relative value, FHPA had to pay the claims as billed because it could not discount the claims. This not only resulted in excess claims payments but increased

[5] FHPA Management Information System personnel told us it recently installed a database from Medata. FHPA told us it switched to Medata because it provided more information than the previous database from the Health Insurance Association of America, particularly the availability of data by RBRVS (Revenue Based Relative Value System). Medata is a data analysis firm which collects and tabulates fee information to form a database. The database is based solely upon Medata's own relative value units derived from a study of more than 30 million provider charges. The installation of this database appears to account for the reduction of 2,997 CPT codes having no relative value.

premiums for CSJEHP participants as well. This is due to CSJEHP premiums being determined annually based on the prior year's claims costs. In other words, higher than necessary claims costs in one year result in higher than necessary premiums in the next year.

PPO Alliance only recently purchased a proprietary medical software program called "Gap-Fill" from Medical Data Resources (MDR). This program provides a relative value for each CPT code. This program will fill the relative value coding holes for approximately 94 percent of all current CPT codes. It should be noted that the account executive for MDR told us this program has been on the market for five to six years.

To determine the effect of the missing relative values in FHPA's computer system on the payment of claims for the CSJEHP, we analyzed the CSJEHP claims that FHPA paid to PPO providers for the period of January 1, 1992, through April 30, 1994--a 28-month period. On August 1, 1990, the City entered into a contract with FHPA to process claims, and in June 1994 FHPA updated the relative values in its computer system to allow more discounting. We selected this 28-month period because it was representative of the August 1, 1990, to June 1994 period in question.

Our analysis showed that FHPA paid as billed, without discount, $2,166,326 for 28,704 procedures. Applying the results of our 28-month analysis to the entire August 1990 to June 1994 period, we estimate FHPA paid $3,558,974 as billed without discount for 47,150 procedures. Given that the overall average percentage discount realized through CSJEHP PPO providers is 25 percent, we estimate the City lost discounts amounting to about $890,000.

In order to corroborate our estimate of $890,000 in lost discounts, we further analyzed the payments to PPO physicians for medical procedures having no relative value from our April 1994 statistical sample of claims.[6] We found 65 procedures in our April 1994 sample that were paid as billed without discount. We estimate that the City would have saved $19,322 had these 65 claims been discounted. Applying our estimated monthly discount lost of $19,322 for the 46-month period from August 1990 to June 1994, we estimated the total to be $888,812 which is almost exactly the same as our other estimate of $890,000. It should be noted that although the actual savings may vary each month, the systemic condition that caused these lost discounts has been pervasive from August 1, 1990, through May 31, 1994.

We contacted two other TPAs to determine what their practices are when they have no relative values for CPT codes. Both TPAs indicated they do not have an inordinate number of CPT codes with no relative values. Both TPA administrators indicated manual intervention, not nondiscretionary computer controls, is necessary to determine the amount to be paid when a CPT code has no relative value. For example, the Santa Clara County authorizes its TPA to pay a percentage of the UCR fees when there is no relative value for a CPT code. As a result, the County still realizes a payment savings even when these CPT codes have no relative value.

PPO Alliance negotiated a similar arrangement with its medical service providers. According to the PPO Alliance's <u>Physician Reimbursement Schedule</u>, the discounts for charges when there was no relative value for a CPT code were

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[6] Our sample excluded claims less than $200.

10 percent from May 1, 1990, through April 30, 1992, and 20 percent from May 1, 1992, and thereafter. However, FHPA did not take the discounts when it reimbursed applicable charges. As a result, we estimate that from August 1, 1990, to August 31, 1994, active and retired City employees lost $582,000 in already-negotiated and available discounts.[7]

Jeffrey Mamorsky says the following in his chapter on "Auditing Claims Administration Performance," Health Care Handbook: "*The accuracy of claim payment affects both the cost of benefit programs and employee satisfaction with the programs either directly or indirectly*." With a self-insured claims payment process, the City is at risk for the TPA paying too much for claims.

In our opinion, FHPA and PPO Alliance have not been effective in ensuring that the CSJEHP is able to take full advantage of the physician discount rates. Consequently, from August 1, 1990, to August 31, 1994, the CSJEHP lost (1) actual discounts of approximately $582,000 based on already-negotiated and available discounts and (2) additional potential discounts of $308,000 that would have been available to CSJEHP had all CPT codes been assigned relative unit values. Thus, we estimate actual and potential lost discounts from August 1, 1990, to August 31, 1994, at $890,000.

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[7] See Appendix L.

FHPA Paid About $15,000 On Ineligible Claims During The Last Four Years

The CSJEHP document says the following about conditions of enrollment:

The following persons are eligible for coverage as family Members of the Subscriber:

The Subscriber's Spouse.

Unmarried Children to the 19th birthday.

Unmarried Children from the 19th to the 23rd birthday who qualify as dependents for federal income tax purposes, and are full time students at an accredited college. The claims administrators must receive this information in writing and such eligibility must be confirmed prior to payment of claims each semester.

Unmarried Children enrolled before age 23 who, upon reaching age 23, depend on the Subscriber for support and are unable to work due to mental retardation or physical handicap. A physician must certify this disability in writing. This certification must be received by the claims administrators within 31 days of the Child's 23rd birthday. After the Child's 25th birthday, the claims administrators may request proof of continuing dependency and disability, but not more often than yearly.

Eligible surviving spouse and/or children of deceased Members.

Thus, the CSJEHP is quite specific as to whom the TPA covers.

The CSJEHP has the following relevant cancellation provisions for eligibility:

CANCELLATION OF COVERAGE

CHILD

On the date the Subscriber's coverage is canceled (except when due to the Subscriber's death), or

On the date the child reaches age 19 or is no longer a full time student in an accredited school or no longer qualifies as a dependent for federal income tax purposes or reaches age 23 (unless the child elects Continuation of Coverage)[8]*, or*

On the date of marriage (unless the child elects Continuation of Coverage)

On the date the Plan receives written notice terminating the child's coverage

From FHPA's membership listing as of February 28, 1994, we counted in excess of 150 dependents with a date of birth prior to November 30, 1974. As such, full-time student status would be the only remaining criterion for eligibility. However, the membership listing showed that these individuals did not have student eligibility. We reviewed the history of charges for these dependents and found charges totaling $13,086 for 33 of the more than 150 non-qualifying dependents. Our analysis of FHPA's membership listing as of February 28, 1994, also showed 155 over-aged dependents who would not qualify for coverage regardless of student status. We found ineligible charges totaling $1,708 for 8 of these 155 over-aged dependents. Thus, we identified over 300 ineligible persons on the CSJEHP membership list as of February 28, 1994, of which 41 received CSJEHP medical service benefits totaling about $15,000.

[8] It should be noted that the Benefits Review Forum, the City's labor-management committee, recently approved that the qualifying age for student dependents be increased to 24 in order to establish uniformity with other benefit plans.

It should be noted that our estimate of ineligible claimant payments was limited to FHPA's membership listing as of February 28, 1994. We made no attempt to quantify total ineligible claimant payments for the period of August 1, 1990, to February 28, 1994.

According to the City's current contractual agreement, the City's obligations for enrollment are as follows:

- City shall control enrollment in CSJEHP and enter enrollment changes, additions, or deletions in the eligibility system using the on-line terminal system provided by FHPA. City shall provide FHPA with prompt notice of new enrollees and enrollees no longer entitled to receive CSJEHP benefits.

To implement this contractual provision, the City has developed written procedures which include the following:

- Maintenance of membership is shared by the Employee Services Division and Retirement Section of HRD and the Payroll Section of the Finance Department. The City has assigned the responsibility for eligibility verification to the Employee Services Division of HRD. The Employee Services Division has the following relevant responsibilities:

  1. Verifying student status and flagging membership eligibility;

  2. Making necessary notes in the file regarding membership; and

  3. Adding new members and deleting members who have transferred to other health care plans after the open enrollment period has ended.

According to the City's current contractual agreement with FHPA, FHPA has the following obligations for payment of claims:

- FHPA shall take all reasonable steps necessary to process claims and disburse medical service payments to persons entitled to such payments

under the CSJEHP. To implement this contractual provision for eligibility, FHPA does the following:

1. Sends monthly membership list to the Employee Services Division;
2. Sends letters to members who have children who are reaching the age of 19 informing them of the requirement to maintain full-time student status or requesting information regarding disability; and
3. Sends letters to members who have children reaching the age of 23 informing them of ineligibility and of COBRA.

The City does not periodically receive an exception report from FHPA for potential ineligible participants.

In April 1988, the American Institute of Certified Public Accountants (AICPA) issued Statement on Auditing Standards 55, Consideration of the Internal Control Structure in a Financial Statement Audit which refers to three elements of an entity's internal control structure: the control environment, the accounting system, and control procedures. Control procedures are those policies and procedures instituted in addition to the control environment and accounting system that management has established to provide reasonable assurance that specific entity objectives will be achieved. Generally, control procedures may be categorized as procedures that pertain to the following:

- Proper authorization of transactions and activities and
- Independent checks on performance.

By not effectively monitoring the eligibility of CSJEHP dependents, $15,000 in medical service claims was paid for non-qualifying dependents. These improper payments not only increase costs to the City but cause additional premium charges for CSJEHP members as well.

In our opinion, the HRD needs to

1. Develop and implement more effective procedures to ensure that the current eligibility files for the CSJEHP are complete and accurate;

2. Develop and implement more effective procedures to monitor the continuing eligibility of the employees and their dependents for the CSJEHP. Such procedures could include requesting that the TPA produce an exception report semi-annually of potential ineligible dependents as a basis for monitoring eligibility; and

3. Consult with the City Attorney regarding possible City recourse to recover the amounts paid on ineligible dependent claims between August 1, 1990, and February 28, 1994.

In addition, the HRD and the Benefits Review Forum should request funding for a full-time analyst to provide a variety of functions related to the CSJEHP including:

1. Monitoring claims payment for compliance with plan design and contractual discounts;

2. Reviewing claims reports for abnormal patterns of usage;

3. Monitoring and analyzing utilization reports to determine potential benefit changes (i.e., identify seldom used, frequently used, and abused procedures);

4. Preparing monthly reports on all aspects of utilization;

5. Monitoring enrollment of dependents;

6. Coordinating utilization of all available City benefits;

7. Developing training/wellness strategies for recurrent claims problems (i.e., back injuries, alcohol/drug abuse, lung disease, mental health/stress);

8. Providing educational seminars for employees on appropriate uses of doctors/hospitals, inpatient versus outpatient, and uses of PPOs; and

9. Reviewing and solving employee problems with the PPOs and/or TPA.

Comparing Santa Clara County's Preferred 100 Plan To The CSJEHP

PPO Alliance Has Not Provided The City
Or Its Employees With A Number Of Medical Service Providers
In Its PPO Comparable To Santa Clara County's

The number of physicians in the City's PPO has not ranked in the top ten for the last five years when compared to other PPOs in Santa Clara County. The San Jose Business Journal annually produces a report showing the major PPOs in the County. The Business Journal showed that PPO Alliance had the following rankings based on the number of physicians in its PPO:

Year	PPO Alliance Ranking
1989	13th
1990	13th
1991	11th
1992	12th
1993	14th

Note: Appendix G shows these rankings.

PPO Alliance told us it had 1,043 PPO providers in Santa Clara County as of January 7, 1994, of which 949 were physicians. During the second half of 1994, a supplemental PPO provider directory was sent to CSJEHP members.
PPO Alliance added more PPO providers to the directory as a result of the inclusion of the Stanford University Clinic in the PPO. However, as noted earlier in this report, the addition of providers to the PPO does not guarantee that

the CSJEHP will receive discounts unless FHPA's computer system has relative values for these physician services.

It is in the City's employees' best interest to have as many physicians in its PPO as possible. The more physicians in the PPO, the greater the chance that employees will use a physician in the PPO and save money. Accordingly, by having only the eleventh to fourteenth largest PPO network of physicians in Santa Clara County, the City's employees have lost opportunities to save money on physician services.

PPO Alliance Has Not Negotiated Discount Rates
With The Medical Service Providers
In Its PPO Comparable To Santa Clara County's

PPO Alliance negotiates physician reimbursement rates for various geographical locations for the following categories: medicine, surgery, radiology, pathology, and anesthesia. These negotiated physician reimbursement rates are used to determine the payment to a PPO physician. The payment to a PPO physician is determined by multiplying the negotiated rate by the relative value for each CPT code. Relative values assign comparative numerical values to medical services and procedures. Although the relative values are generally presented in non-monetary units, they can be translated into fees by applying a dollar conversion factor, such as a physician reimbursement rate.

PPO Alliance has negotiated for the City the following physician reimbursement rates for the San Francisco Bay Area including San Benito County:

Category	Rate
Medicine	$7.24
Surgery	$182.58
Radiology	$14.92
Pathology	$1.71
Anesthesia	$38.39--$42.66

When we compared the CSJEHP PPO physician reimbursement rates to Santa Clara County's PPO physician reimbursement rates, we found that the CSJEHP's rates were higher across the board. Specifically, the CSJEHP's rates were higher as follows:

Category	Percentage CSJEHP PPO Physician Rates Are Higher Than Santa Clara County's
Medicine	3.43
Surgery	6.46
Radiology	9.30
Pathology	4.91
Anesthesia	*

Note: The PPO rates for anesthesia and the County's rates for anesthesia cannot be compared because the County pays these charges at 90 percent of UCR fees.

The physician reimbursement rates are important to the City because they affect the payments made for PPO physician services. CSJEHP costs for PPO physician services for the calendar years ending 1991, 1992, and 1993 were $1,338,720, $1,696,496, and $1,744,740, respectively. The medicine and surgery physician reimbursement rates are particularly significant for the

CSJEHP as the payments for these services were 80 percent, 83 percent, and 84 percent, respectively, of the total PPO physician payments for these three years.

Table V shows the CSJEHP payments to PPO physicians for the calendar years ending 1991, 1992, and 1993.

TABLE V

CSJEHP PAYMENTS TO PPO PHYSICIANS
DURING 1991, 1992, AND 1993

Physician Services (CPT)	PPO Paid	Percentage
Medicine	$2,068,971	43
Surgery	1,881,293	39
Radiology	374,440	8
Pathology/Lab	236,709	5
Anesthesia	122,729	3
Uncoded	95,807	2
TOTAL	$4,779,949	100

Santa Clara County's PPO Option--The Preferred 100 Plan

Santa Clara County also has a self-insured health care plan--the Preferred 100 Plan. The Business Journal excluded Santa Clara County's PPO from its analysis. The County negotiates directly with physicians, hospitals, and other providers. As of January 21, 1994, Santa Clara County's Preferred 100 Plan had 3,198 providers in Santa Clara County of which 2,263 were physicians. As was noted earlier, PPO Alliance had only 1,043 Santa Clara County PPO providers as of January 1994 of which 949 were PPO physicians. After January 21, 1994, Santa Clara County's Preferred 100 Plan added more providers to its PPO. These additional providers resulted from the inclusion of the Stanford University Clinic in

the PPO. Appendix H shows the comparison of the number of providers in Santa Clara County in the CSJEHP to Santa Clara County's Preferred 100 Plan as of January 7, 1994.

There are 4,283 physicians in Santa Clara County according to the Medical Board of California. The City's PPO has 949, or 22.1 percent, of the total physicians in Santa Clara County. Santa Clara County's Preferred 100 Plan has 2,263 physicians in its PPO, or 52.8 percent, of the total physicians in Santa Clara County. According to Santa Clara County's Cost Containment personnel, the Preferred 100 Plan has approximately 5,300 physicians and 1,700 other providers such as psychologists, marriage and family counselors, social workers, podiatrists, and chiropractors.

The City Can Benefit From Forming
A Health Care Coalition With Santa Clara County

The president of the Health Research Institute in Walnut Creek provided us with information demonstrating the success of Santa Clara County's labor-management health care committee. In 1991, the State and Local Government Labor-Management Committee in Washington, D.C., made the following comments about Santa Clara County's labor-management health care committee:

> *Since 1983, the Santa Clara County Labor Management Health Committee has implemented a series of innovative programs to contain health care costs in its self-insured indemnity plan. Recent initiatives include an aggressive claims auditing program that reviews all claims to identify inaccurate or inflated charges by hospitals and physicians, the development of a preferred provider option, and expanding enrollment in the plan to employees of other local governments, thereby allowing the plan to negotiate more favorable rate reductions with health providers. The plan covers 4,500 active and 2,500 retired employees and their dependents.*
>
> *In 1988, Santa Clara County's labor and management found a way to work together to contain costs and improve benefit coverage, At that time, SEIU*

> *Local 715, which represents employees of cities and school districts in Santa Clara County, learned that Blue Cross-Blue Shield planned to cancel their group policies. At the same time, Santa Clara County was interested in expanding the number of employees covered by its self-insured plan so it could negotiate even better rates with physicians and hospitals as part of its PPO network. Labor and management, therefore, agreed to open enrollment in the county's self-insured plan to local governments and school districts that entered into an agreement with the county. Within two years, the number of covered employees increased from 800 to 4,500. This expanded employee base helped the county negotiate even greater rate reductions with PPO providers.*

Appendix I presents more detailed comments about Santa Clara County's labor-management health care committee.

In an article entitled "Trimming Health Benefit Costs" in the August 1994 American City and County magazine, Albert Jones said,

> *Increasingly, local governments are pooling together for economies of scale and greater negotiating leverage with insurers and providers. Others are joining coalitions of public employers, labor and private sector employers to negotiate with providers and to develop data initiatives to collect and study the appropriateness and quality of the health care their benefit plans finance.*

Health care coalitions have been used in Florida, Michigan, Washington, Minnesota, Tennessee, Ohio, Colorado, Iowa, Massachusetts, and Illinois. In an article in the September 1993 Personnel Journal, the following comments were made: "*Human Resources executives are banding together in communities throughout the U.S. to form health-care coalitions. Through their purchasing power, these coalitions are changing the way that health care is purchased and delivered in this country.*"

There are close to a hundred of these employer-driven coalitions, according to the National Business Coalition Forum on Health in Washington, D.C. Health care coalitions are not a new idea. Many of them have been around

for more than a decade. They were originally designed for the purpose of exerting raw economic leverage and achieving some significant discounts in the cost of health care. Today, as the coalition movement spreads, employers are demanding both quality and cost effectiveness from the health care system. More than gaining price reduction, members hope to encourage providers to deliver efficient, high quality health care to the local communities. Employer-led coalitions share a common belief that because health care is a local industry, reform must be community-based.

In continuing with the present PPO and the present TPA, CSJEHP will forego during 1994-95 more than $1 million in reduced expenses that it should realize by forming a purchasing alliance with Santa Clara County's self-insured health care plan.

The CSJEHP lags behind Santa Clara County's self-insured health care plan in certain cost savings features. These cost savings features are:

1. Purchasing alliance with other governmental and quasi-governmental jurisdictions;
2. Larger number of physicians in the PPO in the County;
3. Better physician discount rates;
4. Direct negotiation with hospitals, doctors, and other providers;
5. Expedient payment discounts;
6. Expanded concurrent utilization review; and
7. Greater utilization of PPO hospitals and physician services.

By forming an alliance with Santa Clara County's plan, the CSJEHP will be able to

- Gain purchasing economies of scale and attract medical service providers into its PPO;
- Obtain better physician discount rates;
- Obtain expedient-payment discounts;
- Implement additional concurrent utilization reviews; and
- Increase utilization of PPO physicians and hospitals.

In addition, the administrative costs for the CSJEHP would be about 4 percent less with more services provided for those administrative costs. The consultant for Santa Clara County's Preferred 100 Plan said the County's administration costs would compare to the current CSJEHP administration costs as follows:

	Administration Cost Per Enrollee Per Month	
	Current CSJEHP Cost	**Proposed Cost After Consolidation with Santa Clara County**
Claims Administration	$9.23	$10.10
Pre-admission	1.85	2.00*
Concurrent Utilization Review	N/A	*
Large Case Management	**	*
PPO	1.50	*
Totals	$12.58	$12.10

* $2.00 included charges for pre-admission, concurrent utilization review, large case management, and PPO.

** Under the current CSJEHP, the City pays $195 per hour for large case management services which is in addition to the $12.58 per enrollee per month.

In addition, Santa Clara County's plan would have additional annual costs of about $10,000 for brochures, claims forms, and enrollment cards. The CSJEHP costs about 4 percent more with its current rate of $12.58 per enrollee per month. Appendix J presents excerpts of the contract between Santa Clara County and its TPA describing claims administration services offered for Santa Clara County's Preferred 100 Plan.

If The City Forms A Coalition With Santa Clara County,
The City Can Obtain Better Price Discounts For Medical Services

Santa Clara County's Preferred 100 Plan has better physician reimbursement rates than the CSJEHP as shown in Table VI.

TABLE VI

RATES COMPARISON
BETWEEN SANTA CLARA COUNTY'S
PREFERRED 100 PLAN AND THE CSJEHP

Category	Preferred 100 Plan Rates	CSJEHP Rates	Percentage Differences
Medicine	$7.00	$7.24	3.43
Surgery	$171.50	$182.58	6.46
Radiology	$13.65	$14.92	9.30
Pathology	$1.63	$1.71	4.91
Anesthesia Bill Charges	90% of UCR	$38.39 - $42.66	*

* The CSJEHP rates for anesthesia and the County's rates for anesthesia cannot be compared because the County pays these charges at 90 percent of UCR fees.

The CSJEHP could have saved approximately $239,000 for the calendar years ending 1991, 1992, and 1993, or about $80,000 per year, if it had the benefit of Santa Clara County's physician reimbursement rates.

Table VII below demonstrates these savings.

TABLE VII

**COMPARISON OF CSJEHP PAYMENTS
TO SANTA CLARA COUNTY'S RATES
FROM 1991 THROUGH 1993**

Physician Services (CPT)	CSJEHP Paid	Payment With Santa Clara County's Rate	Savings Lost
Medicine	$2,068,971	$1,998,005	$ 70,966
Surgery	1,881,293	1,759,761	121,532
Radiology	374,440	339,617	34,823
Pathology/ Lab	236,709	225,087	11,622
Anesthesia	122,729	*	*
Uncoded	95,807	**	**
Totals	$4,779,949	N/A	$238,943

* The CSJEHP rates for anesthesia and the County's rates for anesthesia cannot be compared because the County pays these charges at 90 percent of UCR fees.

** Uncoded charges cannot be compared because it is not possible to know what these charges are and how much savings could be realized.

**If The City Forms A Coalition With Santa Clara County,
The City Can Obtain Fast Payment Discounts**

Santa Clara County has expedient-payment discount agreements with PPO hospitals. If PPO hospitals are paid within 20 days for hospital inpatient charges, the County receives discounts ranging from 2 percent to 5 percent. If the CSJEHP had similar agreements, the savings conservatively could have been about $29,000 per year on average as is shown in Table VIII.

TABLE VIII

ESTIMATED DISCOUNTS THE CSJEHP COULD HAVE REALIZED BY USING SANTA CLARA COUNTY'S EXPEDIENT-PAYMENT DISCOUNT AGREEMENT WITH PPO HOSPITALS DURING 1991, 1992, AND 1993

Year	PPO Services Available For Discount	Discount	Total Savings
1991	$1,235,107	2%	$24,702
1992	1,401,407	2%	28,028
1993	1,683,857	2%	33,677
Total	4,320,371	2%	$86,407
Three-Year Average			$28,802

If The City Forms A Coalition With Santa Clara County, The City Can Implement Additional Concurrent Utilization Reviews Of Medical Service Bills

William G. Williams, in the book entitled The Handbook of Employee Benefits, stated the following about utilization review:

> *Hospital utilization review (UR) is designed to reduce the incidence of unnecessary or inappropriate hospitalization. This procedure, used for both cost and quality control, involves the use of locally determined criteria to establish guidelines for appropriate admissions, hospital lengths of stay, and course of treatment. These criteria are based on age, sex, and diagnosis. . . .*
>
> *Hospital utilization can be reviewed on a prospective, concurrent, or retrospective basis. A combination of these approaches comprises the most effective UR program, but concurrent review is the most prevalent.*
>
> ***Prospective Review**. A prospective review program involves preadmission screening by physicians, to limit hospital admissions to those "medically necessary;" . . . Physicians in HMOs often use prospective URs to control hospital utilization.*

While prospective review provides an effective front-line defense against unnecessary hospitalization, its usefulness is limited because control is lost once a patient is admitted and the physician is then free to order any number of tests and keep the patient hospitalized as long as he or she would like. When coupled with concurrent and retrospective review, prospective review can be effective.

***Concurrent Review**. A concurrent review program involves determining whether treatment and continued inpatient care during a patient's hospitalization are necessary and appropriate. Because it can lead to a shortened length of stay, this procedure has definite potential to produce cost-savings.*

***Retrospective Review**. A retrospective review program determines the appropriateness of the care that has been provided and the extent to which hospitalization costs should be reimbursed. This mechanism can create substantial economic incentive for changing patterns of care.*

Thus, utilization review is conducted to determine the following:

1. Unnecessary medical services
2. High cost per unit of service
    a. Billing abuses
    b. Use of high-priced providers
3. Inappropriate settings for services
4. Avoidable illness

FHPA stated it uses a registered nurse to provide telephonic concurrent reviews. This review consists of monitoring a patient's hospital stay on a daily basis in conjunction with the hospital's utilization review department and working with the hospital and attending physician to assure that the patient is discharged within the normative parameters for length of stay that FHPA assigned at the time of admission. According to FHPA, the value of this service is evidenced by the low inpatient days per thousand that the CSJEHP experienced over the term of its contract with FHPA.

FHPA stated in a May 3, 1994, memorandum that it does not audit large hospital bills as a standard service for its clients. FHPA stated it will contract with a hospital review firm at the request of the City; however, charges for such services will be passed along to the CSJEHP.

Santa Clara County employs two registered nurses in the Cost Containment Department to do the following utilization review services for the Preferred 100 Plan:

- Prospective utilization reviews;
- On-site concurrent utilization reviews from San Francisco to Monterey;
- Large case management;
- Claims reviews for all hospital bills;
- Negotiation of one-time-only contracts: e.g., the Cost Containment Department will prospectively negotiate discounts for large bills from non-PPO hospitals; and
- Reviews of medical records.

The registered nurses also consult with physicians as needed.

According to documents Santa Clara County's Cost Containment Department provided to us, the Department's utilization reviews saved the County $12,633 per month, or $151,596 annually, in 1992-93, and $19,019 per month, or $228,228 annually, in 1993-94. Thus, Santa Clara County's utilization reviews saved an average of $189,912 per year in 1992-93 and 1993-94.

Because the City's total enrollment in the CSJEHP of 2,386 is about one half of the 5,000 members in Santa Clara County's Preferred 100 Plan, we estimate the CSJEHP could expect savings of approximately $95,000 per year should the City consolidate its plan with Santa Clara County's.

If The City Forms A Coalition With Santa Clara County,
<u>The City Can Improve Employee Use Of The PPO</u>

We reviewed the CSJEHP's Plan Service Analysis reports for calendar years 1991, 1992, and 1993. These reports summarize the CSJEHP payments made for physician services, hospital and facility charges for inpatient and outpatient services, outpatient pharmacy costs, and dental services. In addition, these reports summarize whether these payments were made to physicians, hospitals, or pharmacists who are in the PPO as well as those outside the PPO. Thus, these reports can be used to determine the extent to which the participants are taking advantage of the discounts negotiated by PPO Alliance with the physicians and hospitals.

The extent to which CSJEHP participants use PPO providers versus non-PPO providers is significant. According to HRD personnel, the overall average percentage discount realized by CSJEHP participants using a PPO provider is 25 percent. Thus, when CSJEHP participants use a non-PPO provider, a potential 25 percent discount is lost. Table IX shows the CSJEHP non-PPO costs for 1991, 1992, and 1993 and our estimate of the savings that the City's employees and retirees would have achieved had these services been provided within the PPO. Particularly noteworthy is that the physician services outside the PPO for 1991, 1992, and 1993 were about 56 percent.

It should be noted that these savings are predicated on the basis that negotiated rates are 25 percent less than non-PPO rates and these negotiated rates can be applied to all PPO provider services.

TABLE IX

CSJEHP NON-PPO COSTS AND ESTIMATED RESULTANT SAVINGS LOST DURING 1991, 1992, AND 1993

	1991, 1992, And 1993			
Services	**Total CSJEHP Costs**	**CSJEHP Non-PPO Costs**	**Percentage Of CSJEHP Non-PPO Costs**	**Estimated Savings Lost Due To CSJEHP Use Of Non-PPO Providers**
Physician	$10,824,427	$6,044,469	55.8	$1,511,117
Hospital	13,251,539	6,125,875	46.2	1,531,469
Outpatient Pharmacy	3,013,387	1,819,607	60.4	454,902
Dental Services	42,347	25,405	60.0	N/A
Average	$9,043,900	$4,671,785		$1,165,829

As shown in Table IX, we estimate that the City's employees and retirees would have saved approximately $1,165,829 annually had CSJEHP members used PPO physicians and hospital services instead of going outside the PPO.

Utilization Of The PPO: CSJEHP Compared To Santa Clara County's Preferred 100 Plan

To evaluate the effectiveness of the City's use of discounted PPO provider services, we compared the 1992-93 usage of PPO physicians for both Santa Clara County's Preferred 100 Plan and the CSJEHP. We used the percentage of payments for the medicine and surgery categories as the basis for our comparison because these services comprise about 82 percent of paid physician services. Table X shows this comparison.

TABLE X

COMPARISON OF THE 1992-93 USAGE OF PPO PHYSICIANS FOR SANTA CLARA COUNTY'S PREFERRED 100 PLAN TO THE CSJEHP FOR MEDICINE AND SURGERY CATEGORIES

Category	Preferred 100 Plan Dollars Paid For PPO Services	CSJEHP Dollars Paid For PPO Services	Difference In PPO Utilization
Medicine	79%	44%	35%
Surgery	72%	58%	14%

We calculated the effect of the CSJEHP achieving results similar to what Santa Clara County's Preferred 100 Plan achieved for usage of PPO providers for medicine and surgery. We estimate that the CSJEHP could annually save about $196,000 per year, assuming the difference in PPO utilization shown above and an average PPO provider discount rate of 25 percent. Our estimate of $195,885 in annual savings due to the CSJEHP's PPO utilization replicating Santa Clara County's Preferred 100 Plan is shown in Table XI.

TABLE XI

ESTIMATED SAVINGS DUE TO THE CSJEHP'S PPO UTILIZATION REPLICATING SANTA CLARA COUNTY'S PREFERRED 100 PLAN

	A	B	C	D
CSJEHP Physician Services	**Total CSJEHP Services For 1993**	**Difference In PPO Utilization**	**Estimated PPO Savings**	**Annual Savings (A x B) C**
Medicine	$1,777,092	35%	25%	$155,496
Surgery	1,153,972	14%	25%	40,389
Totals	***$2,931,064***	***N/A***	***25%***	***$195,885***

Appendix K shows the detail of Santa Clara County's Preferred 100 Plan members using PPO providers for physician and surgery services for a two-year period.[9]

Usage Of PPO Hospitals

The CSJEHP's costs for PPO hospitals versus non-PPO hospitals as percentages of the total for 1991, 1992, and 1993 were:

Year	**PPO Percentage**
1991	50
1992	49
1993	60

It should be noted that Santa Clara County's PPO hospital costs in 1993 were 76.15 percent compared to the City's 60 percent. If the CSJEHP were to achieve the same 76.15 percent of hospital charges in its PPO, the annual savings would be $192,276 as follows:

[9] It should also be noted that Preferred 100 Plan participants' utilization of its PPO is somewhat attributable to the following incentives in the Plan:

a. After the Plan has paid $14,000 in benefits for covered charges from a nonparticipating provider for a member in a year, the Plan pays 100 percent of UCR-covered expenses incurred by that member for the remainder of that calendar year. Excluded from Plan stop-loss provisions are outpatient services under Mental or Nervous Disorders, Substance Abuse and Designated Procedures in the Preferred Provider Service Area Incentive Program and items paid under Prescription Plan benefits.

b. The Preferred 100 Plan has 32 procedures for which the Plan pays 100 percent if the member elects to have the procedure done in a participating facility. However, if the member elects to have the procedure done at a nonparticipating facility and there is a participating facility within 50 miles of where the member had the procedure done, the Plan payment for facility-generated charges will be 50 percent of UCR fees. No stop-loss applies to these procedures.

Total hospital charges for calendar year ending 1993 ....$4,762,256.00

Times 16.15 percent (76.15 minus 60.0) $769,104

$769,104.34 times 25 percent (PPO-stated discount) $192,276

If The City Forms A Coalition With Santa Clara County,
The City's Employees And Retirees Can Save More Than $1 Million Per Year
In Medical Service Costs And Health Insurance Premiums

The CSJEHP can save more than $1 million per year by

- Obtaining better PPO physician reimbursement rates;
- Increasing the size of the PPO in Santa Clara County to maximize potential savings and meet its employees' needs;
- Improving the usage by participants of the PPO;
- Implementing additional concurrent utilization reviews;
- Ensuring that the TPA applies the negotiated rates to all physician services; and
- Establishing a cooperative purchasing agreement with the County, resulting in better prices.

Table XII is a summary of the total savings.

TABLE XII

SUMMARY OF TOTAL SAVINGS TO EMPLOYEES AND RETIREES IF THE CSJEHP HAD THE SAME BENEFITS AS SANTA CLARA COUNTY'S PREFERRED 100 PLAN

If City Had The Benefits Of Santa Clara County's Plan	1991 Savings	1992 Savings	1993 Savings	Total Savings	Yearly Average	Average Savings
Savings if the County's physician service rates were in effect	$66,001	$ 85,407	$ 87,535	$ 238,943	$ 79,648	$ 79,648
Savings if the County's expedient-payment discounts were in effect	24,702	28,028	33,677	86,407	28,802	28,802
Savings if the County's utilization reviews were in effect		$151,596	228,228	379,824	189,912	94,956*
Savings if City achieved the County's percentage of PPO utilization for physician services for medicine			155,496	155,496	155,496	155,496
Savings if City achieved the County's percentage of PPO utilization for physician services for surgery			40,389	40,389	40,389	40,389
Savings if City achieved the County's percentage of PPO utilization for hospitals			192,276	192,276	192,276	192,276
Total savings if with County	$90,703	$265,031	$737,601	$1,093,335	$686,523	$591,567
Opportunities/savings to be gained as a result of having relative values for CPT codes.**						231,864
Savings from economies of scale and mitigating future cost increases***						$198,954
Grand Total						$1,022,385****

* Because the CSJEHP's enrollment is approximately 50 percent of the enrollment in Santa Clara County's Preferred 100 Plan, we estimated the City's savings from concurrent utilization review to be 50 percent of $189,912.

** This amount was computed by multiplying the estimated monthly discount lost of $19,322, as discussed on page 35, by 12 to annualize the amount of savings.

*** Estimate of 2 percent provided by the consultant for Santa Clara County's Preferred 100 Plan and confirmed by the president of Health Research Institute in Walnut Creek. We used the average of the CSJEHP payment of claims amounts for the last three years to quantify the estimate.

**** This total amount is actually understated because we have not included an estimate for savings related to subrogation. Subrogation involves recovering payments which were the responsibility of a third party. Savings from subrogation depends on the number of cases identified and pursued. FHPA does not include subrogation work in its claims administration. In contrast, the County's claims administration cost includes such work. Santa Clara County's Preferred 100 Plan estimated savings of about $90,000 in 1994 and $48,000 for the first two months of 1995. While we do not make a separate savings estimate for subrogation, the City's benefits administrator estimated subrogation savings of at least $180,000 in 1990.

Santa Clara County Has Expressed Interest
In A Coalition With The City

During a meeting between Santa Clara County representatives and the City Auditor's Office in June 1994, the County representatives expressed an interest in forming a coalition between Santa Clara County and the city of San Jose. The City is planning to conduct an RFP selection process for the claims administrator and the PPO for the CSJEHP. In our opinion, the City should invite and encourage Santa Clara County to participate in the City's RFP process.

CONCLUSION

The city of San Jose (City) offers its employees three health care plans of which one is the City of San Jose Employees' Health Plan (CSJEHP). The City contracts with PPO Alliance to administer a series of contractual arrangements with a network of physicians, hospitals, and other medical service providers. The medical service providers with which PPO Alliance contracts are the City's preferred provider organization (PPO). As such, it is in the best interest of the City and its employees that PPO Alliance contract with as many medical service providers as possible and that it negotiate the best possible price for specific medical procedures. In addition, the City contracts with a third-party administrator--Foundation Health Preferred Administrators (FHPA)--to pay and administer claims for services to employees in the CSJEHP that medical service providers submit for payment. As such, it is in the best interest of the City and its employees that the FHPA pay claims in a timely manner and take advantage of all negotiated or available medical service discounts.

Our review of the City's contractual arrangement with PPO Alliance and FHPA and their performance under the City's contract revealed the following:

- At the recommendation of the Benefits Review Forum, the City awarded a contract to PPO Alliance without going through a competitive bidding process;

- PPO Alliance has not provided the City or its employees with a number of medical service providers in its PPO comparable to Santa Clara County's;

- PPO Alliance has not negotiated discount rates with medical service providers in its PPO comparable to Santa Clara County's;

- FHPA has not paid medical service claims in a timely manner;

- FHPA has not taken advantage of negotiated or available medical service discounts and as a result cost the City's employees and retirees $890,000 over the last four years; and

- FHPA paid about $15,000 for ineligible claims during the last four years.

Santa Clara County has a PPO option for its employees known as the Preferred 100 Plan. Our review revealed that by consolidating with the County for a PPO, the City and its employees will be able to

– Obtain better price discounts for medical services;

– Obtain fast-payment discounts;

– Implement additional concurrent utilization reviews of medical service bills; and

– Increase employee use of the PPO.

By forming a medical services purchasing alliance with Santa Clara County, we estimate that City employees will save more than $1 million a year in medical service costs and health insurance premiums. In addition, the City should pursue reimbursement of $905,000 in prior years' overpayments.

RECOMMENDATIONS

We recommend that the Human Resources Department:

Recommendation #1:

Require PPO Alliance and Foundation Health Preferred Administrators to provide relative unit values for all applicable medical services and procedures. (Priority 1)

Recommendation #2:

Require Foundation Health Preferred Administrators immediately to apply the already-negotiated and available discounts described in the PPO Alliance's Physician Reimbursement Schedule. (Priority 1)

Recommendation #3:

Set a deadline for Foundation Health Preferred Administrators (FHPA) to provide the documentation that was requested during the audit. If FHPA fails to provide the documentation, disallow the amounts paid for undocumented medical claims. (Priority 1)

Recommendation #4:

Require Foundation Health Preferred Administrators to provide the City with a payment report from August 1, 1990, to April 30, 1992, and a separate report from May 1, 1992, to the present for all PPO procedures which were paid as billed because there were no relative values to compute a discount. Each report should show (1) the claim number, (2) date of service, (3) the procedure

code number and description, (4) the billed and paid amount, and (5) billed and paid totals for the two report periods. After determining the dollar value of 10 percent and 20 percent discounts not taken, request the City Attorney to initiate actions to recover any overpayments. (Priority 1)

Recommendation #5:

Develop and implement procedures to ensure that the current eligibility files for the City of San Jose Employees' Health Plan are complete and accurate. (Priority 3)

Recommendation #6:

Develop and implement procedures to monitor the continuing eligibility of the employees and their dependents for the City of San Jose Employees' Health Plan. Such procedures could include requesting the third-party administrator to periodically produce an exception report of potential ineligible dependents as a basis for monitoring eligibility. (Priority 3)

Recommendation #7:

Consult with the City Attorney regarding possible City recourse to recover amounts paid on ineligible dependent claims between August 1, 1990, and February 28, 1994. (Priority 3)

In addition, we recommend that the Human Resources Department and Benefits Review Forum:

Recommendation #8:

Request funding for a full-time analyst to monitor the City of San Jose Employees' Health Plan. (Priority 2)

Finally, we recommend that the Human Resources Department:

Recommendation #9:

Solicit a proposal from Santa Clara County in the next scheduled City of San Jose Employees' Health Plan request for proposal process for the selection of the claims administrator and the preferred provider organization. (Priority 1)

Recommendation Requiring Budget Action

Of the preceding recommendations, #8 may not be able to be implemented absent additional funding. Accordingly, the City Manager should request during the 1995-96 budget process that the City Council appropriate an amount sufficient to implement recommendation #8.

RECEIVED
MAR 15 1995
CITY AUDITOR

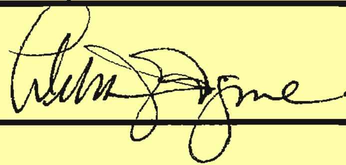
CITY OF SAN JOSE - MEMORANDUM

TO: Finance Committee

FROM: Nona Tobin
Director of Human Resources

SUBJECT: AUDIT RESPONSE:
AUDIT OF CITY OF SAN JOSE
EMPLOYEES' HEALTH PLAN

DATE: March 15, 1995

APPROVED: 

DATE: 3/15/95

INTRODUCTION

The Human Resources Department has reviewed the ***Audit of the City of San Jose Employees' Health Plan***. The Department is generally in agreement with the findings of the audit and provides the following specific responses to the Finding and to each of the Recommendations. Recommendations #4 and #7 involve the Office of the City Attorney in the recovery of funds. Human Resources will consult with the City Attorney's Office as recommended in the Auditor's report.

Human Resources agrees that the City of San Jose Employees' Health Plan (CSJEHP) can be improved to generate savings and improved services to plan participants and will act on these recommendations immediately to achieve this. The $905,000 in prior-years overpayments has been referred to the City Attorney's Office for recovery. However, Human Resources questions whether or not the full $1 million ongoing savings estimate can be realized. This is because the components of the $1 million are based on a comparison between the City's plan and the County of Santa Clara's indemnity plan.

There are significant differences between the City's and the County's respective health plan environments that make much of the savings estimate questionable. Human Resources agrees that $232,000 of the $1 million can be saved. This savings can be done immediately without a plan design change and within the existing plan. A large majority of the balance is subject to major plan design changes that would require a meet and confer obligation with employee groups or negotiations with providers. The City will conduct a request for proposals process for this plan later in 1995. Along with the input from this audit report, we will be able to then determine the full extent of savings that can be achieved. For a detailed discussion of these points, see the discussion under Finding I below.

The City Administration supports and welcomes opportunities for a more cost effective health plan, and thanks the Auditor's Office for their suggestions. However, we need to ensure that the City meets its obligation to meet and confer on issues that result in plan changes.

RESPONSE TO AUDIT

FINDING I: The City of San Jose can improve its health care plan, reduce its employees' and retirees' medical costs by more than $1 million a year, and potentially recover an additional $905,000 in prior year's overpayments.

RESPONSE

Health Care Plan Improvements—Human Resources agrees that the City of San Jose Employees' Health Plan (CSJEHP) can realize immediate ongoing savings by implementing administrative improvements in the way the third-party administrator processes and adjudicates claims. As noted in the audit, these improvements include the correct application of negotiated discounts and increased monitoring of the accuracy of all claims processing activities. These changes are not subject to meet and confer obligations or changing to the County's plan, and can be implemented administratively by the vendors without a plan design change. These changes could generate savings of approximately $232,000. The full $1 million savings is predicated on a comparison between the City and County plans. Before Human Resources responds to each of the individual elements of the $1 million savings estimate, a discussion of the differences between the City and the County's plans is valuable.

City-County Comparison—The $1 million savings estimate is based on a comparison of the CSJEHP to Santa Clara County's Preferred 100 Plus plan, a similar indemnity health plan. Important differences between the City's and the County's approaches to the respective indemnity plans are noted below.

1. Plan Design—One significant difference in comparing the City and County plans is in plan design. Plan design is subject to meet and confer. Plan design generally refers to which services are covered by the plan and how costs are shared between the participant and the plan. While both the City and the County plans cover all medically necessary services, cost sharing is significantly different. One of the most significant differences is San Jose's low annual out-of-pocket maximums. Once the San Jose plan and the participant share the first $2,500 of expenses in any one calendar year, the plan pays all further costs because the participant would have reached the plan's out-of-pocket maximum. This compares to the County's out-of-pocket limit of $14,000. San Jose's relatively low utilization of its preferred provider organization (PPO) is typical of its low out-of-pocket maximums. Once a participant reaches the annual maximum, there is no financial incentive to seek out a preferred provider because the participant has no further out-of-pocket expenses.

   In addition, San Jose's plan shares non-PPO, or non-network, expenses with participants on an 80%/20% basis up to the $2,500 limit. The County's disincentive for non-network expenses dips to a 50%/50% cost sharing

formula. This significant difference in cost-sharing gives County participants a much greater incentive to stay within the PPO network, resulting in plan savings. The out-of-pocket maximums, the cost-sharing formula and any other element of plan design are subject to meet and confer in San Jose.

2. City Emphasis on HMOs Versus Indemnity Plans—Another difference is that the City endeavors to be progressive in the probable migration of employer-sponsored health programs from traditional indemnity plans to health maintenance organizations. HMOs are less expensive for both the participant and the employer, and they emphasize wellness. A natural consequence is greater enrollment in the HMO plans.

   Between Kaiser and Lifeguard, 66% of San Jose's employees and retirees are enrolled in HMOs compared to 43% for the County. Accordingly, the 1.00 FTE of City staff assigned to the health programs allocates time evenly among the three health plans, matching employee health needs to enrollment choices and improving service delivery issues in all three health plans (Kaiser, Lifeguard and CSJEHP). In contrast, the County appears to have committed and focused significant staff resources to the daily administration of its own traditional indemnity plan. For example, according to the audit report, the County directly negotiates all of its 3,200 preferred provider contracts, and the County retains nurses on staff for utilization review.

   For the City to establish the administrative emphasis on its indemnity plan similar to the County, the City must make a significant shift of its resources from that of a health plan service broker to that of an administrator, and the City must commit additional staff resources to health program administration. The cost of this currently-unfunded additional administration was not factored into the Auditor's estimates.

3. First-Year Choice Restriction—Lastly, the County's emphasis on its indemnity plan is further illustrated by its policy to require all new employees to enroll in the Preferred 100 Plus plan. New County employees must enroll and remain in the Preferred 100 Plus or Valley Health (Valley Medical Center only) plans for their first year of employment. Employees may switch to alternative health plans, such as Kaiser, at the first open enrollment period after one full year of service. San Jose employees have the freedom to choose any of our health plans. To restrict or change San Jose employees' choices would be subject to meet and confer.

These three differences must be considered when comparing the City's and the County's approaches to indemnity plan administration.

$1 Million Savings—The $1 million savings estimate in the CSJEHP as suggested in the audit can be achieved with varying degrees of plan changes. A portion ($232,000) will be realized now. These savings are within the capabilities of our current

vendors, and are independent of comparisons with the County. The large majority of the balance ($790,000) of the $1 million savings estimate is subject to negotiations with providers or meet and confer obligations with employee groups, and would only be realized after significant plan design changes.

SUMMARY OF SAVINGS IF CSJEHP HAD THE SAME BENEFITS AS SANTA CLARA COUNTY'S PREFERRED 100

Element	Savings	Response
Savings if the County's physician service rates were in effect	$ 79,648	If the City could obtain these discount rates through PPO Alliance, our current PPO provider, or another PPO network, including the County's, the CSJEHP would realize these savings. The City will not know the savings achievable until after the RFP process. Note that physician service rates would be only one of the criteria used in the selection of a PPO provider.
Savings if the County's expedient payment discounts were in effect	28,802	If the City could obtain these expedient payment discounts through a PPO provider, the CSJEHP would realize these savings. The City will not know the savings achievable until after the RFP process. Again, note that physician service rates would be only one of the criteria used in the selection of a PPO provider.

Element	Savings	Response
Savings if the County's utilization reviews were in effect	94,956	The City's current administrator conducts prospective and concurrent utilization reviews now. The City-County comparison is questionable in that the City's administrator finds it understandably difficult to quantify "avoided costs." The County's methodology for identifying its figures is unclear. At the very least, the $95,000 savings estimate stated in the audit should be offset in consideration of the City's current cost avoidance efforts, and ensure that measurements used for City and County savings are comparable. Also, note that the County does invest more resources in the process and there is no evidence that the County is more successful at cost avoidance.
Savings if City achieved the County's percentage of PPO utilization for physician services—Medicine	155,496	Human Resources feels that the low PPO utilization rate is symptomatic primarily of the rich plan design in the CSJEHP and only secondarily of the network size. The Plan could realize this level of savings only by changing the CSJEHP plan design through meet and confer.

Element	Savings	Response
Savings if City achieved the County's percentage of PPO utilization for physician services—Surgery	40,389	Same as above.
Savings if City achieved the County's percentage of PPO utilization for hospitals	192,276	Same as above.
Opportunities/savings to be gained as a result of having relative values for CPT codes	231,864	The CSJEHP will be recognizing these savings immediately. For PPO procedures without negotiated discounts, the default discount of 20% should be applied as negotiated by PPO Alliance and identified by the audit, effective immediately. Note that these savings will be realized even without this comparison with the County.
Savings from economies of scale and mitigating future cost increases	198,954	This is a general savings estimate that might result from the suggestion that the City share services already established and administered by the County. This suggestion ignores the fact that the City already enjoys this benefit by being one of numerous other clients serviced by our third-party administrator and PPO provider. Thus, Human Resources cannot agree with these savings. The basis of the estimate is vague and needs further development.
TOTAL	$ 1,022,385	

Recover $905,000 in Prior-Year Overpayments—The overpayments consist of two categories: those due to ineligible dependents and those due to missing relative values in the claims processing system.

1. Ineligible Dependents—The overpayments due to ineligible dependents, as noted in the audit, total $15,000 over the past four years. This equals 0.0375% of the $40 million in claims during the same time period. The system error that allowed these ineligible claims was related to a time lag in transmitting eligibility information between the City's claims administrator and our discount pharmacy network. The frequency with which eligibility information is transmitted has now been increased from monthly to weekly so the problem should be completely eliminated.

   Human Resources believes that the high accuracy rate associated with ineligible dependents is very commendable and should not be treated in the audit as a flaw.

2. Missing Relative Values—The overpayments during the past four years due to missing relative values in the claims processing system total $890,000. Human Resources agrees a communication breakdown occurred between our PPO provider and claims administrator in implementing available discounts. Though plan participants still did not suffer out-of-pocket expenses at the point of service due to this breakdown, the plan paid an unnecessary amount for those services, and, consequently, participants paid higher health rates in the following year. Recovery of these expenses has been referred to the City Attorney's Office.

Process to Award PPO Alliance Contract—The audit report includes a statement that "the City awarded a contract to PPO Alliance without going through a competitive bidding process, and documented evidence does not support the City's decision to award a contract to Foundation Health Preferred Administrators." Important points of clarification are that a complete request for proposal process for the third-party administrator was conducted, and the final selection was subject to meet and confer through the Benefits Review Forum (BRF). Once the selection was made, the new administrator provided the BRF with the names of three preferred provider organizations who were known to have automated systems compatible with FHPA's.

PPO Alliance was chosen from among the three PPOs based on the following priorities of the BRF members:

- Of the three PPOs, PPO Alliance had the largest number of local doctors (684).
- PPO Alliance was most eager to solicit the membership of the participants' current doctors, if they were not members already.

- In addition, PPO Alliance equaled its two competitors in discount rates and in having as members the three most popular local hospitals (San Jose Hospital, Good Samaritan and El Camino).

To continue to make improvements to this plan, the Human Resources Department has scheduled, for later in 1995, a request for proposal process to solicit health plan vendors for this plan. Again, the selection is subject to meet and confer through the Benefits Review Forum.

RECOMMENDATION #1:

Require PPO Alliance and Foundation Health Preferred Administrators to provide relative unit values for all applicable medical services and procedures.

RESPONSE: Human Resources agrees with this recommendation. The relative values will allow the claims processing system to recognize already-negotiated and default discounts. These relative unit values were scheduled for installation late in 1994. Human Resources will be verifying its installation and testing its accuracy.

RECOMMENDATION #2:

Require Foundation Health Preferred Administrators immediately to apply the already-negotiated and available discounts described in the PPO Alliance's Physician Reimbursement Schedule.

RESPONSE: Human Resources agrees with this recommendation. Recommendation #1 enables Recommendation #2 to occur. The audit estimates these recommendations will save the plan $232,000 annually. The recommendation will be implemented immediately as indicated in the prior recommendation and in the discussion under Finding I.

RECOMMENDATION #3:

Set a deadline for Foundation Health Preferred Administrators to provide the documentation that was requested during the audit. If FHPA fails to provide the documentation, disallow the amounts paid for undocumented medical claims.

RESPONSE: Human Resources agrees with this recommendation. FHPA should have the documentation available and should comply with the City's right to audit. If FHPA fails to provide the documentation, the City will take appropriate action at that time.

RECOMMENDATION #4:

Require Foundation Health Preferred Administrators to provide the City with a payment report from August 1, 1990, to April 30, 1992, and a separate report from May 1, 1992, to the present for all PPO procedures that were paid as billed because there were no relative values to compute a discount. Each report should show (1) the claim number, (2) date of service, (3) the procedure code number and description, (4) the billed and paid amount, and (5) billed and paid totals for the two report periods. After determining the dollar value of 10 percent and 20 percent discounts not taken, request the City Attorney to initiate actions to recover any overpayments.

RESPONSE: Human Resources will consult with the Office of the City Attorney as recommended in the Auditor's report to implement this recommendation.

RECOMMENDATION #5:

Develop and implement procedures to ensure that the current eligibility files for the City of San Jose Employees' Health Plan are complete and accurate.

RESPONSE: Human Resources agrees with this recommendation, though we note again that the exposure in this area resulted in ineligible claims of $15,000 out of $40 million (0.0375%) over a four-year period. Virtually all ineligible claims were due to a time lag in the prescription program, which has been corrected.

RECOMMENDATION #6:

Develop and implement procedures to monitor the continuing eligibility of the employees and their dependents for the City of San Jose Employees' Health Plan. Such procedures could include requesting the third-party administrator to periodically produce an exception report of potential ineligible dependents as a basis for monitoring eligibility.

RESPONSE: Human Resources agrees with this recommendation as noted in recommendation #7. An eligibility exception report from the third-party administrator will be requested.

RECOMMENDATION #7:

Consult with the City Attorney regarding possible City recourse to recover amounts paid on ineligible dependent claims between August 1, 1990, and February 28, 1994.

RESPONSE: Human Resources will consult with the Office of the City Attorney as recommended in the Auditor's report. However, the staff time in Human Resources and in the Attorney's Office necessary to recover this amount ($15,000), some of which is four years old, from 41 individuals may not be cost-effective for the City.

RECOMMENDATION #8:

Request funding for a full-time analyst to monitor the City of San Jose Employees' Health Plan.

RESPONSE: Human Resources has submitted a 1995-96 budget proposal to the Office of the City Manager for funding such a position. The incumbent would monitor cost and utilization activity, monitor budgets, recommend and implement cost containment strategies, ensure regulatory compliance, and enhance benefits education and communication programs.

RECOMMENDATION #9:

Solicit a proposal from Santa Clara County in the next scheduled City of San Jose Employees' Health Plan request for proposal process for the selection of the claims administrator and the preferred provider panel.

RESPONSE: Human Resources agrees with this recommendation. The County already has been added to the list of invitees for the upcoming request for proposals.

The Council has previously been notified of the four-year cycle with which we intend to re-evaluate the delivery mechanisms and providers of our various benefit programs. We are delaying our request for proposals process for the CSJEHP for several months in order to incorporate the Auditor's suggestions.

CONCLUSION

This audit includes a number of cost-saving recommendations with which Human Resources agrees and will act on immediately. The other recommendations are appropriately subject to negotiations, review by the Office of the City Attorney, or the budget process.

Nona Tobin
Director of Human Resources

OFFICE OF THE CITY AUDITOR
COMMENTS ON THE RESPONSE
OF THE CITY ADMINISTRATION
TO AN AUDIT OF THE CITY OF SAN JOSE
EMPLOYEES' HEALTH PLAN

The following comments are presented to expand upon, clarify, and correct statements in the response of the City Administration to *An Audit Of The City Of San Jose Employees' Health Plan*.

Administration's response - Page 1, Third Paragraph

> *There are significant differences between the City's and the County's respective health plan environments that make much of the savings estimate questionable. Human Resources agrees that $232,000 of the $1 million can be saved. This savings can be done immediately without a plan design change and within the existing plan.* ***A large majority of the balance is subject to major plan changes that would require a meet and confer obligation with employee groups or negotiations with providers****.*

Auditor's Comments

This is inaccurate. The fact is that if the City decided to form a health services purchasing coalition with the County, the Third Party Administrator (TPA) would administer claims in accordance with the existing CSJEHP. No amount of the estimated savings was predicated on any change in plan design.

Administration's response - Page 2, Response, First Paragraph

> *The full $1 million savings is predicated on a comparison between the City and County plans.*

Auditor's Comments

This is also inaccurate. Estimated savings were not based on a comparison of the City's and County's plans, but on:

- current rates in effect for the PPO
- economies of scale for purchasing power
- size of the PPO
- members' use of PPO vs. non-PPO providers
- expedient payment discounts

Our analysis primarily focused on the advantages of lower physician reimbursement rates and members' greater usage of preferred providers in Santa Clara County's plan and

applied them to the CSJEHP actual expenditures to calculate potential savings. At no time did we directly compare the plan design (benefit structure) of the City's plan to the County's.

Administration's response - Page 2, Response, Second Paragraph

> *City-County Comparison - The $1 million savings estimate is based on a comparison of the CSJEHP to Santa Clara County's Preferred 100 Plus plan, a similar indemnity health plan. Important differences between the City's and County's approaches to the respective indemnity plans are noted below.*

Auditor's Comments

As was already noted, no direct comparison between the City's and County's plans was made in this audit. Consequently, addressing differences between the City's and the County's approaches to their respective indemnity plans is irrelevant.

Administration's response - Page 2, Response, Third Paragraph

> *Plan Design - One significant difference in comparing the City and County plan is in plan design. Plan design is subject to meet and confer. Plan design generally refers to which services are covered by the plan and how costs are shared between the participant and the plan.*

Auditor's Comments

The auditor concurs that plan design would be subject to meet and confer if changes were being proposed. However, as already noted, the $1 million estimated savings was not based on any change in plan design. Therefore, switching to a different TPA will not affect services covered and shared costs between participants and the CSJEHP and will not be subject to meet and confer.

Administration's response - Page 2, Response, Paragraph 3

> *While both the City and the County plans cover all medically necessary services, cost sharing is significantly different. One of the most significant differences is San Jose's low annual out-of-pocket maximums. Once the San Jose plan and the participant share the first $2,500 of expenses in any one calendar year, the plan pays all further costs because the participant would have reached the plan's out-of-pocket maximum. This compares to the County's out-of-pocket limit of $14,000.*

Auditor's Comments

The response infers that if the City formed a coalition with the County, the City would have to adopt the County's annual out-of-pocket maximum of $14,000. This is simply not true. We reiterate that there will be no changes to the CSJEHP as a result of this coalition. The City plan's existing covered services and established annual out-of-pocket maximum would be used by the County's TPA to pay CSJEHP claims.

Administration's response - Page 2, Response, Paragraph 3

> *Once a participant reaches the annual maximum, there is no financial incentive to seek out a preferred provider because the participant has no further out-of-pocket expenses.*

Auditor's Comments

The incentive for CSJEHP participants to use preferred providers is lower future premiums resulting from any cost savings to the plan. Any CSJEHP premium amount over and above 90 percent of the City's lowest cost plan is borne by the participant. As noted on page 56 of the audit report, for the last three years CSJEHP non-PPO costs were $4.7 million, resulting in lost savings to the participants averaging $1,165,000 a year. Therefore, if these savings were realized, active and retired employees in the CSJEHP would have paid lower annual premiums.

Administration's response - Page 2, Response, Paragraph 4

> *In addition, San Jose's plan shares non-PPO, or non-network, expenses with participants on an 80%/20% basis up to the $2,500 limit. The County's disincentive for non-network expenses dips to a 50%/50% cost sharing formula. The significant difference in cost-sharing gives County participants a much greater incentive to stay within the PPO network, resulting in plan savings. The out-of-pocket maximums, the cost-sharing formula and any other element of plan design are subject to meet and confer in San Jose.*

Auditor's Comments

We reiterate, there will be no change in CSJEHP's cost sharing formula as a result of forming a coalition with the County. Also, our audit revealed that Santa Clara County's PPO has 2,263 physicians in Santa Clara County as compared to the CSJEHP which has 949 physicians. In our opinion, having more than twice the number of physicians in the PPO significantly increases the probability of members utilizing PPO physicians resulting in reduced plan expenditures. Finally, and as previously stated, out-of-pocket maximums, the cost sharing formula, and any other element of plan design will not change as

a result of forming a coalition with the County, therefore, there will be no need to meet and confer.

Adminstration's response - Page 3, Paragraph 2

> *2. City Emphasis on HMOs Versus Indemnity Plans - Another difference is that the City endeavors to be progressive in the probable migration of employer-sponsored health programs from traditional indemnity plans to health maintenance organizations. HMOs are less expensive for both the participant and the employer, and they emphasize wellness. A natural consequence is greater enrollment in the HMO plans.*

Auditor's Comments

We performed two audits of employee health benefits. In our previous report, *An Audit Of The City Of San Jose Employees' Health Benefits*, page 25, we demonstrated that San Jose's active employees' enrollment in HMOs is 4 percent to 16 percent less than eight other surveyed jurisdictions. We found that 74 percent of City of San Jose active employees were enrolled in HMOs. In our current audit, we found that this HMO percentage of enrollment had not changed. Clearly, the City of San Jose is not as progressive as other jurisdictions in their HMO enrollment.

Administration's response - Page 3, Paragraphs 3 and 4

> *Between Kaiser and Lifeguard, 66% of San Jose's employees and retirees are enrolled in HMOs compared to 43% for the County. Accordingly, the 1.00 FTE of City staff assigned to the health programs allocates time evenly among the three health plans, matching employee health needs to enrollment choices and improving service delivery issues in all three health plans (Kaiser, Lifeguard and CSJEHP). In contrast, the County appears to have committed and focused significant staff resources to the daily administration of its own traditional indemnity plan. For example, according to the audit report, the County directly negotiates all of its 3,200 preferred provider contracts, and the County retains nurses on staff for utilization review.*
>
> *For the City to establish the administrative emphasis on its indemnity plan similar to the County, the City must make a significant shift of its resources from that of a health plan service broker to that of an administrator, and the City must commit additional staff resources to health program administration. The cost of this currently-unfunded additional administration was not factored into the Auditor's estimates.*

Auditor's Comments

The response incorrectly indicates that only 43% of Santa Clara County's active employees and retirees are enrolled in HMO's. In our previous report, *An Audit Of The City Of San Jose Employees' Health Benefits*, page 25, we demonstrated that Santa Clara County's active employees' enrollment in HMOs was 81 percent, as compared to the City's 74 percent. Santa Clara County's <u>total</u> HMO enrollment for the active and retired employees was 76 percent (not 43%) as of April 1993.

On page 49 of this current audit report, we compared the administrative costs for the CSJEHP to the County's administrative costs. Consequently, we found that the City's cost per enrollee per month would be 4 percent less if we use the County's TPA and PPO. Furthermore, the proposed per enrollee per month cost includes additional services we are currently not receiving. Thus, the comment that the City must make a significant shift of its resources from that of a health plan service broker to that of an administrator, thereby committing additional staff resources to health program administration, <u>is not true</u>.

The fund for the CSJEHP currently does not have <u>any</u> costs for internal administration charged to it. Recommendation #8 of this audit report requests that the Human Resources Department and the Benefits Review Forum seek funding for a full-time analyst to monitor the City of San Jose Employees' Health Plan. This position would not be a general fund expenditure, but rather a cost of the CSJEHP borne by the participants. However, any cost savings the analyst identified would accrue to the plan. Thus, the plan participants must decide whether an increased level of administration is warranted and cost beneficial. (See page 41 of the report for a list of some duties the analyst might perform.)

<u>Administration's response - Page 3, Paragraph 4</u>

> *<u>3. First-Year Choice Restriction</u> - Lastly, the County's emphasis on its indemnity plan is further illustrated by its policy to require all new employees to enroll in the Preferred 100 Plus plan. New County employees must enroll and remain in the Preferred 100 Plus or Valley Health (Valley Medical Center only) plans for the first year of employment. Employees may switch to alternative health plans, such as Kaiser, at the first open enrollment period after one full year of service. San Jose employees have the freedom to choose any of our health plans. To restrict or change San Jose employees' choices would be subject to meet and confer.*

Auditor's Comments

The comments about the first year choice restriction are not relevant because there would be no first year choice restrictions to San Jose employees. San Jose employees have the freedom to choose any of the City's health plans, and there would be no change in this freedom of choice.

<u>Administration's response - Page 3, Paragraph 6</u>

These three differences [Plan Design, City Emphasis on HMOs Versus Indemnity Plans, and First Year Choice Restriction] must be considered when comparing the City's and County's approaches to indemnity plan administration.

Auditor's Comments

As noted above, these three differences are irrelevant and do not need to be considered. There will be no changes to the CSJEHP as a result of the coalition. The County and the City can continue to have separate and different plans. The County's TPA and CSJEHP will pay the CSJEHP claims according to CSJEHP provisions. **Plan design will not change with a change in TPA and PPO.**

Administration's response - Page 3, Paragraph 6

$1 Million Savings--The $1 million savings estimate in the CSJEHP as suggested in the audit can be achieved with varying degrees of plan changes. A portion ($232,000) will be realized now. These savings are within the capabilities of our current vendors, and are independent of comparisons with the County. The large majority of the balance ($790,000) of the $1 million savings estimate is subject to negotiations with providers or meet and confer obligations with employee groups, and would only be realized after significant plan design changes.

Auditor's Comments

No plan design changes are needed to achieve the $1 million saving estimate. In addition, the Administration completely discounts any savings that would accrue to the CSJEHP as a result of (1) more than doubling the City's PPO network of physicians, (2) better negotiated PPO rates, (3) expedient payment discounts of 2 to 5 percent, (4) improved utilization reviews, (5) lower administrative costs, and (6) economy of scale savings that tripling the CSJEHP employee base would generate.

Administration's response - Page 7, Paragraph 2

Ineligible Dependents--The overpayments due to ineligible dependents, as noted in the audit, total $15,000 over the past four years. This equals 0.0375% of the $40 million in claims during the same time period.

Auditor's Comments

On page 39 of the audit report we estimated ineligible claimant payments based on our review of FHPA's monthly membership listing as of February 28, 1994. We made no attempt to quantify total ineligible claimant payments for the entire period of August 1, 1990, to February 28, 1994.

Administration's Response - Page 7, Paragraph 3

> *Human Resources believes that the high accuracy rate associated with ineligible dependents is very commendable and should not be treated in the audit as a flaw.*

Auditor's Comments

We identified over 300 ineligible persons on the CSJEHP membership for one month. Of the 300 ineligible persons, 155 were over-aged dependents. This is unacceptable and is considered a serious flaw.

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

[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, Director Human Resources Dept.
Subject:	CITY OF SAN JOSE EMPLOYEE HEALTH PLANS	Date:	November 14, 1994

Approved: Date:

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

BACKGROUND

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

A number of considerations have influenced the design of the City's health plans. 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.

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 an exclusive provider health maintenance organization plan through Kaiser Foundation, an open panel (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. Annual increases from 1991–92 to 1993–94 averaged only 6 to 7%. For 1994-95, rates dropped by an average of 6% from those of the prior year, and are now within 1% of the 1992–93 level.

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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 of San Jose 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, timely health care while containing costs as much 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, Director
Human Resources Department

APPENDIX C

GLOSSARY OF TERMS

To provide clarity and understanding to any reader of this report, definition of several key items is essential. Therefore, significant terms which appear in this report 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.

Coordination of Benefits (COB) -- The provision that prevents duplicate reimbursement for a given expense covered by two or more plans. COB is a useful cost-containment feature for groups with a large number of married employees who are eligible for benefits under both their own and their spouses' plans.

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

CPT Codes -- Acronym for Current Procedure Terminology codes used to describe the interventions by the physician or other health care professionals in treating an episode of illness.

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 prepaid by all members 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 an inpatient or an 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.

Individual Practice Association (IPA) -- A type of health maintenance organization that consists of a central administrative authority and a panel of physicians and other providers practicing individually or in small groups in the community. Providers are usually reimbursed individually either on a fee-for-service or capitation basis.

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

Managed Care -- A term that addresses the causes of higher costing health care. It encourages employees to use less costly care through strong financial incentives/penalties. It also controls the level of care provided through strong utilization controls and in some instances by reducing or eliminating areas of coverage.

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 that the services were performed.

Preferred Provider Organization (PPO) -- A variation of a traditional fee-for-service care arrangement representing a group of physicians, dentists, or hospitals or other practitioners that contracts with employers, insurance companies, unions, or third-party administrators to provide employees with services at reduced rates. Employees have a free choice among the physicians in a PPO arrangement.

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.

Relative Value -- A reflection of the practice of medicine in California. It is a coded listing of physician services with unit values to indicate the relativity within each individual section of median charges by physicians for these services. Since the unit values reflect medians of charges by California physicians, they do not necessarily reflect the charges of any individual physician or the pattern of charges in any specific area of California.

Self-Insurance -- A method of financing a benefit plan without insurance. The employer assumes direct financial responsibility for reimbursing all claims liabilities. Some self-insured 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 third-party administrators 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.

APPENDIX D

EXCERPTS FROM PPO ALLIANCE PLUS DIRECTORY NORTHERN CALIFORNIA 1993-94

By selecting PPO Alliance Plus, your employer has joined with our team of preferred providers. Together, we are committed to holding down the rising costs of health care by providing quality care in a cost effective manner. If you use PPO Alliance Plus every time you seek medical care, you will be able to take advantage of the choice, savings, quality and convenience offered by this innovative plan.

SAVINGS

How much can you save? The following examples demonstrate that you can save from 65 to 75 percent of the amount paid by you if you use a Plus preferred provider.

EXAMPLE ONLY
Potential Hospital Savings
(YOUR PLAN MAY VARY FROM THIS EXAMPLE)

	NON-PPO	PPO	PPO SAVINGS TO YOU
BILLED CHARGE (3-day hospital stay)	$3,750	$3,750	
SAMPLE REDUCTION IN PROVIDER FEES*	N/A	-1,350	
PPO ADJUSTED CHARGE	N/A	$2,400	
PERCENTAGE PAID BY HEALTH PLAN**	70%	90%	
TOTAL AMOUNT PAID BY HEALTH PLAN	$2,625	$2,160	
PAID BY YOU	$1,125	$ 240	$ 885

You can experience similar savings on physician services, as demonstrated by the following example:

EXAMPLE ONLY
Potential Physician Savings
(YOUR PLAN MAY VARY FROM THIS EXAMPLE.)

	NON-PPO	PPO	PPO SAVINGS TO YOU
BILLED CHARGE (for initial visit)	$ 150	$ 150	
SAMPLE REDUCTION IN PROVIDER FEES*	N/A	- 30	
PPO ADJUSTED CHARGE	N/A	$ 120	
PERCENTAGE PAID BY HEALTH PLAN**	70%	90%	
TOTAL AMOUNT PAID BY HEALTH PLAN**	$ 105	$ 108	
PAID BY YOU	$ 45	$ 12	$ 33

* THIS AMOUNT WILL VARY DEPENDING UPON THE SERVICE YOU RECEIVE.

** IT IS IMPORTANT TO CHECK YOUR INDIVIDUAL PLAN TO FIND OUT WHAT YOUR BENEFIT IS, AND IF DEDUCTIBLES AND COPAYMENTS APPLY.

JRG:NS:glk
05/10/93

APPENDIX E

CONTRACT BETWEEN THE CITY OF SAN JOSE AND FOUNDATION HEALTH PREFERRED ADMINISTRATORS

EXHIBIT B

SCOPE OF SERVICES

A. CLAIMS ADMINISTRATION

Upon receipt of a claim for Benefits, CONSULTANT will review the claim to determine whether it has been properly filed and the amount, if any, which is due and payable with respect thereto. The review and determination of Benefits will be made in accordance with the rules and procedures established by CONSULTANT for the administration of claims for benefits.

The claims administration procedures will provide for adequate written notice to any person whose claim for Benefits has been denied and will set forth the specific reasons for such denial. Furthermore, the Plan will afford any person whose claim for Benefits has been denied a reasonable opportunity for review.

CONSULTANT will maintain microfilm or other media records of claims received and determinations thereon for five (5) years. Before the destruction of said records, CITY shall have the right to request that they be transferred to CITY at CITY's cost.

PAYMENT OF CLAIMS

CONSULTANT shall take all reasonable steps necessary to process claims and disburse Benefit payments to persons entitled to such payments under the Plan. Such payments shall be made through a bank account established by the CITY. CONSULTANT shall provide the CITY with a check register for each check run drawn on the bank account and will assist the CITY and the bank in the preparation of the monthly bank account reconciliation report. CITY agrees to maintain at all times funds sufficient to pay claims for Plan Benefits under the Plan and to provide CONSULTANT with such authorizations as shall be necessary to make the required instruments valid claims against the CITY.

B. UTILIZATION REVIEW

CONSULTANT shall provide certain services to assist CITY in implementing the Utilization Review (UR) Program. Such services shall include:

a. Making determinations, within the guidelines of the UR Program, as to whether:

(1) UR Program notification and certification requirements were met;

(2) Purported Emergencies (as defined in the Plan Document attached to this Agreement as Exhibit F) preventing pre-admission notification and certification were true Emergencies;

(3) Surgery is Medically Necessary (as defined in Plan Document;

(4) Selected Medical or surgical procedures are Medically Necessary;

(5) Medically Necessary surgery requires hospitalization;

(6) Medically Necessary surgery requires pre-operative hospitalization;

(7) Non-surgical care requires hospitalization;

(8) Enrollees to be eligible for Plan Benefits;

(9) Proposed services appear to be Plan Benefits; and

(10) Plan Benefits are or were available from a Company contracting provider.

b. Providing, within the guidelines of the UR Program:

(1) Pre-admission certification of selected medical or surgical procedures;

(2) Authorizations for UR Program length of stay and Company concurred in extensions of stay;

(3) Concurrent Review (as defined in Plan Document) of hospital admissions;

(4) Retrospective Review (as defined in Plan Document) of inpatient and outpatient care; and

(5) Notification of Enrollees as to authorization or denial of Plan Benefits and eligibility/non-eligibility and coverage/non-coverage determinations.

c. In non-Emergency cases, arranging for second opinion consultation, when required by the UR Program.

d. Directing Enrollees to Company contracting providers for Plan Benefits, when appropriate.

e. Provide up to two (2) sets of member address labels a year.

f. Provide up to twenty (20) hours of programing/computer time for reports and/or analysis as required.

g. Maintaining adequate staff and arrangements with consultants to perform its obligations with respect to the UR Program under this Agreement.

h. Maintaining the data system capability necessary to promptly retrieve previously collected information, prevent re-entry of previously entered data and assure awareness of previous contract with Enrollees and providers.

C. LARGE CASE MANAGEMENT (LCM) PROGRAM

The LCM Program encompasses the coordination of all Plan Benefits in the selected situations listed on the Plan Document. In the event of any such situation, the LCM Program will be initiated.

The LCM Program involves consultation between an independent physician, or other qualified medical personnel, selected by of on behalf of CITY ("Large Case Manager") and the physician primarily responsible for the overall health care of the Enrollee (employee) on an ongoing basis ("Primary Care Physician"). The Large Case Manager will review the Enrollee's medical situation with the Primary Care Physician, and make recommendations with respect to a treatment plan. The decision as to whether to implement the treatment plan rests entirely with the Primary Care Physician.

The recommended treatment plan may include medical services not included as Plan Benefits. In such event, Company will determine whether to modify Plan Benefits so as to provide coverage for such services.

The Large Case Manager will notify the Enrollee and his or her Primary Care Physician on the initiation of the LCM Program. Additionally, the Large Case Manager will advise the Enrollee of the treatment plan adopted by the Primary Care physician, whether and the extent to which CITY has agreed to modify Plan Benefits so as to provide coverage for the Treatment plan, and the extent to which the Enrollee will be required to pay for services provided pursuant to the treatment plan.

LARGE CASE MANAGEMENT SERVICES

CONSULTANT shall provide such services as are necessary to implement the LCM Program on behalf of CITY. Such services shall include:

a. Identifying circumstances under which LCM Program implementation is required.

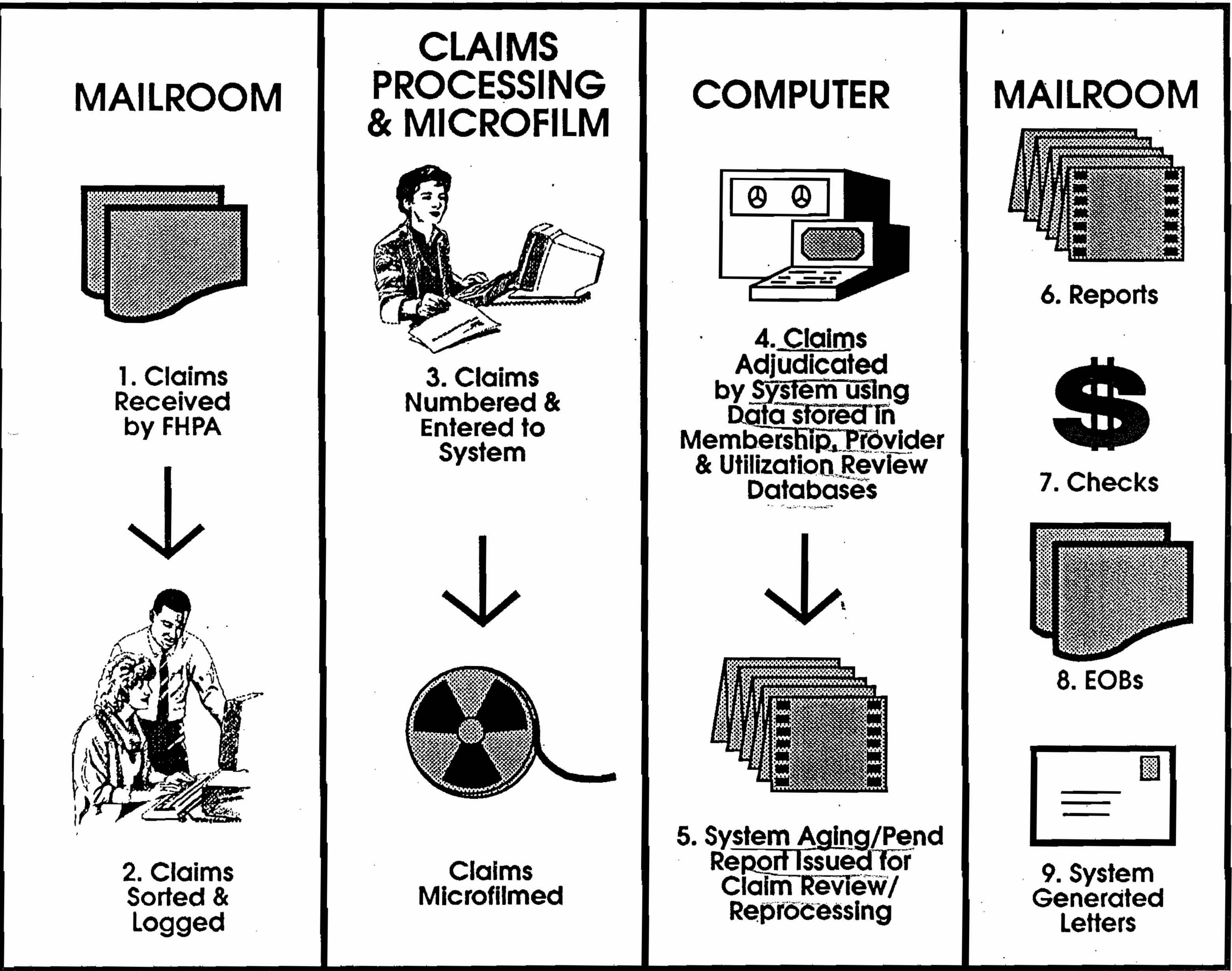
b. Referring Enrollees for large case management when LCM Program criteria are met.

c. Arranging for a physician to consult with the Enrollee's treating physician to develop a LCM Program treatment plan; provided, the treating physician shall be solely responsible for developing and adopting the treatment program.

d. Providing notification to the Enrollee and the Enrollee's treating physician of implementation of the LCM Program.

e. Maintaining adequate staff and arrangements with consultants to perform its obligations with respect to the LCM Program under this Agreement.

CONSULTANT shall provide monthly and quarterly reports to CITY on all claim payments, and utilization review (UR) and large case management (LCM) activities as requested by the CITY.



FHPA CLAIMS PROCESSING FLOW CHART
MAILROOM
1. Claims Received by FHPA
2. Claims Sorted & Logged
CLAIMS PROCESSING & MICROFILM
3. Claims Numbered & Entered to System
Claims Microfilmed
COMPUTER
4. Claims Adjudicated by System using Data stored in Membership, Provider & Utilization Review Databases
5. System Aging/Pend Report Issued for Claim Review/ Reprocessing
MAILROOM
6. Reports
7. Checks
8. EOBs
9. System Generated Letters

APPENDIX G

PPOs IN SANTA CLARA COUNTY
FROM 1988 THROUGH 1993
RANKED BY NUMBER OF PHYSICIANS

	1988			1989			1990	
1.	Blue Cross of California Prudent Buyer Plan	1,654	1.	Blue Cross of California Prudent Buyer Plan	1,744	1.	Foundation of Medical Care for Santa Clara County	1,750
2.	Foundation of Medical Care for Santa Clara County	1,468	2.	Blue Shield PPO	1,636	2.	Blue Shield Preferred Plan	1,700
3.	Private Healthcare Systems Ltd.	1,412	3.	Foundation of Medical Care for Santa Clara County	1,614	3.	Blue Cross of California Prudent Buyer Plan	1,688
4.	Western Health Network	1,100	4.	Western Health Network	1,614	4.	Western Health Network	1,671
5.	Beech Street	1,000	5.	Private Healthcare Systems Ltd.	1,412	5.	Aetna Health Plans PPO	1,500
6.	Cost Care Exclusive Provider Network	1,000	6.	Cost Care Exclusive Provider Network	1,020	6.	Beech Street	1,500
7.	Affordable Health Care	800	7.	Beech Street	1,000	7.	Private Healthcare Systems Ltd.	1,375
8.	American Health Network	766	8.	Partners National Health Plan	1,000	8.	CAPP Care	1,200
9.	CAPP Care	757	9.	American Health Network	965	9.	Affordable Healthcare Concepts	1,100
10.	Med Network	750	10.	Med Network	850	10.	American Health Network	1,023
			11.	CAPP Care	771	11.	Cost Care Exclusive Provider Network	907
			12.	Preferred Health Network	715	12.	Admar Corp.	840
			13.	**PPO Alliance**	**651**	13.	**PPO Alliance**	**750**
			14.	Interplan Corp.	535	14.	Interplan Corp.	742
			15.	Pacific Health Alliance	309	15.	Met-Elect	500
						16.	Preferred Health Network	450
						17.	Pacific Health Alliance	172

	1991	
1.	Private Healthcare Systems Ltd.	3,200
2.	Foundation for Medical Care of Santa Clara County	1,877
3.	Blue Cross of California Prudent Buyer Plan	1,644
4.	Beech Street of California	1,361
5.	Cost Care Inc.	1,120
6.	American Health Network	1,050
7.	Aetna Health Plans	995
8.	Preferred Health Network	938
9.	Community Care Network Inc.	866
10.	Interplan Corp.	800
11.	**PPO Alliance**	**793**
12.	CAPP Care Inc.	640
13.	Medical Dimensions, Inc.	630
14.	Benefit Panel Services Inc.	504
15.	Pacific Health Alliance	484
16.	Blue Shield of California	N/A*

	1992	
1.	Private Healthcare Systems Ltd.	2,240
2.	Foundation for Medical Care of Santa Clara County	1,900
3.	Aetna Health Plans	1,781
4.	Admar Corp.	1,570
5.	MetLife Network	1,527
6.	Cost Care Inc.	1,480
7.	Beech Street of California	1,468
8.	Anthem Health Systems, Inc.	1,400
9.	Take Care Preferred Plan	1,347
10.	Pacific Health Alliance	1,167
11.	Preferred Health Network	1,147
12.	**PPO Alliance**	**916**
13.	Community Care Network	904
14.	Benefit Panel Services Inc.	892
15.	Interplan Corp.	800
16.	Medical Dimensions, Inc.	650
17.	Blue Cross of California Prudent Buyer Plan	N/A*
18.	Blue Shield of California	N/A**

	1993	
1.	CIGNA Health Care	5,000
2.	Blue Shield Preferred Plan	2,675
3.	Foundation for Medical Care of Santa Clara County	2,600
4.	Private Healthcare Systems Inc.	2,240
5.	Blue Cross of California Prudent Buyer Plan	1,702
6.	Cost Care Inc.	1,480
7.	Aetna Health Plans	1,436
8.	TakeCare Preferred Network	1,425
9.	Anthem Health Systems, Inc.	1,414
10.	Preferred Health Network	1,392
11.	Pacific Health Alliance	1,324
12.	PruNetwork	1,236
13.	Interplan Corp.	1,152
14.	**PPO Alliance**	**977**
15.	MetLife Healthcare	853
16.	Delta Plan of California	91
17.	Community Care Network Inc.	N/A*

* These numbers were not available.

** This number was incorrectly stated in the 1992 edition; therefore, it has been omitted.

APPENDIX H

COMPARISON OF THE NUMBER OF PROVIDERS IN THE CITY'S PPO AS OF JANUARY 7, 1994, AND SANTA CLARA COUNTY'S PPO AS OF JANUARY 21, 1994

Category	Effective January 7, 1994, PPO Alliance Plus	Effective January 21, 1994, Preferred 100 Plan
Allergy	13	28
Allergy & Immunology	0	14
Ambulatory Care	0	6
Anatomic Pathology	2	0
Anesthesiology	38	55
Biomedical Engineering	0	0
Cardiology	4	82
Cardiovascular Angiography	0	23
Cardiovascular Disease	32	0
Chemical Dependency	0	3
Child Psychiatry	0	9
Clinics	0	4
Dermatology	18	39
Dermatopathology	0	0
Durable Medical Equipment	0	3
Emergency Medicine	26	53
Endocrinology	1	11
Family Practice	**96**	**180**
Free Standing Diagnostic Facilities	0	2
Gastroenterology	8	38
General Practice	**3**	**108**
Genetics	1	0
Gynecology	2	12
Hematology	6	12
Home Health Agency	0	6
Immunology	0	0
In-Patient Health Care Providers	0	5
Infectious Diseases	2	13
Infertility	0	0

Category	Effective January 7, 1994, PPO Alliance Plus	Effective January 21, 1994, Preferred 100 Plan
Internal Medicine	**129**	**345**
Maxillofacial / Oral Surgery	2	0
Neonatology	1	0
Nephrology	4	22
Nerurotology	0	0
Neuro-Ophthalmolary	0	0
Neurology	18	22
Nuclear Medicine Facility	1	0
Obstetrics / Gynecology	**108**	**182**
Occupational Medicine	0	0
Oncology	0	24
Ophthalmology	38	67
Ophthalmology, Retinal Vitreous	1	0
Otolaryngology	19	43
Otology	0	0
Otorhinolaryngology	0	0
Pain Control Therapy	0	8
Pathology	8	0
Pediatric Allergy	0	13
Pediatric Cardiology	2	7
Pediatric Dermatology	0	0
Pediatric Endocrinology(see supplement)	0	1
Pediatric Gastroenterology	1	2
Pediatric Hematology & Oncology	0	2
Pediatric Nephrology	0	0
Pediatric Neurology	2	2
Pediatric Ophthalmology	0	0
Pediatric Pulmonary Diseases	0	3
Pediatric Rheumatology	0	0
Pediatric Surgery (see Surgery, Pediatric)	0	0
Pediatric Urology	0	2
Pediatrics	**87**	**177**
Psychiatric Physicians	0	97

Category	Effective January 7, 1994, PPO Alliance Plus	Effective January 21, 1994, Preferred 100 Plan
Physical Medicine & Rehabilitation	4	38
Podiatry	39	67
Psychiatry	31	0
Pulmonary Disease	0	38
Pulmonary Medicine	6	0
Radiation Oncology	0	0
Radiation Therapy	0	1
Radiology	4	28
Radiology / Nuclear Med / Oncology	24	0
Rehabilitation Center	1	0
Reproductive Endocrinology	0	0
Rheumatology	5	15
Surgery, Cardiac	0	28
Surgery, Colon & Rectal	0	6
Surgery, Colon / Rectal	2	0
Surgery, General	47	88
Surgery, Hand	1	13
Surgery, Head & Neck	0	6
Surgery, Neuro	12	20
Surgery, Oral	0	3
Surgery, Orthopedic	45	85
Surgery, Pediatric (see supplement)	1	3
Surgery, Plastic	15	24
Surgery, Retinal	0	0
Surgery, Thoracic	15	32
Surgery, Trauma	0	3
Surgery, Vascular	2	26
Surgical Centers	2	4
Therapeutic Radiology	0	0
Urology	20	30
Subtotals	**949**	**2,283**
Acute Care Hospital	7	8
Chiropractic	32	193
C T /M R I	4	0

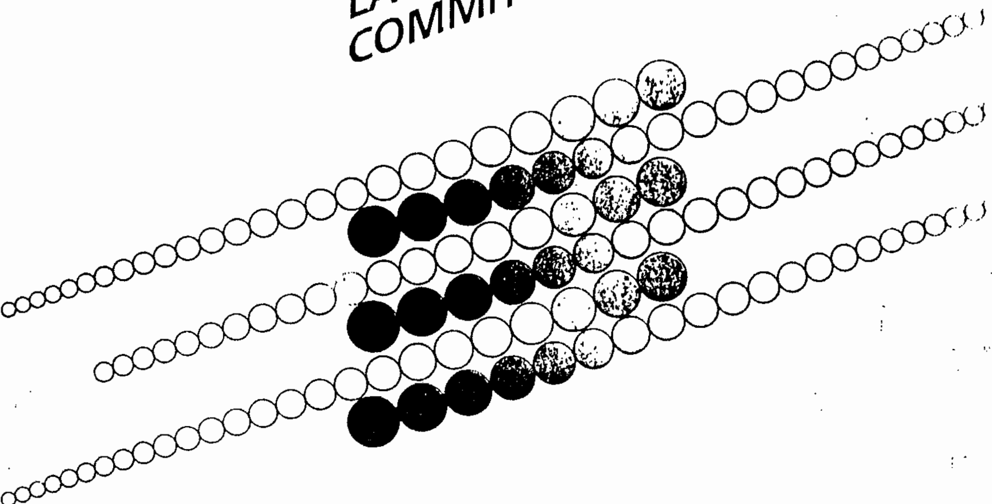
Category	Effective January 7, 1994, PPO Alliance Plus	Effective January 21, 1994, Preferred 100 Plan
Dentistry	1	0
General Radiology Facility	1	0
Independent Physicians Association	2	0
Laboratory Services	29	0
Licensed Clinical Social Workers	0	138
Marriage, Family & Child Counselors	0	376
Medical Group	1	0
MRI Centers	0	6
Physical Therapists	16	0
Psychologists	0	214
Psychology	1	0
Subtotals	**94**	**935**
TOTALS	**1,043**	**3,218**
Total number of physicians in the County	**4,283**	**4,283**
Number of physicians in each plan as a percentage of the total physicians in County	**22.16**	**53.30**

APPENDIX I

SANTA CLARA COUNTY'S
LABOR-MANAGEMENT HEALTH CARE COMMITTEE

The president of the Health Research Institute in Walnut Creek provided us with information demonstrating the success of the Santa Clara County's (County) labor-management health care committee. In 1991, Washington, D.C., acknowledged the success of County's labor-management health care committee for controlling public employee health care costs. The State and Local Government Labor-Management Committee in Washington, D.C., comments about the County's labor-management health care committee in the following document.

CONTROLLING PUBLIC EMPLOYEE HEALTH CARE COSTS THROUGH LABOR-MANAGEMENT COMMITTEES



State and Local Government Labor-Management Committee

Santa Clara County, Calif. Labor-Management Health Care Committee

Overview

Since 1983, the Santa Clara County, Calif. labor-management health committee has implemented a series of innovative programs to contain health care costs in its self-insured indemnity plan. Recent initiatives include an aggressive claims auditing program that reviews all claims to identify inaccurate or inflated charges by hospitals and physicians; the development of a preferred provider option; and expanding enrollment in the plan to employees of other local governments, thereby allowing the plan to negotiate more favorable rate reductions with health providers.

The plan covers 4,500 active and 2,500 retired employees and their dependents.

Background

Dramatic cost increases in the county's indemnity plan led to a change at the bargaining table in 1982. Many of the healthier, younger employees enrolled in HMOs, driving up the premiums in the indemnity plan. In 1982, the insurance carrier,Blue Cross-Blue Shield, announced its decision to refuse to cover any new county employees and proposed premium increases that would have made the plan largely unaffordable to current employees. The union representing county employees, Service Employees International Union (SEIU) Local 715, suggested instituting cost containment alternatives. County management wanted to keep an indemnity option, which was especially important to older employees. Therefore, labor and management agreed to change their focus from traditional arguments over who should pay the increases and whether or not employees overuse services, and include the union in figuring out how to respond to the insurance companies. In the 1983 contract, labor and management agreed to form a joint health care committee.

Committee Structure

Labor representatives to the committee include representatives from each of the five bargaining units represented by SEIU Local 715. Other county unions have participated intermittently. Management representatives include the employee benefits director, the employee health administrator, and staff. The employee health administrator and a union staff representative serve as co-chairs.

The committee meets at least quarterly and more often when necessary.

Actions Taken

First Steps to Contain Costs

When the committee began meeting, the county offered two indemnity plans. A Blue Cross-Blue Shield option was available to those employees who had enrolled before 1982, and a new self-insured plan was available for new employees and others who elected to switch into this plan. The major focus of committee action (and of this case study) is on efforts to strengthen the self-insured indemnity plan.

The committee was essentially educational in its first year,meeting weekly at times to interview other employers and to consider alternative strategies. From this process the first round of cost containment initiatives were developed. Based on committee recommendations, they were incorporated into the 1985 contract. They included:

- Pre-certification requirements for scheduled hospital admissions and concurrent review of hospital stays. The service was provided by a third-party contractor.
- Mandatory second opinions for designated procedures.
- Mandatory designated out-patient procedures.
- Creation of a position called employee health plan administrator. This person is employed by the county to supervise the cost containment programs and pursue additional options.

Second Stage of Cost Containment Programs

While these programs worked for several years, by 1987 costs again began to spiral, and the committee began to explore new approaches to contain costs. The committee explored a number of options. The following recommendations were negotiated into the 1987 contract:

- A preferred provider option.
- Claims auditing of doctor and hospital bills to identify excess and inaccurate charges.
- Bringing the case management, pre-certification, and utilization review programs in-house, under the direct supervision of the employee health plan administrator. In addition, this office added other responsibilities to ensure employees received quality, cost-effective care.

The Preferred Provider Plan

In 1988, as a result of committee recommendations that were negotiated into the contract, the self-insured plan adopted a preferred provider approach, called the Preferred 100 Plan. To encourage use of network providers, the plan fully reimbursed all costs for physicians, lab work, and certain surgical procedures when employees went to participating network providers. However, employees were required to pay 20 percent of the cost for these procedures at a non-network provider. (Previously, the indemnity plan required a 20 percent co-payment for all procedures.) Hospital stays were fully reimbursed.

The employee health administrator set up the PPO network. She negotiated reduced rates with area physicians and hospitals. The negotiated hospital rates resulted in average savings of $800 to $1,000 per day in the hospital. Employees whose family physician did not initially join the

network were asked to submit their physicians' names to the employee health administrator, who then contacted the physician to encourage joining the network.

In addition to seeking discounted fees, the plan rewards PPO family practitioners and internists with an enhanced payment for primary care, such as initial visits and routine exams. It found that this reduces the number of doctor visits, and also lowered attendant charges for laboratory and other diagnostic work commonly ordered on each visit.

In 1988, Blue Cross-Blue Shield (which covered older employees who had been grandfathered in since 1982), announced that it would cancel its plan the following year. The self-insured plan was immediately faced with a potential 40 percent premium increase as this large group of older employees moved into the self-insured plan.

Immediately, the labor-management committee mobilized to search for solutions. The committee met intensively to prevent rate increases in the PPO Preferred 100 Plan that would drive everyone into the HMOs.

It was at that point that the plan adopted the Service Area Incentive Program with even greater financial incentives to encourage employees to use participating providers. Enrollees were required to use participating facilities for 28 procedures. For those who went to non-network providers, coinsurance rates were raised to 30 percent, and deductibles and limits on pre-existing conditions were increased as well.

In return for expected savings, some employee benefits were added including an increase in the outpatient psychiatric benefit, a hearing aid benefit, and well baby care. In exchange for setting up the Service as an incentive PPO network, there was no increase in the employee share of dependent premium costs.

Bill Auditing

The competitive health care environment in California makes bill auditing particularly important in restraining the use of excessive and unnecessary procedures and technology. The county health plan administrator reviews all large bills and randomly selected smaller claims to identify inflated or inaccurate charges. In addition, the process has focused attention on specific areas in which health providers consistently order unnecessary treatments. This, in turn, has lead to changes in the indemnity plan's reimbursement structure and reinforced the need for a preferred provider hospital network. Employees are not responsible for bills by doctors after the health plan administrator has identified inaccurate or inflated claims. Examples of changes that resulted from bill auditing include:

- County bill auditors discovered that psychiatric institutions were inappropriately warehousing adolescents to take advantage of a generous mental health benefit. To curb this abuse, the labor-management committee recommended capping the dollar amount of the benefit, and the union negotiating committee agreed to accept the proposal in its contract. Since the cap took effect, no one has filed a claim that exceeded the benefit cap. The solution has worked so far.

- After the county adopted a flat fee for maternity cases, bill auditors discovered that local doctors began charging up to $500 per bill for lack of menstruation. Plan administrators notified providers that those charges were inappropriate and denied the claims. Members were protected from further billing by the doctors.

- Non-preferred hospital providers also added new charges to their claims such as wheeling patients to the operating room. Plan administrators caught this over-charge and refused to pay. Plan administrators also discovered excessive mark-ups as high as 450 percent by non-PPO hospitals for drugs, anaesthesia packs,and other items.

Plan administrators developed a good relationship with the insurance committee of the local medical society, which helped rein in doctors who charge significantly above the usual and customary rates.

The committee involved both labor and management in identifying and learning the importance of these abuses which increase plan charges. This paved the way for an agreement on mutually acceptable solutions such as the PPO requirement.

Expanding the Employee Base

In 1988, labor and management found yet another way to work together to contain costs and improve benefit coverage. At that time, SEIU Local 715, which represents employees of cities and school districts in Santa Clara County, learned that Blue Cross-Blue Shield planned to cancel these group policies. At the same time, Santa Clara County was interested in expanding the number of employees covered by its self-insured plan so it could negotiate even better rates with physicians and hospitals as part of its PPO network.

Labor and management, therefore, agreed to open enrollment in the county's self-insured plan to local governments and school districts that entered into an agreement with the county. Within two years, the num-

ber of covered employees increased from 800 to 4,500. This expanded employee base helped the county negotiate even greater rate reductions with PPO providers.

Evaluation

The various components of the committee's approach have kept costs down. For example, in the six-month period from July to December 1990, the self-insured indemnity plan showed contractual savings of $600,000 through using preferred providers. The strategy of keeping indemnity plan premium payments roughly competitive with HMO premiums has helped keep healthy, younger employees in the indemnity plan. Other measures of success include:

> Case management and concurrent review requirements produced average monthly savings of $10,000 to $15,000. County nurse practitioners who operate the review program have built up a rapport with local doctors that facilitates the job. The concurrent review process also identifies potentially expensive cases, and the health plan is flexible enough to permit innovative alternatives, such as home care. In one instance, the plan paid for a motel room (rather than a hospital room) during chemotherapy treatments for a patient who lived a long distance from the hospital.
>
> The expansion of the plan to include other employers meant a jump from 800 members in the self-insured plan in 1987 to 4,500 in fiscal year 1988-1989, offering increased leverage in negotiations with providers, and lower costs for both employers and employees.

Further, labor and management perspectives are identical on the value of the cooperative process in improving knowledge and communication on the health care issue, gaining acceptance of plan changes by employees, and controlling plan costs. Only resistance from providers and time constraints are mentioned as barriers to working together to control costs.

However, both labor and management are concerned that the "great peaceful interval" might be drawing to a close. Having tried most of the known cost containment initiatives, they are concerned that future cost increases might force them back to arguing over trading off salary increases for health benefits. Paid claims are up 20 percent in 1990-1991 over the previous fiscal year. (See Table 5.)

Future Actions

In addition to continuing to monitor data and expanding membership in the self-insured indemnity plan, the committee plans to re-evaluate the dental plan. The county tried a pre-paid dental plan which resulted in unsatisfactory patient care. The committee is exploring other ways to keep the dental plan affordable.

TABLE 5
Annual Health Care Costs — Santa Clara County

Year	Cost Per Employee	% Change Over Prior Year
1988-89	$2,256	
1989-90	$2,495	+ 10.6%
1990-91	$3,012*	+ 20.7%

*Pro-rated based on 10 months of data for 1990-91.
Source: Santa Clara County, Calif.

APPENDIX J

EXCERPTS FROM CONTRACT BETWEEN SANTA CLARA COUNTY AND ITS THIRD-PARTY ADMINISTRATOR

A. General

Contractor will provide the County with services for the administration and operation of the Plan.

The services provided by the Contractor will be coordinated by an account executive to assure effective and efficient operation of the Plan. In addition to coordinating all of the services of the Contractor, he will assist in identifying and resolving administrative, benefit payment, and communication problems and he will provide guidance and advise to the County on the operation of the Plan.

Consulting services to be provided by the Contractor include, but are not restricted to:

1) Advise and Assistance with development and design of the Plan, both initially and in connection with benefit revisions, additions, and extensions, including:

   A. general underwriting assistance and utilization projections,

   B. assistance with developing cost projections of the type and variety which would be applicable if the plan were insured,

   C. assistance in the preparation of descriptions for each of the benefit programs under the Plan;

2) Advise and Assistance with the enrollment of employees;

3) Advise on development, design, and installation of administrative and recordkeeping systems;

(2)

4) Advise on development, design, and installation of the benefit-account structure for the Plan which may be structured separately by class of employee and by subdivision, or subsidiary, or associated company of the County;

5) Advise and assistance in the following areas:

   A. Plan Coverage Document Preparation

   B. Plan Preferred Provider Agreement Preparation

   C. Plan Brochure Preparation

   D. Plan Preferred Provider Material Preparation

   E. Newsletter preparation for communication with employees on benefit matters

   F. Newsletter preparation for communication with Preferred Providers on PPO matters

   G. Annual Rate and Budget setting forecast

   H. Benefit change cost analysis

   I. Preferred Provider reimbursement analysis and fee change impact forecasts

   J. Plan utilization analysis

   K. Plan membership analysis by employee category type, sex and age

B. Relationship of Parties

The Contractor in performing its obligations under this Contract is acting only as agent of the County and the rights and responsibilities of the parties shall be determined in accordance with the law of agency except as otherwise herein provided. The County hereby delegates to Contractor authority to make determinations on behalf of the County with respect to benefit payments under the Plan and to pay such benefits, subject however, to a right of the County to review and modify any such determination. For the purposes of the Federal "Employee Retirement Income Security Act of 1974" and any applicable state legislation of similar nature, the County shall, however, be deemed the Administrator of the Plan. All final decisions affecting the Plan and it's ongoing management, and all resultant and contingent liabilities resulting from such aforementioned decisions remain the responsibility and liability of the County.

C. Audit and Final Authority on Plan Management

Randomly, ten (10) claims per Contractor Analyst per week will be audited for conformity to plan standards and eligibility. In addition, all claims submitted under this agreement will be audited that exceed the following:
Hospital: $25,000 Professional: $10,000 and Combined: $35,000

Authority and responsibility to affect benefit increases and reductions, to incorporate benefit disincentives, and to implement Managed Care Plan changes; provide and oversee arbitration involving claims disputes and offset expenses and representation relating to litigation matters relating to the Plan will be the

responsibility of the County with daily management of these matters in the hands of the County's Utilization and Review's; P.P.O.; Benefit, and Legal Management Divisions. All liabilities and financial expenses incurred within this management area will be retained by the County.

D) Financial Procedures

1) Plan Financing

Monthly and/or biweekly premium charges will be determined annually in an amount estimated by the County to be sufficient to cover expected, unexpected as well as deferred claims liability.

Plan premiums will be deposited in a Santa Clara County Health Care Trust Fund within the County Treasury. Those organizations whose payroll is prepared by Santa Clara County will make their payments via inter fund transfers on a payroll cycle basis. Those organizations which prepare their own payroll will forward their payments, made payable to the County, to the Contractor along with membership eligibility reports. The Contractor will forward the payment to the County for deposit.

The County treasurer will invest the amount on hand in the Trust Fund as part of the County Treasury Pool. Quarterly, the Trust Funds will receive a prorated share of the Treasury interest earnings based upon the Fund's average daily cash balance.

E. Plan Disbursements

Claims payments on all eligible medical expenses will be administered by the Contractor within a ten (10) day working period unless such claims, upon being received by the Contractor, are found to be incomplete, unidentifiable, or in need of further medical or eligibility investigation. Further, the County retains final authority at all times to require the Contractor to hold claims payment mailings and the Contractor agrees to abide by the County's instructions to withhold claims payment from Providers and Patients.

The Contractor will provide warrant issue information for bank reconciliation purposes to the County's warrant clearing bank.

Disbursements by Contractor issued warrants will be limited to the payment of claims. All administrative charges, will be billed to the County and payment made to the Contractor after acceptance by the County of the charges. Approved administrative charges will be paid within 25 days of invoice receipt by the County.

F. Fees

The following fees will be paid to the Contractor for all services performed pursuant to this agreement:

1. $10.10 per contract to the County's active and retiree enrollees
2. Fee increase adjustments by Contractor during the first three years of service to the County under this contract shall be limited to no more than five (5) percent per year.

G. Administrative Services Provision

The Contractor will provide the following:

1. Biweekly and monthly premium billing reconciliation using both E.D.P. tape interface and normal hardcopy premium billing along positive membership listing reporting lines. The Contractor will provide unlimited group account billings.

2. Full biweekly and monthly period eligibility recordkeeping services through use of membership applications.

3. Complete claims processing services including adjudication, processing, payment and communication.

4. Accounting of payments to claimants and employer.

5. Analysis of statistics and installation of systems and procedures to control specific situations.

6. Preparation and reporting of all required 1099 tax information on Tape meeting Federal Government format specifications. Preparation and reporting of all required 1099 tax information on Tape to meet all State Government format specifications. Production and printing of all original 1099 notices for all affected Providers and mailing of these notices to the Providers on or before January 31st of each year.

7. Full bank reconciliation and reporting (preferable via E.D.P. tape exchange) plus full audit trail ability on all system transactions.

8. Warrant draft, I.D. card and, form design.

9. System interface with Santa Clara County Government Utilization and Review Department and P.P.O. management staff.

10. Eligibility and claims information storage for minimum of two (2) years on line and seven (7) years off line.

11. Santa Clara County based claims processing and employee service center.

12. Underwriting review services on late adds attempting to come on plan via qualification through Medical Questionnaire.

13. Control of claims abuses.

14. Coordination of benefits

15. Third Party Lien filing and collection.

H. Special Required Services to be Provided by Contractor in Conjunction with Plan Administration

1. To assist the County's benefit staff with employee and provider communications on benefit matters, the Contractor will supply the County with three (3) computer terminals (or P.C.'s) and the software programs necessary to establish an electronic data communications interface link with the Contractor host computer location. Included in this shall be input access to Contractor computer employee

eligibility and claims history records, provider status and claims pay records, and group history income and expense records.

2. Contractor will load all current and future County benefit levels for processing of benefit plan transactions according to Plan Document coverage terms on its system.

3. Contractor will load the County's PPO network and payment schedules onto it's computer payment system. Contractor will provide for production of RVS type unit value assignments for all CPT codes not included in the RVS schedule listing so to meet the fee calculation requirements of County Contractual Agreements with its Preferred Providers in this area.

4. Owing to bargaining requirements, Contractor County Plan I Non-PPO payments will be based upon a 70th percentile of UCR determination. Again owing to bargaining requirements, Contractor Transit District Plan II Non-PPO payments will be based upon a 90th percentile of UCR determination. Contractor UCR's will be updated every 6 months. UCR determinations are to be computer enforced at time of entry so to create complete uniformity on application and must be available for application to all medical and lab or X-ray procedure services as well as to all surgical procedure services.

5. Plan expenses are supported through a setting of insured like employee charges for coverage. Currently a two and three rate premium charge structure is used for this purpose. Because of County accounting methods, rates are calculated on both a monthly and biweekly charge basis. Due to experience rating by grouping, there are

approximately 15 different rate charge levels in effect for the County.

In line with the above, separate individual billing by the following County group classifications will be provided by the Contractor for income and expense accounting purposes:

A. County Active Employee Bi-Weekly

B. County Active Employee Monthly

C. County Retiree Non Medicare Monthly

D. County Retiree Medicare Monthly

E. County Active Employee on Leave Monthly

F. County Terminated Employee Continuation Plan Monthly

G. County Terminated Employee COBRA Monthly

H. County Survivors Monthly

I. County Medicare Split Monthly

6. The Contractor will provide up to 20 sub-group JPA category billings (by similar employee category designation) on a monthly basis with a positive membership and premium listing to each sub-group along hard copy billed premium lines. The Contractor will also be responsible for premium collections from the sub-groups and forwarding of same to the County with full auditable accounting records on these

transactions. The Contractor will, in addition, be required by some sub-groups to bill and collect retiree health plan contributions to and from the State STRS and PERS Pension systems.

7. The County uses two outside service vendors for payment of prescription drug expenses incurred by Plan members. The vendors used for member drug services are PCS and Thrift Drug - Mailaway. The Contractor will supply these vendors with copies of their system membership eligibility records via EDP tape transmittal to the Drug vendors on a bi-weekly and monthly basis. Eligibility tapes will be formatted according to PCS and Thrift specifications at Contractor expense.

   Drug Plan I.D. Cards will be transmitted to the Contractor by the vendors for required Contractor mailing to Plan Members residence location.

8. Claims payment reimbursement to the Drug vendors for the Drug charges being incurred will be provided by the Contractor through computer reconciliation of a vendor supplied bi-weekly EDP tape listing member charges and payments. The tape will be run on the Contractor system for payment and for posting of individual claims charges to proper employee and employee group cost accounting records plus for recheck on member eligibility at time of service plus for check on possible duplicate billing of charges. Since drug co-pays are eligible for collection under Plan II major medical provisions, the tape is also used to post co-pay charges to a members claims history record so to gain automatic proper application to deductible credit and major medical payment reimbursement.

A bi-weekly claims payment check equal in amount to billed minus rejects will then be produced by the Contractor for the drug vendor along with a hard copy referencing claim payment by submitted employee purchase transaction plus rejects and reasons for same.

9. All claims payments issued will be on County Warrants designed to County specifications and will be drawn against a County specified Bank Account through the Bank of the West. A daily claims payment EDP Tape reflecting on Warrants issued will be supplied by the Contractor to Bank of the West for bank account reconciliation and audit purposes. Tape will be formatted to Bank of the West requirements with cost for same included in County base fee charge.

10. The Contractor system will be able to accept quarterly tape information from County's Worker's Compensation payor for sort against health plan payments in an effort to detect employee double dipping from both accounts. The programming costs for this activity is included in the Contractor's base fee.

11. The Contractor will provide hard copy printouts reflecting upon all tape recorded transactions.

12. The Contractor will provide service interaction with current and new JPA sub-group members. Service to be provided will be dissemination of information on Plan benefits and rates and attendance at coverage meetings on same. The Contractor will be the required prime contact point for the JPA unit on all Plan matters. Notice on

Plan coverage and annual rate changes will be handled by the Contractor.

13. The Contractor will provide interaction with present and new Preferred Provider members. Services shall consist of assisting County representatives in negotiating meetings with hospitals and professional groups on rate setting for services. Statistics from the Contractor claims system will be provided for analysis as an aid to the rate setting process. Additional time in Preferred Provider meetings will be provided to resolve any Preferred Provider problems with the Contractor or its systems. Assistance on sign up of new Preferred Providers and help with network maintenance and expansion will be provided by the Contractor.

14. The Contractor will, from membership records contained on its system, periodically supply the County with address stickers for mailing of Plan information to members and providers.

15. The Contractor will provide the County with daily pick-up and delivery courier service for purpose of necessary expediency in communication between the Contractor and the County and to meet time deadlines imposed by the County for many services.

16. The Contractor will provide the County with unlimited medical consultant review services on all normal questionable claim matters.

17. The Contractor will use personalized County Plan I.D. Cards bearing employees name identifying County and Contractor service locations in line with County specifications for each employee and dependent member. The Contractor will mail these cards along with a coverage description to each members home.

18. The Contractor will provide any special computer programming necessary to meet the exact present and future processing needs of the County.

19. In all instances not requiring special programming and on a reasonable need basis, the Contractor will provide all statistical information reports requested by the County.

20. The Contractor will at least annually mail other insurance and over age child dependent status questionnaires to employee homes as a means for cost control abuse in these areas.

21. The Contractor for COBRA and other legal purposes will notify the employee and the County (three months in advance of the event) of possible dependent child cancellation of coverage due to child reaching maximum age for coverage.

22. The Contractor will provide for assistance in case preparation and administrator's court time on impacted claims matters, and the Contractor will also provide for setting up of any arbitration proceedings on same.

23. The Contractor will provide a fully integrated claims pay and membership eligibility system so to gain maximum advantage for avoiding claims pay for services rendered before or after time of coverage.

24. The Contractor will provide a toll free "800" phone line service for use by Plan members.

25. The Contractor will provide a separate claims and phone service unit dedicated to Santa Clara County group members.

26. The Contractor will provide all assistance as may be required for program set up and management.

27. The Contractor will attend and provide help and advise in Plan management meetings on benefit administration matters.

I. <u>Administrative Requirements</u>

1. In the event of an overpayment of a claim made in error, the Contractor shall endeavor to recover the amount overpaid or paid in error. If recovery is not secured, notification shall be given to the County.

2. In the event of non-payment of claims on account of incomplete or insufficient data, the Contractor shall acknowledge such fact to the claimant within ten (10) working days from the receipt of the claim form no later than that time frame provided by the specific state insurance statute.

APPENDIX K

PHYSICIAN AND SURGERY SERVICES
SANTA CLARA COUNTY

Detail of Santa Clara County's Preferred 100 Plan members using PPO providers for physician and surgery services for a two-year period.

Physician And Surgery Services

We analyzed Santa Clara County's payments and utilization of the preferred provider organization (PPO) for the periods from April 1, 1991, to April 1, 1992, and April 1, 1992, to April 1, 1993, for the following services:

a. Physician Office Visits
b. Surgery Services

For the period from April 1991 to April 1992, members in the Preferred 100 Plan had 28,742 physician office visits of which 20,456, or 71.17 percent, were visits to PPO providers. The total payment for all physician office visits was $1,248,641 of which $941,762, or 75.42 percent, was to PPO providers.

For the period from April 1992 to April 1993, members in the Preferred 100 Plan had 24,939 physician office visits of which 18,371, or 73.66 percent, were visits to PPO providers. The total payment for all physician office visits was $936,390 of which $735,162, or 78.5 percent, was to PPO providers.

For the period from April 1991 to April 1992, members in the Preferred 100 Plan had 9,602 surgery services of which 5,754, or 59.93 percent, were done by PPO providers. The total payment to all PPO providers for the surgery services during this period was $2,091,738 of which $1,433,819, or 68.55 percent, was paid to PPO providers.

For the period from April 1992 to April 1993, members in the Preferred 100 Plan had 8,940 surgery services of which 5,635, or 63.03 percent, were done by PPO providers. The total payment to all PPO providers for the surgery services during this period was $1,768,976 of which $1,280,990, or 72.41 percent, was paid to PPO providers.

	April 1991 - April 1992			April 1992 - April 1993		
Physician Office Visit Services	**PPO**	**Non-PPO**	**PPO & Non-PPO Total**	**PPO**	**Non-PPO**	**PPO & Non-PPO Total**
Number of Visits	20,456	8,286	28,742	18,371	6,568	24,939
Payment	$941,762	$306,879	$1,248,641	$735,162	$201,228	$936,390
Average Annual Visits Per Contract	4.3	1.8	6.1	4.6	1.6	6.2
Average Annual Payment Per Contract	$199.15	$64.89	$264.04	$182.60	$49.98	$232.58
PPO Vs. Non-PPO Use	71.17%	28.83%	100%	73.66%	26.34%	100%
PPO Vs. Non-PPO Payment	75.42%	24.58%	100%	78.51%	21.49%	100%

	April 1991 - April 1992			**April 1992 - April 1993**		
Surgery Performance Services	**PPO**	**Non-PPO**	**PPO & Non-PPO Total**	**PPO**	**Non-PPO**	**PPO & Non-PPO Total**
Number of Visits	5,754	3,848	9,602	5,635	3,305	8,940
Payment	$1,433,819	$657,919	$2,091,738	$1,280,990	$487,986	$1,768,976
Average Annual Visits Per Contract	1.22	0.81	2.03	1.4	0.82	2.22
Average Annual Payment Per Contract	$303.20	$139.12	$442.32	$318.18	$121.21	$439.39
PPO Vs. Non-PPO Use	59.93%	40.07%	100%	63.03%	36.97%	100%
PPO Vs. Non-PPO Payment	68.55%	31.45%	100%	72.41%	27.59%	100%

APPENDIX L

SUMMARY OF THE ESTIMATED LOST DISCOUNTS
FOR THE PERIOD OF AUGUST 1, 1990, THROUGH AUGUST 31, 1994

	Lost Discount Amount
For the period of August 1, 1990, through April 30, 1992	$139,188*
For the period of May 1, 1992, through August 31, 1994	442,904**
Total	$582,092

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* The PPO Alliance Physician Reimbursement Schedule effective May 1, 1990, states:

> *For procedures identified in the 1974 CRVS as "by report" procedures, for procedures not identified in the CRVS, and for procedures for which relativity has not been established, reimbursement shall be at 90% of Provider's usual and customary billed charges, including Participant copayments and deductibles.*

In order to estimate the discounts lost for the period of August 1, 1990, through April 30, 1992, we analyzed the PPO procedures that were paid as billed for the first four months of 1992. The average monthly amount of discounts lost for these four months was $6,628. Applying this amount to the period of August 1, 1990, through April 30, 1992 (21 months), we estimate the discounts lost to be $139,188.

** The PPO Alliance Physician Reimbursement Schedule effective May 1, 1992, states:

> *For procedures identified in the 1974 CRVS as "by report" procedures, for procedures not identified in the 1974 CRVS, and for procedures for which relativity has not been established, reimbursement shall be at 80% of Provider's usual and customary billed charges, including Participant copayments and deductibles.*

The PPO Alliance Physician Reimbursement Schedule effective May 1, 1994, states:

> *For procedures identified in the 1974 CRVS/CPT Gap-Fill conversion factors as "by report" procedures, for procedures not identified in the 1974 CRVS/CPT Gap-Fill conversion, factors, and for procedures for which relativity has not been established, reimbursement shall be at 80% of Provider's usual and customary billed charges, including Participant copayments and deductibles.*

In order to estimate the discounts lost for the period of May 1, 1992, through August 31, 1994 (28 months), we analyzed the PPO procedures that were paid as billed for the period of May 1, 1992, through April 30, 1994 (24 months). The average monthly discounts lost for these 24 months was $15,818. Applying this amount to the period of May 1, 1992, through August 31, 1994, we estimate the discounts lost to be $442,904. We were unable to quantify the discounts lost after August 31, 1994, because FHPA said that Gap-Fill was installed in September 1994. The installation of Gap-Fill would significantly reduce the number of procedures paid without a discount.