Office of the City Auditor

Report to the City Council
City of San José

AUDIT OF THE EMPLOYEE MEDICAL BENEFITS

HR Needs to Improve Its Process for Identifying Employees Eligible for Medical Benefits, Estimating Premium Payments, and Accounting for Premium Contributions

HR Can Improve its Administration of Employee Medical Benefits

The City Should Consider Immediate Cost-Containment Reforms

The City Should Continue to Pursue Other Cost-Containment Strategies

Report 09-06
June 2009

CITY OF
SAN JOSE
CAPITAL OF SILICON VALLEY

Office of the City Auditor
Sharon W. Erickson, City Auditor

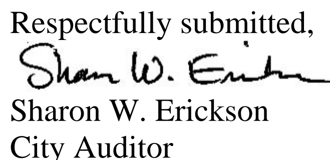
June 10, 2009

Honorable Mayor and Members
of the City Council
200 East Santa Clara Street
San Jose, CA 95113

Transmitted herewith is the report *Audit of the Employee Medical Benefits.* This report is in accordance with City Charter Section 805. An Executive Summary is presented on the blue pages in the front of this report. The City Administration's response is shown on the yellow pages before Appendix A.

This report will be presented at the June 18, 2009 meeting of the *Public Safety, Finance & Strategic Support Committee*. If you need any additional information, please let me know. The City Auditor's staff members who participated in the preparation of this report are Steven Hendrickson, Jorge Oseguera, and Michael Houston.

Respectfully submitted,



Sharon W. Erickson
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Office of the City Auditor

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City of San José

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Executive Summary

In accordance with the City Auditor's 2008-09 Audit Workplan, we have completed an *Audit of Employee Medical Benefits*. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We limited our work to those areas specified in the "Audit Objective, Scope, and Methodology" section of this report.

The City Auditor's Office thanks the Human Resources Department, the Department of Information Technology, the Retirement Services Department, the Finance Department, the Office of Employee Relations, and the City Attorney's Office for giving their time, information, insight, and cooperation during the audit process.

Finding I HR Needs to Improve Its Process for Identifying Employees Eligible for Medical Benefits, Estimating Premium Payments, and Accounting for Premium Contributions

The City's medical providers depend on the City to identify all employees and dependents who are eligible for medical benefits. The City's medical providers also depend on the City to calculate the correct amounts owed to the providers for the employees covered through the City's medical plans. However, we found that the amounts the City paid to the providers did not always match the amounts collected from employees and City departments for employees' medical premiums. Testing for the causes of the problem uncovered numerous contributing issues. Among these were:

- The City's practice of sending medical providers eligibility reports once a month is insufficient;
- HR fell behind on investigating past discrepancy reports from the medical providers;
- Terminated employees were not always processed timely;
- The City does not always collect outstanding premium contributions from employees on leaves of absence and terminated employees; and

- Reporting errors resulted in employees being excluded from payment estimate reports.

The Employee Benefits Division (Benefits) requested our assistance in determining recurring shortfalls in the City's Benefits Fund.[1] The Employee Benefits Division surmised that the shortfall could have been caused by unreconciled prior discrepancies, uncollected premium contributions, and premium overpayment to the providers. Given the many different factors that affected the accuracy of the City's billing, we agree with their assessment and believe a multi-pronged approach should be implemented to mitigate the problem.

RECOMMENDATIONS

We recommend the Human Resources Department:

Recommendation #1 **Establish a written procedure for submitting eligibility files and institute a single methodology to be used by Benefits staff to determine eligibility and premiums owed for both medical providers. (Priority 2)**

Recommendation #2 **Prepare and submit electronic eligibility reports to the medical providers at least twice each month. (Priority 2)**

Recommendation #3 **Produce the eligibility files in a format that can be analyzed by HR staff. (Priority 2)**

Recommendation #4 **Create an internal process for identifying discrepancies between the monthly eligibility report and the premium reports. (Priority 2)**

Recommendation #5 **Confirm whether any excess premium payments were made to Kaiser in 2008, and determine if other years' payments should be analyzed as well. (Priority 2)**

Recommendation #6 **Continue providing training to ensure HR liaisons are regularly and accurately reporting changes to employees' status. (Priority 3)**

Recommendation #7 **Coordinate with the Finance Department and IT to improve processes for collecting outstanding premiums. (Priority 2)**

[1] The Benefits Fund is Fund 160. Fund 160 pays for things such as vision and medical benefits, and the Employee Assistance Program.

We recommend the Human Resources Department:

Recommendation #8 **Continue monitoring the accuracy of the premium payment reports and modify the report if other issues are identified. (Priority 2)**

Finding II HR Can Improve its Administration of Employee Medical Benefits

The Human Resources Department's Benefits Division strives to provide employees with a wide array of high-quality, affordable and responsive benefits services, and to make accessing and utilizing these services as seamless and trouble-free to beneficiaries as possible. In an era of increasingly more expensive medical costs, it is imperative that employers efficiently administer their medical benefits programs. We have reviewed many aspects of the City's administration of employee medical benefits and have found several areas where improvements can be made. Specifically, we found:

- HR staff are operating without formal policies and procedures for administering employee medical benefits;
- HR's Benefits Division could more frequently verify the eligibility of full-time students; and
- The City should execute a formal contract with its benefits expert.

By addressing these areas of concern, HR will improve its ability to effectively administer its benefits program.

RECOMMENDATIONS

We recommend the Human Resources Department:

Recommendation #9 **Develop and implement a policies and procedures manual that includes data entry processes, preparing reconciliations, and documenting adjustments. (Priority 3)**

Recommendation #10 **Monitor the eligibility of college-aged dependents on a semi-annual basis. (Priority 2)**

Recommendation #11 **In structuring a contract with the City's medical expert, the City should compensate the selected expert directly. (Priority 3)**

Finding III The City Should Consider Immediate Cost-Containment Reforms

As medical expenses continue to rise, the City is pressured into identifying new strategies to minimize the impact of rising medical insurance costs. In considering cost-containment strategies, we identified some options that would result in cost savings to the City while minimally impacting employee benefits overall. Specifically, we found:

- The City can reduce costs by eliminating City-provided redundant medical coverage;
- The City can reduce costs by reducing payments through its Health In-Lieu Plan; and
- The City can save by implementing a retiree in-lieu program that results in fewer retirees covered by City-provided medical plans.

By focusing on these strategies, the City could preserve essential medical benefits while significantly reducing costs.

RECOMMENDATIONS

We recommend the Human Resources Department:

Recommendation #12 **Prohibit employees from being simultaneously covered by City-provided medical benefits as a City employee, and as a dependent of another City employee, and work with the Office of Employee Relations on potential meet-and-confer issues that such a change would present. (Priority 2)**

Recommendation #13 **Reduce cash in-lieu payment amounts, and work with the Office of Employee Relations on potential meet-and-confer issues that such a change would present. (Priority 2)**

Recommendation #14 **Prohibit participation in the Health In-Lieu Plan among City employees who are already receiving other City-provided medical benefits and work with the Office of Employee Relations on potential meet-and-confer issues that such a change would present. (Priority 2)**

We recommend the Retirement Services Department and the City Attorney's Office:

Recommendation #15 **Clarify the rights of City retirees to suspend and re-enroll in their medical benefits. (Priority 3)**

We recommend the Retirement Services Department and the Human Resources Department:

Recommendation #16 **Continue to explore an in-lieu program for qualified City retirees who suspend their medical benefits and work with the Office of Employee Relations on any potential meet-and-confer issues that such a change would present. (Priority 2)**

Finding IV The City Should Continue to Pursue Other Cost-Containment Strategies

Medical insurance expenses continue to increase at rates that exceed most public employers' revenue growth. The City's current cost containment strategies focus on annual independent actuarial reviews, regular competitive processes to minimize cost increases, and active participation with local coalitions to explore other risk reduction options. In addition, the City is also promoting healthy lifestyles through the Wellness Program in order to prevent chronic health problems and decrease healthcare utilization. Given the trend of steadily rising medical premiums, we believe the City should continue its cost-containment efforts and should consider further promoting cost-sharing among employees and pursuing alternative plan designs for employee medical benefits.

RECOMMENDATION

We recommend the City Administration:

Recommendation #17 **Pursue at least one or a combination of the aforementioned cost-containment strategies and work with the Office of Employee Relations on potential meet-and-confer issues that such a change would present. (Priority 2)**

Introduction

In accordance with the City Auditor's 2008-09 Audit Workplan, we have completed an *Audit of Employee Medical Benefits*. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We limited our work to those areas specified in the "Audit Objective, Scope, and Methodology" section of this report.

The City Auditor's Office thanks the Human Resources Department, the Department of Information Technology, the Retirement Services Department, the Finance Department, the Office of Employee Relations, and the City Attorney's Office for giving their time, information, insight, and cooperation during the audit process.

Background

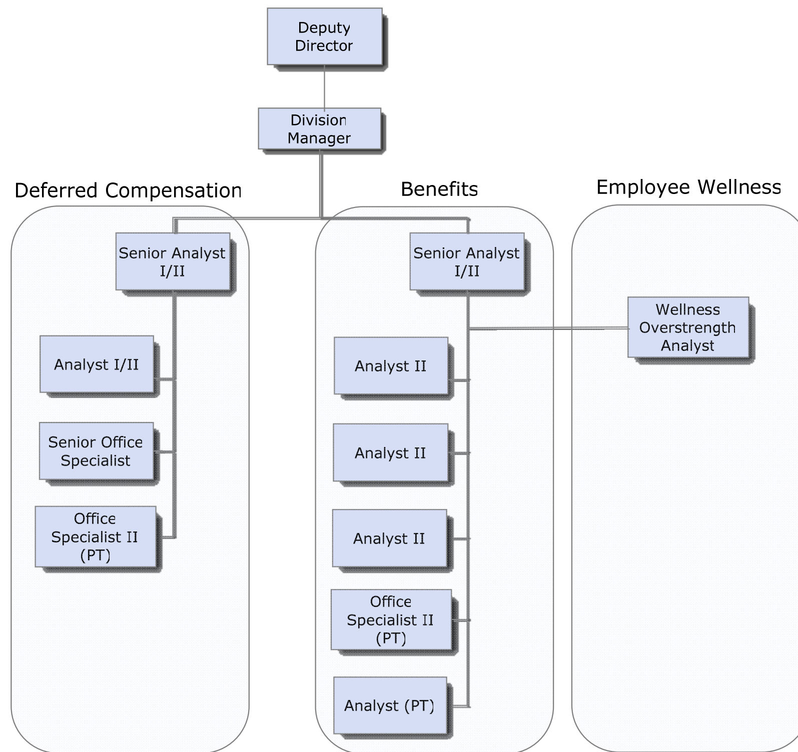
The Human Resources Department

The Human Resources Department's (HR) mission is "to attract, develop and retain a quality workforce." In fulfilling this mission, HR has four divisions: Employee Benefits, Employment Services, Health and Safety, and Workforce Resources and Diversity. The Employee Benefits Division seeks to "provide benefit programs that best meet the needs of employees, retirees, their dependents and the City, and assist participants to utilize their plans effectively."

HR's Employee Benefits Division provides a critical role in providing eligible City employees with fringe benefits. Specifically, the Employee Benefits Division manages the administration of employees' medical, vision, dental, and a variety of other benefits. The Employee Benefits Division is also responsible for selecting benefit providers and authorizing payments to them.

As of May 1, 2009, HR's Employee Benefits Division contained three subdivisions: Deferred Compensation, Benefits, and Employee Wellness. Together, these three subdivisions contained 13 positions as shown in the organization chart below.

Exhibit 1: Human Resources Employee Benefits Organization Chart



Source: Re-adapted by the audit team based on chart provided by HR's Benefits Division.

In 2006, HR led a competitive process to select medical providers. As part of that process, the Employee Benefits Division assembled a Review Committee consisting of representatives from HR, the Retirement Services Department, and other stakeholders. The Committee consulted with a private broker to draft the request for proposal (RFP). The Employee Benefits Division intends to ensure that City employees and retirees receive cost effective benefits by facilitating a competitive process about every four years.

Employee fringe benefit terms are negotiated between the various employee bargaining units and the City Manager (led by the Office of Employee Relations). Most of the negotiated terms for benefits under the distinct

bargaining units' contracts are similar, with a few differences such as differences in employee contribution levels, differences in co-pays, and differences in maximum allowable expenses.

The Benefits Review Forum (BRF) seeks to recommend benefit programs, facilitate approval on meet-and-confer issues, and communicate with participants in order for stakeholders to receive the maximum value from and understanding of the benefit programs. The BRF meets regularly throughout the year, and consists of representatives from HR staff, employee bargaining units, medical industry experts, the retirement boards, and the City Administration. We should note that the meet-and-confer process occurs separately and outside the BRF.

Medical Plans for City of San José Employees

To meet the medical needs of themselves and their eligible dependents, full-time and part-time benefited employees may enroll in their choice of four medical plans or a Health In-Lieu Plan.

- The Kaiser HMO plan is a group practice health organization which provides direct services through Kaiser Foundation hospitals, medical offices and physicians only.
- The Blue Shield HMO plan is a health maintenance organization that contracts with medical groups and facilities to provide medical services to its members.
- The Blue Shield PPO (preferred provider organization) plan is a two-tiered preferred/non-preferred provider health care plan in which members may choose from in- or out-of-network providers using a broader network of medical providers.
- The Blue Shield POS (point-of-service) plan is a three-tiered point of service health care plan that provides varying levels of coverage and offers participants the greatest freedom of choice—the ability to choose at any time among low-cost HMO providers, specialist PPO providers or out-of-network providers.

In 2008, roughly 9,000 active City employees and their dependents had medical coverage through a City-provided Kaiser medical plan, and roughly 5,300 active City employees and their dependents had medical coverage through a City-provided Blue Shield medical plan at a total cost of approximately $60 million.[1]

The Health In-Lieu Plan is an optional benefit plan that gives employees the ability to suspend City-provided medical coverage in exchange for cash. An employee who elects to participate in the Health In-Lieu Plan will receive 50 percent of the City's contribution to their respective lowest-cost medical plan. Taxable in-lieu payments are issued to eligible participants through their paychecks. The City's Health In-Lieu Plan document states "the City of San José reserves the right to amend or terminate the Plan at any time, subject however to applicable collective bargaining agreements." In 2008, about 900 City employees were enrolled in the City's Health In-Lieu Plan.

Most full-time City employees enroll in City-provided medical benefits. The City pays 90 percent, and employees pay 10 percent of the premiums of the lowest-cost City-provided medical plans (assuming it does not exceed the maximum employee contribution noted in the bargaining contracts). Employees' contributions are withdrawn from their paychecks on a semi-monthly basis. If an employee selects a plan other than the lowest-cost plan, the employee is required to pay the difference between the cost of the selected plan and the City's contribution towards the lowest-cost plan.

According to the City's Employee Benefits Handbook, employees and eligible dependents may use their selected health plans starting on the first day of the month following the date of enrollment. The employee will be given the date on which coverage takes effect during online enrollment or when Employee Benefits receives completed enrollment forms. Health coverage for employees or their dependents will end on the last day of the month in which benefits eligibility or enrollment terminates. Continuation of coverage is available under Consolidated Omnibus Budget Reconciliation Act (COBRA).

[1] These figures do not include approximately 3,500 covered retirees and the approximately $36 million associated cost to provide them with medical benefits. Retirees have access to similar medical benefit plans as those offered to active employees with additional options for those who qualify for Medicare. The Retirement Services Department administers retiree benefits.

Rising Costs of Medical Benefits

Medical providers use historical data outlined in "experience rating"[2] reports to project how much it will cost them to insure City employees. These experience ratings are derived from historical data of the group that will be served. The results of these experience ratings serve the basis for the premiums.

According to HR, City of San José employee medical premium expenses are increasing faster than the City's revenue growth because of several factors including longer life spans, the cost of prescription drugs, direct marketing to consumers of prescriptions, emerging technologies, cost shifting from uninsured to insured, and state and federal legislation. These conditions have been exacerbated by the increasing average age of employees.

As shown in Exhibit 2, total medical plan costs grew from $76 million in 2005 to $107 million in 2009.[3]

Exhibit 2: Medical Plan Costs Have Grown Over Time

	2005	2006	2007	2008	2009
Active Employees Estimated Cost					
Employer Kaiser Contribution	$ 27,553,470	$ 30,952,342	$ 30,547,549	$ 33,201,137	$ 33,967,800
Employee Kaiser Contribution	1,088,700	1,954,840	3,408,940	3,680,513	3,761,148
Employer BlueShield Contribution	14,143,986	16,406,232	17,794,936	19,057,620	19,071,702
Employee BlueShield Contribution	4,836,504	3,873,829	5,130,154	5,022,568	6,453,955
Employer Contribution to In-Lieu	3,269,581	3,966,623	4,096,089	5,041,050	5,600,402
Total	50,892,241	57,153,865	60,977,668	66,002,887	68,855,007
Retired Employee Estimated Costs					
Employer Contribution for Retirees	21,680,677	26,414,056	29,452,090	31,505,396	35,101,045
Retiree Contribution for Retirees	3,499,555	2,876,663	3,174,947	4,087,387	3,411,183
Total	25,180,232	29,290,719	32,627,036	35,592,784	38,512,228
Grand Total: City Medical Cost	$ 76,072,473	$ 86,444,584	$ 93,604,704	$ 101,595,671	$ 107,367,235
Percent Increase Over Prior Year		14%	8%	9%	6%

Source: Compiled by the audit team using estimated cost data provided by HR.

During the past ten years, the cost of medical premiums has steadily risen. However, until recently, employees did not necessarily pay the prescribed 10 percent employee contribution toward their medical premiums due to

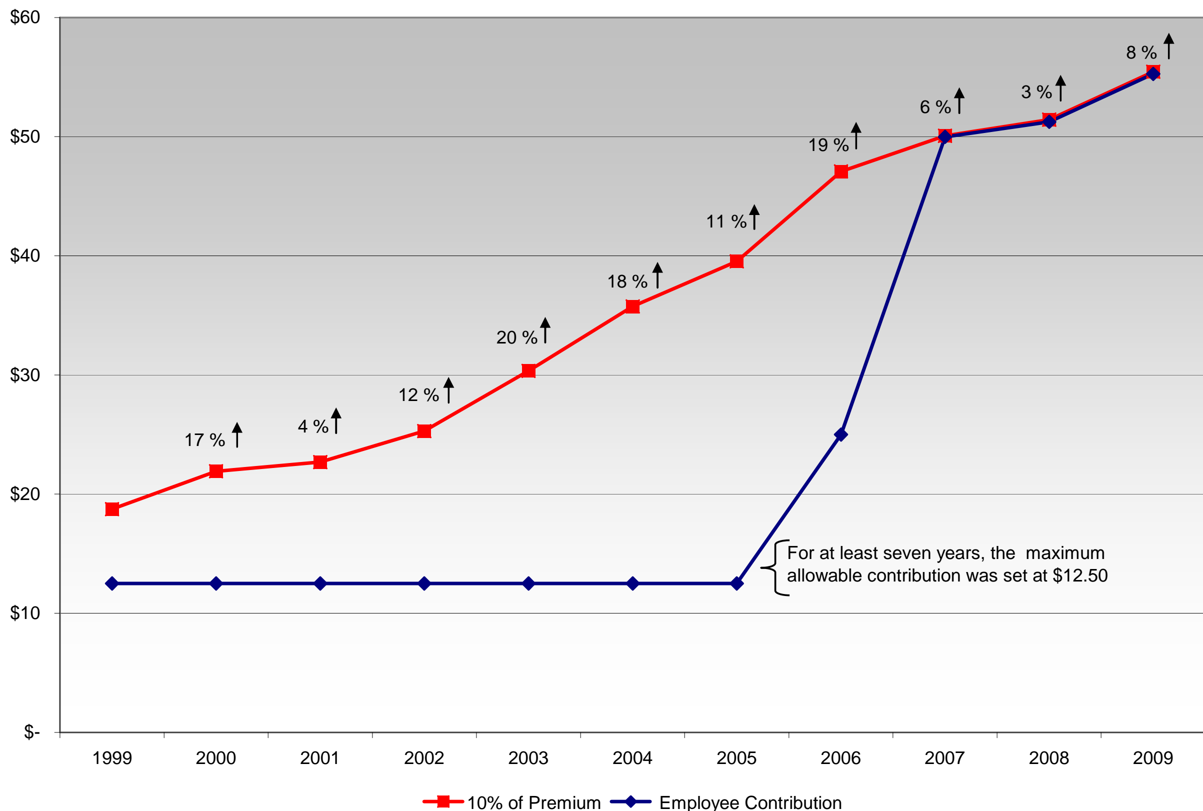
[2] According to the Handbook Of Employee Benefits, under an experience-rating arrangement, "the actual previous financial experience of the employer's plan is the basis for determining the future plan year's premium rates…the medical insurance premium charge is based on expected paid claims, inflation/utilization trend, underwriting margin, reserve adjustments, pooling charge and administrative costs…these factors cumulatively determines the experience-rated medical premium charge."

[3] The City's "2009 Health and In-Lieu Plan Semi-Monthly Rates" are attached in Appendix B.

negotiated maximum contribution limits. From 1999 to 2005, most of the employee contracts placed a limit of $12.50 per pay period for employee premium contributions. Exhibit 3 illustrates how the increase in medical premiums were primarily absorbed by the City prior to 2007.

Since 2005, the Office of Employee Relations has been working with employee bargaining units to more closely align employees' contributions to truly reflect 10 percent of the actual medical premiums. As a result of increased maximum contribution rates, in 2007 employees started paying the full 10 percent portion of their medical premium costs as shown in the Exhibit 3.

Exhibit 3: City Employees' Per Pay Period Contributions to Kaiser[4] HMO Family Plan Premiums: 1999 Through 2009



Source: Compiled by the audit team using past City rate sheets.

[4] The City of San José bases its premium contribution on the lowest-cost medical plan, which currently is the Kaiser HMO plan.

The Office of Employee Relations continues to work with the bargaining units to adjust the terms in the bargaining units' contracts. As shown in Exhibit 4, all but two of the bargaining units' contracts have eliminated the maximum allowable employee contribution limits. The two remaining bargaining units with limits have caps of $150 per month. However, under the current 90-10 premium split, employees do not hit the $150 contribution limit. We should note that the City is currently in negotiations with the two bargaining units that have $150 caps.

Exhibit 4: Monetary Caps to Employee Premium Contributions Have Phased Out

Bargaining Unit	2008	2009
Association of Building, Mechanical and Electrical Inspectors	no cap	no cap
Association of Engineers and Architects, IFPTE, Local 21, Units 041 & 042	$150	no cap
Association of Engineers and Architects, IFPTE, Local 21, Unit 043	$150	no cap
Confidential Employees' Organization, AFSCME, Local 101	$150	no cap
International Association of Firefighters, Local 230	$150	$150
International Brotherhood of Electrical Workers, Local No. 332	$150	no cap
International Union of Operating Engineers, Local No. 3	$150	$150
Municipal Employees' Federation, AFSCME, Local 101	$150	no cap
San Jose Police Officers' Association	$150	no cap
Bargaining/Employee Unit	2008	2009
Association of Maintenance Supervisory Personnel	$150	no cap
City Association of Management Personnel	$150	no cap
Unclassified Non-Management	$150	no cap
Executive Management & Professional Employees	$150	no cap

Source: Compiled by the audit team using information contained in the bargaining units' contracts and information provided by the Office of Employee Relations.

Despite rising medical costs, the City has been able to secure reasonable premium rates when compared to rates that other public-sector employers pay. We surveyed several large California public-sector employers with Kaiser HMO plans[5] and found that the City of San José's Kaiser premiums were comparable as shown in Exhibit 5.

Exhibit 5: Monthly Premiums Vary Across Employer-Provided Kaiser HMO Plans[6]

Region	Government Employer	Total Monthly Premiums		
		Single	2-Party	Family
Bay Area/Sacramento	CalPERS Bay Area	$508	$1,017	$1,322
	County of Santa Clara	$453	$950	$1,312
	City and County of San Francisco	$439	$876	$1,239
	County of San Mateo	$426	$856	$1,210
	County of Sacramento	$459	n/a	$1,175
	CITY OF SAN JOSÉ (most employees)	**$445**	**n/a**	**$1,109**
Los Angeles	CalPERS Los Angeles	$388	$776	$1,009
	City of Los Angeles	$376	$828	$978
Southern California	CalPERS Southern California	$425	$850	$1,105
	City of Riverside	$359	$696	$887
	City of San Diego	$291	$636	$883

Source: Compiled by the audit team using employers' medical plan descriptions. Amounts listed reflect premium rates effective January 2009.

HR's continued efforts to better position the City in the healthcare market should help the City retain competitive premium rates in the future.

[5] We reviewed employers that offered Kaiser plans because the City of San José bases its premium contribution on the lowest-cost medical plan, which currently is the Kaiser HMO plan.

[6] Comparing medical premium rates across different regions in the state is complicated due to inter-regional differences in the healthcare industry. Premium rates vary across state regions and may not be reflective of attainable rates.

Audit Objective, Scope, and Methodology

The objective of our audit was to identify ways to improve the administration of the employee medical benefits program and optimize employee medical benefits. Specifically, we evaluated: 1) HR's administrative practices; 2) the key features and costs of the City's medical benefit plans; 3) HR's process for determining employee eligibility; and 4) HR's payments to providers.

Our audit scope focused on calendar year 2008. In our review, we compared the benefit programs of several cities, counties, CalPERS and the California state government with those of the City of San José.[7] We obtained access to the City's PeopleSoft system to run pertinent reports for analysis. We created a database that consolidated over a year of HR's eligibility reports, estimated premiums-owed reports, and payroll reports. We also interviewed staff of the Human Resources Department, the Department of Information Technology, the Retirement Services Department, the Finance Department, the Office of Employee Relations, and the City Attorney's Office. We also interviewed personnel of other government entities and professionals in the health insurance field.

Our audit scope did not include a full eligibility audit, a workload assessment, or a reconciliation of all benefit expenses and premium payments. We should note that as City employees, the Auditor's Office staff participates in the medical benefits program we audited.

[7] We selected our sample based on the entity being located in California, the size of the entity, and being located near San José. The entities we selected for this report may differ from those the City would use in conducting other surveys.

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Finding I HR Needs to Improve Its Process for Identifying Employees Eligible for Medical Benefits, Estimating Premium Payments, and Accounting for Premium Contributions

The City's medical providers depend on the City to identify all employees and dependents who are eligible for medical benefits. The City's medical providers also depend on the City to calculate the correct amounts owed to the providers for the employees covered through the City's medical plans. However, we found that the amounts the City paid to the providers did not always match the amounts collected from employees and City departments for employees' medical premiums. Testing for the causes of the problem uncovered numerous contributing issues. Among these were:

- The City's practice of sending medical providers eligibility reports once a month is insufficient;
- HR fell behind on investigating past discrepancy reports from the medical providers;
- Terminated employees were not always processed timely;
- The City does not always collect outstanding premium contributions from employees on leaves of absence and terminated employees; and
- Reporting errors resulted in employees being excluded from payment estimate reports.

The Employee Benefits Division (Benefits) requested our assistance in determining recurring shortfalls in the City's Benefits Fund.[8] The Employee Benefits Division surmised that the shortfall could have been caused by unreconciled prior discrepancies, uncollected premium contributions, and premium overpayment to the providers. Given the many different factors that affected the accuracy of the City's billing, we agree with their assessment and believe a multi-pronged approach should be implemented to mitigate the problem.

[8] The Benefits Fund is Fund 160. Fund 160 pays for things such as vision and medical benefits, and the Employee Assistance Program.

Eligibility and Payment Reporting

The City is responsible for accurately identifying for the medical providers, individuals who are eligible to access care through the City-provided medical plans. To achieve this, the City, on a monthly basis:

1) Uses PeopleSoft[9] to identify employees currently enrolled in medical plans;

2) Generates a monthly electronic eligibility report that identifies these enrolled employees and dependents;[10]

3) Electronically submits the report to the medical providers; and

4) Bills itself based on a separate report that is also run monthly.

In order to estimate monthly premiums owed to the providers, the City determines the number of employees contributing to the first half of the month's premiums and doubles that amount.[11] Once all this information has been given to the provider, the provider then reconciles the eligibility report and the premiums-owed report and produces a discrepancy report which it sends to the City for confirmation. Discrepancies may include events such as: changes in rates, over- and underpayments, missed payments, and unreported changes in enrollment. The City investigates the discrepancies and reports back to the provider the status of the discrepancies.

The City's Practice of Sending Medical Providers Eligibility Reports Once a Month is Insufficient

Medical plan providers depend on the City to identify on a monthly basis, all employees and dependents eligible for medical benefits. The City sets the timing for running the eligibility report to the City's payroll cycle. Eligibility reports are generally processed monthly, on the day before the first payday of the month. Since the first payday of the month varies depending on the month, the eligibility run date varies as well.

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[9] PeopleSoft is a human resources management system that the City uses to administer employee benefits.

[10] Current eligibility reports are DAT files. DAT files are data files that have information listed in a text string organized by the number of characters in a data field. In order for this information to be useful for our analysis, we converted these files into Excel and then created an Access database.

[11] This practice assumes that all employees that are identified as having contributed their portion of medical premiums for the first half of the month will also contribute to the second half of the month. This practice does not facilitate adjustments for mid-month changes to enrollment.

The practice of reporting eligibility once a month creates spans of time during which employees who should not qualify for medical benefits are covered, and employees who should qualify for medical benefits are not covered. These scenarios are most frequently associated with employees who have separated from the City.[12] When employees separate from the City after eligibility is determined, the City may not collect the full premium from the employee prior to separation. This is due to the current process which notifies the carrier of employee eligibility before the full cost of monthly premiums have been collected through payroll deductions.

Suboptimal timing for producing the eligibility reports also resulted in employees not being included on the eligibility reports during months for which they had paid. We discovered instances in which employees separated from the City after already contributing to subsequent month's benefits. Some of these employees did not appear on the subsequent months' eligibility reports. In these instances, separated employees and employees on leaves of absence were at risk of being denied services for which they had paid.

During our review, we learned that other government entities submitted more frequent eligibility files. We interviewed one of the City's medical benefits representatives who suggested that sending eligibility to the provider more frequently than once a month would improve the providers' ability to more accurately monitor and reflect employee eligibility. If Benefits processed and submitted at least two eligibility files a month, it would improve the accuracy of the providers' information. According to the Human Resources Information Systems (HRIS) staff, running the electronic eligibility report only takes a few minutes per report.

We should also note that Benefits currently uses two different methodologies – one each for Kaiser and BlueShield – for determining employee eligibility and premiums owed for medical benefits.[13]

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[12] An employee's medical coverage begins on the first day of the month following the date of enrollment. Medical coverage will end on the last day of the month in which benefits eligibility or enrollment terminates.

[13] The Kaiser methodology estimates premiums owed based on the establishment of eligibility and the corresponding elected provider premium rate, where as the Blue Shield methodology estimates premiums owed based on the establishment of eligibility and whether an employee incurred a payroll premium deduction.

We recommend the Human Resources Department:

Recommendation #1

Establish a written procedure for submitting eligibility files and institute a single methodology to be used by Benefits staff to determine eligibility and premiums owed for both medical providers. (Priority 2)

Recommendation #2

Prepare and submit electronic eligibility reports to the medical providers at least twice each month. (Priority 2)

HR Fell Behind on Investigating Past Discrepancy Reports from the Medical Providers

As part of the monthly eligibility and payment process, the medical providers review the eligibility file and monthly payment information provided by the City, and produce discrepancy reports.[14] Although the providers submit monthly discrepancy reports, the Benefits Division fell behind on resolving the noted discrepancies. As a result, at the time of our audit, numerous over- and underpayments had not been identified or resolved.

Exhibit 6 shows our analysis of payroll premiums collected versus amounts paid to Kaiser and Blue Shield during the 2008 calendar year. Assuming that payroll premiums accurately reflected employee coverage, the City potentially underpaid Blue Shield by about $220,000 and overpaid Kaiser by about $140,000 for employee coverage in 2008.

[14] Kaiser Permanente provides a monthly reconciliation report which is a compilation of all prior discrepancies. Blue Shield provides a monthly discrepancy report that is solely based on the current month's reconciliation.

Exhibit 6: The City Potentially Overpaid Kaiser and Underpaid Blue Shield in 2008

Calendar Year 2008	Estimated Over / (Underpayments) to Kaiser				Estimated Over / (Underpayments) to BlueShield			
	HR Estimated Premiums Owed	Payroll Premiums Collected	Difference Between Owed and Collected Over / (Under)	Percent Difference	HR Estimated Premiums Owed	Payroll Premiums Collected	Difference Between Owed and Collected Over / (Under)	Percent Difference
January	$ 3,033,000	$ 3,023,790	$ 9,210	0.30%	$ 1,840,126	$ 1,986,713	$ (146,586)	-7.97%
February	$ 3,044,487	$ 3,034,353	$ 10,135	0.33%	$ 1,969,370	$ 1,988,851	$ (19,481)	-0.99%
March	$ 3,033,079	$ 3,027,209	$ 5,870	0.19%	$ 1,984,531	$ 1,986,394	$ (1,863)	-0.09%
April	$ 3,014,406	$ 3,002,006	$ 12,400	0.41%	$ 1,969,941	$ 1,971,054	$ (1,113)	-0.06%
May	$ 3,013,051	$ 3,010,140	$ 2,911	0.10%	$ 1,968,715	$ 1,966,497	$ 2,217	0.11%
June	$ 3,011,832	$ 3,000,865	$ 10,967	0.36%	$ 1,949,466	$ 1,961,997	$ (12,531)	-0.64%
July	$ 3,011,772	$ 2,983,776	$ 27,997	0.93%	$ 1,951,987	$ 1,953,233	$ (1,246)	-0.06%
August	$ 3,012,271	$ 2,996,576	$ 15,695	0.52%	$ 1,938,292	$ 1,970,348	$ (32,055)	-1.65%
September	$ 3,001,692	$ 2,991,666	$ 10,027	0.33%	$ 1,975,740	$ 1,977,740	$ (1,999)	-0.10%
October	$ 3,004,538	$ 2,995,992	$ 8,546	0.28%	$ 1,974,878	$ 1,977,857	$ (2,979)	-0.15%
November	$ 3,017,922	$ 3,006,972	$ 10,950	0.36%	$ 1,977,708	$ 1,976,101	$ 1,607	0.08%
December	$ 3,018,148	$ 3,000,699	$ 17,449	0.58%	$ 1,966,010	$ 1,972,324	$ (6,314)	-0.32%
Total	**$ 36,216,199**	**$ 36,074,043**	**$ 142,156**	**0.39%**	**$ 23,466,765**	**$ 23,689,108**	**$ (222,343)**	**-0.95%**

Source: Table compiled by the audit team using the City's eligibility reports and payroll reports. Dollar amounts are rounded to the nearest dollar.

In November 2008, Blue Shield made a claim against the City which included outstanding discrepancies dating back as far as 2005. The claim identified over $480,000 in underpayments and $50,000 in overpayments. The Benefits Division assigned staff to investigate the claim and reconcile the prior discrepancies identified in the claim. Staff were also directed to remain current on future discrepancy reports from Blue Shield.[15]

According to Benefits staff, providers allow the City to submit adjustments after the fact if errors are identified. However, HR does not currently have an internal process in place to identify discrepancies. Therefore, although the City may have incorrectly paid Kaiser in the past, no internal work is currently underway to identify potential past over- and underpayments to Kaiser. In order to complete such an exercise, Benefits would need to perform an exercise similar to the one performed in our audit, to identify past discrepancies. This would involve converting past eligibility reports from their current DAT file format (a stream of data), into a spreadsheet or table that Benefits staff could then use to compare to other City records and determine whether errors were made. A multi-year assessment of payments may be necessary.

[15] Prior to issuing this audit, HR staff completed the reconciliation of the outstanding Blue Shield discrepancies, and paid Blue Shield $253,907 for underpayments through 2008.

We recommend the Human Resources Department:

Recommendation #3

Produce the eligibility files in a format that can be analyzed by HR staff. (Priority 2)

Recommendation #4

Create an internal process for identifying discrepancies between the monthly eligibility report and the premium reports. (Priority 2)

Recommendation #5

Confirm whether any excess premium payments were made to Kaiser in 2008, and determine if other years' payments should be analyzed as well. (Priority 2)

Terminated Employees Were Not Always Processed Timely

When processing employee terminations, it is important that departments and HR coordinate their efforts. Currently, HR receives separation information from the departments and processes the submitted information. Providers are not notified of these changes in employee status until the following month when the City submits the eligibility reports to the providers. System restrictions prevent designating an employee as terminated until after their last paycheck has been processed. During the monthly reconciliation of eligibility, Benefits staff cancels the coverage retroactively.

However, while reviewing PeopleSoft records, we found instances in which separated employees and employees on leaves of absence remained on monthly eligibility reports even when they were no longer eligible for benefits. In one of these examples, an employee had separated from the City but was not recorded as terminated until two months later. As a result, the City paid for almost two months' of medical coverage for which the employee had not contributed.

HR staff meet regularly with the various HR Liaisons to provide updated direction on their day-to-day duties. However, there are no formalized procedures for reporting terminations. The guide currently in place is an "employee exit checklist" which is available through the HR intranet site. However, this guideline appears outdated and does not contain any timelines.

Improving interdepartmental coordination of employee leaves of absences and terminations should result in fewer eligibility and premium reconciliation issues.

We recommend the Human Resources Department:

Recommendation #6

Continue providing training to ensure HR liaisons are regularly and accurately reporting changes to employees' status. (Priority 3)

The City Does Not Always Collect Outstanding Premium Contributions from Employees on Leaves of Absence and Terminated Employees

Employees are required to fund a portion of their medical benefit premiums. When on some types of leaves of absence, employees who wish to retain their medical benefits need to submit payments for their contribution to medical premiums. However, according to HR, the City does not always collect employee contributions even though employees continued to receive medical benefits.

Benefits staff reported to us that employees are provided with written guidance for continuing their City-provided medical benefits while on leave, but employees do not always follow the premium submission instructions. For example, according to Benefits staff, employees on leave sometimes send contribution payments to the wrong place or employees start submitting premium contributions, but after several months, fall behind in submitting premiums. Once an employee returns from a leave of absence, the City can deduct from the employees' paychecks any past-due contributions for medical premiums. However, the City does not have in place a process for collecting past-due contributions for employees who are on leave and never return to work.

Furthermore, Benefits staff does not have a formalized practice in place to identify and collect premiums from terminated employees who did not pay for their entire month's premium prior to termination. As a result, the City may be owed by former employees for past-due medical premium contributions. The uncollected premiums would be owed by departments and by employees for their respective portions of uncollected premiums. Benefits staff report that staffing constraints have prevented them from completing timely billing reconciliations and pursuing collection of outstanding amounts. It may be possible that the PeopleSoft system can be programmed to assist with some of the premium billing to former employees.

We recommend the Human Resources Department:

Recommendation #7

Coordinate with the Finance Department and IT to improve processes for collecting outstanding premiums. (Priority 2)

Reporting Errors Resulted in Employees Being Excluded from Payment Estimate Reports

Currently, the City pays its monthly medical premiums to the providers by doubling the amount shown on the premium payment report for the first half of the month. First, absent a strong reconciliation process, it is unusual to pay based on an estimate. Second, during our review, we identified errors in the premium payment report. Although for most months, the estimated amounts owed differed from the amounts collected through payroll by less than 1% as shown in Exhibit 6, the premium payment report for January 2008 omitted over 100 employees who were eligible for benefits. This error resulted in the City underpaying Blue Shield for January by almost $150,000.

We also noticed that when an eligibility report was run on the first day of the month, the report failed to capture all eligible employees. When we asked about the cause of the errors, IT was unable to determine the specific cause for the reporting errors.

We discussed our concerns with HR, and with the help of IT, HR has already begun making changes to mitigate or eliminate some of the errors we identified. For example, in October 2008, IT made adjustments to the payment reports in an attempt to improve their accuracy. Subsequent testing showed significant improvements in the accuracy of the monthly estimated premiums owed. However, we believe additional testing and monitoring is necessary to ensure the continued accuracy of the report.

We recommend the Human Resources Department:

Recommendation #8

Continue monitoring the accuracy of the premium payment reports and modify the report if other issues are identified. (Priority 2)

Finding II HR Can Improve its Administration of Employee Medical Benefits

The Human Resources Department's Benefits Division strives to provide employees with a wide array of high-quality, affordable and responsive benefits services, and to make accessing and utilizing these services as seamless and trouble-free to beneficiaries as possible. In an era of increasingly more expensive medical costs, it is imperative that employers efficiently administer their medical benefits programs. We have reviewed many aspects of the City's administration of employee medical benefits and have found several areas where improvements can be made. Specifically, we found:

- HR staff are operating without formal policies and procedures for administering employee medical benefits;
- HR's Benefits Division could more frequently verify the eligibility of full-time students; and
- The City should execute a formal contract with its benefits expert.

By addressing these areas of concern, HR will improve its ability to effectively administer its benefits program.

HR Staff Are Operating Without Formal Policies and Procedures for Administering Employee Medical Benefits

It is essential that clear and precise policies and procedures be in place in order to ensure smooth and consistent operation in an organization's day-to-day activities, such as data entry, reconciliations, and adjustments. Policies and procedures allow employees to understand their roles and responsibilities within predefined limits which offer management the opportunity to guide operations without constant intervention. However, we found that the Benefits Division does not currently have formal polices and procedures. Instead, they have a compilation of informal documents which appear to be incomplete and outdated. We learned that Benefits staff rely on word-of-mouth direction and on-the-job training to learn how things operate. Without formal policies and procedures, HR runs the risk of inconsistently carrying out day-to-day activities.

We recommend the Human Resources Department:

Recommendation #9

Develop and implement a policies and procedures manual that includes data entry processes, preparing reconciliations, and documenting adjustments. (Priority 3)

HR's Benefits Division Could More Frequently Verify the Eligibility of Full-Time Students

The City requires that dependents of active employees who are between 19 and 24 years of age provide evidence of full-time student status at an accredited college, university, or technical, trade or occupational school to retain their dependent medical coverage. In 2008, the City extended medical benefits to approximately 250 college-age dependents.

Currently, the City accepts evidence of enrollment during the fall term of the year in which Open Enrollment occurs, or the spring term of the year of eligibility. If the employee provides evidence of the dependent's enrollment for the fall 2008, the dependent is covered for the entire calendar year 2009. This practice exposes the City to the possibility of covering for up to 12 months, employees' dependents who have lost their full-time student status.

The City's Retirement Services Department requires City retirees to submit evidence of their dependents' full-time student status twice a year, during the fall and spring, to qualify for medical benefits. By so doing, Retirement Services reduces the possibility of covering for a full year, dependents who no longer have full-time student status, and would otherwise not qualify for City medical benefits.

Like City retirees, active employees should also be required to submit evidence of their dependents' full-time student status twice a year. Doing so would further improve the City's ability to avoid paying for dependents who have lost their full-time student status. See "Alternative Schedule" in Exhibit 7.

Exhibit 7: Schedules for Verifying Eligibility of Full-Time Student Dependents

		2008					2009											
		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Active Employees	Fall Term																	
	Open Enrollment																	
	Deadline to Submit Fulltime Student Status					1st												1st
	Eligible For Benefits						1	2	3	4	5	6	7	8	9	10	11	12
Retired Employees	Fall Term																	
	Open Enrollment																	
	1st Deadline to Submit Fulltime Student Status					1st												1st
	Eligible For Benefits						1	2	3	4	5	6	7	8				
	Spring Term																	
	2st Deadline to Submit Fulltime Student Status													31st				
	Eligible For Benefits														1	2	3	4
Alternative Schedule	Fall Term																	
	Open Enrollment																	
	1st Deadline to Submit Fulltime Student Status					1st												1st
	Eligible For Benefits						1	2	3	4	5	6						
	Spring Term																	
	2nd Deadline to Submit Fulltime Student Status											30th						
	Eligible For Benefits												1	2	3	4	5	6

Source: Compiled by the audit team using verification timelines for active and retired City of San José employees.

Furthermore, removing dependents who should not be covered by City-provided medical benefits may potentially improve the City's experience rating, and ultimately reduce its medical costs.

We recommend the Human Resources Department:

Recommendation #10

Monitor the eligibility of college-aged dependents on a semi-annual basis. (Priority 2)

The City Should Execute a Formal Contract with its Benefits Expert

Many cities turn to the services of benefit consultants, agents or brokers to assist with decisions related to medical benefits. Like other public-sector employers, the City has been using the services of a benefits broker for a number of years.

In 2005, the City issued a Request for Proposals (RFP) to select a new benefits expert. The City received 11 proposals to the RFP. From this process, the selection committee recommended SST Benefits Consulting to

represent the interests of the City in managing the City-provided employee benefit plans. According to HR, the City's benefits broker provides services to the City that assure participants will have ongoing access to high quality, nationwide, effective benefit care and coverage. The broker also augments the City staff by assisting in managing the insurance carrier policies, analyzing experience trends, resolving disputes with providers, benchmarking, and providing legal updates.

However, the City currently does not have a written contract with the broker. As the broker of record, the broker receives compensation directly from the health plan in return for servicing the client needs. The broker's compensation is currently incorporated in the premiums that the City pays for medical benefits. According to HR, this method of compensation is standard practice in the insurance industry. Although we have no reason to believe that this arrangement has negatively impacted the broker's ability to provide the City with excellent service, we should caution that the potential for perceived conflicts of interest exist given that the providers pay the broker directly and that the broker's compensation is directly related to the number of enrolled beneficiaries.

According to the Wall Street Journal, it is not uncommon for a broker to be compensated through a flat fee paid for directly by the employer. Also, it would be prudent for the City to engage in a written contract with the provider. This alternative arrangement would help address potential perceived conflict of interest. In addition, by securing a contract with a broker, the City could include in the contract some incentives to reward performance.

We recommend the Human Resources Department:

Recommendation #11

In structuring a contract with the City's medical expert, the City should compensate the selected expert directly. (Priority 3)

Finding III The City Should Consider Immediate Cost-Containment Reforms

As medical expenses continue to rise, the City is pressured into identifying new strategies to minimize the impact of rising medical insurance costs. In considering cost-containment strategies, we identified some options that would result in cost savings to the City while minimally impacting employee benefits overall. Specifically, we found:

- The City can reduce costs by eliminating City-provided redundant medical coverage;
- The City can reduce costs by reducing payments through its Health In-Lieu Plan; and
- The City can save by implementing a retiree in-lieu program that results in fewer retirees covered by City-provided medical plans.

By focusing on these strategies, the City could preserve essential medical benefits while significantly reducing costs.

The City Can Reduce Costs by Eliminating City-Provided Redundant Medical Coverage

The City is committed to providing employees and their dependents with medical benefits, and it strives to do so in a way that fulfills the needs of employees. During our review, we observed instances in which City employees were simultaneously receiving benefits as an employee and as a dependent of a City employee (City-provided redundant coverage).

Exhibit 8 outlines examples of City-provided redundant coverage scenarios. Ideally, two City employees who qualify as each other's dependents would subscribe to one family plan to cover their medical needs; such coverage costs the City $11,980 per family (as shown in Scenario 1 in Exhibit 8). However, we found that some City employees who could have been covered by just one family plan, enrolled in two separate family plans, costing the City twice as much ($23,960, as shown in Scenario 3 in Exhibit 8).

Exhibit 8: Redundant Medical Coverage Creates Excess Premium Costs to the City

Hypothetical Households with 2 City Employees (2009 City Contributions)			Annual Costs to the City
Scenarios	Coverage #1	Coverage #2	
Scenario 1	Family Medical	None	$11,980
Scenario 2	Single Medical	Family Medical	$16,790
Scenario 3	Family Medical	Family Medical	$23,960

Source: Scenarios compiled by the audit team using 2009 premium contribution rates.

Redundant coverage among City employees is due to the fact that the City does not discourage nor prohibit employees from pursuing such coverage. Other California public-sector employers explicitly prohibit it. For instance, CalPERS deals with the redundant coverage issue by stating: "*Dual CalPERS coverage occurs when you are enrolled in a CalPERS health plan as both a member and a dependent or as a dependent on two enrollments. This duplication of coverage is against the law. When dual CalPERS coverage is discovered, the enrollment that caused the dual coverage will be retroactively canceled. You may be responsible for all costs incurred from the date the dual coverage began*."

The County of Santa Clara similarly prohibits redundant coverages: *"If you and your spouse or partner are both County employees, only one employee is allowed to carry health plan coverage. One employee may choose to enroll in family coverage and the other employee must waive their health plan coverage and be enrolled as a dependent."*

Like these other public-sector employers, the City should prohibit redundant medical coverage. We estimate that in 2008, about 50 two-City employee households may have received City-provided redundant coverage at an estimated total cost of about $500,000[16] in additional premiums. Eliminating redundant coverage therefore could save up to $500,000 during the first year of implementation. Eliminating redundant coverage will also reduce the claims experience which occurs through coordination of benefits. In addition to the excess premium costs, redundant coverage by two City-provided medical plans increases City costs by raising treatment limits and reducing co-pays. Future impacts on premiums would depend on actual claims experience.

We recommend the Human Resources Department:

Recommendation #12

Prohibit employees from being simultaneously covered by City-provided medical benefits as a City employee, and as a dependent of another City employee, and work with the Office of Employee Relations on potential meet-and-confer issues that such a change would present. (Priority 2)

[16] This estimated amount is based on the Audit team's analysis of employees' addresses. We should note that some of these City employees may not qualify as dependents of each other, and may include instances in which City employees are roommates, siblings, or are using common addresses. We should also note that we were unable to identify all of the potentially double-covered households due in part to inconsistent address entries, and employees' use of addresses other than their actual residences.

The City Can Reduce Costs by Reducing Payments Through its Health In-Lieu Plan

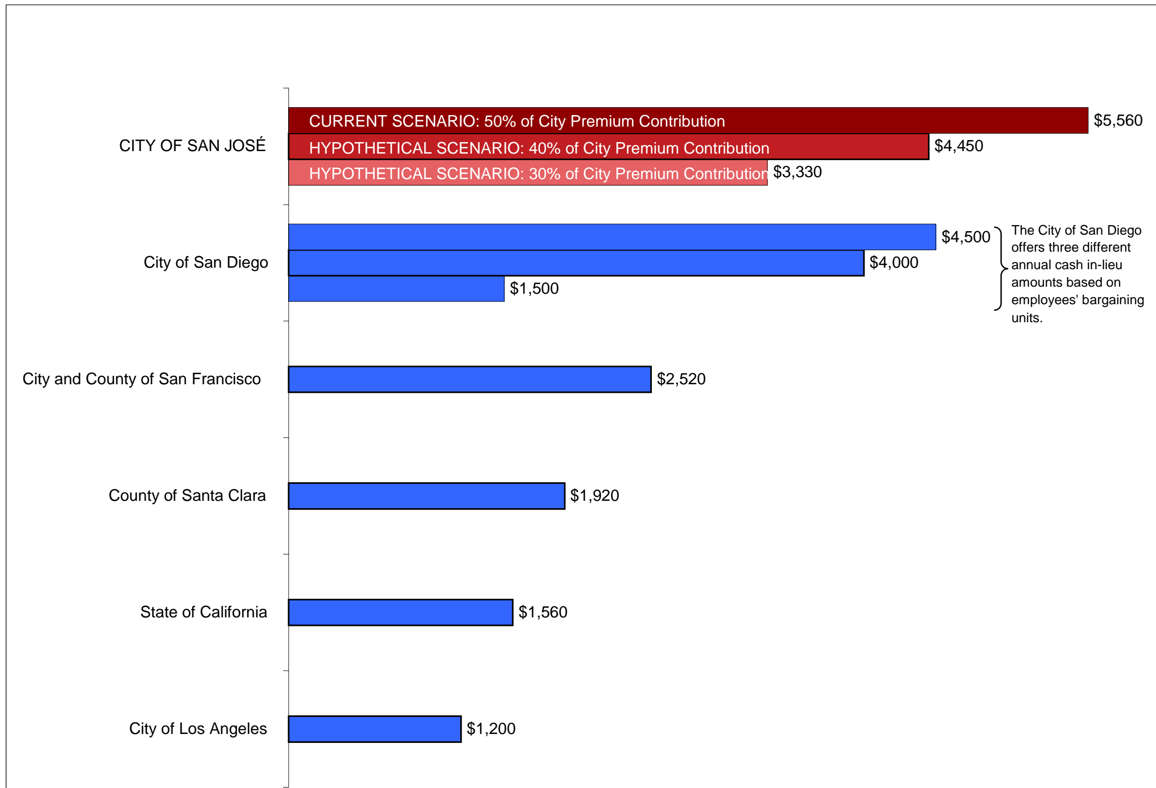
The Health In-Lieu Plan is an optional benefit plan that allows employees to forgo City-provided medical coverage in exchange for cash, as long as employees can demonstrate evidence of alternative coverage. The Health In-Lieu Plan was implemented as a cost-savings measure that would mutually benefit employees and the City. The benefit provides employees who suspend City-provided medical coverage with a cash payment equivalent to 50 percent of what the City would have otherwise paid toward employee medical benefits. For example, if the City normally pays $10,000 toward an employee's medical premium annually, those who participate in the plan would receive cash payments totaling $5,000 per year, and the City would save $5,000 per year.

In 2008, the City paid about 900 participants approximately $5 million in cash payments through the Health In-Lieu Plan, with the typical participant receiving $5,560 per year. This payout was greater than those offered by other public-sector employers. Among comparable California employers with in-lieu benefits, none offered participating employees a cash payout as large as ours. In fact, as shown in Exhibit 9, the City of San José's in-lieu rate was 24 percent higher than that of the next highest-paying in-lieu program offered by comparable California public-sector employers.

We believe the City's in-lieu payments should be more in-line with those of comparable employers.[17] If the City were to reduce its in-lieu payout to 40 percent of the City's contribution rate, the typical annual payout would be $4,450 and thereby save the City $1 million. If the City were to reduce its in-lieu payout to 30 percent of the City's contribution rate, the typical annual payout would be $3,330 and thereby save the City $2 million.

[17] The average in-lieu payment in Exhibit 8 is $2,877. The average reflects the highest annual payment totals per employer.

Exhibit 9: The City of San José's Annual In-Lieu Payments Exceed Those of Other California Public-Sector Employers



Source: Chart compiled by the audit team per 2008 in-lieu payments of surveyed public-sector employers (family coverage).

As shown in Exhibit 9, either one of these scenarios would still result in in-lieu payments that are greater than those offered by most of the employers we surveyed.

The City's current in-lieu participation rate is about 14 percent of medical benefits-eligible employees. Should the City pursue a reduction in the in-lieu payment, it should be careful not to lower payments to the point that significantly reduces the demand for the Health In-Lieu Plan. In implementing an in-lieu payment reduction plan, the City may consider incrementally reducing in-lieu payments. After considering the effect on the demand for the program, it could phase in additional reductions until it reaches the optimal participation and savings rates.

We recommend the Human Resources Department:

Recommendation #13

Reduce cash in-lieu payment amounts, and work with the Office of Employee Relations on potential meet-and-confer issues that such a change would present. (Priority 2)

The City Can Reduce Costs by Prohibiting Participation in the Health In-Lieu Plan by City Employees Who Are Already Receiving City-Provided Medical Benefits

Ideally, all of the City's Health In-Lieu Plan participants would have medical coverage only through plans outside of the City's benefits program. However, we estimate that in 2008, approximately 110 of those participants were also covered by a City-provided medical plan as a dependent of another City employee. Allowing this practice diminishes the intended benefit to the City of having the Health In-Lieu Plan and results in higher medical costs to the City. For example, households with two City employees who enroll in both a City family medical plan and the family Health In-Lieu Plan cost the City approximately $17,540 per year. In contrast, a two-City employee household that is covered by a City-provided family medical plan costs $11,980 per year. By allowing this practice, the City spends approximately $5,770 more for a two-City employee household that elects both a family medical plan and a family Health In-Lieu Plan, than it would otherwise spend.

Because City employees should be disallowed from being covered by two separate City-provided medical plans (as we discuss in the earlier section on City-provided redundant medical coverage), the Health In-Lieu Plan should not be available to City employees whose medical coverage is already being provided by the City.

The County of Santa Clara addresses this problem by prohibiting employees who are covered by a County medical plan either as an employee or as a dependent from participating in its "Health Care Bonus Waiver Program." Specifically, Santa Clara County directs: "*An employee who is married to or is a partner of another County employee and both employees have one medical plan between them are not allowed to participate in the Health Care Bonus Waiver Program.*"

The California State University has similar language in its description of benefits: *"You are not eligible to participation in FlexCash if you are covered for medical and/or dental as a dependent of another CSU employee or retiree."*

If the City restricts participation in the City's Health In-Lieu Plan to only those who can demonstrate medical coverage through a medical plan outside of the City, the City would reduce its costs by over $500,000 per year.

We recommend the Human Resources Department:

Recommendation #14

Prohibit participation in the Health In-Lieu Plan among City employees who are already receiving other City-provided medical benefits and work with the Office of Employee Relations on potential meet-and-confer issues that such a change would present. (Priority 2)

The City Can Save by Implementing a Retiree In-Lieu Program that Results in Fewer Retirees Covered by City-Provided Medical Plans

After 15 years of service with the City, employees become eligible for lifetime medical benefits when they reach qualifying retirement age. However, some retirees do not need the City's coverage because they qualify for medical benefits through an employer other than the City. Like active employees, retirees with comparable non-City medical coverage could benefit from a program that provides them with an incentive to suspend City-provided medical benefits in exchange for an in-lieu reimbursement.

Barriers to Implementing an In-Lieu Program for Retirees

Retirees have been interested in pursuing a retiree in-lieu program for some time. Restrictions on the use of retiree medical funds have prevented any progress to develop such a program. Internal Revenue Code Section 401[18] restricts the use of retiree medical funds only for retiree medical expenses. As such, using retiree medical funds to provide retirees with cash payments is not a viable option. However, during an interview with a current retiree, it became clear that unrestricted cash payments was not the only alternative to meet the need of retirees. Specifically, we believe there is potential for an in-lieu program that reimburses retirees for qualified medical expenses.

Retirees would be more likely to suspend City medical benefits if they were given some kind of incentive to suspend benefits and were given assurance that they could re-enroll after a qualifying event. For example, during our review, we were approached by a City retiree who is receiving medical

[18] Section 401(h) of the Code permits a pension or annuity plan to provide for payment of benefits for sickness, accident, hospitalization and medical expenses for retired employees, their spouses and dependents.

coverage through two former employers, the U.S. Government, and the City of San José. This retiree preferred the coverage sponsored by the U.S. Government, but he is not motivated to suspend or waive his City-provided medical benefits. He mentioned that if the City provided him with enough money to cover his portion of contributions to the coverage provided by the U.S. Government, he would be motivated to dis-enroll from the City-provided medical benefits. In this case, a monthly payment of $100 would cover the expenses he personally incurs to sustain his U.S. Government-sponsored medical benefits. This $100 per month would have been sufficient incentive to persuade him to suspend City benefits, and pales in comparison to the $1,000 per month in premium contributions the City is paying for the medical coverage which he currently does not use. This arrangement could potentially address the limitations of Internal Revenue Code Section 401.

A Perceived Lack of Flexibility in Suspending and Re-Enrolling in Medical Benefits

Even if the City was successful in developing a vehicle for a retiree in-lieu program, we learned that retirees would need assurance that they can temporarily suspend and re-enroll in their medical benefits, should they lose their alternative coverage. During our review, we learned that some retirees are concerned that if they choose to suspend their medical benefits, they may lose the right to re-enroll in the City's benefit plans. Any retiree in-lieu program needs to be accompanied by clear enrollment/suspension procedures, so that prospective participating retirees are assured that if they suspend their medical benefits, they can re-enroll at any time. We learned that there is uncertainty on the part of staff of the Retirement Services Department about the ability for retirees to temporarily suspend medical benefits.

We recommend the Retirement Services Department and the City Attorney's Office:

Recommendation #15

Clarify the rights of City retirees to suspend and re-enroll in their medical benefits. (Priority 3)

A Possible Method for Creating a Medical In-Lieu Program for Retirees

A retiree in-lieu program would be limited to retirees who can demonstrate alternative group medical coverage through plans not sponsored by the City, and who choose to suspend City-provided medical insurance coverage in exchange for retiree in-lieu reimbursement. Such a program would incentivize retirees who are already covered elsewhere to suspend their City-provided insurance by paying the premiums and co-pays for their alternate insurance coverage not to exceed a pre-determined reimbursement limit. The source of the reimbursements would be the same funds used for paying retiree medical expenses. Reimbursement limits would be large enough to incent retirees to suspend their City-provided benefits, but lower than the amounts the City would otherwise pay toward these retirees' medical premiums. By structuring the retiree in-lieu program in this manner, we believe the City would remain compliant with IRS' restrictions on the use of retiree medical funds while accommodating retirees with unnecessary double coverage and achieving cost savings for the City.

An in-lieu program for retirees could save the City substantially in annual retiree medical expenses, and may also improve the City's projected long-term retiree healthcare liability. Currently, there are over 3,500 retired employees with City-provided medical benefits. If just 50 current retirees elected to participate in a retiree in-lieu program, we estimate the City could save over $250,000 annually. If 200 retirees were to participate in such a program, we estimate the City could save over $1 million per year in retiree medical benefit costs.

We recommend the Retirement Services Department and the Human Resources Department:

Recommendation #16

Continue to explore an in-lieu program for qualified City retirees who suspend their medical benefits and work with the Office of Employee Relations on any potential meet-and-confer issues that such a change would present. (Priority 2)

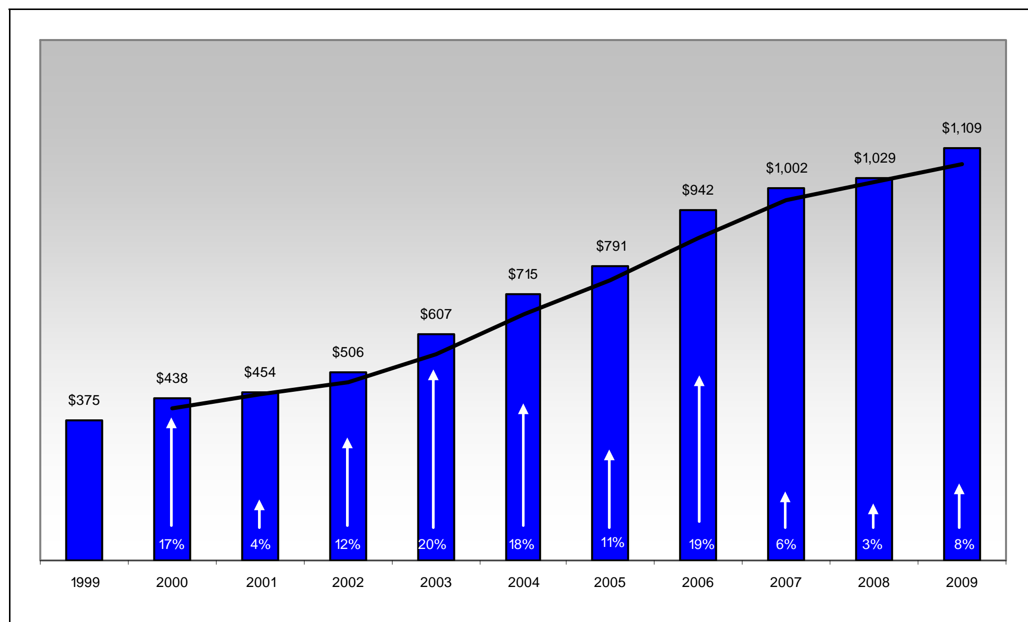
Finding IV The City Should Continue to Pursue Other Cost-Containment Strategies

Medical insurance expenses continue to increase at rates that exceed most public employers' revenue growth. The City's current cost containment strategies focus on annual independent actuarial reviews, regular competitive processes to minimize cost increases, and active participation with local coalitions to explore other risk reduction options. In addition, the City is also promoting healthy lifestyles through the Wellness Program in order to prevent chronic health problems and decrease healthcare utilization. Given the trend of steadily rising medical premiums, we believe the City should continue its cost-containment efforts and should consider further promoting cost-sharing among employees and pursuing alternative plan designs for employee medical benefits.

Rising Costs of Medical Benefits

According to HR, City of San José employee medical premiums expenses are increasing faster than the City's revenue growth. This year's medical premium for the City's lowest-cost family plan is nearly three times what it was in 1999. Over the last 10 years, medical premiums for the City's lowest-cost family plan has increased on average, 12 percent per year as illustrated in Exhibit 10 below.

Exhibit 10: Employees' Monthly Medical Premiums Have Nearly Tripled Between 1999 and 2009



Source: Prepared by the audit team using past premium rates for City-provided Kaiser HMO family plans.

Such increases in medical costs are putting a tremendous burden on the City. The continued increases in cost make it imperative that premium increases be reduced.

The City's Wellness Program As a Cost-Containment Strategy

In 2008, the City Council directed HR to move forward with total health management and risk reduction strategies through the Wellness Program. Since the inception of the program, HR reports that they have implemented the following:

- A total health and disease manager;
- Wellness newsletter and website;
- Monthly wellness workshops;
- Health lifestyle reward incentives for Blue Shield and Kaiser members, including rewards/discounts for participation in Weight Watchers;
- A pilot project to increase prescription compliance for Blue Shield members with diabetes and asthma; and
- A pilot incentive program designed to improve neonatal care and reduce neonatal hospital days.

Through its Wellness Program, HR has demonstrated commitment to improving the health and productivity of City employees and their dependents, which could have long-term savings in the City's medical costs. We support HR's continued effort to expand the cost-containment features of the Wellness Program in its efforts to manage escalating medical benefit costs,

Increasing Employees' Share of Medical Premiums

The City pays 90 percent toward the total medical premium of the lowest-cost plan to which employees are eligible. This level of cost-sharing resulted from negotiations between the City Administration and the various employee bargaining units. During our review, we learned that other employers use a variety of methods to define the employer and employee contributions including fixed monetary contributions, defined employer-employee contribution ratios, and tiered benefit offerings.

We observed some variance in the employee and employer contribution rates for medical premiums for comparable medical plans through other public-sector employers. Some public-sector employers contributed 100

percent toward their employees' benefits, while others, like the City of Fresno, contributed no more than 80 percent, even for the lowest cost medical plan. Exhibit 11 below illustrates some of the variance among premiums and contribution rates offered to select employees of comparable public-sector employers.

Exhibit 11: Employer and Employee Contributions to Medical Premiums Vary Across Employer-Provided Kaiser HMO Plans

Government Employer	Employer Contribution		Employee Contribution	
City of Hayward [19]		100%		0%
County of Santa Clara		100%		0%
City and County of San Francisco [20]	employee-only	100%	employee-only	0%
	employee + one	98%	employee + one	2%
	family	82%	family	18%
City of Los Angeles		100%		0%
City of Riverside		100%		0%
City of San Diego		100%		0%
County of Sacramento		90%		10%
CITY OF SAN JOSÉ		**90%**		**10%**
County of San Mateo		90%		10%
County of Contra Costa		87%		13%
City of Vallejo [21]		80%		20%

Source: Compiled by the audit team using 2009 figures for select employees of California public-sector employers.

[19] The City of Hayward contributes a maximum of $1,457 toward monthly medical premiums. This exceeds the monthly premiums for all Kaiser plans offered through CalPERS Bay Area.

[20] The City and County of San Francisco is the only employer we surveyed that contributes different rates toward medical premiums depending on employees' enrollment in either employee-only, employee-plus-one, or family plans.

[21] Effective January 1, 2010, the City of Vallejo will contribute 80 percent towards Kaiser HMO premiums for some new employees' employee-only, employee-plus-one, and family plans. Employees will contribute the remainder of the premiums. Until then, the City's contributions are 100 percent of the Kaiser HMO premiums for employee-only, employee-plus-one, and family plans.

As shown in the table above, the City's contribution rate appears to be in line with those of other government entities. However, as medical expenses continue to increase, the City may need to explore increasing cost sharing among its employees. During our review, we observed several examples of other public-sector employers who have increased their employees' share of medical premiums. According to the 2007 National Compensation Survey from the U.S. Bureau of Labor Statistics, the average local government employer paid only 73 percent toward their employees' family medical premiums.

If the City achieved a more even balance between employer and employee contributions to medical premiums, it could save significantly. For instance, if the City negotiated a cost-sharing arrangement in which the City paid 80 percent toward the total medical premium of the lowest-cost plan to which employees are eligible, it would save about $4 million per year.

Similarly, the City could achieve significant savings if it were to introduce monetary caps to its contributions to employee benefits. For instance, the City could continue to contribute 90 percent toward employees' contributions, but introduce monetary limits for its contributions. This would protect the City from potential increases in medical premiums over time.

Introducing a New Lower Premium Medical Plan (Deductible Plan)

We found that other public-sector employers offer medical plans with lower premiums than our lowest cost plans. One employer we surveyed, Sacramento County, offers its employees traditional single and family plans through Kaiser that are similar to the existing lowest cost plans offered by the City of San José. However, in addition, to the traditional Kaiser HMO plan, Sacramento County offers a deductible Kaiser plan with annual deductibles of $1,500 for individuals and $3,000 for families. Both the traditional and deductible Kaiser plans offer similar services, but the deductible plan requires employees to cover all initial medical costs until they reach the annual deductible limit. If employees meet their annual deductible limit, any additional medical expenses are borne by Kaiser. In 2008, the monthly premiums of Sacramento County's deductible Kaiser HMO plans are 21 percent lower than their non-deductible Kaiser single and family plans.

The City of San José could experience similarly lower premium rates if it were to include a deductible plan among its choices of medical plans. Absent any other cost-containment options, if the City were to introduce

new single and family plans with 20 percent lower premiums than those of our existing lowest-cost plans, we estimate the City would save $10 million per year.

Pursuing Alternative Plan Design

We found the array of services available through City-provided medical plans were generally in-line with those available in medical plans offered to employees of other California public-sector employers. Still, if it deemed it necessary, the City could negotiate plan design changes that could yield significant savings.

Increasing Medical Co-Pays

By introducing co-pays in the City-provided medical plans in 2008, the City successfully achieved more balanced cost-sharing between the City and the employees. Through the City-provided plans, employees and their dependents' co-pays range from $5 for prescription drugs, to $10 for doctor visits to $50 for emergency room visits. We observed some variance in co-pays offered by other employers' medical plans, but most comparable employers we surveyed offered their employee's medical plans with co-pays that were similar to San José's (see Exhibit 12 below).

Exhibit 12: Co-Pays Vary Across Employer-Provided Kaiser HMO Plans

Government Employer	Co-Payments for Select Services Offered by Kaiser HMO Plans				
	Office Visits	Emergency Room	In-Patient Hospitalization	Prescription Medications	
				Generic	Brand Name
CITY OF SAN JOSÉ (most employees)	**$10**	**$50**	**$0**	**$5 (100-day)**	**$10 (100-day)**
CITY OF SAN JOSÉ (OE3)	**$0**	**$0**	**$0**	**$5 (100-day)**	**$5 (100-day)**
County of Santa Clara	$5	$5	$0	$5 (100-day)	
CalPERS Bay Area	$15	$50	$0	$5 (100-day)	$15 (100-day)
City of Los Angeles	$10	$35	$0	$10 (100-day)	$20 (100-day)
City and County of San Francisco	$10	$50	$100	$5 (30-day)	$15 (30-day
County of Sacramento	$15	$35	$0	$10 (30-day)	$20 (30-day)
City of San Diego	$10	$50	$0	$10 (100-day)	$20 (100-day)

Source: Compiled by the audit team using 2008 figures for select employees of California public-sector employers.

As co-pays increase, medical providers lower their premiums. According to the City's benefits broker, an increase in the co-pays for Kaiser insureds from $10 to $25, would result in a savings of over $2.8 million if implemented for all covered City employees and dependents.

In addition, according to Mercer Consulting, as co-pays increase, insureds tend to more carefully evaluate the necessity for medical visits. Decreased use of medical services improves the providers' "Experience Rating" of the City, which could also yield lower premiums.

Considering One or More Cost-Containment Strategies

The City could potentially implement these cost-containment strategies through negotiations with the employee bargaining units for current employees and/or through a tiered system in which new City employees are offered different benefit terms than existing City employees. For example, Sacramento County employees who were hired after December 31, 2006, pay more towards their medical premiums than their counterparts who were hired before that date. During our review, we observed that other employers had two-tiered medical benefit plans based on date of hire.

We recommend the City Administration:

Recommendation #17

Pursue at least one or a combination of the aforementioned cost-containment strategies and work with the Office of Employee Relations on potential meet-and-confer issues that such a change would present. (Priority 2)

CITY OF
SAN JOSE
CAPITAL OF SILICON VALLEY

Memorandum

TO: Sharon Erickson
City Auditor

FROM: Mark Danaj

SUBJECT: **RESPONSE TO AUDIT OF EMPLOYEE MEDICAL BENEFITS**

DATE: June 5, 2009

APPROVED: Deanna Santana **DATE:** 6/5/09

The Human Resources Department has reviewed the final draft report of the *Audit of Employee Medical Benefits* and agrees with the findings and recommendations of the report. The following is the Administration's response to each recommendation.

BACKGROUND

In July of 2008, the Human Resources Department was notified that the Auditor's Office was interested in auditing employee medical plans. Human Resources was in the initial stages of reviewing and identifying areas for benefit administration improvement. Human Resources met with the Auditor's Office and shared the list of areas identified as needing improvement. Recognizing the value of combining the skill sets of Human Resources and the Auditor's office, Human Resources asked the Auditor's Office to partner with Human Resources in establishing a comprehensive work plan to accomplish the desired changes. This audit is the result of this concerted effort and correctly identifies the areas of concern and the priorities for improvement.

In 2008, the City paid nearly $60 million for active employee medical coverage. The audit estimates that improving internal processes would eliminate or reduce reporting eligibility errors, improve the timing of reporting eligibility, ensure premiums are collected appropriately and accurately pay premiums to medical health plan carriers for active employees. For example in 2008, there is a potential overpayment to Kaiser of $142,156 (0.39% of the total premium) and a potential underpayment to Blue Shield of $222,342 (0.95% of the total premium). Improving benefit administration processes and procedures may result in some cost savings to the City.

The Audit survey also indicates that while our benefits are generally consistent to other large governmental agencies in the Bay Area, the City's premiums are generally lower. This audit recommends areas in which Human Resources can further limit the City's liability exposure related to rising medical plan costs. The Audit recommends mitigating costs through the implementation of cost savings strategies, such as eliminating redundant or unnecessary coverage for employees and retirees and negotiating benefit changes. These actions reduce the City's share of the medical costs through cost-shifting to employees.

The Auditor's Office also supports Human Resources' efforts to develop and implement wellness programs. Wellness programs are long-term solutions aimed at improving the overall

health status of the employee population. Wellness programs improve health outcomes by preventing disease and illness from occurring, improving the early detection of disease and illness and educating employees on the best, most appropriate care. Wellness programs not only reduce the City's cost for medical plan coverage, but also reduce the employees' share of cost as well.

As a result of this audit, Human Resources will be developing new procedures and processes, which may result in additional workload. Given the City's difficult and continued fiscal challenges and the relatively low staffing levels of Strategic Support, some projects may be delayed due to resources or may require additional staffing to either develop or maintain additional workload. When additional staff is required to maintain a new workload, Human Resources will conduct a cost and benefit analysis. The cost and benefit analysis will be shared with the City Manager's Office with proposed recommendations to meet the audit requirements.

RECOMMENDATIONS AND RESPONSE

Recommendation #1: Establish a written procedure for submitting eligibility files and institute a single methodology to be used by Benefits staff to determine eligibility and premiums owed for both medical providers. (Priority 2)

Administration Response: Agree. The Administration will develop a single methodology to establish medical plan eligibility and report eligibility electronically to the medical plans. The Administration will coordinate reconciliation approaches with each of the medical plan carriers to insure that premiums owed to the medical plans are accurately paid. The Administration's ability to implement the new procedures will be impacted by the Administration's ability to obtain both internal and external programming resources. The City's programming requests will be made and their merits will be evaluated within the context of the City's and the medical plans' overall programming requirements.

Recommendation #2: Prepare and submit electronic eligibility reports to the medical providers at least twice each month (Priority 2).

Administration Response: Agree. The Administration plans to develop a methodology to submit electronic eligibility reports to the carriers twice per month and coordinate all changes to the current process with the medical plans. The Administration's ability to implement the new procedures will depend on obtaining both internal and external programming resources. The Administration's programming requests will be made and their merits will be evaluated within the context of the City's and the medical plans' overall programming requirements.

Recommendation #3: Produce the eligibility files in a format that can be analyzed by HR staff. (Priority 2)

Administration Response: Agree. The Administration will submit a request to develop a report in a format that can be used for analysis by Employee Benefits staff. The Administration's programming requests will be made and their merits will be evaluated within the context of the City's and the medical plans' overall programming requirements.

Recommendation #4: Create an internal process for identifying discrepancies between the monthly eligibility report and the premium reports. (Priority 2)

Administration Response: Agree. The Administration plans to develop reports to identify discrepancies between the monthly eligibility reports sent to the medical plan and the premium collection reports. Procedures will be developed to identify discrepancy issues between the reports. For any required process or report that requires programming, the Administration will submit a programming request to IT. The Administration's programming requests will be made and their merits will be evaluated within the context of the City's and the medical plans' overall programming requirements.

Recommendation #5: Confirm whether any excess premium expenses were made to Kaiser in 2008, and determine if other years should be analyzed as well. (Priority 2)

Administration Response: Agree. The Administration will review the outstanding Kaiser discrepancies and coordinate resolution of the premiums with the medical plan, City Departments and employees. The Administration will coordinate a review of prior outstanding Kaiser reported discrepancies and ensure that any of the Kaiser reported prior year discrepancies affecting either eligibility and/or premium payments are completely resolved with Kaiser.

Recommendation #6: Continue providing training to ensure HR liaisons are regularly and accurately reporting changes to employees' status. (Priority 3)

Administration Response: Agree. The Administration will develop an outreach to departments to insure accountability for submitting changes in employees' status timely within 60 days. The Administration will monitor and, as necessary, outreach to HR liaisons to assure timely reporting of personnel transaction. In addition, the accountability for accurate and timely reporting of key employee transactions will be elevated to department Administrative Officers citywide.

Recommendation #7: Coordinate with the Finance Department and IT to improve processes for collecting outstanding premiums. (Priority 2)

Administration Response: Agree. In May 2009, the Administration approved funding for a benefits billing module within PeopleSoft, the City's human resources and payroll system. The benefits billing module is designed to identify uncollected premiums, bill employees for missed premiums and track uncollected premiums. Subject matter experts from Finance, IT and HR will begin planning this project in late summer.

Recommendation #8: Continue monitoring the accuracy of the premium payment reports and modify the report if other issues are identified. (Priority 2)

Administration Response: Agree. The Administration will write a procedure and assign staff to monitor the premium payment reports monthly. The procedure shall include responsibility for notifying appropriate personnel of any benefit report or electronic eligibility file issues identified within the PeopleSoft system. PeopleSoft is system used by Human Resources and Finance to pay salaries and benefits to employee. Employee Benefits will continue to participate in the cross-functional team meetings comprised of Employees Benefits, Human Resources Information Systems, Finance, and Information Technology. The cross-functional team meetings coordinate issue resolution and develop system solutions to automated Human Resources or Payroll functions.

Recommendation #9: Develop and implement a policies and procedures manual including data entry processes, preparing reconciliations, and documenting adjustments. (Priority 3)

Administration Response: Agree. The Administration will analyze the gaps in procedures and policies. Ares that will be reviewed will include data entry processes, preparing reconciliations and documenting eligibility adjustments to the medical plans. Many of the recommendations within this report require programming which will modify the current procedure. As the Administration works with IT to develop and implement new reports and processes, the Administration will develop the policies and procedures documenting the specific changes.

Recommendation #10: Monitor the eligibility of college-aged dependents on a semi-annual basis. (Priority 2)

Administration Response: Agree. The Administration acknowledges the benefits of conducting eligibility of college-aged dependents on a semi-annual basis. This recommendation needs to be evaluated in the greater context of the Department's current fiscal environment. Currently, this annual audit is conducted through the hiring of a temporary analyst to perform the audit. The Administration is currently exploring opportunities to outsource this function to the medical plan providers.

Recommendation #11: In structuring a contract with the City's medical expert, the City should compensate the selected expert directly. (Priority 3)

Administration Response: Agree. The Administration plans to issue a Request for Proposal (RFP) for Consulting & Actuarial Services for Employee Benefit Programs & Defined Contribution Retirement Plans on June 5, 2009. It is the intent of the Administration to restructure the payment of consulting services from the health and welfare plans to the City, without a change in total cost to the City.

Recommendation #12: Prohibit employees from being simultaneously covered by City-provided medical benefits as a City employee, and as a dependent of another City employee and work with the Office of Employee Relations on potential meet-and-confer issues that such a change would present. (Priority 2)

Administration Response: Agree. The Administration agrees that revising eligibility rules to prevent duplicate enrollment in City benefits may result in cost savings. The Administration worked with Kaiser Permanente to evaluate the City's enrolled population and determine the rate impact if a policy change is implemented. Kaiser reports that the current incidence of duplicate coverage is insignificant. Due to the minimal number of employees with duplicate coverage, Kaiser Permanente does not anticipate a rate impact if the City implements this recommendation and there will be a premium cost savings by eliminating duplicate coverage. For the savings to be fully realized, it is recommended that the audit recommendation in #14 below would also have to be concurrently implemented. The Administration will propose eligibility changes to the labor agreements via the collective bargaining process. The proposals will be made and their merits will be evaluated within the context of the City's overall negotiating strategy.

Recommendation #13: Reduce cash in-lieu payment amounts and work with the Office of Employee Relations on potential meet-and-confer issues that such a change would present. (Priority 2)

Administration Response: Agree. The Administration will propose structural changes to the labor agreements which govern the City's cash in-lieu of medical plan enrollment program (as outlined in this recommendation) via the collective bargaining process. The Administration recommends that a reduction in cash in-lieu payments occur simultaneously or after a policy change for eliminating redundant coverage (see Audit Recommendation #12 above) as this will result in both maintaining the premium cost savings and obtain an additional reduction in cash payment savings. The proposal will be made and its merits will be evaluated within the context of the City's overall negotiating strategy.

Recommendation #14: Prohibit participation in the Health In-Lieu Plan among City employees who are already receiving other City-provided medical benefits and work with the Office of Employee Relations on potential meet-and-confer issues that such a change would present. (Priority 2)

Administration Response: Agree. The Administration will propose structural changes to the labor agreements which govern the City's cash in-lieu of medical plan enrollment program (as outlined in this recommendation) via the collective bargaining process. The proposal will be made via the collective bargaining process and its merits will be evaluated within the context of the City's overall negotiating strategy.

Recommendation #15: Clarify the rights of City retirees to suspend and re-enroll in their medical benefits. (Priority 3)

Administration Response: Agree. The Administration will propose structural changes to the labor agreements and Municipal Code which govern a retiree's retirement benefit of medical plan enrollment (as outlined in this recommendation). The proposal will be made via the collective bargaining process and its merits will be evaluated within the context of the City's overall negotiating strategy.

Recommendation #16: Continue to explore an in-lieu program for qualified City retirees who suspend their medical benefits and work with the Office of Employee Relations on any potential meet-and-confer issues that such a change would present. (Priority 2)

Administration Response: Agree. The Administration, in conjunction with the Retirement Department, will explore and identify alternative strategies to encourage retirees enrolled in unnecessary retiree medical plan coverage (e.g. duplicative coverage with a City or other group plan) to disenroll from the City's medical plans. The proposals will be submitted to the Office of Employee Relations via the collective bargaining process and their merits will be evaluated within the context of the City's overall negotiating strategy.

Recommendation #17: Pursue at least one or a combination of the aforementioned cost-containment strategies and work with the Office of Employee Relations on potential meet-and-confer issues that such a change would present. (Priority 2)

Administration Response: Agree. The Administration is currently working on a cost-containment strategy for a Colorectal Cancer Screening Program for Kaiser Permanente members. Kaiser reports that colon cancer is the number three cause of death in the United States. The City's current participation in Kaiser's colorectal cancer screening program is 62%. Kaiser Permanente and the City would like to increase the participation to at least 75% in 2010 and a staged communication plan to reach the final screening compliance goal of 100%. Kaiser

projects that an additional 64 cases of colon cancer would likely be diagnosed if no improvement is made to increase the current screening level. Kaiser estimates the potential savings for either avoiding or early detection of 64 colon cancer cases over the next ten years could range from $17,000 to $460,000. The Administration will continue to work with the Benefits Review Forum (BRF), a labor/management committee, to design and implement a Kaiser colorectal screening program by 2010.

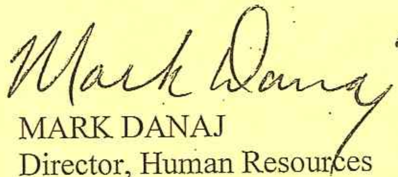
The Administration will continue to research and implement both short- and long-term cost-containment strategies and to make proposals via the collective bargaining process. The proposals will be made and their merits will be evaluated within the context of the City's overall negotiating strategy.

CONCLUSION

This Audit makes valid recommendations for revising and improving the processes by which the City proactively manages medical plan eligibility, premium collection and cost containment strategies. The Administration will take decisive actions to address the recommendations. The Administration will also coordinate any additional staffing requirements required to either develop and/or maintain a newly developed process/procedure through the City Managers Office and the Budget Office. The Administration thanks the City Auditor and her staff for the hard work and thoughtful analysis that went into the Audit.

COORDINATION

This memorandum has been coordinated with the Office of Employee Relations, Retirement Department, Information Technology and Finance.



MARK DANAJ
Director, Human Resources

For questions please contact Jeanne Groen, Benefits Manager of Human Resources at (408) 975-1428.

APPENDIX A

DEFINITIONS OF PRIORITY 1, 2, AND 3
AUDIT RECOMMENDATIONS

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

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

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

[2] For an audit recommendation to be considered related to a significant fiscal loss, it will usually be necessary for an actual loss of $50,000 or more to be involved or for a potential loss (including unrealized revenue increases) of $100,000 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.

[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.

APPENDIX B

City of San José
Human Resources Department

2009 Health and In-Lieu Plan Semi-Monthly Rates

Effective from 1/1/2009 (PP 1) through 12/31/2009 (PP 27)

OE3 and POA

(Health premiums are deducted the first 2 paydays of each month, and are pre-tax)

	Kaiser Single	Kaiser Family	Blue Shield HMO Single	Blue Shield HMO Family	Blue Shield POS/PPO Single	Blue Shield POS/PPO Family
100% Benefits: Full-Time Employees Including RWW Employees who work 32 - 39 Hrs						
Employee Contribution	**23.39**	**58.25**	**38.10**	**114.51**	**124.64**	**337.15**
City Contribution	211.27	526.07	211.32	526.22	211.57	526.88
Total	234.66	584.32	249.42	640.73	336.21	864.03
75% Benefits: Part-Time Employees who work 30 - 39 Hrs & RWW Employees who work 30 - 34 Hrs						
Employee Contribution	**76.20**	**189.76**	**90.93**	**246.06**	**177.53**	**468.87**
City Contribution	158.46	394.56	158.49	394.67	158.68	395.16
Total	234.66	584.32	249.42	640.73	336.21	864.03
62.5% Benefits: Part-Time & RWW Employees who work 25 - 29 Hrs						
Employee Contribution	**102.61**	**255.52**	**117.34**	**311.84**	**203.97**	**534.73**
City Contribution	132.05	328.80	132.08	328.89	132.24	329.30
Total	234.66	584.32	249.42	640.73	336.21	864.03
50% Benefits: Part-Time & RWW Employees who work 20 - 24 Hrs						
Employee Contribution	**129.02**	**321.28**	**143.76**	**377.62**	**230.42**	**600.59**
City Contribution	105.64	263.04	105.66	263.11	105.79	263.44
Total	234.66	584.32	249.42	640.73	336.21	864.03

ABMEI, AEA, AMSP, CAMP, CEO, IAFF, IBEW, MEF, Unit 99 and Unrepresented

(Health premiums are deducted the first 2 paydays of each month, and are pre-tax)

	Kaiser Single	Kaiser Family	Blue Shield HMO Single	Blue Shield HMO Family	Blue Shield POS/PPO Single	Blue Shield POS/PPO Family
100% Benefits: Full-Time Employees Including RWW Employees who work 35 - 39 Hrs						
Employee Contribution	**22.19**	**55.27**	**45.91**	**133.72**	**135.42**	**363.99**
City Contribution	200.46	499.13	200.52	499.35	200.79	500.04
Total	222.65	554.40	246.43	633.07	336.21	864.03
75% Benefits: Part-Time Employees who work 30 - 39 Hrs & RWW Employees who work 30 - 34 Hrs						
Employee Contribution	**72.30**	**180.05**	**96.04**	**258.55**	**185.61**	**489.00**
City Contribution	150.35	374.35	150.39	374.52	150.60	375.03
Total	222.65	554.40	246.43	633.07	336.21	864.03
62.5% Benefits: Part-Time & RWW Employees who work 25 - 29 Hrs						
Employee Contribution	**97.36**	**242.44**	**121.10**	**320.97**	**210.71**	**551.50**
City Contribution	125.29	311.96	125.33	312.10	125.50	312.53
Total	222.65	554.40	246.43	633.07	336.21	864.03
50% Benefits: Part-Time & RWW Employees who work 20 - 24 Hrs						
Employee Contribution	**122.42**	**304.83**	**146.17**	**383.39**	**235.81**	**614.01**
City Contribution	100.23	249.57	100.26	249.68	100.40	250.02
Total	222.65	554.40	246.43	633.07	336.21	864.03

Health In-Lieu Plan Payments

Payment in-lieu of coverage is available for qualified enrollees (full-time and RWW who work 32+ Hours)
Payments are made every payday, are taxable, and are subject to withholding

	OE3 & POA	ABMEI, AEA, AMSP, CAMP, CEO, IAFF, IBEW, MEF, Unit 99 & Unrepresented
If eligible for family coverage	**233.81**	**221.84**
If not eligible for family coverage	**93.90**	**89.09**