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A Performance Audit of the Public Employees Health Program (PEHP) and Children's Health (Insurance Program (CHIP)

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Digest of A Performance Audit of the Public Employees Health Program (PEHP) and Children's Health Insurance Program (CHIP)

The Public Employees Health Program (PEHP) is a non-profit, self-funded trust managed by the Utah State Retirement Board. PEHP administers health and other insurance for the State of Utah and other public agencies. PEHP offers all benefit plans on a self-funded basis to decrease some of the variable costs and maintain lower fixed costs by managing the risk for employers. Current insurance coverage appears to be competitively attractive to state employees.

PEHP offers high-quality, yet cost-effective, health insurance for its covered employers; but some improvements can be made to benefit the state and its members. Following the introduction in Chapter I, Chapters II through V review the following areas:

- Premium trends,
- Use of services,
- Contracted fees with health providers,
- Employee benefits,
- Administrative costs, and
- Internal operations.

This report also reviews the Children's Health Insurance Program (CHIP) administered by the Department of Health. CHIP contracts with two health care networks, PEHP and another insurance carrier, to assist families that are financially struggling to provide adequate health insurance for their children. CHIP is discussed in Chapter VI of this report. Chapters II through VI are summarized below.

Chapter II: How does State of Utah premium trends compare with national trends?

State of Utah Premium Rate Increases Are Similar to Increases in National Trends. Utah premiums increased an average of 10 percent annually the last five years; national premiums increased 8 percent annually. In 2002, workers nationally were paying an average employee

premium cost share of $174 (a 16 percent increase from 2001 levels) per month for family coverage. State of Utah employees were paying family premium costs for the Preferred Care plan of $52 (a 12 percent increase from 2001 levels) per month. On average, workers throughout the country are paying 27 percent of their family coverage premium, more than four times that paid by a Utah employee.

Utah members use more medical and pharmaceutical benefits per member than other PEHP employer groups. Since 1998, State of Utah usage of medical services grew 44 percent while PEHP's other employer groups utilized 20 percent more services. Increased utilization of services is a major contributor to increased insurance premiums.

Chapter III: How does PEHP compare with Utah's intrastate insurance carriers and other states?

PEHP Controls Costs and Offers Good Benefits. PEHP's benefits and costs to the state and its employees appear to be competitively attractive compared within the local industry and with other states. PEHP's low administrative costs, low to mid-range claim costs, and mid-range contracted fees for services, exhibit PEHP efforts to maintain a cost-effective insurance program.

Utah employees receive excellent benefits compared to the other states surveyed for this audit. Utah contributes the largest employer percentage of the monthly premium and state employees generally have lower copayments for basic medical services. Although Utah benefits are good compared to intrastate carriers and other states, employee benefits have declined since 1998.

Chapter III Recommendation

1. We recommend that the Legislature continue to review employee compensation packages and make benefit and salary adjustments as necessary.

Chapter IV: How can can PEHP be more cost effective?

PEHP Can Take Steps to Be More Cost Effective. Several of PEHP's operations and programs were reviewed in accordance with the audit objectives to determine if PEHP is managed effectively. Overall, PEHP is well managed, but further efforts can be made. PEHP should continue to monitor administrative costs, especially large and/or fast growing line-items. PEHP can better follow its procurement policies and procedures to appropriately acquire goods and services. PEHP should consider enhancing their smoking cessation program that would benefit

members and provide cost benefits to PEHP. In 2002, PEHP recovered over $450,000 in
adjustor overpayments to health providers. PEHP should continue to look for additional ways to recover overpayments.

Chapter IV Recommendations

1. We recommend that PEHP monitor changes and trends in administrative costs, by line item, to determine if changes or trends are appropriate and in line with PEHP's objectives.

2. We recommend that PEHP follow their established procurement policies and procedures.

3. We recommend that PEHP require the following:
   - A written contract for services with consultants, insurance carriers, and health providers,
   - A rebidding process for long-term contracts to assure that PEHP is acquiring the best service for the least cost, and
   - A conflict of interest disclosure statement on all contracts.

4. We recommend that PEHP avoid related-party transactions.

5. We recommend that PEHP consider enhancing its smoking cessation program.

6. We recommend that PEHP continue to look for additional ways to recover overpayments sent to health providers.

Chapter V: What can PEHP do to improve its pharmacy benefit?

PEHP Can Increase Pharmacy Benefit Cost Savings. Nationally, prescription drug costs have increased 19 percent annually since 1999. PEHP needs to be more aggressive in its efforts to control pharmacy benefit costs. PEHP's ongoing cost-containment efforts include adopting increased co-insurance rates, negotiating better rebates and networks, and the addition of a specialty drug program. However, further effort is needed. PEHP should consider implementing a four-tier formulary and percentage payment structure in the future. Such a change would have saved PEHP $1.3 million in fiscal year 2003. Also, initiating audits of their pharmacy benefits manager will help PEHP monitor and continuously improve the pharmacy benefit.

Chapter V Recommendations

1. We recommend PEHP consider implementing a four-tier formulary and percentage payment structure.

2. We recommend PEHP develop more incentives to increase generic drug utilization.

3. We recommend PEHP continue to develop audit policies and procedures in order to conduct regular reviews on the current pharmacy benefit manager. PEHP should consider implementing the following:
   - PEHP audit tests should occur at least once a year using the guidelines as outlined by PEHP's audit policy,
   - External audits of PEHP's PBM should occur at least once during the contracted period, preferably before any contract renewal, and
   - PEHP should conduct a thorough analysis of their mail-order benefit.

Chapter VI: How can CHIP be more effective?

CHIP Can Negotiate Contracts More Aggressively. CHIP provides health insurance coverage for about 28,000 children. One of CHIP's responsibilities is to provide age-appropriate vaccinations for all members. Currently, CHIP expends nearly $400,000 per year for vaccines it has already purchased. Contract oversights from CHIP administration led to the forfeiture of $160,000 in reimbursements from an insurance carrier. In addition, CHIP should explore utilizing HMO plans where available to provide plan options for its members and realize some cost savings.

During the 2003 General Session, HB 72 was passed and state funding for CHIP was increased by $1.5 million. This increase allows CHIP to draw an additional $6 million in federal funding. This additional $7.5 million restored dental benefits and insures an additional 4,000 children.

Chapter VI Recommendations

1. We recommend that CHIP make contract provisions to protect itself from paying twice for vaccines.

2. We recommend that CHIP explore the possibility of utilizing the HMO plans in the rural areas of the state.

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Chapter I
Introduction

PEHP benefits and costs are competitively attractive in the Utah market.

Public Employees Health Program (PEHP) is a non-profit, self-funded trust managed by the Utah State Retirement Board. PEHP administers health insurance programs for public agencies including: State of Utah, counties, cities, groups of smaller municipalities, and school districts. Currently, PEHP provides health insurance coverage to state employees through four different plans. PEHP's benefits and costs to the state and its employees appear to be competitively attractive within the current market.

Utah Retirement Systems (URS) is an independent governmental agency and PEHP is a program within URS. PEHP was created by the state legislature that began as a division of state government. Group Insurance was established by mandate in 1961 to provide insurance coverage for public employees. At that time, Group Insurance was a division of the Department of Finance, and benefits were administered by an outside company. In 1976, Group Insurance was made a division of the Utah Retirement Systems. Then in 1977, the administration of the health insurance program was brought in-house, and the Public Employees Health Program was established.

PEHP's mandate is to offer high quality yet cost-effective health insurance for its covered employers. PEHP's benefit plans are self-funded. PEHP self-funds to decrease some variable costs and maintain lower fixed costs by managing risk for employers. These savings allow PEHP to offer employers greater flexibility and control over health plan benefits and allow for a wide variety of employee options.

PEHP Self-funds to Attain Cost Savings

PEHP self-insures and self-administers plans to retain additional cost savings.

PEHP offers all benefit plans on a self-funded basis. Self-funding health insurance is where employers assume responsibility for health care losses of its covered employees. Employers fund their plan's costs out of their general assets or by establishing a trust—PEHP is one such trust. For fully-insured plans, employers are not responsible for claims that exceed total premiums; the insurance company assumes the risk. The trend in recent years for U.S. employers has been toward self-funding. Recent

surveys indicate that 56 percent of U.S. employers self-fund their health insurance benefits. In addition, PEHP plans are self-administered—the administration of the plan is done by the employer, so employers can realize additional cost savings.

The main reason PEHP self-funds is to avoid some of the insurance costs by having employers retain the risk. Participating employers, such as the State of Utah, self-fund to retain the "profits" that normally flow to the insurance company. If the State of Utah didn't self-fund, the state would pay premiums that include a profit margin as well as a fee for PEHP to assume the risk. Self-funded plans save money and are beneficial because they are not subject to premium taxes, they omit cost spent on agent/broker fees and commissions, and administrative costs are lower from being self-administered.

PEHP Has Created a Framework to Help Mitigate the Risks of Self-funding

PEHP protects the program by purchasing re-insurance coverage for expensive insurance claims.

PEHP provides a self-funded reinsurance plan—a method of limiting the risk that participating employers assume. This risk limiting method, stop-loss coverage, protects the risk pools from large medical claimants that have claims dollars that exceed a set level. All claims dollars for any individual that exceeds $75,000 are shared by the entire PEHP membership. Spreading large claims across the entire population removes the volatility that these claims create for any individual employer. In addition, PEHP purchases individual stop-loss coverage for catastrophic claims that exceed $700,000.

Each employer or agency with PEHP is a single or part of a "risk pool"—a pool of funds set aside to be used for defined expenses, such as medical or dental expenses. To assure the adequacy of rates to cover actuarially projected costs, PEHP has set participation guidelines. To singly self-fund, the employer should cover at least 1,000 employees. Smaller employers may participate, but they join one of PEHP's multiple employer risk pools.

Self-funded Plans Are Exempt From State Regulation

Self-funded plans are governed by federal regulations such as the Employer Retirement Insurance Security Act (ERISA), the federal benefits law; the Consolidated Omnibus Budget Reconciliation Act (COBRA), a

continuation of coverage for group medical and dental benefits for eligible employees whose coverage terminates; and Health Insurance Portability and Accountability Act (HIPPA), which governs access to personal health information.

In Utah, there are two types of employer-based health insurance: self-funded health benefit plans and commercial health insurance. Both types of health plans are regulated by ERISA. However, commercial health insurance is subject to ERISA's exemption clause which allows the states to regulate the commercial insurance carriers. Self-funded plans are exempt from state regulation and are regulated by the Department of Labor.

Due to PEHP's self-funding status, the program is not subject to the same state regulations as commercial carriers.

This "exemption clause" means that commercial health insurance plans are directly regulated by state insurance law and each state insurance department. As a self-funded benefit plan, PEHP is not considered the "business of insurance" under ERISA and is exempt from state health insurance regulation except as dictated by state law. Thus, PEHP is generally not subject to Title 31 of the ***Utah Code*** and generally exempt from Utah Insurance Department's oversight, such as financial exams and market conduct reviews. However, specific state law requires oversight of PEHP by the Utah Insurance Department. ***Utah Code*** 49-20-405 requires the insurance commissioner to perform a limited review PEHP's financial status every two years or allows the insurance commissioner to accept the audited annual financial statement annually. ***Utah Code*** 31A-22-605.5 requires that PEHP implement in its state employee risk pools any legislated mandates that become effective after January 1, 2002.

Another advantage with self-funded plans is that employers have more freedom than the packaged products of insurers with state regulation. This freedom allows self-funded employers the flexibility and control to design benefit plans to meet the needs of their workforce. However, federal mandates still apply to self-funded benefit plans.

State Retirement Board Provides Oversight for PEHP. While PEHP is not regulated like commercial insurance carriers, it still has oversight. Since PEHP is a division of Utah Retirement Systems, the Utah State Retirement Board provides oversight for PEHP. In accordance with ***Utah Code*** 49-11-202, the board consists of seven members: four members with experience in investments or banking, one member is a school employee, one member is a public employee, and one member is the state treasurer, an *ex officio* board member.

As described in this chapter, PEHP is a large program providing comprehensive services. Health insurance is a complex business, and since PEHP is generally exempt from state regulation, the board has an important role in providing oversight for PEHP.

PEHP Provides Comprehensive Health Care Services

Medical and dental benefits are available to all State of Utah employees and their families. PEHP's goal is to create easy-to-use, cost-effective programs with comprehensive benefits. Employees have the option to choose among two or three medical plans depending on where employees live within the state. Employees also can choose from among three dental plans.

In addition to offering medical and dental benefit plans, PEHP's insurance products include Group Term Life, Long Term Disability, Accidental Death and Dismemberment, Flex Plan Administration, COBRA, Conversion, Early Retirement, and Medicare Supplement.

Medical Insurance. The State of Utah offers preferred and managed care health plans to its employees and eligible dependents—the spouse to whom the employee is legally married, and unmarried children to the age of 26, who are dependent on the employee for support. Medical plans offered include the following:

- **Preferred Care** – a preferred provider organization (PPO) plan that offers the largest provider network to state employees, it includes over 4,000 providers and hospitals. This plan provides worldwide as well as state coverage for members and their dependents. Preferred Care provides members with a financial incentive to receive care from a "preferred" provider.

- **Exclusive Care** – a health maintenance organization (HMO) plan with an IHC provider and hospital network. Exclusive Care has lower out-of-pocket expenses, but is more restrictive. This plan is available to members that live in urban areas and some rural areas of the state.
- **Summit Care** – an HMO plan with a non-IHC provider and hospital network. This plan's benefits closely mirror Exclusive

Care. Summit Care is available to members that live in urban areas and some rural areas of the state.

- **Comprehensive Care** – a major medical plan with a $100 front-end deductible and most benefits at 80 percent after deductible. Members may use any provider without penalty. Comprehensive Care is only available where Exclusive Care and/or Summit Care plans are not available.

The majority of state employees have selected the Preferred Care plan, while the membership in the Exclusive plan and Summit Care plan are somewhat similar. Figure 1, below, shows the membership for each of the four health plans.

Figure 1. State of Utah's Membership by Health Plan. Fifty-four percent of state members use the Preferred Care plan.

Plan Type	Number of Members	Percent
Preferred Care	38,596	54%
Exclusive Care	14,954	21
Summit Care	17,030	24
Comprehensive Care	325	1
Total	**70,905**	**100%**

State employees and their families constitute 48 percent of PEHP membership.

The figure above only shows the State of Utah's membership. PEHP's total membership is approximately 148,000 members. The State of Utah consists of 48 percent of PEHP's total membership.

Dental Insurance. Dental benefits are available to all State of Utah employees and their eligible dependents. Eligibility requirements for dependents are the same as medical insurance. There are three choices of dental plans: PEHP Preferred Choice, PEHP Traditional, and Dental Select Platinum. The medical and dental plans are separate and do not require that a member choose the same plan for each benefit.

Term Life Insurance. Group Term Life is available to all State of Utah employees. A minimum benefit of $25,000 is provided to each employee as part of their employer-sponsored benefits. Optional Group

Term Life insurance is also available for the employee's spouse and eligible dependents. Eligibility requirements for dependents are the same as medical and dental insurance.

Long Term Disability. LTD is an employer-funded benefit provided to all permanent, full-time State of Utah employees. The LTD program provides a benefit for accidental bodily injury, disease or illness that leaves the employee disabled and unable to perform his or her own occupation for up to two years and thereafter if unable to perform any occupation.

Accidental Death and Dismemberment. PEHP offers an Accidental Death and Dismemberment program that provides benefits for death, permanent loss of use of limbs, speech, hearing or eyesight due to an accident on or off the job. State of Utah members have the option to enroll.

Flex Plan Administration. PEHP administrates the State of Utah Flexible Reimbursement Program (FLEX$); it is available to all State of Utah employees. It allows employees to set aside money, before taxes, to pay for eligible out-of-pocket medical, dental, and day care expenses.

COBRA. Continuation of coverage for group medical and dental benefits is available to most eligible former employees whose coverage terminates. Under federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that most employees have the opportunity for a temporary extension of coverage where coverage would otherwise end.

Conversion. The conversion policy allows members who are not eligible for COBRA, or when COBRA terminates to continue benefits. The conversion plan is available to the insured until age 65 as long as premiums are received.

Early Retirement Insurance Benefit. Employees who qualify for early retirement will receive paid up medical insurance for themselves and qualified dependents for 5 years or up to age 65, whichever comes first. To qualify, employees must retire under the age of 65 and have at least 30 (20 for Public Safety) years of service at any age, or at least 20 years at age 60-65, or at least 10 years at age 62-65.

Medicare Supplement. PEHP provides a supplement to Medicare for retirees who receive a benefit from the Utah Retirement Systems and are age 65 or over. Two Medicare Supplement plans are available: Low Option and High Option Medicare Supplement. The High Option includes prescription drug benefits.

CHIP Provides Health Insurance to Children

The Children's Health Insurance Program (CHIP) assists families that are financially struggling to provide adequate health insurance for their children. CHIP is available to families that have children 18 years or younger, that earn too much for Medicaid eligibility, but cannot afford health insurance. To be eligible for CHIP, a child must live in a household with an income between 100-200 percent of the federal poverty level; however, kids under age 6 are covered by Medicaid 0-133 percent of the federal poverty level. The current poverty level income for a family of four is $18,100. Currently there are 28,000 children enrolled in the program.

CHIP currently serves 28,000 children. HB72 of the 2003 General Session allows CHIP to increase its membership and benefits.

The CHIP program began in August 1998 and is administered by the Utah Department of Health. CHIP contracts with two health care networks, PEHP and another insurance carrier, to provide health care services. CHIP provides both medical and dental insurance. CHIP receives funds from the Tobacco Settlement Agreement and a four-to-one match from the federal government. CHIP was originally allocated $5.5 million from the Tobacco Settlement Agreement, but that funding was increased by $1.5 million with the passing of HB72 during the 2003 General Session. This additional funding will help CHIP enroll more children and provide full dental coverage.

Audit Scope and Objectives

We were asked to determine PEHP cost-effectiveness for the state and its employees.

This audit was requested by a legislator, who asked us to determine whether PEHP provides cost effective programs to the state and its employees. PEHP was compared with intrastate insurance carriers in four areas: utilization, negotiating discounts with providers, benefits, and the cost to administer and deliver benefits. Information was gathered from interstate insurance carriers to compare the plans and benefits offered to

employees in other states. PEHP's trends were also compared with national trends.

PEHP's administrative costs were reviewed to determine if expenses are appropriately allocated to the risk pools and to determine if administrative costs as a percentage of total costs are reasonable. PEHP contingency reserves were reviewed to determine if the funds in the reserves met reserve requirements. Several other internal areas were reviewed to assess PEHP's cost effectiveness including: prevention programs, procurement and contracts with consultants and providers, claims auditing, and pharmacy benefit.

In addition, we were asked to audit CHIP and review the rising costs of the program. Since the beginning of the program, the number of members enrolled continually increased until December 2001, when a cap was placed on enrollment. Besides reviewing enrollment, other areas reviewed include utilization and associated costs, the administrative costs to operate the program, internal functions, and the contracts with the two health care networks that provide services for CHIP.

This audit report covers the following: Chapter II reviews the State of Utah's premium trends and use of services in comparison to industry trends. Chapter III shows comparisons between PEHP and intrastate and interstate carriers. Chapter IV reviews administrative costs and other internal areas and suggests actions that PEHP should consider to improve cost effectiveness. Chapter V describes PEHP's pharmacy benefit program. Chapter VI describes CHIP's operations and costs and suggests actions that CHIP should consider to operate the program more efficiently.

Chapter II
Insurance Trends Show Increased Premium and Utilization Growth

The state's premium costs and member utilization are somewhat higher than other employer groups. In the future, the Legislature may want to consider increasing the employee cost share as an incentive to help reduce utilization and premium rate increases. PEHP has the basic structures in place to control costs and provide adequate insurance to state employees:

- PEHP is self-funded (as discussed in Chapter I),
- PEHP provides employees with a choice among managed care plans—one PPO plan and two HMO plans,
- PEHP requires employee cost-sharing mechanisms (copayments— a flat dollar amount charged for services; deductibles—an amount that members pay before the plan starts paying for services; coinsurance—a percentage of the cost that is charged for services), and
- PEHP requires prescription drug coinsurance.

This chapter reviews trends of PEHP's state pools, specifically premium costs and employee use of services, and compares them with other PEHP employer groups and national trends. It is important to note that PEHP serves a variety of public employer groups besides the State of Utah.

Premium Rate Increases Follow National Trend

PEHP premiums increased an average of 10 percent the last five years; national premiums increased 8 percent.

Premium increases for the State of Utah are similar to premium increases nationwide. The state's premiums have averaged an annual increase of 10 percent for the last five years while national premiums have increased 8 percent. State members' use of health and dental services has also increased in recent years, a factor that drives premium increases.

Insurance premiums measure the cost of offering health care coverage to employees; they do not measure the actual cost of employee health care. Overall, premiums may not be a good short-term indicator of actual health

care costs because insurance companies set their premiums using historical and projected claims data. This method results in "premium cycles" where increases in premiums tend to lag in times of volatile medical inflation. For this reason, we looked at a variety of measures to determine PEHP's cost effectiveness including utilization, benefits, contract rates with health providers, administrative costs, and internal operations.

Insurance Premiums Have Increased Annually

Health care costs are increasing, and these costs are reflected in rising premium rates for employers and an increase in employee cost-sharing requirements such as monthly premium payments and higher copayments. The state's premiums have increased 10 percent per year for the Preferred Medical plan (PPO), and the Exclusive and Summit Care plans (HMO) since 1998. Part of this increase is due to utilization. Utilization is measured by the number of claims submitted to PEHP per member per year. State members have utilized 58 percent (about 15 percent per year) more medical services since March 1997 which has contributed to increased premium costs.

Premiums for the PPO plan have increased as much as 21 percent and as low as 3 percent per year.

Premium rates have increased as much as 21 percent per year. Part of the premium increases have been passed directly to members where before 1999, state employees did not pay a percentage of the biweekly premium. After 1999, PPO plan subscribers have paid at least five percent of their insurance premiums and currently pay seven percent of the premium. State employees that chose HMO coverage did not have a biweekly premium until 2002, which is now two percent of the total premium.

Figure 2 specifies employee/employer dollar shares, percentage shares, and annual premium percentage increases for State of Utah family PPO and HMO insurance plans. Percent increases and member cost-sharing percentages are the same for the single and family coverages, therefore only the largest represented group–family PPO and HMO coverages are listed below. Single and employee and spouse premiums are presented in Appendix B.

Figure 2. Monthly Utah Family PPO/HMO Premium Rates and Cost-sharing Data Since 1998. Utah PPO and HMO premium rates annually increased an average of 10 percent.

Family PPO

	Dollar Share		Percent Share		Premium Increase
Year	Employer	Employee	Employer	Employee	All
1998	$ 457.15	$ 0	100%	0%	6%
1999	470.92*	0	100	0	3
2000	510.83*	27.91	95	5	8
2001	615.90	46.37	93	7	21
2002	689.82	51.91	93	7	12

Family HMO

	Dollar Share		Percent Share		Yearly % Increase
Year	Employer	Employee	Employer	Employee	All
1998	$ 448.44	$ 0	100%	0%	4%
1999	470.92*	0	100	0	5
2000	510.80*	0	100	0	8
2001	615.90	0	100	0	21
2002	676.00	13.80	98	2	10

** Includes policyholder experience dividends for the State—$4.8 million in 1999 and $5.1 million in 2000.*

Per year family premiums have increased $3,420 and $2,892 since 1998 for Utah PPO and HMO plans respectively.

Utah family PPO rates have increased $285 per month ($3,420 annually) since 1998. During the same period, Utah family HMO premiums grew $241 per month ($2,892 annually). The state has only shifted a small portion of the rising costs to the employee. As noted, State of Utah members of both PPO and HMO plans are paying seven percent and two percent respectively of the total premium, which is a much lower share than the national average.

In the past, the Legislature made the decision to provide a higher level of benefits to state employees rather than cost-of-living adjustments. Currently, a one percent cost-shift to employees represents an additional cost of $1.5 million. As an example, a three percent increase in the

employee share of the premium would shift approximately $4.5 million of the state's share of the premium to employees.

State of Utah Premium Growth Rates Are Similar to National Rates

Although state premiums have been higher in recent years, the state's overall growth rates are quite similar to national growth rates. State rates are higher since some of the benefits provided are better than the national average benefit plans.

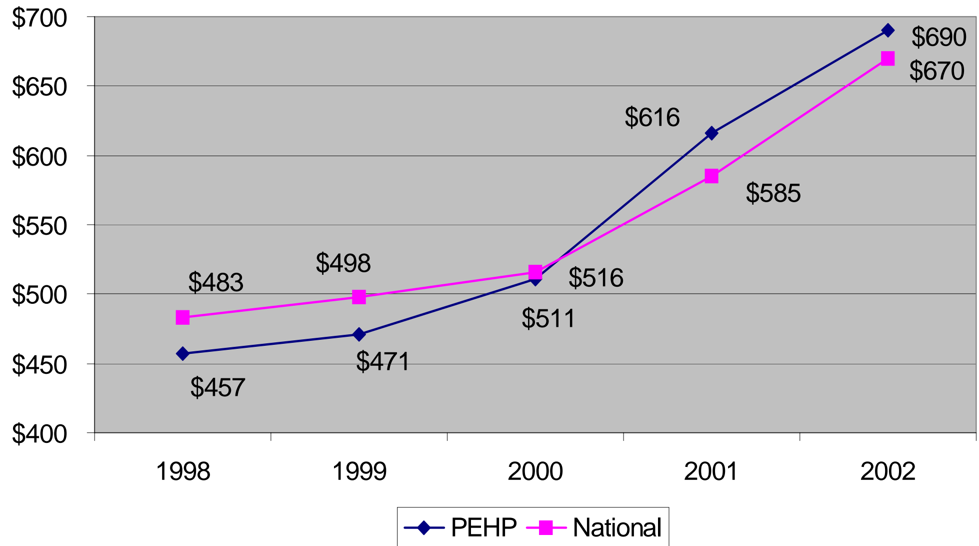
Nationally, families pay 27 percent of their insurance premium. Utah employees pay seven or two percent of their family premiums depending on the selected plan.

In 2002, workers nationally were paying an average employee premium cost share of $174 (a 16 percent increase from 2001 rates) per month for family coverage. Comparatively, State of Utah families are paying preferred family premium costs of $52 (a 12 percent increase) per month. On average, workers throughout the country are paying 27 percent of their family coverage premium, more than four times that paid by a Utah employee.

Figures 3 and 4 compare total insurance premiums for PEHP family plans with national family plans below. Cost differences between PEHP and national plan averages can be explained by factors such as: benefit levels, family size, and the average age of members.

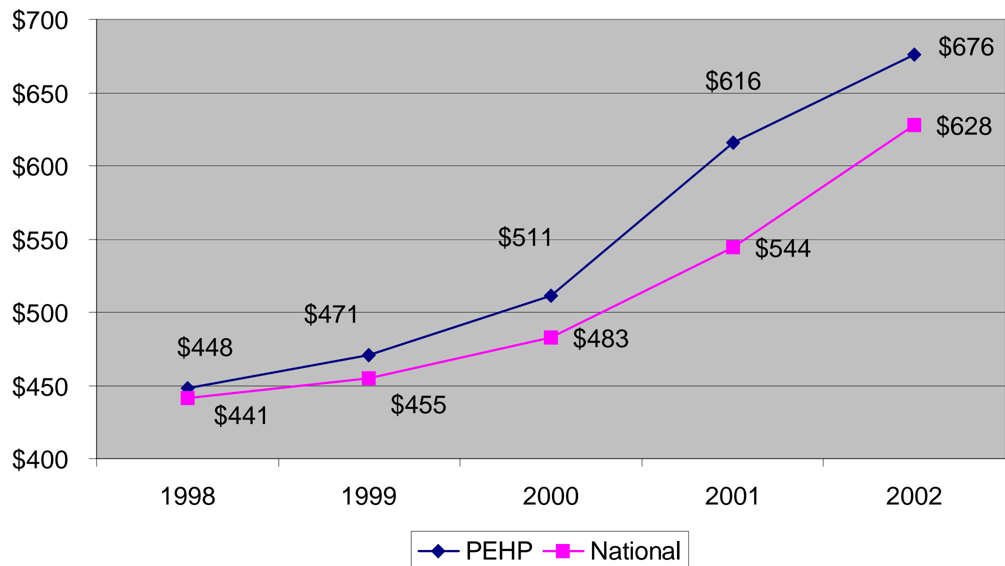
Since 1998, Utah family PPO premiums grew 51 percent compared to national increases averaging 39 percent.

Figure 3. Comparison of the State's Family PPO Premium Growth with National Increases. State premium increases are growing faster than national trends.



Since 1998, Utah family HMO premiums grew 51 percent compared to national increases averaging 43 percent.

Figure 4. Comparison of the State's Family HMO Premium Growth with National Increases. State HMO premium increases are somewhat higher than national trends.



Figures 3 and 4 show the state's and national premium growth trends are similar. A review of percentage change of premium rates more clearly shows actual growth rates. Since 1998, the State of Utah's family PPO

and HMO family premiums grew 51 percent. In comparison, national family PPO rates increased 39 percent, and HMO family rates grew 42 percent for the same time period. Utah's elevated growth percentages appear to be directly related to several factors increasing member utilization discussed later in the chapter.

Employee Use of Services Has Increased

Increased employee utilization is one of the factors contributing to premium growth.

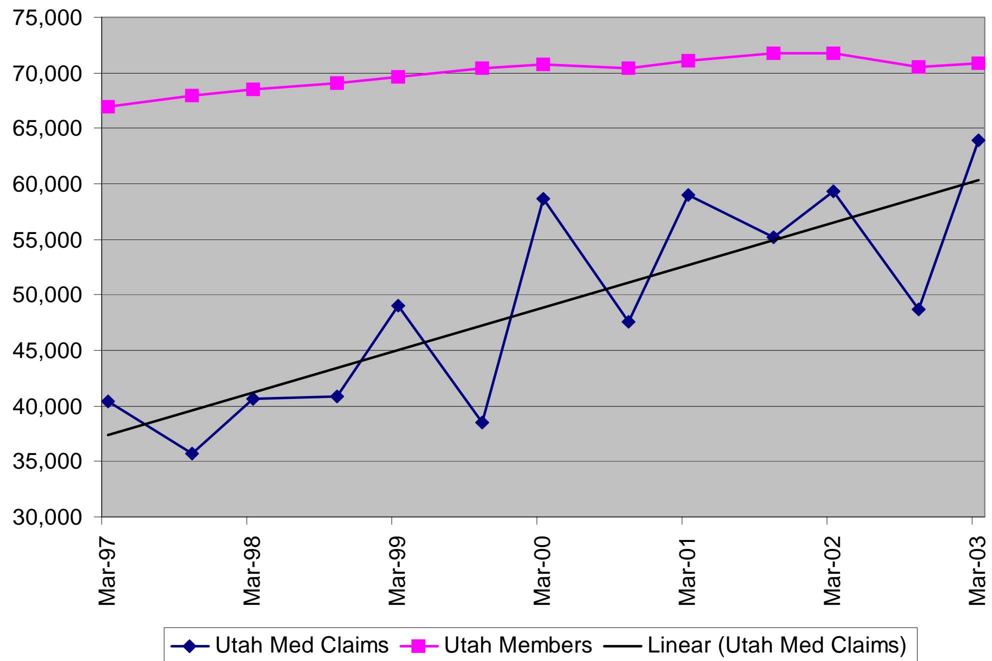
State of Utah employees and their families are using more medical and pharmaceutical insurance benefits. State members are using their benefits more frequently than their counterparts in other PEHP risk pools. Increased utilization eventually translates into higher overall premiums for members and increased costs for PEHP. PEHP explains that these higher costs for state members compared to PEHP's other risk pools are governed by three factors: state members are utilizing more services, members are utilizing more costly services than other PEHP members, and the benefits offered to state members are better than those offered to other PEHP groups.

Increased Member Utilization Generates Higher Premiums

Since 1997, state members' claims have increased 58 percent.

In addition to the growing cost of health care services, PEHP member premiums are increasing because member service utilization is increasing. State of Utah PEHP membership has grown by approximately 5,000 individuals (6 percent) since March 1997. During the same time period, the number of medical claims filed by membership has increased by nearly 25,000 claims (58 percent). Figure 5 shows the growth in state membership compared to the number of medical claims filed for the last six years.

Figure 5. State Membership and Medical Claims Growth. State medical claims utilization is outpacing membership growth.



Since 1997, members have utilized, per member, more medical services. The increased utilization of services has resulted in increased per member per month (PMPM) and per member per year (PMPY) utilization rates—these units are used to generate future premium rates. In order to compare utilization patterns, insurance analysts use the PMPM and PMPY units to make sure comparisons are fair and accurate. As the following figures show, state members are using more medical and prescription services per member per year as compared to PEHP's other risk pools. PEHP's other risk pools are using more dental services per member per year.

State Members Are Using More Services than in the Past

Utah members are using more medical and pharmaceutical services than PEHP's other members.

By looking at utilization data on a PMPY basis, state member utilization can be accurately analyzed. PEHP data shows that state members are utilizing more services than members of other PEHP's risk pools. However, benefits offered to state members are also better than those offered to other PEHP groups and may account for some of the differences in use of medical, prescription, and dental services between state members and other PEHP groups.

Since 1998, state usage of medical services grew 44 percent while PEHP usage of medical services increased 20 percent.

As noted in Figures 6, 7, and 8, state members have a higher PMPY utilization rate in medical and prescription claims, but not in dental claims.

Figure 6. State of Utah and Other PEHP Medical Per Member Per Year (PMPY) Utilization Comparison. State use of services are higher, but growth rates are similar to PEHP's other risk pools.

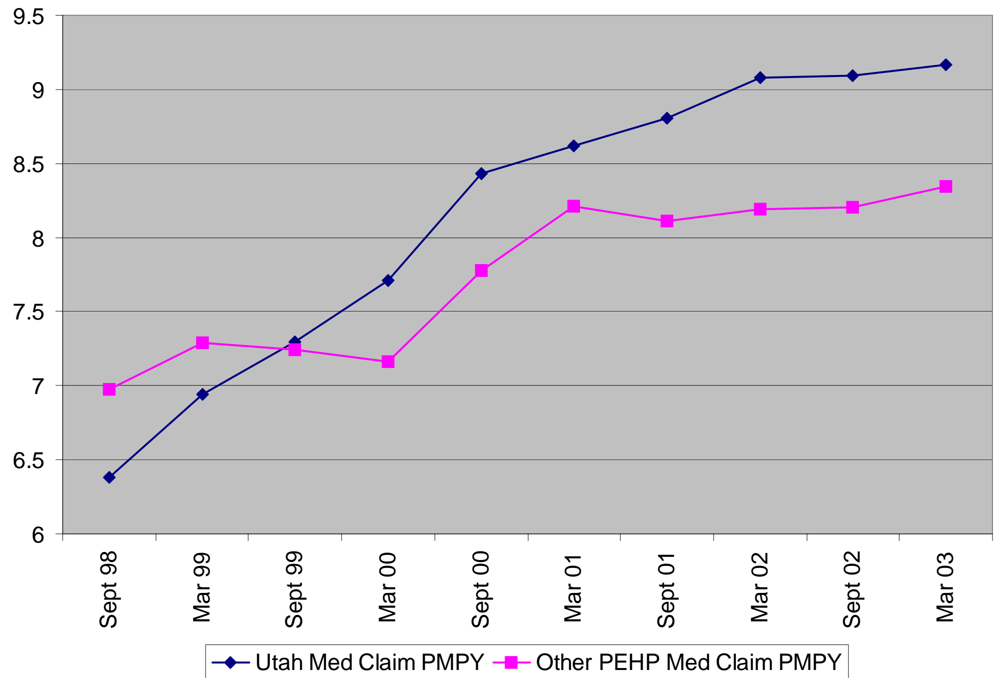
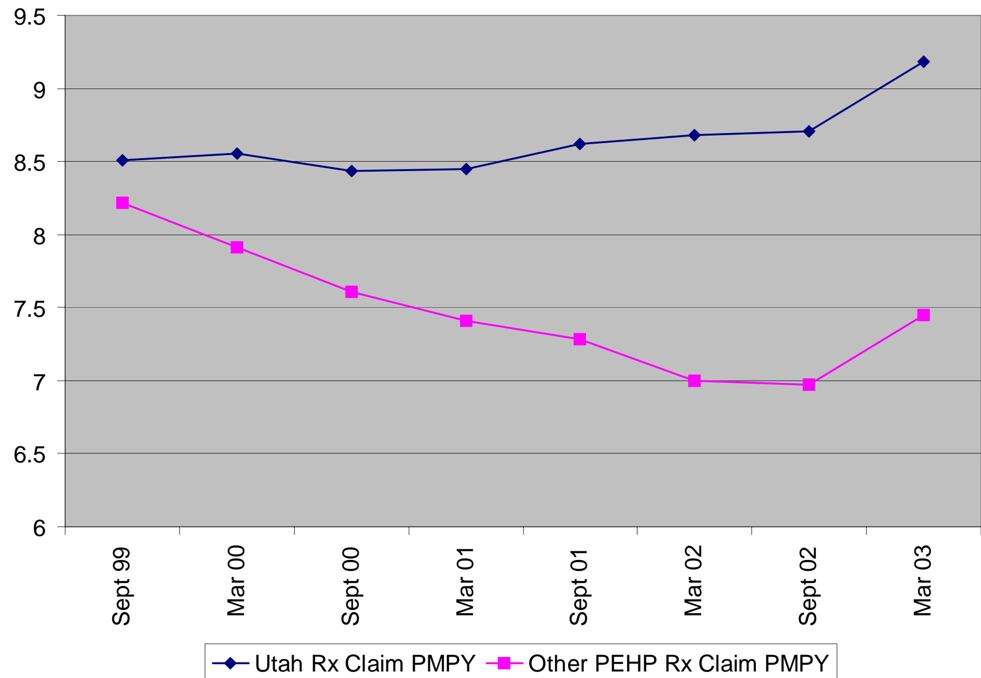


Figure 6 shows that state and other PEHP's medical risk pools PMPY growth trends are similar. However, the percentage change of the PMPY rates shows a clearer picture of the actual growth rate. Since 1998, state PMPY utilization increased 44 percent. In comparison, PEHP utilization increased 20 percent for the same time period. The drop in medical claims per member for PEHP in March 1999 is the result of gaining membership through the addition of a new risk pool—the Utah School Board Association (USBA). The USBA risk pool consists of several of Utah's school districts. Therefore, PEHP's medical claims are lower because claims were then applied to the larger population of PEHP's other risk pools.

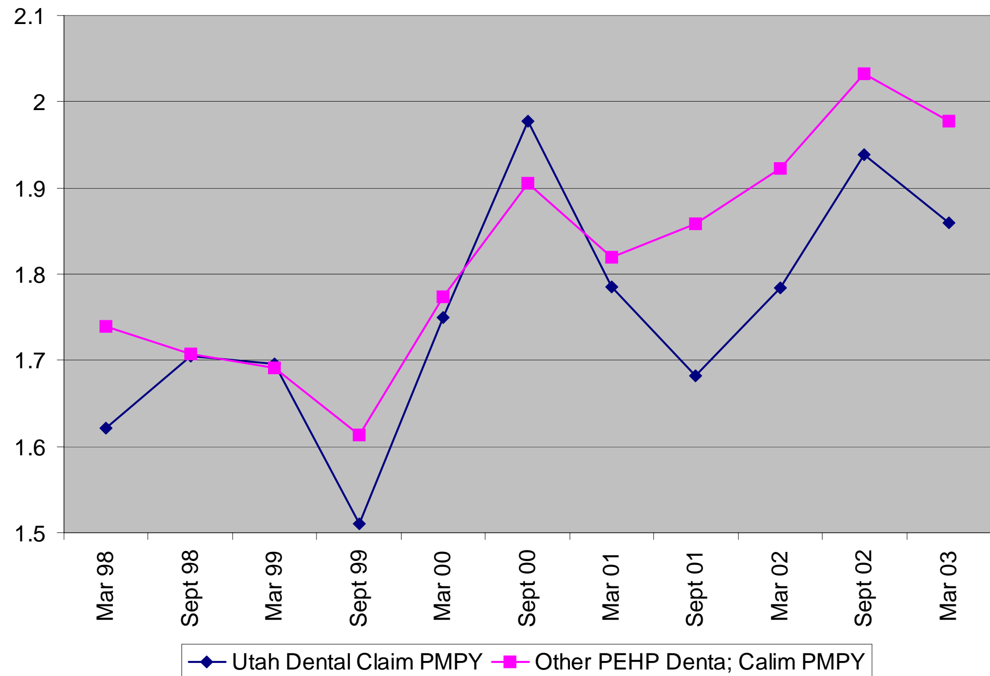
Figure 7. State of Utah and Other PEHP Prescriptions Per Member Per Year Utilization Comparison. State prescription utilization rates are higher than PEHP's other risk pools.



Since 1999, Utah's prescription use increased 8 percent.

Figure 7 shows that the state and PEHP's other employer groups prescription growth trends are similar. However, the percentage change of the PMPY rates show a clearer picture of the actual growth rate. Since 1999, the state's prescription PMPY utilization increased eight percent. In comparison, PEHP's other employer groups utilization decreased nine percent for the same time period. Prescription benefit utilization and cost growth will be discussed in greater detail in Chapter V.

Figure 8. State of Utah and Other PEHP Dental Per Member Per Year Utilization Comparison. Other PEHP employer groups' utilization of dental services is generally higher than state members.



State use of dental services increased 15 percent to PEHP's 14 percent. However, PEHP members still use their dental services more often.

Figure 8 shows the state's and PEHP's other employer groups dental PMPY growth trends are increasing. Dental utilization per member is lower for state members compared to PEHP members. The percentage change of the PMPY rates shows that state members' dental utilization increased 15 percent to PEHP's 14 percent from 1998 levels.

Utilization Helps Determine Premium

PEHP analyzes claims and premiums to determine future coverage rates.

Utilization is one of many factors that drive premium levels. PEHP looks at claims divided by premiums, the loss ratio, as a guideline to help determine if premiums need to be increased. When the loss ratio is consistently above 96 percent, PEHP has to consider increasing premiums to cover claims expense and administrative costs because, at that level, slight cost increases could negatively affect reserves. The figure below shows the loss ratio for the State of Utah for the past five years.

Figure 9. State of Utah's Aggregate Loss Ratio. The loss ratio for the state has recently been decreasing.

Year	Claims	Premiums	Loss Ratio
1998	$ 71,159,910	$ 70,962,951	100%
1999	88,023,537	82,042,925	107
2000	100,830,664	93,063,257	108
2001	120,672,457	119,171,563	101
2002	132,231,346	142,198,037	93

The State of Utah risk pool loss ratio is improving.

The loss ratio for the State of Utah increased through 2000 then, as a result of earlier premium adjustments, decreased in 2001. Even though the loss ratio continued to decrease to 93 percent by 2002, PEHP still had to consider the factors, mentioned earlier in the chapter, to determine if the premium rate increases for 2003 would be necessary to prevent further reductions in reserves.

Several Factors Have Contributed to Increased Health Insurance Costs

The most influential factors contributing to increased insurance costs are prescription drugs, age, medical technology, market conditions, and changes in the managed health care industry.

A variety of inter-related factors have contributed to the general rise in health insurance costs. According to research literature, the most important factors contributing to premium increases include prescription drug use, an aging member population, technological advances, market consolidation, and a "backlash" against managed care.

Prescription Drug Spending. A recent study found that prescription drug spending nationwide grew an average of 19 percent from 1999 to 2002, making it the fastest growing area of health care spending. Prescription drugs accounted for 22 percent of the total growth in health care spending. The study attributed the rapid growth in prescription drug spending to three factors: inflation of drug prices, increased member utilization of prescription benefits, and newly released drugs on the market.

Age is a factor contributing to most of the costs associated with health care inflation.

Aging Population. The age of an insured population is an important determinant of health care costs. As employees grow older, health care costs increase. National estimates of annual average expenditures for

persons over the age of 45 are approximately twice the average annual expenditures for person under the age of 45. The average age of commercial business employees with a local insurance carrier is 41.1, and the average age of covered members is 28.3. The average age of the state employee is 44.7, and the average age of covered state member is 30.2. It appears that state employees and members are two to three years older than members in commercial business groups; this age difference contributes to the state's increased costs.

Technological Advances. During the past few decades, rapid advances in medical technology, including new medical equipment, procedures, and treatment therapies have helped many people. Technological advances, while improving the quality of life, generally raise rather than lower health care costs.

In 2002, Utah's insurance market was dominated by four companies, accounting for 94 percent of the local market.

Market Conditions. Some health care cost increases are due to the increased number of consolidations at both the health plan carrier and provider level. Although consolidation proponents cite efficiency and quality control as the primary motives behind consolidation, opponents emphasize the anti-competitive nature of health care mergers. PEHP negotiates health plan contracts in a limited marketplace of health plans and providers. According to the Department of Insurance, the health insurance market in Utah is dominated by four large companies that enrolled 93.6 percent of the insured market in 2002.

Managed Care Backlash. Consumer demands and expectations are other factors that research cites as contributing to rising costs—often described as a "backlash" against managed care principles. Consumers have stepped up their demands for more access to health care services. Consumers often view the restrictions inherent in managed care plans as threats to health care quality. Furthermore, consumers think that managed care sometimes saves money by simply rationing services rather than providing services more efficiently. Dissatisfaction with their ability to make health care choices has resulted in consumers moving away from the less costly, more restrictive forms of managed care, such as HMOs, into more costly, less restrictive plans, such as the PPO plan.

As a result of this "backlash," PPO membership is increasing. For 2003, 54 percent of State of Utah's membership is enrolled in the PPO plan. In 2002, 52 percent of employees nationwide were enrolled in PPO plans, up from 48 percent the previous year and 41 percent in 2000.

Nationwide enrollment in HMO plans was 26 percent in 2002. HMO enrollment in 2001 was 23 percent—lower than any other year since 1993. For the remaining 22 percent, nationwide employees are enrolled in other health plans such as indemnity and point-of-service plans.

In addition, health plans nationwide are becoming less restrictive in that provider networks are getting broader, and some managed care requirements, such as gatekeepers and preauthorization requirements, have been relaxed somewhat. As of 2002, State of Utah members enrolled in PEHP's HMO plans were no longer required to obtain a referral from their primary care physician to see a specialist.

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Chapter III
PEHP Controls Costs and Offers Good Benefits

PEHP compares well when measured to the local insurance industry and other states' insurance plans. PEHP offers comprehensive and competitive health, dental, and life insurance to State of Utah employees and their families. Overall, PEHP appears to control their costs and provides excellent insurance benefits to state members.

PEHP Is Competitive Compared to the Local Industry

PEHP appears to control their costs when compared with the local health insurance industry. PEHP was compared with five major local health insurance carriers in terms of administrative costs, contract rates with provider groups, total claim costs, frequency of office visits, and number of days spent in hospitals—some of the significant factors that drive premium rates. The surveyed insurance carriers comprise 84 percent of Utah's market. Actuaries from each of the insurance carriers as well as other actuaries were consulted to develop an appropriate methodology for making a reasonable comparison among the insurance carriers. The data time frame used for this comparison was calendar year 2002. The information requested from local carriers is in Appendix C.

PEHP Administrative Costs Are Low

Low administrative costs save the state over $6 million annually.

PEHP's administrative costs were the lowest of the local insurance carriers participating in this survey. PEHP's administrative costs are 66 percent less than the industry average. On an annual basis, the State of Utah realizes over $6 million in cost savings due to PEHP's low administrative costs.

PEHP's low administrative costs, when compared with commercial insurance carriers, is expected because PEHP avoids intermediaries by self-funding and self-administering their health plans. As a public employer insurance program, PEHP has a limited marketing department; they don't advertise or pay commissions since they only compete with other carriers

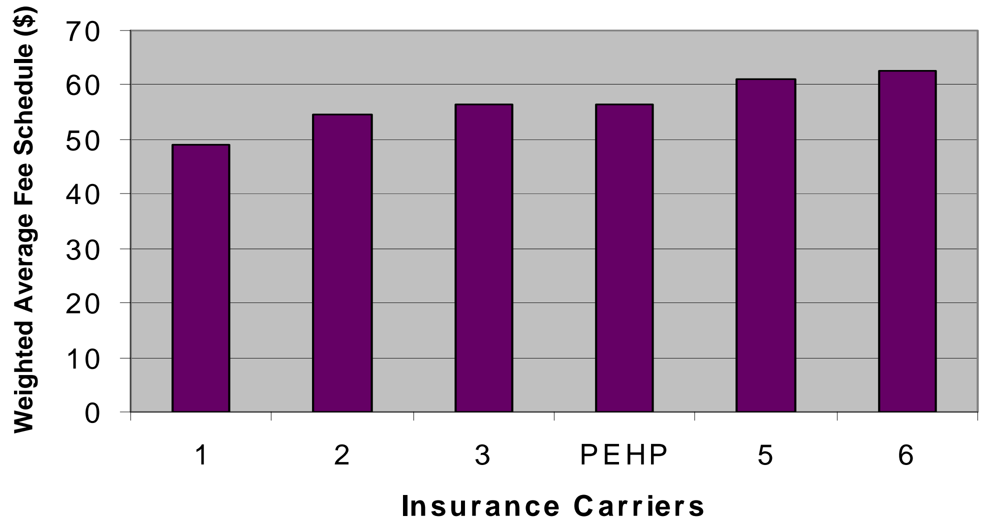
for business within the public sector. To make a reasonable comparison, administrative costs were compared on a per subscriber basis, and each carrier removed premium tax, commissions, and reinsurance charges. PEHP's administrative costs are discussed in detail in Chapter IV.

PEHP's Contract Rates Are Slightly Higher Than Some Insurance Carriers

PEHP's contracted fee schedule rates with health providers are slightly higher than the middle compared to other local insurance carriers' rates. This comparison applied the costs associated with each of the six carriers' fee schedules to PEHP's state member utilization over a 12 month period. In other words, an overall cost for each carrier was calculated, as if each of the carriers had paid for the same type and number of procedures used by PEHP members. The weighted average fee schedule for the insurance carriers is shown in the figure below.

For the 25 selected medical procedures, PEHP contract rates are slightly above the average.

Figure 10. Fee Schedules. PEHP's fee schedules are slightly above the middle among the insurance carriers.



Fee schedules are a listing of the maximum dollar amount that insurance companies pay health providers for specified medical procedures. For this comparison, each carrier provided their fee schedules for 25 different medical procedures. A copy of the fee schedule request, listing the 25 procedures, is in Appendix C. Insurance companies periodically

negotiate fee schedules with health provider groups. PEHP's negotiations have provided a cost savings for the State of Utah. For the services considered, PEHP is realizing a cost savings of almost $3 million over the carrier with the highest fee schedule, but the carrier with the lowest fee schedule is realizing an additional cost savings of $3.3 million over PEHP.

PEHP's Claim Costs Are Commensurate With the Local Industry

PEHP's two health maintenance organization (HMO) plans' claim costs were lower than the overall local carriers costs, while PEHP's preferred provider organization (PPO) plan's claim costs were average. Claims costs were analyzed using the allowed amount, the maximum charge that an insurance carrier will reimburse a provider for a given service, on a per member per month (PMPM) basis. The PMPM is the cost for each enrolled member each month. For this comparison all claims, including hospital claims and pharmacy claims, were reviewed. The two figures below show claim costs for the insurance carriers for both PPO and HMO plans.

PEHP's PPO claim costs fall in the middle of the surveyed carriers.

Figure 11. PPO Claim Costs. PEHP claim costs are in the middle of the other carriers.

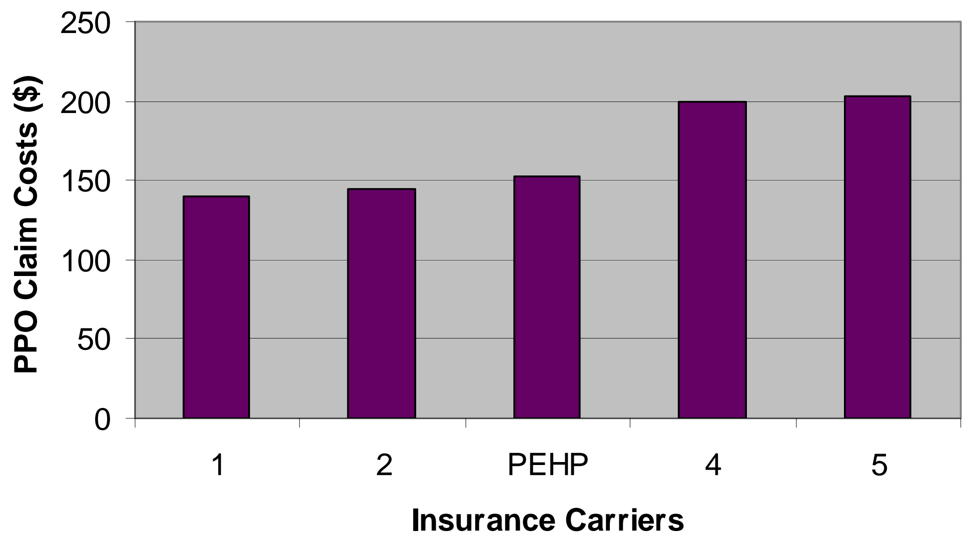
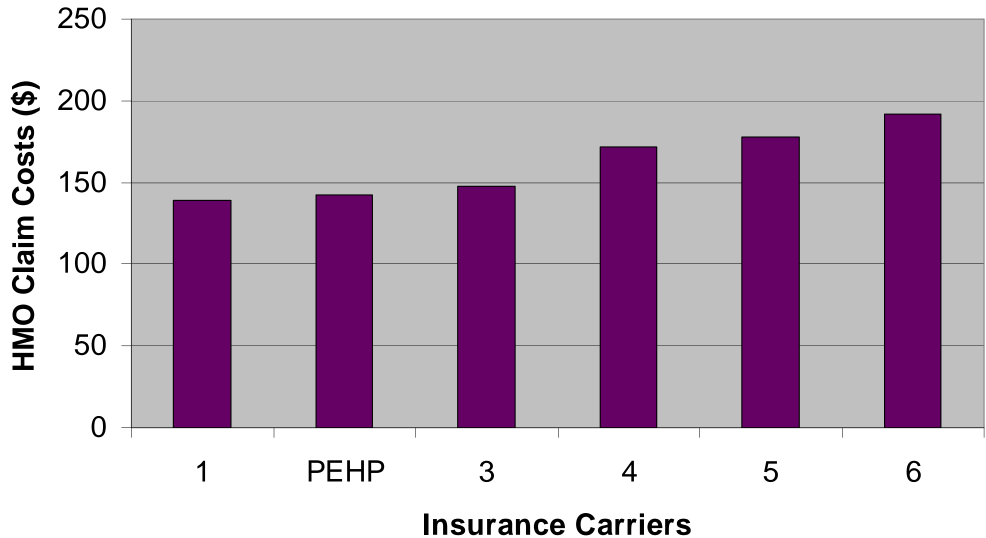


Figure 12. HMO Claim Costs. PEHP's HMO claim costs are second to the lowest.



PEHP HMO claims costs were among the lowest of the surveyed insurance carriers.

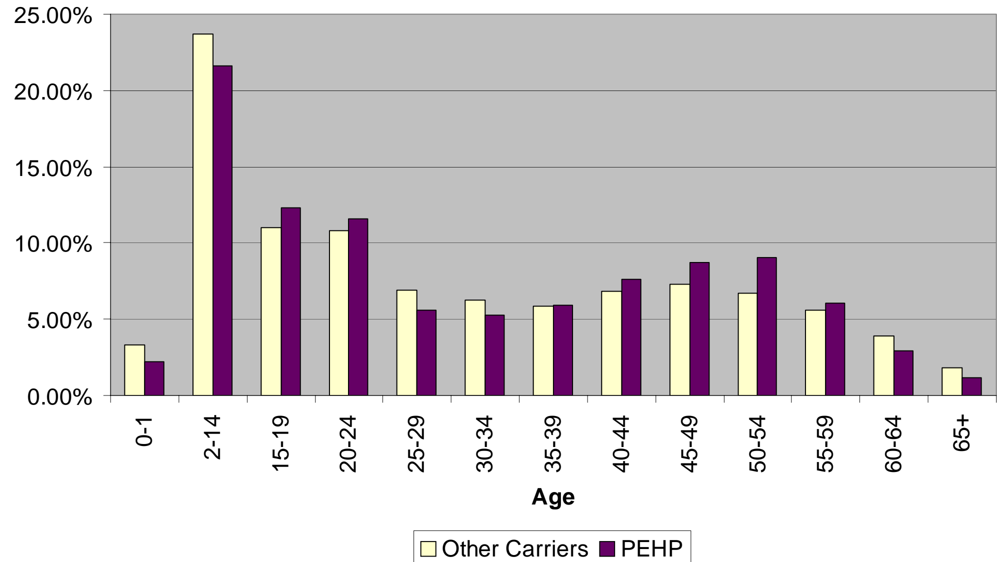
An additional analysis was done using the PMPM values for all claims, pharmacy claims, and administrative costs. These combined values provided an overall picture of costs associated with each carrier. Results were similar to the above analyses. For the HMO plans, only one local carrier would have had costs less than PEHP, and for the PPO plan, PEHP's costs again fall in the middle of the carriers.

It is difficult to make a precise comparison between carriers and plans, but the claim costs comparison provides a high level review. PPO plans offer a large selection of health providers and tend to cost more. HMO plans offer a more restrictive selection and tend to cost less.

Many factors influence PMPM, such as demographics—age and gender mix, the severity level of individual claims, fee schedules, contracts with facility providers, etc. One reason that the PPO plan has higher claim costs than the HMO plans is that the PPO option tends to have a higher concentration of members in the 40 to 60 age groups than the other carriers, which contributes to higher claim costs. The figure below shows PEHP's PPO membership ages compared to the other local carriers.

Age is a contributing factor to higher claim costs.

Figure 13. Comparison of Age Distribution Among PPO Plans. PEHP has more members in the 40 to 60 age groups than other insurance carriers.



Members in the 40 to 60 age group have more and higher costing claims, so a carrier with a higher concentration of members in these age groups would reflect a higher PMPM value. PEHP HMO plans' age distribution is consistent with the other carriers.

State members' utilization of office visits are in the mid-range compared to other carriers.

As part of this comparison, member use of office visits and the number of days spent in facilities were reviewed. Overall, State of Utah members are not visiting the doctor more frequently or staying longer in the hospital than other local insurance carriers' members. For the two HMO plans, utilization of office visits were in the mid-range of the other carriers, and the number of days spent in hospitals were less than the overall industry. For the PPO plan, utilization of office visits was slightly less frequent than the overall industry, and the number of days spent in hospitals were in the mid-range.

PEHP has made efforts to keep claims cost low. For example, PEHP brought case management in-house in 2002 to closely monitor high-cost members. A case manager works with the members, their families, providers, and PEHP to coordinate a comprehensive medically appropriate treatment plan for complex cases.

PEHP continues to educate members about health care costs.

Recently, PEHP added "myPEHP" to their internet site. The "myPEHP" internet site gives members access to their coverage information on-line. Members can review their coverage and search their claims history. PEHP needs to continue to educate members and help them become more aware of health care costs. In addition, PEHP's members have good benefits, and the Legislature may need to consider shifting more of the costs to members.

Utah Employee Benefits Compare Well with Other States

Utah state employees generally pay less for their medical benefits than their counterparts in selected states that offer self-funded plans. In comparing Utah with seven other states, Utah contributes the largest employer percentage of the monthly premium, and state employees generally have lower copayments for basic medical services. Utah, as do most states, offers several dental plans and a competitive basic life insurance program.

To obtain an accurate comparison, we only compared Utah to other states that had self-funded plans. As mentioned in Chapter I, for self-funded plans, the employer acts as its own insurance company and bears the financial risk of health care costs. In contrast, for fully-insured plans the insurance company bears the financial risk. A major advantage of self-funded insurance is that it eliminates insurance company profit gained through "risk charges" that are built into premiums and allows the employer to retain any reserves.

State employees are offered a choice among health plans.

Utah offers a variety of health plans to its employees: one PPO, two HMOs, and one indemnity plan. Plan variety is important as it allows users to individually tailor the insurance provided to their needs. Each plan represents a different mix of providers, services, and cost participation. Of the seven states in our sample, three offered more plans, three offered fewer, and one offered the same number of health plans as Utah (see Figure 14 below).

Figure 14. Health Plans Offered in Other States. Three of the seven states surveyed offer more plans to their employees than Utah.

State	Type of Plan			
	HMO[1] Offered	PPO[2] Offered	POS[3] Offered	Indemnity[4]
Kansas	4	2	0	1
Montana	3	0	0	2
Nebraska	1	1	1	0
Nevada	1	1	0	0
New Mexico	2	0	2	0
Washington	7	1	0	0
Wyoming	0	2	0	0
Utah	**2**	**1**	**0**	**1**

[1] ***HMO*** *(Health Maintenance Organization) is the most tightly controlled type of managed care plan. Services are provided through a restricted network of health care providers.*
[2] ***PPO*** *(Preferred Provider Plan) provide members with a financial incentive to receive care from a provider under contract, referred to as a preferred provider. Members can visit providers or hospitals not on the preferred list, but they pay more.*
[3] ***POS*** *(Point of Service) are considered "hybrids" in that they combine the cost controls of HMO and the provider choice of PPO.*
[4] ***Traditional Indemnity Plans*** *are insurance plans in which a member is reimbursed for covered expense. Members can use any covered health care provider they choose, but they also pay a larger portion of the cost for services.*

The State of Utah obtains cost savings by self-administering and self-funding their insurance benefits at PEHP.

Figure 14 presents all plans offered in each of the states in our sample. Utah is the only state among those surveyed that offers health plans on a self-administered basis—the administration of the plan is done by the employer. By self-administering the health plans, the state and employees realize additional cost savings.

Utah State Employees Pay Less for Medical Benefits

Utah employees pay lower monthly premiums than employees in other states surveyed.

We compared Utah's plans with those offered in other states based on the basic benefits. Overall, we found that Utah's health plans cost less to state employees in terms of monthly premiums and employee cost-sharing. But state employees' cost-sharing has increased over the last five years.

Insurance premiums do not cover the full cost of providing health care coverage because they exclude out-of-pocket expenses that employees have

to pay, such as copayments, coinsurances, and deductibles. Out-of-pocket expenses, such as a copayment, cover only a portion of a provider's total charge for a service. These cost-sharing mechanisms share costs with employees to help keep premiums low, educate employees about the true costs of health care, and help reduce unnecessary utilization of health services.

Utah's PPO Plan Offers Good Coverage. Utah's premium costs and basic benefits are compared with other states that offer self-funded PPO plans in Figure 15, shown below.

Figure 15. Comparison of PPO Health Plans. PPO members in Utah pay a smaller percentage of the monthly premium compared to the other states surveyed.

	Utah	Kansas	Nebraska	Nevada[1]	Washington	Wyoming[2]
PREMIUM COST SHARING—Single Plan						
Employee Share	**7%**	25%	21%	0%	12%	7% or 0%
Employer Share	**93%**	75%	79%	100%	88%	93% or 100%
Deductible	**$0**	$200	$400	$250	$200	$350 or $750
PREMIUM COST SHARING—Family Plan						
Employee Share	**7%**	25%	21%	42%	13%	60%
Employer Share	**93%**	75%	79%	58%	87%	40%
Deductible	**$0**	$400	$800	$500	$600	$700 or $1,500
BENEFITS—Member Costs						
Individual Out-of-Pocket Max	**$1,500**	$1,000	$1,400	$2,400	$1,125	$2,000/ $4,000
Lifetime Maximum	**Unlimited**	$2 million	Not Specified	$2 million	$1 million	$2 million
Office Visit - Primary Physician	**$ 20**	$15	20%	$15	10%	15%
Office Visit - Specialist	**$ 20**	$15	20%	$20	10%	15%
Inpatient Hospital	**10%**	10%	20%	20%	$200/Day $600 Max Co-pay/yr	15%
Outpatient Surgery	**10%**	10%	20%	20%	10%	15%
Emergency Room	**$ 50**	$75 then 10%	$ 50	$75	$75 then 10%	15%

1 *Rates include dental premiums*
2 *Wyoming offers two PPO plans with different deductibles*

Utah funds 93 percent of the PPO premium.

Utah is the only state of those surveyed that pays over 90 percent of the premium costs for the family plan. Employee fees for inpatient hospitalization, outpatient surgery, and emergency room visits in Utah are less than average. The $20 cost for office visits to a primary care physician in Utah appears somewhat higher.

Utah's Two HMO Plans also Offer Good Benefits to State Employees. Utah's plans were compared with three other states with self-funded HMO plans: Montana, Nebraska, and New Mexico (see Figure 16). The State of Utah contributes a higher percentage toward monthly premiums than do other states.

Figure 16. Comparison of HMO Health Plans. Utah's HMO plans cost state employees less in terms of monthly premiums and copayments for basic medical services.

	Utah	Montana	Nebraska	New Mexico
PREMIUM COST SHARING—Single Plan				
Employee Share	**2%**	0%	21%	38%
Employer Share	**98%**	100%	79%	62%
Deductible	**-0-**	$300	-0-	-0-
PREMIUM COST SHARING—Family Plan				
Employee Share	**2%**	varies*	21%	38%
Employer Share	**98%**	app. 73%*	79%	62%
Deductible	**-0-**	$600	-0-	-0-
BENEFITS—Member Costs				
Individual Out-of-Pocket Maximum	**$1,500**	$2,000 Single $4,000 Family	$1,500 Single $3,000 Family	$2,000 Single $6,000 Family
Lifetime Maximum	**Unlimited**	$1 million	Unlimited	Unlimited
Office Visit - Primary Physician	**$ 15**	$ 15	$ 10	$ 15
Office Visit - Specialist	**$ 20**	$ 15	$ 10	$ 15
Inpatient Hospital	**-0-**	25%	20%	$ 250
Outpatient Surgery	**-0-**	25%	20%	$ 75
Emergency Room	**$ 50**	$ 75	$ 50	$ 75

** Montana contributes enough money to cover 100% of each employee's monthly premium plus some extra to be used by the employee for purchasing coverage for dependents or life insurance.*

Utah funds 98 percent of the HMO premium.

Utah was the only state where employees did not pay for inpatient hospitalization and outpatient surgery for fiscal year 2003. Utah's HMOs copayments for emergency room and visits to primary care physician are

similar to the copayments in the other states. However, Utah's charges for an office visit to a specialist are higher than other states in our sample.

Approximately 50 percent of the states fund single coverage and family coverage at different percentage levels.

Utah employees pay the same percentage of the monthly premiums for both single and family coverage. In about half of the states, employees with family coverage pay a higher percentage of the monthly premium than employees with single coverage. The State of Utah employee coverage consists of the following: 57 percent have family coverage, 25 percent have employee and spouse coverage, and 18 percent have single coverage.

Looking at all 50 states, seventeen states pay the full cost of the premium for an employee with single coverage, the employee pays nothing, and in several other states the employee has the option of selecting a plan that the premium will be fully paid by the employer. Six states pay the full premium for family coverage. In most states, the amount paid by the employee varies by the plan and coverage option selected.

Utah's Insurance Benefits Are Higher as a Percentage of Total Compensation. Figure 17 compares and details wages and salary, insurance benefits, and other benefits as a percent of total average compensation for state and national employees.

Figure 17. State and National Insurance Benefits as a Percentage of Compensation. On average, Utah insurance benefits are higher to employees than other government workers, but wages are lower.

Insurance benefits comprise 18 percent of Utah employees' total compensation package.

	Utah State Government		State and Local Government Workers		Civilian Workers	
Compensation	**Hourly Rate**	**Percent**	**Hourly Rate**	**Percent**	**Hourly Rate**	**Percent**
Total Compensation	$28.41	100%	$31.20	100%	$23.20	100%
Wages & Salary	17.45	61	22.00	71	16.78	72
Insurance	5.13	18	2.78	9	1.56	7
Other Benefits	5.83	21	6.42	20	4.85	21

As noted in Figure 17, Utah state employees receive less in wages and salary as compared to other state and local workers. The difference can be attributed to a Legislative decision to pay a higher percentage of insurance benefit compensation rather than increase wages and salaries. However, the chart does not factor in differences in benefit levels or whether or not other state, local, and national employees are paying a higher cost-share for their insurance benefits.

Some benefits have decreased over time.

Some of the Health Care Costs Have Been Shifted to the Employees. State employees are offered good benefits, but looking at the past five years overall benefits have decreased. Some of the costs have been shifted to employees, which accounts for a portion of the decrease; however, health plans have also changed. State employees are offered more restrictive, tightly managed health plans than in the past. The state's benefits, such as physician visits, hospital services, etc., can be totaled to provide a total benefit value for each plan year. Total benefit adjustments since 1998 are as follows:

- 1998 – total benefits decreased 5.23 percent
- 1999 – total benefits decreased 2.79 percent
- 2000 – total benefits decreased 5.32 percent
- 2001 – total benefits decreased 2.47 percent
- 2002 – total benefits decreased 1.20 percent

Benefits were adjusted each year to compensate for rising health care costs, to help reduce the increase in premium rates, and as an incentive to help reduce utilization. Appendix D shows the actual change in the basic benefits for state employees for the last five years, while the list above provides the overall percentage change.

Utah Offers Good Dental Benefits and Other Insurance

PEHP provides good dental benefits through a variety of plan options.

Utah's three dental plans compare well to the self-funded plans offered in five other states (see Figure 18 below). Utah offers the highest number of plans and is the only state with no deductible. The coinsurance for basic dental services for Utah and four of the five states is the same (20%). The PPO plan in the State of Oklahoma charges 15 percent for basic dental benefits, but Oklahoma's coinsurance for the managed care plan is more than double of what Utah employees pay.

Figure 18. Comparison of Dental Plans. Utah's plans are the only plans that do not have a deductible for their members.

State	Types of Plans	Deductible Employee/Family	Employee's Coinsurance for Basic Services
Kansas	1 PPO	$35 / $105	20%
Montana	1 Managed Care	29 / 47	20
Nevada	1 PPO	50 / 150	20
New Mexico	2 PPOs	50 / 150	20
Oklahoma	1 PPO 1 Managed Care	25 (PPO) 0 (DMO)	15% (PPO) $5 then 50%
Utah	**1 Indemnity** **2 PPO**	**0**	**20**

Dental insurance is provided to employees or made available at employee cost in all fifty states. In some states, the availability of dental insurance depends on the health plan selected. In 20 cases, the state pays all of the costs for employee-only coverage. The employee pays all costs associated with individual dental insurance in 13 states.

Utah employees receive minimum life insurance at no cost to the employees.

Utah Employees Do Not Pay for their Minimum Life Insurance Coverage. Three of the five states surveyed provide their employees with minimum life insurance at no charge. Utah and Washington provide minimum coverage for $25,000 and Nevada for $40,000. The employees in the other two states, Montana and New Mexico, have to pay for minimum coverage.

Figure 19. Comparison of Minimum Life Insurance Coverage. Utah and two other states provide minium life insurance to state employees at no cost.

State	Minimum Coverage	Employee Monthly Contribution
Montana	$14,000	$2.80
Nevada	40,000	0
New Mexico	40,000	3.49 - 5.58*
Washington	25,000	0
Utah	**25,000**	**0**

** Depends on employee salary level.*

The most common of insurance plans provided to state employees, other than group health insurance, is life insurance. Forty-six states provide at least a minimum life insurance benefit at no cost to the employee, and four states offer insurance at some cost to the employee. Twenty-seven states base the amount of insurance on the employee's salary, 22 states provide a fixed dollar amount, and in 13 states insurance costs are age-related. Many states allow employees to purchase additional insurance or dependent coverage.

PEHP also offers accidental death and dismemberment (AD&D) and long-term disability insurance. Forty states provide AD&D insurance to their employees, and six states report that such insurance coverage is available at the employee's expense. With respect to disability insurance coverage, 20 states indicated that long-term disability insurance is provided.

Recommendation

1. We recommend that the Legislature continue to review employee compensation packages and make benefit and salary adjustments as necessary.

Chapter IV
PEHP Can Take Additional Steps To Be More Cost Effective

Overall, PEHP is well managed, but further efforts can be made. PEHP should monitor changes and trends in administrative costs to be more aware of increases in expenses and to determine if they are acquiring the goods and services needed to operate programs effectively and efficiently. They should follow their procurement policies and procedures to appropriately acquire goods and services. PEHP should also consider enhancing its smoking cessation program to benefit members and provide cost benefits. In addition, PEHP should continue to look for additional ways to recover overpayments sent to health providers.

Several of PEHP's operations and programs were reviewed in accordance with the audit objectives to determine if PEHP is managed effectively. The areas reviewed in this chapter include administrative costs and contingency reserves, procurement policies and procedures, prevention programs, and claims auditing.

Notable Changes and Trends in Administrative Costs Should be Reviewed

PEHP's administrative costs were reviewed to determine that costs are accurately distributed among the risk pools. Several expense line items had large increases within the last five years. PEHP should monitor changes and trends in administrative expense line items to determine if changes or trends are appropriate and in line with PEHP's objectives. PEHP should also continue to review reserves and make adjustments as needed to meet reserve requirements.

Administrative Costs Are Equitably Distributed Among Risk Pools

Administrative costs are allocated among the risk pools and lines of business and are appropriately factored into employer and employee contributions. After reviewing how PEHP allocates administrative costs

among the medical and dental risk pools, administrative costs are equitably allocated to participating employers within risk pools.

A risk pool is funds used for defined medical or dental expenses.

Each participating employer or agency in PEHP's medical and dental programs is a single or part of a "risk pool"—a pool of funds set aside to be used for defined expenses, such as medical or dental. The size of the agency determines whether the agency can be a single risk pool or be part of a multi-employer risk pool. Employers should have at least 1,000 employees to financially support a self-funded medical or dental risk pool.

PEHP divided its insurance programs into six service areas (business lines): medical, dental, long-term disability, term life, retiree life, and death benefit. Each of the last four lines of business stand alone and are not subdivided into risk pools. Medical and dental lines of business have several risk pools based on the size of participating employers. These lines serve the purpose of establishing employer/employee contribution rates, providing policyholder dividends, and retaining the risk of loss from such insurance products within the pools. PEHP has nine risk pools within its medical line and four risk pools within its dental line of business.

State of Utah members comprise 48 percent of PEHP total membership.

Administrative costs for medical and dental lines of business and risk pools have been allocated to the employer groups based on the group's percentage of membership. For example, the state's medical membership is 48 percent of total membership, so the state is allocated 48 percent of the administrative costs for their medical risk pool.

PEHP's newly developed model will improve allocation of administrative expenses among the risk pools.

PEHP recently developed a model allocating the administrative costs for the lines of business based on the expenses incurred by the individual employer groups at PEHP. For example, if an employee spends half of his or her time working with the state's group and half of his or her time working with Salt Lake City's group, then half of the costs incurred would be allocated to the state's portion of administrative costs and half to Salt Lake City's portion of administrative costs. PEHP is now implementing this model.

The allocation of administrative costs based on the new model showed a similar allocation as the method based on membership. The model confirms that allocating administrative costs based on membership has been an equitable method for distributing administrative costs among the risk pools. For fiscal year 2002, the new model showed that for the medical risk pools the allocation of administrative costs based on employer

use resulted in an average difference of 1.5 percent from the allocation based on membership. The state employee medical risk pool difference was 2.4 percent. The new model decreased the state's medical administrative costs by $386,601 and would appropriately allocate that amount to other risk pools where the expense occurred.

The dental risk pools resulted in an average difference of 4 percent from the allocation based on membership. The state employee dental risk pool difference was 5.9 percent. The new model increased the state's dental administrative costs by $326,996. But combining the difference for both the medical and dental pools for 2002; the model decreased administrative costs by $59,605 or 1.1 percent. PEHP will begin allocating administrative costs using the new model during fiscal year 2004.

Several Expenses Have Contributed to the Increase of Administrative Costs

For the last five years, administrative costs averaged four percent of premium; however, total administrative costs increased 111 percent over this same five year period. It is difficult to determine if this increase in administrative costs is reasonable due to many factors that affect administrative costs such as membership, claims, medical inflation, etc. For the last five years, total PEHP membership has increased 37 percent, total medical claim count has increased 73 percent, and medical inflation has increased between 12 to 19 percent annually.

PEHP administrative costs average four percent of premium.

In Chapter III, administrative costs were compared to intrastate carriers, who provided the information for a comparison. That comparison showed that PEHP administrative costs per employee are low compared to the other carriers. It would be difficult to compare administrative costs as a percentage of total costs with other states because the structure of those programs and the supporting information could not be verified. PEHP's administrative costs were reviewed by line item to determine which line items constituted the majority of the administrative costs, and which line items have had large increases in recent years.

Figure 20 shows, on average, the most significant administrative expenses for the last five years. Administrative costs for 2002 were $11,412,566. Salaries, wages, and benefits are the largest administrative expenses. For the last five years, salaries and benefits have consistently averaged 59 percent of total administrative expenses. PEHP's administration and employee salaries appear reasonable. The number of

full-time employees (FTEs) also appears reasonable. PEHP's growth will be discussed later in this chapter. Appendix E shows the expenses for each of these ten line items for the last five years.

Figure 20. Significant Line Items. For the last five years, these ten line items constituted the majority of administrative costs.

Line Item	2002 Expense	Percent of Total Administrative Costs
Salaries and Wages	$ 4,745,663	42%
Benefits	2,293,564	20
Office Rental	550,536	5
Printing and Binding	511,394	4
Postage and Handling	395,354	3
Consulting Services	268,326	2
Legal Services	251,695	2
Main Frame Hardware	211,574	2
Temporary Labor	120,791	1
PC Hardware	108,165	1
Other Line Items	**1,537,878**	**13**
Total	**$11,412,566**	**100%**

As expected, salaries and wages constitute the highest percentage of administrative costs at 42 percent. Salaries and benefits combined account for 62 percent of administrative costs.

Administrative line items that showed the largest increases within the last five years were reviewed. Figure 21 below shows the line items that have increased more than $100,000 in the last five years.

Figure 21. Largest Increases in Administrative Costs. For the last five years, these seven line items have increased $4.4 million.

Line Item	Dollar Increase	Percent Increase
Salaries and Wages	$ 2,441,874	106%
Benefits	1,086,787	90
Printing and Binding	222,740	77
Office Rental	190,686	53
Consulting Services	169,675	172
Legal Services	148,388	144
Telephone	162,781	236

PEHP does a cursory review of administrative costs monthly and a more in-depth review annually during the budget preparation process. During these reviews, PEHP should look for notable changes and be aware of trends in administrative costs. From these reviews, PEHP should have an understanding of increases/decreases by line item, and make the determination if expenses are appropriate to meet the objectives and goals of the organization. Below is a summary of the increases in the seven line items listed in the figure above.

FTEs have increased 54 percent since 1998 to handle the program's growth.

Salaries, Wages and Benefits. The most significant administrative increases are for salaries and wages. Salary and benefit increases are mainly due to the increase in FTEs. Forty-nine FTEs have been added throughout the organization over the last five years to handle the workload increase caused by PEHP's membership growth. Merit and cost-of-living adjustments (COLA) explains a portion of the increase. For the last five years merit and COLA increases averaged 4.3 percent per year.

Looking back at the last five years, FTEs were added to manage the new groups that PEHP acquired. New groups include CHIP, Utah School Board Association (USBA), Box Elder School District, Murray City, Dixie State College, and Salt Lake City – dental. These new groups increased PEHP's total membership by 31,000. Also, some positions were added to meet the demands caused by growth in the existing groups. Case management was brought in-house, as well as some actuarial functions, which required additional FTEs. One FTE was also added to handle the state's flex plan administration.

Printing and Binding. Printing and binding costs have also increased due to membership growth. PEHP membership has increased by approximately 40,000 members or 37 percent since 1997, and, thus, the quantity of publications needed has increased. In addition, PEHP offered another plan, Summit Care, to the state and local government's risk pools. This addition created a need for a new provider list and additional pages in the benefits booklet.

PEHP membership has increased 37 percent since 1997.

Office Rental. PEHP has acquired more space at Utah Retirement Systems (URS). In the last four years PEHP space has increased by 85 percent. This increase includes the mail room that is shared with URS. Even though PEHP has expanded, PEHP did renegotiate a lower rental rate with URS in 2000.

Consultant Services. PEHP uses consultants to provide a variety of services. Some consultants have provided a one-time service, while a few consultants have provided continual or periodic services for several years.

Two consultants have provided services for several years. A data processing consultant has helped PEHP with tasks such as developing PEHP's data processing system, pharmacy processing system, case management system, policy holder reporting package, and other data processing needs. A business process analyst has reviewed several PEHP business processes including a feasibility study to combine the PEHP mail room and URS mail rooms and reviews of claims auditing, enrollment, and customer service functions.

The services provided by both of these consultants have contributed to the increase in the consultant services costs. Figure 22 below shows the fees PEHP has paid both of these consultants since 1998.

Figure 22. Fees Paid to Two Consultants. These two consultants' fees have become the majority of the consultant services line item costs.

Year	Data Processing Consultant	Business Process Consultant	Combined Total
1998	$ 10,575	$ 4,956	$ 15,531
1999	62,955	34,824	97,779
2000	57,690	73,889	131,579
2001	33,210	56,989	90,199
2002	97,860	104,325	202,185
Total	$ 262,290	$ 274,983	$ 537,273

PEHP should determine if needed services or projects should be outsourced, or if some of the projects could be completed more cost effectively in-house.

The services provided by these two consultants have contributed to the increase in consultant services costs. For 2002, their fees combined totaled $202,185 or 75 percent of the year's total consulting costs of $268,326. After reviewing the invoices detailing the services provided, we question if all services were appropriately outsourced. PEHP should determine if needed services or projects should be outsourced, or if some of the projects could be completed more cost effectively in-house.

Legal Services. PEHP's internal legal services separated from URS and PEHP in 1993. Now, as external counsel, PEHP has the same basic legal support, but legal services costs as approved by the board have increased significantly. To respond to the increase in the number of PEHP's employer groups in recent years, PEHP's law firm has dedicated the equivalent of one full-time attorney to handle appeals, especially Long-term Disability appeals, and to provide counsel to new programs, which include CHIP, Utah School Boards Association (USBA), and the State of Utah's flexible spending program. In addition, the law firm negotiated contracts with new entities providing services to PEHP, such as the HMO plans—Summit Care and Exclusive Care. Figure 23 below shows PEHP's legal fees for the past 10 years.

Figure 23. PEHP's Legal Fees. Legal services have been outsourced since 1993.

Year	Legal Fees	Year	Legal Fees
1993	$ 56,356	1998	$ 165,832
1994	73,961	1999	260,119
1995	66,404	2000	210,311
1996	107,153	2001	172,658
1997	103,307	2002	251,695

PEHP legal services have increased over 144 percent in the past five years.

Legal fees most significant increases were in 1998 and 1999. In 1998 legal fees increased 61 percent, and fees increased 57 percent 1999. During those two years PEHP experienced a lot of growth and added new groups including Dixie State College, Murray City, Salt Lake City – dental, and Box Elder School District.

Telephone Expense. Utah Retirement Systems (URS) allocates the telephone expenses between URS and PEHP. PEHP has always paid for their long distance phone calls, but in the past URS did not charge PEHP for hardware, maintenance, or other related expenses. Two years ago URS began allocating expenses, so that PEHP is now paying their share of all related telephone expenses, and these expenses resulted in an increase in line item costs.

PEHP has experienced significant membership growth the past few years. As seen above, this growth has increased administrative costs in PEHP's organizational activities.

Contingency Reserves Help Reduce Financial Risk

Reserves are generated from premiums to provide a fund for committed but undelivered health care services and other unanticipated financial liabilities. PEHP is in a difficult position because they cannot meet actuary recommendations and management goals using standard premium and expense management procedures without exceeding the federal limitation for the state employee medical and dental risk pools.

Management of the state employee risk pools within the federal limitation leaves the risk pools at risk of deficits resulting from one or more

of the items enumerated below. These deficits could be avoided or mitigated by state contributions that do not include any federal funds. This change would require separate tracking of state and federal funds, or buyout of the federal portion of reserves.

Actuarial principles require self-funded plans to maintain contingency reserves. Reserves are monies earmarked to cover unanticipated claims and operating expenses. Contingency reserves protect the employer from financial risk. Specifically, contingency reserves are designed to cover the following:

1. Unexpected changes in medical or dental trend,
2. Changes in medical or dental practice leading to higher cost or use,
3. Epidemics and other catastrophic health care costs,
4. In-house catastrophic events requiring outsourcing of claim processing and/or other functions,
5. Loss of one or more large employer groups reducing the base over which costs can be spread, and
6. Fluctuations in the earning power of investments.

PEHP must balance conflicting industry standards and federal requirements governing contingency reserves.

Industry standards dictate it is appropriate to have medical and dental contingency reserves at a level no lower than that equal to three months of annual claims, so PEHP also uses this benchmark for all other medical and dental lines of business and risk pools.

On the other hand, federal requirements limit the contingency reserve level to no more than 60 days of cash expense for those lines of business and risk pools that contain federal funding. If reserves rise above 60 days, then the excess federal amount must be returned to the federal government. The risk pools that contain federal funding are the state medical, state dental, and long-term disability line of business.

Figure 24, below, shows the reserves for the two risk pools and long-term disability line of business that are needed to meet the federal requirement.

Figure 24. Reserves Monitored by the Federal Government. Reserve levels have two conflicting goals: following federal limits and maintaining sufficient reserves for actuarial soundness.

2002 Year End Reserves			
Risk Pool or Line of Business	Actual Percent of Annual Claims	Federal Limit	Actuarial Goal
State Medical	9.8%	16.7%	25%
State Dental	39.6	16.7	25
Long-term Disability	31.8	16.7	25

Even though state medical reserves are below the federal limit, they should be increased closer to 16.7 percent. Since PEHP has been partially funding the premium increase from contingency reserves to lower the state dental reserves, they were not required to return the excess portion to the federal government. The long-term disability line of business is above the limit, so PEHP returned the excess federal portion in the amount of $212,391.

With a benchmark of 25 percent, the state employee dental risk pool is currently at 40 percent, which is above the recommended level. Even though the reserve amount is high at this time, reserves are volatile and fluctuate depending on the number of claims. The state employee medical risk pool, which is more volatile, is currently below the recommended level by 15 percent. In order to increase the contingency reserves for the medical line of business to the recommended level, contribution rates must be increased. For the July 2003 - July 2004 plan year, PEHP has increased employer and employee medical contributions by 8.5 percent for all plans.

Procurement and Contract Procedures Can Be Better Defined

PEHP should closely follow their established procurement policies. PEHP should have contracts in place for business transactions with consultants, insurance carriers, and health providers and prudently define contract terms and conditions. To prevent potential conflicts of interest, PEHP should also avoid related-party transactions.

PEHP Should Follow Established Purchasing Policies

PEHP has purchasing policies and procedures that approximate those of the state. PEHP generally follows these procedures to procure consultants. However, procurement procedures and contracts with consultants can improve.

Of nine consultants to whom PEHP paid fees in excess of $5,000, two were procured using an Request for Proposal (RFP), one a written bid, and three were sole-sourced. Three other consultants were not competitively selected. According to PEHP procurement policies, of the three noncompetitively bid consultants, one should have been procured with a written bid, and the other two should have gone through the RFP process. These three consultants provided services for multiple years, and each consultant received more than $20,000. It is difficult for PEHP to assure that it got the best service for the least cost for those three consultants.

Selecting a consultant isn't based on cost alone; it often involves making judgmental decisions. According to policy, consultants being considered for expensive projects and/or multiple projects should generally be selected using an RFP, so PEHP can consider experience, qualifications, references, and capability to complete the project within time and budget—those items that set consultants apart from one another.

By following their procurement procedures, PEHP can be more assured of procuring qualified consultants to meet their needs at a reasonable cost.

PEHP's purchasing policies are similar to the state's policies. As with the state, PEHP's policies don't require an RFP unless purchases are over $20,000. It is usually not cost effective for an organization to advertise if a project is less than $20,000. For projects under $20,000, PEHP should generally obtain a competitive written bid. For one-time, low-cost projects under $10,000, PEHP doesn't need to do a formal bid or RFP, but they should obtain three written or telephone bids. On occasion, it may be necessary to sole-source for a very specific project, given the unique nature of the business. By following procurement procedures, PEHP can be more assured of procuring qualified consultants to meet needs at a reasonable cost.

Contract Guidelines Can Be Improved

PEHP can also tighten their contract procedures and better define contract terms and conditions. PEHP should always have a signed contract in place with consultants, insurance carriers, and health providers to fully delineate and protect PEHP's needs. Of the nine consultants reviewed, PEHP did not have a contract with one consultant. Another did not have a contract for the first year of service. A third consultant did not have a contract for the first two years of service.

PEHP contractual agreements can be improved through more specific terms and conditions.

The lack of contracts is not exclusive to consultants; PEHP did not have a contract with one health provider for several years. PEHP had only a verbal agreement with the health provider since 1995. A contract was not in place until 2002, even though the health provider asked PEHP to sign an agreement in 1998.

In addition to not having a contract, PEHP can be slow to renegotiate. PEHP's 2001-2006 contract with the Department of Health (DOH) went nearly a year without signing. The old contract expired in July 2001, and the new contract was not finalized until April 2002. It appears that both PEHP and the DOH could have taken steps to expedite the process so the contract could have been completed in a more timely manner.

PEHP should generally avoid open-ended contracts so a consultant or vendor cannot take advantage of the situation by taking longer than necessary to complete the contracted work. In the past, PEHP has had several open-ended contracts and two large contracts that have exceeded six years. A common time frame for contracts is three years. Options to renew vary, but generally they don't go longer than three years. If services are needed after a three year renewal, PEHP should consider obtaining new bids to help assure procurement of the best available consultant.

PEHP should also include a conflict of interest statement in the contract's terms and conditions or in the RFP. The statement should require a consultant or vendor to disclose possible conflicts of interest; then PEHP can make the decision whether it is appropriate to do business.

PEHP Should Avoid Related-party Transactions

PEHP should avoid related-party transactions to help prevent conflict of interest situations from developing and avoid the appearance that

business decisions could be made in favor of the related-party rather than the best interest of the organization.

A related-party transaction can create potential conflicts of interest.

A related-party transaction occurs when PEHP purchases goods or services from someone, or an entity that employs someone, that has a close relationship with a key employee of PEHP. Related-party transactions should be avoided because they can create potential conflicts of interest. In 1999, PEHP entered into a business contract with another insurance carrier where PEHP's director's spouse is employed. This related-party transaction could create a potential conflict of interest.

In 1999, PEHP had a contract with only one HMO network. However, PEHP wanted to contract with a second HMO network to provide PEHP's members with another health plan option and offer an opportunity for competition within the insurance community. Before PEHP considered pursuing the procurement process, the director disclosed that his spouse worked for an insurance carrier to the Utah State Retirement Board and the executive director of Utah Retirement Systems.

With the board's acknowledgment, PEHP administration acquired a consultant to develop a RFP to procure a second network. The consultant sent an invitation to nine companies to respond to an RFP. Only two companies responded. The consultant performed an analysis of the two responses and sent the results to a selection committee. A seven-member selection committee, not including the director of PEHP, selected the insurance carrier that would provide the additional network. The carrier that was selected was the only logical choice. The carrier selected was the only one of the two responses that could provide the case management, claims processing, as well as provide the doctor and hospital panels as requested in the RFP. Twenty-four percent of the state's membership is currently enrolled in this HMO network.

A potential conflict of interest can have a negative impact on PEHP.

Two concerns with this contract are (1) even though the director was not a part of the selection committee, there is the question—did the insurance carrier have an unfair advantage during the procurement process because of the relationship; and (2) while the second network provides an additional, low cost plan to members, it has had the appearance of a negative impact on PEHP. This business arrangement has raised concern with employees and members, and has raised questions of a potential conflict of interest among some members of the local insurance

community. Unfortunately, the lack of competitive bidders in the local market limited PEHP's choices when selecting a second HMO network.

Prevention Programs Provide Benefits to Members and PEHP

PEHP should consider enhancing their smoking cessation program for members. Smoking cessation provides a public health benefit, a personal health investment, and a cost benefit to insurance programs and employers. PEHP recognizes that the lack of weight management is becoming a prominent health care issue; 50 percent of the people in Utah are overweight. PEHP is in the process of developing an in-depth weight management program. PEHP has standard prenatal and immunization benefits for members.

PEHP sponsors the Healthy Utah Wellness Program for state employees and their families.

Healthy Utah provides some prevention programs, but it focuses on wellness. PEHP started the Healthy Utah Program in 1982. Healthy Utah, the health and wellness promotion program, is offered to employees and spouses whose employer has elected to offer a plan that includes this program. Most employers, including the state, offer Healthy Utah to their employees. Healthy Utah is paid for by PEHP and is administered through the Department of Health. Healthy Utah provides several programs:

- health screenings – blood pressure, cholesterol, weight, and body composition,
- wellness seminars,
- health promotion programs, and
- incentive rebates for exercising, losing weight, reducing blood pressure, reducing cholesterol levels, and smoking cessation.

Additional Benefits for Smoking Cessation Should Be Offered to Members

A smoking cessation program is an investment. Such programs have been proven to save years of life, increase the quality of life, and provide a cost benefit to employers and the insurance programs. Of the five local insurance carriers contacted, two currently provide smoking cessation benefits to their members.

Tobacco use is not as a big a problem in Utah as in some states, but it is a problem. Thirteen percent of adults in Utah smoke. One out of ten deaths are due to tobacco use. It is the second highest epidemiologic cause of death in Utah. Cigarette smoking is responsible for 21 percent of all coronary heart disease deaths, 87 percent of lung cancer deaths, and 88 percent of deaths from chronic obstructive pulmonary disease. In overall health care claims, smokers cost 18 percent more than non-smokers.

Tobacco users are less productive and cost more, on average, than their non-smoking counterparts.

Tobacco users are less productive and more costly workers, on average, than their non-smoking counterparts. Employees that smoke are absent from work 6.5 days per year more than non-smokers.

Two effective programs that include medical treatment are: (1) Nicotine Replacement Therapy (patches and gum) combined with counseling—phone or group counseling, and (2) Zyban—drug therapy. It depends on the individual which program works best. These programs can be offered at a low cost and provide large returns in terms of health and cost savings. Evidence is available that verifies that smoking cessation programs assist smokers to make a life-time change to a non-smoker. Measurable outcomes are available for smoking cessation programs.

If PEHP enhances their smoking cessation program, approximately 720 lives could be extended in the first ten years.

A cost model based on PEHP's membership shows that if PEHP provides both of these programs to members, PEHP will obtain an 8 percent return if both are implemented. After ten years, PEHP will be able to realize at least $220,000 in claim reductions. Employers can save $1,457 per year for each employee that quits smoking. In addition, approximately 720 members' lives can be extended over a 10-year period.

The cost model is based on statistics that, for each program mentioned above, three to five percent of adult smokers try to quit annually. Of those adults that will try to quit in a year, statistics show that 25 to 30 percent successfully quit.

Healthy Utah does provide a limited program. Phone counseling is available for smoking cessation and so is an incentive rebate for members that quit smoking. The incentive rebate is a one-time $100 rebate and is self-reported. Healthy Utah tracks the number of people that sign up for the rebate, and the number that receive the rebate, but it cannot currently provide accurate information on the number of members that have quit.

The two programs discussed above, Zyban and Nicotine Replacement Therapy (NRT), provide both medical treatment and counseling and have shown evidence of long-term success. Zyban and NRT should be added to the state's current programs. An NRT program includes phone counseling, but Healthy Utah is not available to all PEHP members. Phone counseling services are available through the Utah Tobacco Quit Line and could be considered for those members not eligible for Healthy Utah.

PEHP Is Developing an In-depth Weight Management Program

PEHP recognizes the negative medical effects that excess weight has on many health conditions. PEHP wants to develop a more extensive program than the current programs offered through Healthy Utah before excess weight leads to further health problems and higher costs. Obese individuals have 34 percent higher costs for pharmacy claims and 12 percent higher health care claims costs than those at ideal weight. Tobacco use and poor diet/lack of activity have similar death rates. One to two deaths out of 10 in Utah are due to poor diet/lack of activity and is the highest epidemiologic cause of death in the state.

PEHP envisions a weight management program that includes education, counseling, and long-term follow up for members.

PEHP has received many requests from outside vendors and members regarding various weight management programs. Based on those requests, PEHP conducted a survey to obtain information and assess members' needs regarding weight management. The survey indicated that members would like support from PEHP. Before the completion of this audit, PEHP had not finished developing a program; however, PEHP envisions a program that includes education, counseling, and long-term follow up for obese members.

Unlike smoking cessation programs, there is no study available that shows weight management programs' long-term efficacy. Of the five local insurance carriers that were contacted, only one had a weight management program and that was a broad-based educational program. We recommend that when PEHP establishes a program, it is a low-cost program for a large population.

Currently, there are broad-based programs available for weight management through Healthy Utah. Healthy Utah has programs and incentives to help members through the following:

Healthy Utah has broad-based weight management programs designed for state members.

1. Weight management class – the class focuses on nutritional facts, exercise and the behavioral part of weight management.
2. Weight 4 Me – online program members can use for a resource.
3. Weight loss rebate – for members that are above 120 percent of their ideal body weight, they can earn up to $130 for losing 25 pounds and maintaining the loss for six months.
4. Exercise rebate – members can earn $60 annually for exercising 100 days in a year.
5. Pre-approved program rebate – members can earn up to $40 if they attend a pre-approved program such as Weight Watchers or Simply Fit for Life.
6. Life coaching – a philosophy for people motivated to lose weight.

Members can earn the rebates annually and are welcome to take the weight management class, and online program more than once.

Prenatal and Immunization Benefits Are Similar to Other Plans

PEHP's prenatal benefits are designed using a global fee. A global fee is a one-time charge for a specific set of services. All five of the local insurance carriers that were contacted generally offer 100 percent global fee coverage from conception to birth. This coverage has become the industry standard.

The first office visit initiates the prenatal benefit. The only copayment members must pay is the first office visit. The global fee includes all office visits except the first one; the delivery—normal delivery, cesarean section, complications, abortion, and miscarriage; and post delivery care for six weeks. Global fee benefits are payable at time of delivery. For members on the PPO plan, the global fee benefit is 90 percent. For members on the Exclusive Care and Summit plans, the global fee benefit is 100 percent coverage; however, lab and X-ray charges are covered 100 percent under $350 and 80 percent over $350.

PEHP also offers WeeCare, an intervention program, to all members. WeeCare is PEHP's pregnancy case management service. WeeCare was designed by PEHP in cooperation with the Department of Health, Division of Child and Family Services, and the Baby Your Baby program. The goal is to help find women who may have health problems which could lead to high-risk pregnancy. It is a prenatal risk reduction program

offering educational, consultive, and pregnancy case management to expectant mothers.

WeeCare calculates an actual cost savings and potential cost savings for each client. Figure 25 below shows the cost analysis of case-managed clients delivering between July 1, 2001 and June 30, 2002.

Figure 25. WeeCare Cost Savings. WeeCare managed 113 pregnancies in fiscal year 2002, and resulted in $165,563 net savings.

Description	Total	Average Per Case
Cost Savings	$ 349,040	$ 3,089
Administrative Costs	183,477	222
Net Savings (Cost Savings minus Admin. Costs)	**$ 165,563**	**$ 1,465**

PEHP's prenatal program, Weecare, generated over $165,000 net savings to the program.

Cost savings represent only the savings that can be clearly documented during the pregnancy and postpartum period for each client. An example of actual cost savings is the coordination of home health care in lieu of hospitalization.

Potential cost savings for 2002 was $327,175. Potential savings represent an estimated dollar amount for health care of the client and/or her baby that was avoided due to WeeCare's involvement with the client's pregnancy. An example of potential cost savings is the prevention of hospitalization for actual pregnancy-related conditions by providing clients with support, early referrals to specialists, education, and follow up.

Immunizations are a standard benefit nationwide.

Immunizations. Immunizations are a standard benefit nationwide. Immunizations are covered 100 percent from birth until two years old for PEHP members, but the office visit copayment must be paid by the member. Required or recommended immunizations over age two can be paid from the members' annual $300 WellCare Program allowance. All five local insurance carriers contacted generally offer 100 percent immunization benefits at least until two years. Provider benefits vary based on the contracts with employers.

Insurance carriers in Utah and on a national level cover the American Committee on Immunization Practices (ACIP) recommended vaccines for children, adolescents, and adults. The ACIP is a national committee that looks at immunization practices and provides recommendations.

Quality Assurance Has Increased Efficiency

At the beginning of January 2003, Quality Assurance—the auditing department—separated the random claims audit and the preliminary claims audit into two samples. By separating the two audits, the sample size for the random audits can be selected more precisely, and the rating of adjustors will be more accurate. The preliminary audit process has also been modified. As a result, the department's workload has been reduced, and the department continues to collect overpayments from health providers. Since 1998, overpayment collections have increased 14 percent.

The purpose of auditing claims is to identify adjustor accuracy and processing consistency. The office standard for claims adjustors is 97 percent accuracy. For 2002, PEHP's accuracy rate was 96.7 percent.

Sample Size for the Random Claims Audit Has Been Reduced

PEHP decreased their random claims audit while maintaining a statistically-valid sample, and, thus, saving the program $50,000.

After separating the preliminary audit from the random audit, PEHP reduced its random audit sample size to increase efficiency while still maintaining a precise, statistically-valid sample. For the random audit, a statistically random sample of all adjudicated claims from all claims adjustors is selected. The random audit selects a standard sample size at a 90 percent confidence level and a three percent precision range. Before making these sampling changes, PEHP was over sampling. The sample size has been reduced by 32 percent, and that change reduces the number of claims audited by an estimated 28 claims per day.

The number of claims that need to be adjudicated fluctuates, as well as adjustors' accuracy rates. Auditors use a sampling table to maintain a sample size at a 90 percent confidence level and a three percent precision, as the number of claims and adjustors' accuracy rates change.

Preliminary Audit Process Has Been Modified

The preliminary audit is based on a non-statistical sample. Claims are selected that only meet specific criteria to assure that complex or high dollar claims were adjudicated correctly. When a claim is selected for a preliminary audit, the auditors used to review the entire claim. In February 2003, the process was modified, so that auditors only review the part of the selected claim that is "flagged" for the preliminary audit. This change reduces the amount of time spent reviewing each claim for the preliminary audit. For the preliminary audit, only those claims that meet the following criteria are selected:

The preliminary audit reviews claims that meet selected criteria.

1. Any payment over $12,000,
2. Paying a member more than $500,
3. Duplicate payment,
4. Claims processed one year after date of service,
5. Procedure codes for which PEHP only pays 50 percent,
6. Foreign claims,
7. Pre-existing condition,
8. PEHP employee "flag" to review claim, and
9. Coordination of benefits—PEHP is the second payer.

Claims Auditing Changes Provide Cost Benefits to PEHP

Reducing the random audit's sample size and modifying the preliminary audit created three benefits and helped the department audit claims more effectively. First, the reduction and modification give the audit staff more time to review and discuss complex claims. Second, they give more time to identify potential training issues. Third, they reduced the number of FTEs needed to audit claims. PEHP has not needed an overfill position to help audit claims since the changes have been made. The department has two full-time auditors and two other staff members that assist in auditing. The changes in the department have reduced the two other staff members' audit workload by 59 percent. This reduction allows PEHP to shift some of the two staff members' responsibilities to other areas. This reduction of FTEs will also decrease annual wage expense for claims auditing by an estimated $50,000.

PEHP's claims auditing changes have increased staff efficiency and effectiveness.

Claims Auditing also Helps Recover Overpayments. An overpayment occurs when PEHP pays a health care provider an amount in excess of eligible charges. When auditors find overpayment errors, quality

assurance staff make an effort to collect the overpayment amount from the provider. PEHP has procedures in place to collect overpayments, which includes a contract with a collection agency to help recover larger overpayment amounts. For 2002, PEHP recovered $403,600 due to adjustor errors. It is estimated that the total amount of adjustor overpayments for 2002 was approximately $2 million, so PEHP recovered about 20 percent. PEHP continues to look for solutions to recover overpayments and educate health providers.

Recommendations

1. We recommend that PEHP monitor changes and trends in administrative costs by line item to determine if changes or trends are appropriate and consistent with PEHP's objectives.

2. We recommend that PEHP follow their established procurement policies and procedures.

3. We recommend that PEHP require the following:

   - A written contract for services with consultants, insurance carriers, and health providers,
   - A rebidding process for long-term contracts to assure that PEHP is acquiring the best service for the least cost, and
   - A conflict of interest disclosure statement on all contracts.

4. We recommend that PEHP avoid related-party transactions.

5. We recommend that PEHP consider enhancing its smoking cessation program.

6. We recommend that PEHP continue to look for additional ways to recover overpayments sent to health providers.

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Chapter V
PEHP Can Increase Pharmacy Benefit Cost Savings

The prescription drug benefit is one of the most costly parts of the health care benefit offered to PEHP members. Increasing drug prices, member usage, and utilization of higher-cost drugs drive the increase in pharmacy benefit costs. Factors contributing to drug inflation constitute 22 percent of health insurance cost increases. In order to help curb the effects of an increasing drug trend, PEHP should consider implementing a four-tier formulary and percentage payment structure in the future. In addition, initiating audits of their pharmacy benefits manager will help PEHP monitor and continuously improve the pharmacy benefit.

The national prescription drug trend has increased 19 percent annually since 1999.

In the early '90s, the cost of offering a prescription drug benefit increased at an annual rate of less than 10 percent. Since 1999, the national prescription drug trend averaged 19 percent annually. Tufts Health Care Institute reports expenditures for prescription drugs were $122 billion dollars in 2000, nearly double the amount spent in 1995. According to the Office of the Actuary for the Centers for Medicare and Medicaid Services, these expenditures are expected to increase at an average annual rate of 12.6 percent through 2005. Given the increasing trend in pharmacy benefit costs, cost-saving efforts are an important part of PEHP operations.

PEHP's PBM processes 104,000 claims per month.

The PEHP pharmacy benefit operated in-house until 1998. Since 1998, PEHP has outsourced their pharmacy benefit management services. PEHP selected one of the three largest pharmacy benefit managers in the nation. On average, PEHP's pharmacy benefit manager (PBM) adjudicates 104,000 PEHP claims per month. PEHP provides pharmacy coverage for approximately 54,000 state members. Another 17,000 state members are covered by the Summit Care plan that administers member pharmacy benefits through another insurance carrier's pharmacy benefit manager.

PEHP allows participating employers to choose the state employee benefit design or create their own pharmacy plan. Several of the plans other than the state plan have different payments (set dollar amount payments or set percentage payments based on the selected drug type) to

encourage more utilization of generic drugs as opposed to brand-name drug use. Currently, none of the plans mandate the use of a generic drug if a brand drug has therapeutic alternatives. PEHP's list of approved drugs, called a formulary, is a clinically-restricted formulary created by their PBM. Clinically-developed formularies were selected by PEHP to provide the best therapeutic treatments while maintaining value for the members and the program.

Increasing Drug Prices and Drug Use Drive Pharmacy Benefit Costs

Three factors increase the drug trend—prices, utilization, and shifts from lower to higher-cost drugs.

According to the National Institute for Health Care Management Research and Educational Foundation, three major factors drive the drug trend—drug prices, member utilization, and shifts from lower to higher-cost drugs. The drug trend constitutes the factors that drive pharmacy benefit costs. PEHP cost-containment responses to these three factors are discussed later in the chapter.

PEHP's drug trend is lower than the national trend. Figure 26 shows that for the last four years, the PEHP drug trend was an average of 3.7 percent less than the national trend.

Figure 26. Comparison of Drug Trends. Overall, PEHP cost-containment efforts resulted in a lower drug trend than the national drug trend.

Year	National Drug Trend	PEHP Drug Trend	Difference
1999	16.6%	19.1%	2.5%
2000	18.1	13.5	-4.6
2001	19.7	14.2	-5.5
2002	21.4	14.4	-7.0

PEHP's drug program increases have been lower than national plans.

Figure 26, above, shows that PEHP and their PBM have been able to keep their pharmacy benefit increases below national trends. While PEHP savings are important, their overall drug trend still increased at a 15.3 percent annual rate.

Drug Price Inflation Yields Higher Pharmacy Expenses

PEHP drug prices contributed to 31 percent of the increase in the pharmacy benefit last year. Analysis indicates PEHP drug pricing increases mirror national evidence. Nationally, drug prices contribute 22 percent of the increase in the health cost trend. Pharmaceutical prices have doubled since 1994, and trends indicate a double-digit inflation rate may continue.

PEHP uses coinsurances, or percentage payments, and member cost shifts to help control cost increases.

Member cost sharing will continue increasing as double-digit drug price inflation continues. One cost-sharing mechanism is a set percentage of the prescription price known in the insurance industry as coinsurance. PEHP currently uses percentage payment rates as a cost-sharing device for their pharmaceutical benefits. Actuarially, percentage payment rates make it easier for PEHP to plan and adjust benefits for the following reasons: such rates allow PEHP to keep track of trend increases, and percentage payments encourage member consumerism. Thus, members are more aware of the actual costs of the drugs they use. PEHP's current member percentage payment rates are as follows:

- 25 % for generic formulary drugs,
- 25 % for brand-name formulary drugs, and
- 50 % for non-formulary drugs.

Although percentage payments of the prescription cost may make member payments more complex to calculate, they index cost-sharing against inflationary pressure.

Member Utilization of the Pharmacy Benefit Adds to the Effects of Drug Inflation

Member utilization of the drug benefit accounts for the majority of PEHP pharmacy benefit increases.

PEHP member utilization has increased an average of 60 percent since 1999. PEHP utilization reports indicate that as Utah state employees age, drug utilization increases. In the first quarter of 2003, members between the ages of 40 and 65 utilized 60 percent of the prescriptions filled. In other words, 30 percent of program membership accounted for nearly two-thirds of pharmacy benefit use and cost.

Nationally, increased prescription use constitutes the most influential factor of the drug trend. Forty-two percent of the 2001 pharmacy benefit increases stem from utilization. Also, the number of prescriptions per person has risen 40 percent since 1988. As the workforce continues to

grow older, their reliance upon drug therapies increase. PEHP is experiencing many of the same increases in its utilization patterns.

Some Members Change Prescriptions To Newer, Higher-cost Drugs

National trends show member prescription changes from lower to higher-cost drugs are the third component increasing drug program costs. Research shows that member drug switches come as a result of pharmaceutical manufacturer's direct-to-consumer advertising.

Advertising entices members to switch from their lower-cost prescriptions to newer, higher-cost drugs. Spending on direct-to-consumer advertising has increased over 216 percent since 1996. For example, 2001 sales increased 31.9 percent, and prescriptions dispensed grew 25 percent for the 50 most heavily-advertised drugs. One insurance carrier, in an effort to control the effects of advertising, is creating a pharmacy benefit in which members will have higher cost-sharing responsibilities for using heavily-advertised drugs. PEHP may want to consider such a change in the future.

PEHP may want to track member drug shifts as a potential cost savings and educational tool.

Currently, PEHP does not compile information regarding member switches from lower to higher-cost drugs. PEHP may be able to realize savings if they tracked such information and further educated members of therapeutic, but less-expensive, alternatives.

PEHP Continues to Make Cost-containment Efforts

PEHP cost-containment efforts are summarized below in two categories: PBM administration and on-going efforts.

PBM Administration. Prior to 1998, PEHP administered their pharmacy benefits in-house. In an effort to reduce pharmacy administration costs and increase benefits, PEHP made a Request for Proposal (RFP) for a pharmacy benefits manager that could provide the following services:

- Claims processing,
- Clinically-based drug program planning,
- A provider network with greater pharmacy discounts,
- A clinically-based formulary with drug rebate programs,
- A drug pre-authorization program,

- A full-service customer support program,
- Mail-order home delivery services,
- Program progress reports,
- Drug Utilization Review (a computer review program to insure customer safety and cost effectiveness), and
- Maximum Allowable Cost (MAC) drug pricing.

PEHP improved and increased pharmacy benefits by selecting the PBM in 1998.

After reviewing the submitted RFP responses, the PBM was selected and provided more services than PEHP was able to offer in-house. PEHP and their PBM established the initial standards listed above in the 1998 contract. Since that time, PEHP and the PBM have implemented program improvements including: a new pharmacy network and formulary, a 50 percent percentage payment of the prescription price for non-formulary drugs, a change to percentage payments for mail-order drugs, and a $5 minimum payment. PEHP also improved their drug utilization review to promote better drug use and cost savings.

PEHP's on-going cost-containment efforts include adopting increased coinsurance rates, negotiating better rebates and networks, and the addition of a specialty drug program.

On-going Cost-containment Efforts. PEHP's on-going efforts include implementing Maximum Allowable Cost (a list of off-patent drugs subject to a maximum allowable cost payments schedule developed by the PBM) pricing for mail-order generic drugs and negotiating greater rebates and network discounts while lowering dispensing fees. PEHP recently implemented a five percent coinsurance increase which escalated cost-sharing responsibilities for members and the adoption of a specialty drugs program. The specialty drugs program identifies savings with single source formulary drugs that have non-standard pharmaceutical manufacturer discounts and fees.

PEHP Should Consider Adopting a Four-tier Benefit in the Future

Our review indicates that PEHP should consider adopting a four-tier formulary and percentage payment structure. A four-tier pharmacy benefit design separates available drugs into four distinct percentage payment categories based on the following four drug types or tiers:

- generic drugs,
- lower-cost brand-name drugs,
- higher-cost brand-name drugs, and
- non-formulary drugs.

Utah members pay 25 percent for formulary drugs and 50 percent for non-formulary drugs.

PEHP recently changed their percentage payment rates to 25 percent for

generic drugs and 25 percent for brand-name drugs while maintaining non-formulary drugs at a 50 percent rate. Changing to a four-tier plan would require higher percentage payments and a division of brand-name drugs into lower-cost and higher-cost drug categories. An example of a four-tier structure might require members to pay 25 percent for generic drugs, 30 percent for lower-cost brand drugs, 35 percent for higher-cost brand drugs, and 50 percent for non-formulary drugs.

Nationally, carriers and programs are adopting four-tier programs as the pharmacy benefit management tool of choice. Since 2001, PEHP lost at least $1.5 million by not changing to a three-tier structure when a majority of other states adopted a three-tier structure.

Potential four-tier savings based on PEHP 2002 utilization data would exceed $1.3 million. PEHP should differentiate percentage payment rates (based on drug choice) by using a four-tier structure to encourage its membership to further increase lower-cost drug utilization. Differentiation will increase member responsibility for their expensive choices.

For the three and four-tier models discussed in the chapter, utilization and member behavior variables are held constant because they are difficult to predict. The analysis cannot be trended for premium increases because premium adjustments factor in utilization and member behavior variables. The models adjust member cost-sharing responsibilities; shifting costs from PEHP to members. The models, if implemented, can influence members to select lower-costing therapeutic drugs when available and reduce the utilization of higher-costing multi-source drugs.

National Trend Encourages Lower-cost Drug Use

National insurance carriers and programs are rapidly adopting four-tier pharmacy benefits to encourage lower-cost drug use. Four-tier benefit designs and coinsurance structures that give members incentives for using the most cost-effective drugs are critical for a well-managed drug benefit. Four-tier payments—based on a set percentage of the prescription cost—raises members' awareness of the real cost of prescription drugs by aligning their out-of-pocket expense more closely with the relative cost of the drug. Four-tier cost-sharing arrangements, as noted by their increasing popularity and implementation, are the future of cost-sharing arrangements with insured members.

National insurance carriers are increasingly adopting four-tier pharmacy benefits.

An industry consultant said that "if insurance plans haven't adopted a four-tier plan, these same carriers and their clients are quickly moving to implement four or more tiered plans." In a recent report, researchers found that 13 percent of the 83 HMOs surveyed offer more than three tiers in their coinsurance structure and drug formulary, and 37 percent plan to offer more than three tiers in the near future.

Good pharmacy benefits are designed so that members are financially responsible for their costly drug choices.

Good pharmacy benefits are designed so that members are monetarily responsible for their more expensive drug choices. With PEHP's current percentage payment rates, the consumer receives the same percentage discount whether he or she chooses a generic drug or a brand-name drug. PEHP encourages generic drug use without mandatory generic policies to preserve both member and physician drug choices. PEHP's PBM has also improved their physician education efforts to encourage program doctors to prescribe generic drugs rather than brand-name drugs when generics will meet members' therapeutic needs.

PEHP generic substitution rates, substitution of a generic drug for a brand-name drug, grew from 85.4 percent in 1998 to 91.7 percent in 2001. The increase is commendable, yet more member education coupled with a four-tier benefit design could result in even higher generic substitution rates and the substitution of higher-cost drugs for lower-cost prescriptions.

Industry-leaders' generic substitution rates average 95 percent. A PBM annual report states "each percentage point increase in generic dispensing rate represents a savings of 0.5 percent in ingredient cost." If PEHP were to increase generic substitution to slightly above 95 percent, PEHP should realize a 1.75 percent ingredient cost savings. If such a generic substitution level were achieved, PEHP could save over $439,000 annually in total ingredient costs.

Nationally, reporting firms considered higher percentage payments for brand-name drugs relative to generic drugs as the second most effective factor in controlling prescription drug costs. Recently, the Federal Employees Health Benefits Program recommended mechanisms for restraining cost increases such as promoting generic drug programs, use of less costly brand-name drugs, and tiered coinsurance systems that promote appropriate prescription drug use.

PEHP Could Have Saved Money by Adopting A Three-tier Benefit in 2001

PEHP could have saved at least $1.5 million over the last 2.5 years by restructuring their benefit as recommended by their PBM.

PEHP lost an average at least $1.5 million in potential savings for the past 2.5 years had a three-tier structure been in place. A typical three-tier benefit structure has the following tiers differentiated by drug type:

- Tier 1 – formulary generic drugs,
- Tier 2 – formulary brand-name drugs, and
- Tier 3 – non-formulary drugs.

In the *PEHP Prescription Drug Program Review and Forecast May 2000,* PEHP's PBM recommended a change to a three-tier percentage payment structure. PEHP management did not adopt a three-tier structure at that time because they were concerned with negative member reactions with multiple changes to their benefit. PEHP implemented the following cost-saving mechanisms for fiscal year 2001:

- A more restrictive formulary, and
- A percentage payment increase for non-formulary drugs.

PEHP percentage payment changes have saved the program over $1.7 million.

We and PEHP have been unable to determine whether the 2001 formulary change resulted in cost-savings to members and the program. The increased non-formulary drug percentage payment saved PEHP approximately $1.7 million in the past 2.5 years. These savings are in addition to the savings PEHP could have realized due to the adoption of a three-tier drug benefit.

PEHP Pharmaceutical Costs Can Be Reduced

Analysis indicates PEHP could have saved $1.3 million in FY 2003 had a four-tier benefit structure been in place.

Analysis indicates PEHP could attain greater cost-savings by adopting a four-tier formulary and percentage payment structure. Fiscal Year 2003 savings, based on 2002 utilization data, could have saved PEHP at least 6.0 percent ($1.3 million) depending on the benefit design. The four-tier model used in the analysis use the following cost-sensitive design:

- Tier 1 comprises formulary generic drugs,
- Tier 2 includes lower-cost brand drugs priced at or below a specified Average Wholesale Price (AWP),
- Tier 3 includes higher-cost brand drugs priced above a specified AWP, and
- Tier 4 is reserved for non-formulary drugs.

Figure 27, below, compares PEHP's fiscal year 2003 percentage payment pharmacy benefit design with the model developed to analyze the cost-saving benefits of the four-tier structure.

Figure 27. Four-tier Model Percentage Payment Structure Comparison. The model percent payment analysis was compared to PEHP's fiscal year 2003 percent payment structure.

Formulary Drug Class	FY 2003 Percent Payment Structure	Four-tier Percent Payment Structure
Generic	20%	20%
Low-Cost Brands	20	25
High-Cost Brands	20	30
Non-Formulary	50	50

According to analysis, PEHP could have saved at least $1.3 million in fiscal year 2003 by implementing a four-tier coinsurance structure.

PEHP has a two-tier percentage payment structure. Currently, formulary drugs, both generic and brand-name, are available for a member payment of 25 percent of the prescription price. Non-formulary drugs can be obtained after paying a 50 percent payment. Potential savings realized by PEHP's five percent coinsurance increase for fiscal year 2004 are estimated to be $850,000. An additional $400,000 cost savings could be realized in fiscal year 2004 if a four-tier pharmacy benefit was implemented It should be noted that these analyses were based on 2002 drug use by Utah members, and future savings would be different due to changes in utilization.

A four-tier arrangement will allow PEHP to move drugs to higher tiers if there are clear therapeutic alternatives, the cost is significantly higher, and the incremental therapeutic benefits are marginal. PEHP must work closely with their PBM and their prospective external auditor to analyze utilization patterns and potential rebate losses before undertaking any benefit design changes.

Pharmacy Benefit Manager Needs Increased Oversight

PEHP has not audited their PBM since outsourcing the pharmacy benefit in 1998. PBM lawsuits and settlements also indicate PEHP should have had an auditing mechanism in place. PEHP is in the process of selecting an outside vendor to audit the efficiency and effectiveness of their PBM. In addition, benefit changes may be necessary after an analysis of PEHP's mail-order benefit.

PEHP Has Not Performed Formal Audits of Pharmacy Data

PEHP has not performed an audit of their pharmacy benefits manager (PBM).

PEHP has not conducted a formal financial, performance, or data accuracy audit of their PBM. Contractual rights to audit the PBM have not been exercised by PEHP since contracting for services. PEHP is currently negotiating a new contract with their PBM without first conducting an audit of the PBM's cost-effectiveness, reliability, or customer satisfaction efforts. PEHP should have exercised its audit rights in the last five years.

PEHP relies upon PBM-generated reports to ascertain cost savings, contractual guarantees of service, customer service, or other facets of the pharmacy benefit. It is difficult to support the claim that the program is saving money by using the PBM because comparison data is not readily available.

Audits will provide information instrumental to proactively improving the pharmacy benefit.

Audits Provide Protection and May Improve Pharmacy Benefit Management. Instituting audits will give PEHP valuable information necessary for planning, improving, and implementing the pharmacy benefit. Auditing can provide data instrumental for setting and achieving short and long-term goals. Most important, regular examinations will protect PEHP resources and ensure a cost-effective benefit. Periodic audits can ensure data accuracy, improve customer service, and may recover PEHP overpayments.

Five of the six states sampled conduct audits of the PBM and the services rendered.

Other States' Auditing Practices. Comparing PEHP with six other state insurance systems that also use PEHP's PBM suggests that external audits should be standard PEHP policy. Of the six state insurance systems contacted, five of the agencies audit the PBM. These five state insurance systems that audited the PBM identified and implemented changes to improve their pharmacy benefit.

Pending Litigation and Recent PBM Settlements Suggest the Need for Audits

The implications of PBM settlements and possible infractions with the State of West Virginia merit regular internal and periodic external audits of PEHP's pharmacy service. In March 2002, the PBM's parent company disclosed it was facing several lawsuits. Plaintiffs alleged that the parent company used the PBM to increase market share and entered transactions favoring the company's products. In addition to a $42.5 million settlement, the PBM agreed to modify or continue business processes designed to ensure clients have an even greater understanding of, and realize maximum value for, their investment in pharmacy health care services. Of particular interest to Utah is a lawsuit filed by the State of West Virginia.

West Virginia charges stem from the fact that the PBM does not disclose some of the data that supports their reports, thereby making it hard to determine PBM performance. Utah, like West Virginia, lacks valuable pharmacy benefit information that could be disclosed by audits. Regular audits will provide PEHP management additional information with which to base pharmacy benefit decisions.

PEHP Is Developing an Audit Process

PEHP has retained a consultant to develop audit guidelines, procedures, and the policies used to evaluate the performance of PEHP's PBM. PEHP plans to have audit functions operational within a year. Audits will focus on all aspects of PBM performance and their contractual responsibilities. All processes and standards should be evaluated according to industry benchmarks and contractual agreements.

PEHP should conduct a PBM audit at least once per contract period—preferably before signing a new contract.

An independent, external audit of PEHP's PBM should occur at least once during the contracted period, preferably before any contract renewal or the selection of a PBM. Ongoing audit tests, testing for data and eligibility accuracy, should occur at least once a year.

PEHP Should Conduct a Mail-order Benefit Analysis. As part of an audit, a retail and mail-order pricing analysis should also be conducted. PEHP's PBM continues to encourage PEHP to further utilize the mail-order benefit. The PBM claims that mail-order prescriptions deliver more discounts and yield higher rebates per prescription. Whether the PBM does deliver higher discounts and lower costs per prescription can be

answered by an analysis. Any action to change or modify the mail-order benefit should wait for the results of PEHP's impending external audit results.

Recommendations

1. We recommend PEHP consider implementing a four-tier formulary and percentage payment structure.

2. We recommend PEHP develop more incentives to increase generic drug utilization.

3. We recommend PEHP continue to develop audit policies and procedures in order to conduct regular reviews of the current pharmacy benefit manager. PEHP should consider implementing the following:

   - PEHP audit tests should occur at least once a year using the guidelines as outlined by PEHP's audit policy,
   - External audits of PEHP's PBM should occur at least once during the contracted period, preferably before any contract renewal, and
   - PEHP should conduct a thorough analysis of their mail-order benefit.

CHAPTER VI
CHIP Can Be More Cost Efficient

The Utah Children's Health Insurance Program (CHIP) could address the health insurance needs of more children by improving its insurance provider contracts. Membership increased more than expected and has forced the program, as it reached its funding limit, to place controls over the number of children who receive benefits. CHIP can become more cost efficient by negotiating contracts more aggressively.

CHIP provides insurance coverage for over 28,000 children in Utah.

CHIP was established in Utah in August 1998 and is administered by the Department of Health. In October 2003, CHIP management changed and the program has a new director. CHIP provides health insurance coverage for about 28,000 uninsured, non-Medicaid eligible children under the age of 19, whose parents' income is below 200 percent of the federal poverty level (FPL). According to 2003 guidelines, a family of four with a yearly income of up to $36,800 can be eligible for CHIP.

CHIP offers benefits that cover most standard services, including hospital and physician charges. The program's preventative care includes routine physical exams, immunizations, vision and hearing screenings, and basic dental services. For these services, CHIP contracts with two insurance programs: PEHP and an insurance carrier. In the rural areas, the children are automatically assigned to PEHP's Preferred Care (PPO) plan, but in the urban areas they can choose between PEHP's Exclusive Care (an HMO plan) and another insurance carrier's HMO plan.

This chapter identifies some areas where CHIP can become more cost efficient and provide services to more needy children in Utah.

CHIP Managed Growth By Limiting Access and Reducing Benefits to Children

CHIP's budget has increased dramatically since the program's inception. This budget increase is the result of state and federal officials recognizing a growing need for health care insurance for this segment of the population and the increase of health care costs in recent years. In 2002, CHIP's enrollment reached the limits of its funding, and

management implemented several cost-control measures, such as establishing a cap on enrollment, implementing membership premiums, increasing copayments, and reducing dental benefits for enrollees. Through funding approved during the 2003 General Session, CHIP has restored the dental benefits and beginning fiscal year 2004, CHIP has enrolled an additional 4,000 children.

CHIP Expenditures Increased Primarily Due to Membership Growth

CHIP's membership grew 328 percent in the first four years.

Figure 28 shows that, during CHIP's first four years, membership grew 328 percent (from 5,565 to 23,801), as the program became better known. The membership growth resulted in higher program expenses because CHIP pays monthly premiums to insurance programs for medical and dental coverage for each enrolled child. The figure also shows that, in spite of the growth, the program's cost per child did not change drastically over time.

Figure 28. CHIP Membership and Total Expenditures Have Increased Each Year. In spite of the rapid growth, CHIP's overall costs per child did not increase over time.

Fiscal Year	Average Children Enrolled	Federal Costs	State Costs	Total Cost per Child per Year
1999	5,565	$ 4,894,197	$ 2,000,000	$ 1,239
2000	13,477	12,427,043	3,224,904	1,161
2001	20,068	18,679,920	4,884,289	1,174
2002	23,801	23,416,435	5,495,800	1,215

Overall health care costs have increased and the number of children enrolled have increased, but CHIP has kept costs per child close to the same amount each year by making benefit adjustments.

CHIP Has Implemented Several Cost-control Mechanisms

The rapid growth in membership led to the overall increase in CHIP's costs. CHIP's funding is limited and comes as a one-to-four state/federal match. For every one dollar the state spends for CHIP, the federal

government contributes four. Thus, CHIP's total funding depends on the amount contributed by the state.

In order to contain the rising costs, CHIP implemented several cost-control measures.

In 2002, CHIP reached its funding limit when membership exceeded 26,000. In order to contain costs, CHIP management took the following measures:

- In December 2001, a cap on enrollment was established and CHIP switched from continual enrollment to limited semi/or annual open enrollment sessions.

- In January 2002, all copayments were increased, and the dental service was limited to only preventative and emergency care.

- In February 2002, monthly membership premiums were implemented: plan A (parents with income below 150 percent of federal poverty level, FPL) members pay $5 per month and plan B (parents with income between 151 and 200 percent of FPL) members pay $10 per month.

- In July 2002, CHIP changed the membership premiums from $5-$10 per member per month to $13-$25 per family per quarter.

Additional funding will allow CHIP to restore full dental benefits and insure additional children.

During the 2003 General Session, the Legislature was presented with information declaring that there were 27,000 CHIP eligible children in Utah currently not covered by the program. As a result, HB 72 passed, and the amount of state funding for CHIP was increased by $1.5 million. Starting fiscal year 2004, CHIP's total state funding is $7 million. This increase will allow CHIP to draw an additional $6 million in federal funds. The additional funding raises CHIP's budget to slightly over $35.5 million and restored dental benefits and insures an additional 4,000 children.

CHIP Can Be More Cost Efficient by Negotiating Contracts More Aggressively

CHIP can extend coverage to more children by using its limited resources more efficiently. The rapid startup of the CHIP program minimized the program's planning time and resulted in some problems. Our review has identified some areas where greater efficiency could be gained by:

- Improving vaccine protocol with state-vaccine supplied providers,
- Renegotiating contracts to participate in the insurance carrier's profit sharing, and
- Utilizing the HMO plans in the rural areas of the state.

CHIP Frequently Pays Twice for Vaccines

CHIP purchases vaccines at reduced rates through a federal program.

To reduce cost of immunization, CHIP purchases vaccines at reduced rates through a federal program and distributes them to medical providers. However, many of these providers bill PEHP for the costs of the pre-paid vaccines. PEHP pays, on average, $32,400 each month on such claims submitted by CHIP providers. These costs are then passed on to CHIP because by contract, CHIP is required to pay all expenses incurred by PEHP in serving CHIP members. Currently, CHIP has not established provisions with PEHP to protect itself from paying twice for the costs of vaccines.

One of CHIP's responsibilities is to provide age-appropriate vaccinations for all members. CHIP can pay market prices for the vaccines or use a federal program, Vaccines for Children (VFC), to purchase vaccines at half price. In January 2002, CHIP signed a contract with the State Immunizations Office to purchase vaccines at VFC rates and distribute them to participating providers. Providers should use the pre-paid VFC vaccines for CHIP members and submit only claims for administering the vaccines but not for the cost of the vaccines.

CHIP pays nearly $400,000 per year for vaccines it already purchased.

In spite of the ongoing efforts of the State Office of Immunizations to train VFC-participating medical providers, billing for the cost of VFC vaccines is still a concern. Ninety-four percent of PEHP providers immunizing CHIP members participate in the VFC program but are billing PEHP for the cost of the pre-paid vaccines. This amounts to $32,400 per month, which PEHP passes on to CHIP. In effect, CHIP pays nearly $400,000 per year for vaccines it already purchased.

The Center for Medicaid and State Operations advised all state CHIP programs to make contract provisions with insurance providers to avoid paying twice for vaccines. Currently, CHIP has not established such provisions with PEHP. PEHP does not distinguish between VFC and non-VFC providers and does not deny the claims for the costs of the pre-paid vaccines. CHIP needs to include in its contract with PEHP provisions to protect itself from paying twice for the costs of vaccines.

CHIP Forfeited Premium Reimbursements Due to Contract Changes in Fiscal Year 2002

An oversight from CHIP administration led to forfeiture of $160,000 for fiscal year 2002.

CHIP currently contracts with two insurance programs for managing the health care needs of its members—PEHP and an insurance carrier. Due to an oversight from CHIP's administration, the clause in the insurance carrier's contract regarding profit sharing was removed, and CHIP forfeited reimbursement of $160,000 for fiscal year 2002. The clause was reinstated in the 2004 contract.

CHIP pays the insurance programs monthly premiums for enrolled children. The rates for the premiums, however, are actuarial estimates of the actual costs. CHIP has outlined in its contracts the financial responsibilities should there be any differences between estimated and actual costs.

The contracts with the two insurance programs vary significantly. The contract with PEHP, for example, states that CHIP will pay the full cost of PEHP's claims and administrative expenditures incurred in providing for CHIP members as required by the organizational charter. Thus, if CHIP overpaid in premiums throughout the year, PEHP will return the difference to CHIP and vice versa. Between 1999-2002, CHIP received over $680,000 (1.3 percent of total premiums) from PEHP.

The other contract is with an insurance carrier, a for-profit company that has an incentive to keep managed care costs low. The contract with the insurance carrier also requires CHIP to reimburse the carrier if the claims and administrative expenditures exceed the premiums paid by CHIP. This contract, however, differs from the PEHP contract because of the profit-sharing clause. The 2001 contract, for example, stated that if CHIP paid more in premiums than the carrier's expenditures, the carrier could retain up to 55 percent from the excess premiums as profit, but it is required to return the rest to CHIP.

Currently CHIP has this type of contract with only one insurance carrier, but in the past it contracted with two other insurance carriers. CHIP overpaid in premiums each year and due to the profit-sharing clause, the insurance carriers returned to CHIP on average $183,000 (4.7 percent of total premiums) per year between 1999-2001.

In 2002, the premium rates were increased and the clause requiring the insurance carrier to share some of its profit with CHIP was removed from the contract. With this change, the rates CHIP negotiated with the insurance carrier in the beginning of each contract year are final. A cost-benefit analysis would not have supported this contractual change since CHIP has overpaid in premiums each year. If the contract had not been changed in 2002, the insurance carrier would have repaid CHIP $160,000 (11 percent of total premiums) as part of the profit-sharing provisions.

The clause requiring the insurance carrier to share some of its profit with CHIP was reinstated in fiscal year 2004.

After discovering the change in the 2002 contract, CHIP management made efforts to restore the clause. During the contract negotiations for fiscal year 2004, the insurance carrier agreed to reinstate the clause regarding profit sharing. Further, the insurance carrier consented to retroactively apply these provisions for fiscal year 2003, even though the contract did not require it. This change is expected to be beneficial to CHIP.

CHIP Should Consider Utilizing the HMO Plans Where Available

CHIP can provide more options to its members by utilizing the HMO plans in the rural areas.

In the past, CHIP contracted with PEHP to use the PPO statewide and the HMO for the urban counties of Davis, Salt Lake, Utah, and Weber. However, the HMO plan is available to state employees in nine rural counties. Also, the other insurance carrier, is making plans to expand its HMO plan in the rural areas. We recommend that CHIP explore the options of utilizing the HMO plans in the rural areas of the state in order to provide more plan options for its members and realize some cost savings.

Premium Collections Process Is Improving

In February 2002, CHIP implemented a membership premium participation program with the intent of generating additional revenue in order to insure more children. For this purpose, CHIP hired additional staff and purchased an insurance premium database. However, because of budgetary constraints, the database did not have the ability to identify members with overdue premium payments. As a result, during fiscal year 2003, CHIP could not identify which of its members were delinquent and how much they owed.

In order to estimate the percentage of members who did not pay their premiums on time, we selected a random sample of CHIP members who are required to pay premiums. Sixty-three percent of the cases in our sample were delinquent on their premiums for more than 90 days.

Management stated that with the upgraded premium database, CHIP will tighten the premium collection process.

As of September 2003, the database was upgraded, and CHIP employees are able to identify delinquent payments and accurately calculate the balance for each member. Management stated that with the upgraded system, CHIP will also tighten its premium collection process. Starting January 2004, the premium payments will be due on the first day of each quarter. The members who do not pay by the 14th of the second month in the quarter will have their membership terminated.

Recommendations

1. We recommend that CHIP make contract provisions to protect itself from paying twice for vaccines.

2. We recommend that CHIP explore the possibility of utilizing the HMO plans in the rural areas of the state.

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Appendices

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Appendix A

Insurance Definitions

Basic Definitions:

Health Benefit Plan: Sets of benefits that employers have established for their employees.

Health Plan Carrier/Plan Administrator: Companies or programs that administer health plans. The carriers provide a network of providers, process claims, and provide other administrative services.

Provider Group: Organized networks of health care providers that carriers contract with to deliver health services to plan members. They may include doctors, hospitals, outpatient centers, mental health clinics, and other specialized services.

Types of Health Plans:

Health Maintenance Organization (HMO) Plan: Tightly controlled type of managed care. HMOs generally only cover health care when members receive it from a specified network of physicians or hospitals.

Traditional Indemnity Plan: Insurance plan in which health care providers are usually reimbursed at a fixed percent of billed charges. Members can use any covered health care provider they choose, but they also pay a larger portion of the cost for services.

Point-of-Service (POS) Plan: Considered "hybrid" plans in that they combine the cost-control mechanisms of HMOs with the provider choice options of PPOs.

Preferred Provider Organization (PPO) Plan: Retain many of the elements of traditional indemnity plans, but provide members with a financial incentive to receive care from a "preferred" provider. Members can see physicians or hospitals not on the preferred list, but they pay more.

Types of Insurance Plan Funding:

Self-Funded Plans: Health plans where employers pay insurance claims out of funds retained internally. The employer essentially acts as its own insurance company and bears the financial risk of health care costs. Federal law exempts self-insured plans from state regulation, including fund reserve requirements, mandated benefits, premium taxes, and consumer protection regulations.

Fully-Insured Plan: Plans where employers pay premiums to insurance companies to administer their health plans and pay health claims. Employers are not responsible for health-related claims that exceed total premiums.

Cost-Sharing Mechanisms:

Copayments: Flat dollar amounts charged every time a service is provided and may include doctor visits, prescription drugs, emergency room and urgent care, and other services. For example, health plans may require that members pay a $50 copayment for each visit to an emergency room.

Deductibles: Annual amounts that plan members must pay each year for certain services before the plan starts paying for these services. A "$100 deductible" means that plan members pay the first $100 per year before the plan will begin covering the cost of those services.

Coinsurance: A percentage of the cost that is charged for certain services after the deductible has been paid. For example, a coinsurance level of 90 percent means that the plan member first pays the deductible, then the plan pays 90 percent of the costs and the member pays the remaining 10 percent of the costs.

Maximum Allowable Cost Prescription List: A list of off-patent drugs subject to maximum cost payment schedules developed by a Pharmacy Benefits Manager (PBM).

Out-of-Pocket Maximum: Maximum sum of the copayments, deductibles, and coinsurance amounts that members could pay during a single year.

Formulary and Non-formulary Drugs:

A formulary drug: A list of drugs covered by a health plan at the least cost to the employee. The process for developing a formulary varies by health plan. The formularies for State of Utah employees: are lists of preferred drugs selected by a professional committee of physicians and pharmacists on the basis of quality and efficacy, and include both generic and brand-name drugs.

A non-formulary drug: Drugs covered at a greater cost to the employee or not at all.

Other Definitions:

Adjudication: Processing claims according to contractual agreements.

Allowed Amount: The maximum dollar amount for which an insurance carrier will reimburse a provider for a given service.

Epidemiology: The study of the determinants of disease within a population.

Fee Schedule: A listing of the dollar amounts that an insurance company will pay health providers for specified medical procedures.

Loss Ratio: Incurred claims plus expenses, divided by paid premiums.

Per Member Per Month (PMPM): Applies to a revenue, cost, or utilization for each enrolled member per month.

Pharmacy Benefits Manager (PBM): A company that manages prescription benefits, claims processing, and pharmacy networks for health plans according to contractual agreements.

Reinsurance: Insurance purchased by an insurance company or health plan from another insurance company to protect itself against losses.

Wellness Programs: Programs designed to assist insurance members in developing healthy lifestyles, such as physical exercise, good nutrition, and smoking cessation.

Appendix B

PEHP Single and Double Premium Growth Data

Employee (Single) and Employee + Spouse (Double) Monthly Premium Rates Since 1998

PPO - Employee Coverage	Dollar Share		Percent Share		Premium Increase
Year	Employer	Employee	Employer	Employee	All
1998	$166.05	$0.00	100%	0%	6%
1999	159.16	0.00	100	0	-4
2000	173.15	10.14	95	5	9
2001	223.75	16.84	93	7	29
2002	250.60	18.87	93	7	12

HMO - Employee Coverage	Dollar Share		Percent Share		Premium Increase
Year	Employer	Employee	Employer	Employee	All
1998	$ 163.32	$0.00	100%	0%	4%
1999	159.16	0.00	100	0	-3
2000	173.15	0.00	100	0	9
2001	223.75	0.00	100	0	29
2002	245.59	5.01	98	2	10

PPO - Employee and Spouse Coverage	Dollar Share		Percent Share		Premium Increase
Year	Employer	Employee	Employer	Employee	All
1998	$342.44	$0.00	100%	0%	6%
1999	348.07	0.00	100	0	2
2000	377.75	20.91	95	5	9
2001	431.35	34.73	93	7	14
2002	516.71	38.89	93	7	20

HMO - Employee and Spouse Coverage	Dollar Share		Percent Share		Premium Increase
Year	Employer	Employee	Employer	Employee	All
1998	$332.80	$0.00	100%	0%	4%
1999	348.07	0.00	100	0	5
2000	377.75	0.00	100	0	9
2001	461.35	0.00	100	0	22
2002	506.37	10.34	98	2	10

** The 1999 and 2000 employer share has been adjusted to reflect policyholder experience dividend returns to the State.*

Appendix C

Local Carrier Information Request Form

Legislative Audit Request

Time Frame: July 2001 to June 2002 (with run out through Dec, 31)
Fully insured, large commercial groups (for groups 51 or more)
Only include Utah members and exclude retired members
Provide information by product and describe plan type. Give percentage of membership for each product.
Exclude plans with less than 5% of the total business
Include only primary claims
Include disabled lives if part of active population

1. All Claims

	Male			Female		
Age Groups	Member Months	PMPM Allowed Amount	PMPM Paid Costs	Member Months	PMPM Allowed Amount	PMPM Paid Costs
0-1						
2-14						
15-19						
20-24						
25-29						
30-34						
35-39						
40-44						
45-49						
50-54						
55-59						
60-64						
65+						

2. All medical claims over $100,000 removed -- Hospital Only Claims

	Male				Female			
Age Groups	Member Months	PMPM Allowed Amount	PMPM Paid Costs	No. of Claimants	Member Months	PMPM Allowed Amount	PMPM Paid Costs	No. of Claimants
0-1								
2-14								
15-19								
20-24								
25-29								
30-34								
35-39								
40-44								
45-49								
50-54								
55-59								
60-64								
65+								

3. Pharmacy -- before rebates, count mail order as 3 scripts, exclude injectables

	Male				Female			
Age Groups	Member Months	PMPM Allowed Amount	PMPM Paid Costs	No. of Claims	Member Months	PMPM Allowed Amount	PMPM Paid Costs	No. of Claims
0-1								
2-14								
15-19								
20-24								
25-29								
30-34								
35-39								
40-44								
45-49								
50-54								
55-59								
60-64								
65+								

4. Facilities -- exclude psychiatric and newborn ICU

	Male		Female	
Age Groups	Bed Days per 1000 Members	Average Length of Stay	Bed Days per 1000 Members	Average Length of Stay
0-1				
2-14				
15-19				
20-24				
25-29				
30-34				
35-39				
40-44				
45-49				
50-54				
55-59				
60-64				
65+				

5. Administrative Cost on per subscriber basis

Remove:
- Premium tax
- Commission
- Reinsurance charges
- Rebates

6. Non-consultation Office Visits CPT Codes: 99201-99215

Count Per Member Per Year

Age Groups	Male	Female
0-1		
2-14		
15-19		
20-24		
25-29		
30-34		
35-39		
40-44		
45-49		
50-54		
55-59		
60-64		
65+		

Legislative Audit Request (Cont.)

6a. Comparison by CPT Code
If you have multiple fee schedules please provide three most common
Fee Schedules as of July 2002
Exclude fee schedules for less than 5% of business

Category	CPT Code	Description	Fee Schedule	Fee Schedule	Fee Schedule
Office -- Primary Care	99203	New patient 30 minutes			
	99204	New patient 45 minutes			
	99213	Established patient 15 minutes			
	99214	Established patient 25 minutes			
Medical Services	90806	Individual Pychotherapy 45-50 minutes			
	92002	New patient eye exam			
	92557	Comprehensive audiometry threshold evaluation			
	93000	Routine ECG with interpretation			
Inpatient	99221	Intial care 30 minutes			
Surgery	29870	Arthroscopy, knee, diagnostic			
	33513	Four coronary venous grafts			
	47562	Cholecystectomy			
	66984	Cataract removal			
	49650	Laparoscopy, repair initial inguinal hernia			
Lab	80061	Lipid panel			
	84443	Thyroid stimulating hormone (TSH)			
	81000	Urinalysis			
	85023	Hemogram and platelet count (CBC)			
Pathology	88304	Surgical pathology, gross microscopic examination (level 3)			
	88305	Surgical pathology, gross microscopic examination (level 4)			
Radiology	71020	Chest X-ray, two views			
	72010	Spine X-ray, anteroposteriror and lateral			
	70220	Sinuses, paranasal, complete			
	73560	Knee X-ray, one or two views			
	73600	Ankle X-ray, two views			

Appendix D

Selected Benefit Comparison for State Employees Since 1998

Benefit Comparison for State Employees Over Time
Selected Benefits

Preferred Care (PPO)

Year	Maximum Out-of-Pocket Expenses	Physician Visits Member Copayment	Pharmacy Member Copayment Preferred Drug List	Pharmacy Member Copayment Non-Preferred Drug List	Emergency Room Member Copayment	Hospital Services
1998	$1500 Per person $2000 per family	$10 primary $10 specialist	10% + $2 for generic; 15% + $2.5 for name brand		$50	Plan pays 90%
1999	$1500 Per person $2000 per family	$10 primary $10 specialist	20%	20%	$50	Plan pays 90%
2000	$2000 Per person $2000 per family	$15 primary $15 specialist	20% ($5 minimum)	20% ($5 minimum)	$50	Plan pays 90%
2001	$2000 Per person $2000 per family	$20 primary $20 specialist	20% ($5 minimum)	50%	$50	Plan pays 90%
2002	$1500 Per person $3000 per family	$20 primary $20 specialist	20% ($5 minimum)	50%	$50	Plan pays 90%
2003	$1500 Per person $3000 per family	$20 primary $20 specialist	25% ($5 minimum)	50%	$50	Plan pays 90%

Exclusive Care (HMO)

Year	Maximum Out-of-Pocket Expenses	Physician Visits Member Copayment	Pharmacy Member Copayment Preferred Drug List	Pharmacy Member Copayment Non-Preferred Drug List	Emergency Room Member Copayment	Hospital Services
1998	$1000 Per person $2000 per family	$5 primary $5 specialist	$5 generic $10 brand name	$25 non-formulary	$50	Plan pays 100%
1999	$1000 Per person $2000 per family	$5 primary $5 specialist	$5 generic $10 brand name	$25 non-formulary	$50	Plan pays 100%
2000	$1000 Per person $2000 per family	$10 primary $10 specialist	$5 generic $10 brand name	$25 non-formulary	$50	Plan pays 100%
2001	$1000 Per person $2000 per family	$15 primary $15 specialist	20% ($5 minimum)	50%	$50	Plan pays 100%
2002	$1500 Per person $3000 per family	$15 primary $15 specialist	20% ($5 minimum)	50%	$50	Plan pays 100%
2003	$1500 Per person $3000 per family	$15 primary $20 specialist	25% ($5 minimum)	50%	$50	Plan pays 95%

Summit Care/Other (HMO)

Year	Maximum Out-of-Pocket Expenses	Physician Visits Member Copayment	Pharmacy Member Copayment Preferred Drug List	Pharmacy Member Copayment Non-Preferred Drug List	Emergency Room Member Copayment	Hospital Services
1998*	$1000 Per person $2500 per family	10% primary 10% specialist	$5 generic	$13 non-formulary	$40 copay + 10%	Plan pays 90%. Member pays 10% up to copay max
1999**	$1000 Per person $2000 per family	$5 primary $5 specialist	$5 generic $10 brand name	$25 non-formulary	$50	Plan pays 100%
2000	$1000 Per person $2000 per family	$10 primary $10 specialist	$5 generic $10 brand name	$25 non-formulary	$50	Plan pays 100%
2001	$1000 Per person $2000 per family	$15 primary $15 specialist	$5 generic $10 brand name	$25 non-formulary	$50	Plan pays 100%
2002	$1500 Per person $3000 per family	$15 primary $15 specialist	$5 generic $10 brand name	$25 non-formulary	$50	Plan pays 100%
2003	$1500 Per person $3000 per family	$15 primary $20 specialist	$5 generic $15 brand name	$35 non-formulary	$50	Plan pays 95%

* the contract was with Pacificare
** the contract was with Altius

State Of Utah
2003/04
Benefit Changes
Effective July 1, 2003

PEHP Preferred Care Medical

Prescription drug copay will go from 20% to 25% of the discounted cost of the drugs on the Preferred Drug List.

Exclusive Care Medical *(Available in limited areas)*

Inpatient hospital facility benefit will go from 100% bene fit to 95%.
Prescription drug copay will go from 20% to 25% of the discounted cost of the drugs on the Preferred Drug List.
PLAN NOW AVAILABLE IN GARFIELD, TOOELE AND WASHINGTON COUNTIES!
Davis North Hospital in Layton is now a participating hospital provider
Chiropractic coverage
Expanded provider network

Summit Care Medical *(Available in limited areas)*

Inpatient hospital facility benefit will go from 100% benefit to 95%.
Retail prescription drug copays will go from *$5,* $10 and $25 to $5, *$15* and $35 for a 30-day supply.
The mail order copay will go from 1 times the retail copay to 2 times the retail copay.
PLAN NOW AVAILABLE IN IRON COUNTY!

Comprehensive Care Medical *(Available in limited areas)*

Prescription drug copay will go from 20% to *25%* of the discounted cost of the drugs on the Preferred Drug List.

Preferred Dental Care

Member contribution will go from zero to *5%* of the total rate.

Benefit Reminders:

On Exclusive, Summit and Comprehensive Care, members must live in the plan's service area to be eligible to enroll.

On Exclusive and Summit Care, members must pre-authorize inpatient hospital services.

On Exclusive and Summit Care, members must use the specific plans providers and facilities to receive benefits.

On Preferred and Comprehensive Care, members must pre-notify inpatient hospital services.

Members enrolling in Dental Select or one of the premium based optical plans must fill out the plans applicable enrollment form.

Members wanting a premium based optical plan must re-enroll each pear.

In addition to Open Enrollment, employees may change medical plans once during the benefit year, at the employee's discretion.

Information regarding PEHP benefits and provider listings can be found on the PEHP website at: www. pehp. org

Information regarding PEHP member specific benefits can be found on the PEHP web site at: www.mypehp.org

Public Employees Health Program

Appendix E

Significant Administrative Line Item Expense Analysis

Top 10 Administrative Line-Item Expenses Since 1998

Rank	Category	2002	2001	2000	1999	1998	5 Year Totals
1	Salaries and Wages	$ 4,745,663	$ 4,171,184	$ 3,775,214	$ 3,102,769	$ 2,549,235	$ 18,344,065
2	Benefits	2,293,564	2,200,122	2,030,014	1,602,857	1,344,198	9,470,755
3	Printing and Binding	551,394	612,440	725,986	619,682	528,317	2,997,819
4	Postage and Handling	395,354	902,548	582,506	510,992	477,197	2,868,596
5	Office Rentals	550,536	557,444	486,027	436,773	412,484	2,443,264
6	Legal Services	251,695	172,658	210,311	260,119	165,832	1,060,615
7	DP Hardware Purchases PC	108,165	221,551	361,163	158,198	94,395	943,472
8	Temporary Labor	120,791	204,661	227,522	136,579	155,982	845,536
9	Consulting Services	268,326	137,163	177,691	167,142	74,206	824,528
10	DP Hardware Purchases MF	211,574	128,445	48,822	310,903	34,612	734,356

Total Top 10 Admin Expenses	$ 9,457,062	$ 9,308,216	$ 8,625,257	$ 7,306,012	$ 5,836,457	$ 40,533,004
Total Admin Expenses	$ 11,412,566	$ 10,763,169	$ 9,947,018	$ 8,223,275	$ 6,648,128	$ 46,994,156
Top 10 Admin/Total Admin	83%	86%	87%	89%	88%	86%

Appendix F

Selected Research Article List

Research Articles and Studies

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Utah Retirement Systems, *History of Utah Retirement Systems* (1993)

Workplace Economics, Inc., *2002 State Employee Benefits Survey* (2002)

Agency Response

Wayne L. Welsh
Legislative Auditor General
130 State Capitol
Salt Lake City; Utah

Dear Wayne,

We at PEHP greatly appreciate the professional conduct of your staff as they completed a performance audit of the Public Employees Health Program. The auditors took the time and effort to understand the issues, survey other carriers, and to involve the actuaries from the various health plans to assist them in their evaluations. We find your final report to be comprehensive and valuable.

Attached is our response to the Audit. You will note that we made general comments on the important issues contained in each of the five chapters. We then respond to each of the six recommendations made at the end of chapter IV, and the three recommendations made at the end of chapter V.

All nine of the recommendations address important issues surrounding PEHP's performance, as well as concerns raised as the auditors conducted the audit. We appreciate the research and thoughtfulness given to each of the recommendations. You will note in our response that we are very willing to make changes. In some areas improvements to our existing programs and policies will be made, and in other areas new programs will be established to achieve the improvements suggested. You will note in our general comments, many of the recommendations are already being addressed.

If you have further questions or suggestions as you review our response let me know.

Sincerely,

Linn J. Baker
Director

Response to Legislative Audit of Public Employees Health Program

Chapter I

The majority of large employers, both public and private, self-fund their health plans to take advantage of the savings provided by assuming the risk. The State of Utah has realized substantial savings over the past 27 years it has self-funded its health benefits through PEHP. The State of Utah was the first state in the nation to self-fund and self-administer its health plans.

Chapter II

Premium Rates Follow National Trends
The continuing increase in health care costs is rapidly becoming a national crisis. PEHP is subject to the same trends experienced by all national carriers. We believe that the Federal Government could and should take action to enhance the competitive market place.

The State has experienced premium increases in-line with both national trends and state governments. Based on a national survey by Mercer (Mercer National Survey of Employer-Sponsored Health Plans, 2002), health benefit costs among large employers have increased on average 10.14% from 1999 to 2003. In addition, a national survey of State and local government health care costs by the Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends has found that the family premiums have increased on average, 11.85% from 1997 to 2001 (2001). During the same time period, PEHP's annual increases have averaged 10.62%.

Chapter III

Administrative Costs are Low
PEHP believes the Legislative Auditor properly assessed PEHP's cost-effectiveness relative to other carriers in the local market. The auditor took the time and effort to understand the issues, survey other carriers, involve the actuaries from PEHP and other carriers, and correctly evaluate the results.

PEHP's low administrative costs have provided substantial savings to public employers over the years. PEHP leases two of the three networks offered to State employees, thereby self-funding all the options offered to policyholders.

Fee Schedules
Of the three provider networks offered, the two HMO networks have the lowest provider fee schedule, but can not be offered state-wide. Preferred Care is the PEHP network with a statewide provider panel. This expanded network is

necessary to provide coverage to all areas of the state. As noted in the audit, if all employees could have access to the HMO networks, additional savings could be achieved.

Comparison of Age Distribution
As noted in Figure 13 of the audit, PEHP covers an older employee population than other Utah carriers. There are also a large number of early retirees in the State risk pool. The older members contribute to higher utilization rates, which result in higher premiums for the active State employees.

Utah State Employees Pay Less for Medical Benefits
PEHP is aware that State employees share in less of the premium when compared to other states. It is important to note that in the past, State employees have negotiated lower employee premium share in lieu of higher wage increases. If the trend to fund the increase in benefit costs and freeze wages continues, benefits will continue to become a larger percentage of the compensation package.

Employees Health Benefits
PEHP systematically monitors the benefit packages offered by large employers and other states, and makes recommendations each year to maintain benefits at a competitive level.

Chapter IV

Administrative Costs
As pointed out in chapter IV, PEHP's increased administrative costs in the categories shown in *Figure 21 page 41*, have been a result of considerable growth in existing programs and new programs offered to employees. Membership in PEHP medical programs has increased 37 percent. In addition, membership in PEHP dental plans has increased 22 percent, and PEHP has seen growth in PEHP Life Insurance of 25 percent, and 17 percent in the Long Term Disability program.

During this period, PEHP implemented the following new programs:

- Flexible Spending Plan
- In-house Medical Case Management
- Value Added Program
- Spouse and Dependent Term Life
- Retiree Death Benefit

PEHP's administrative costs have been impacted by HIPAA compliance and bringing actuarial and underwriting staff in-house. The marketing department

has been impacted by growth, and has added additional services to aid policyholders and members.

As noted in the audit, PEHP's administrative costs continue to be 66.7% less than those surveyed.

Contingency Reserves
PEHP periodically consults with State Finance regarding the unreasonable requirement the Federal Government has imposed, pertaining to the level of the reserves PEHP maintains.

Consultant Services
Several comments were made regarding the use of two consultants and their open-ended contracts. Neither consultant is currently working at PEHP. One of the consultants helped develop PEHP's medical claims software that was purchased over 20 years ago. Whenever PEHP had an *immediate* need to make changes or additions to the software, PEHP used the consultant and paid a competitive hourly rate to make the changes. By using this consultant, PEHP did not hire additional in-house staff, thus avoiding an ongoing cost. Bringing in a new consultant was not an option because it would have required additional time and expense to train them on the system. The second consultant provided assistance in making PEHP's business processes more efficient. This consultant brought extensive knowledge of PEHP's operations gained while previously employed by the State. He worked on more than a dozen projects, resulting in annual cost savings of approximately $1 million.

PEHP's Medical Director has provided valuable and cost effective consulting services for over 15 years. He is paid a rate that is lower than other carriers pay their consulting physician. The knowledge he has regarding our culture, and the consistency he has provided to the review process justifies the current arrangement with him.

Related Party Transactions
A decision was made to add a second HMO network to increase choice and promote competition. When the Director disclosed to the Board that a related party transaction was possible as they selected an additional HMO network, the Board and PEHP:

- Removed the Director from any involvement in the selection process
- Hired a national consulting firm to draft the RFP and analyze the responses
- Selected a committee that included several individuals outside of PEHP to review the RFP and recommend a network to the Board

The committee was compelled to make the recommendation based on a more complete provider network, and the projected savings the network would generate.

PEHP appreciates the auditor's thoroughness in investigating a potential conflict of interest the Director of PEHP may have had as the Retirement Board selected the Summit Care Network. PEHP agrees with the auditor's analysis that PEHP and the State Retirement Board followed a process that was objective, transparent, and in the best interest of the members. The process also addressed any potential conflict of interest. PEHP agrees with the auditor's statement: *" the carrier selected was the only logical choice*. "

Response to Recommendations

1. We recommend that PEHP monitor changes and trends in administrative costs by line item to determine if changes or trends are appropriate and consistent with PEHP's objectives. PEHP agrees to continue monitoring changes and trends in administrative costs by line item, to help maintain administrative costs well below industry norms.

2. We recommend that PEHP follow there established procurement policies and procedures: PEHP will continue to follow policies and procedures currently in place, and make improvements as necessary.

3. We recommend that PEHP require the following:

- **A written contract for services with consultants, insurance carriers, and health providers**
- **A rebidding process for long-term contracts to assure that PEHP is acquiring the best service for the least cost, and**
- **A conflict of interest disclosure statement on all contracts.**

PEHP has always had strong procurement policies and contracting procedures, and will enhance them further as recommended by the auditor. Currently, a conflict of interest disclosure is required in our contracts.

4. We recommend that PEHP avoid related-party transactions: We agree that related-party transactions should be avoided whenever possible. We agree with the auditor's analysis that PEHP and the State Retirement Board followed a process that was objective and in the best interest of members, and that avoided any potential conflict of interest. We also agree with the auditor's statement: " the carrier selected was the only logical choice. "

When the Director disclosed to the Board that a related party transaction was possible as PEHP and the Board selected another HMO network, the Board initiated the following process:

- Removed the Director from any involvement related to the selection process
- Hired a national consulting firm to help draft an RFP, and to analyze all the responses
- Selected a committee (including several individuals outside of PEHP) to review the RFP and to select the carrier

As trustees, acting in the best interest of the members, the committee and the Board were compelled to make the selection based on providing a more complete provider network, and the projected savings the network would generate.

5. We recommend that PEHP consider enhancing it's smoking cessation program: PEHP agrees with the auditor's recommendation. While there has been a long-standing smoking cessation program coordinated through Healthy Utah, PEHP will consider, with Healthy Utah's input, enhancing the program by adding benefits for over-the-counter aids such as gum and patches. PEHP will re-assess its existing benefits for the prescription drug aids noted in the audit.

6. We recommend that PEHP continue to look for ways to recover overpayments sent to health providers:

In 2002, PEHP retained the services of an independent outside firm to audit its claims. In a letter dated April 1, 2002, the audit firm states " . . . [our] audit of your claims yielded quite remarkable results. . . . our audit . . . revealed a questionable payment rate averaging only 1% of total claims paid . . . This rate is really outstanding when you consider that the typical questionable claims payment rate we detect is between 2.5% and 3.5% of paid claims. . . . This is indeed one of the lowest overpayment rates we have seen while performing an initial audit service."

PEHP overpayments are well below the national norm, as certified above. PEHP is in the process of implementing procedures to increase overpayment recoveries, as well as decrease the time it takes to collect the overpayments.

The key components for improving overpayment collections are:

1. Improving the internal processes to shorten the time intervals between the written requests to the providers
2. Initiating a system of deducting overpayments from future payments to providers

These changes were based on a comprehensive study of PEHP's internal processes, coupled with a survey of the practices of other local carriers.

While not addressed in the audit, PEHP conducted a corollary study to determine the primary causes of overpayments and take steps to minimize them.

Chapter V

Employee Incentives

In 1981 PEHP began its own drug card program because private vendors could not administer a pharmacy program that used co-insurance (*percentage cost sharing from the member*). Instead they used only co-payments (*a fixed dollar amount paid by the member*). PEHP believed that members should be aware of the drug cost, and pay a larger share of the cost when the drug was more expensive. A percentage cost share also provided an automatic increase in cost sharing as the price of drugs increased. To our knowledge, PEHP was the first drug card manager in the country to use co-insurance. Because members pay a larger share of the cost for more expensive drugs, PEHP has always had an excellent generic drug substitution rate. These same incentives encourage members to use the mail order house when the drugs can be purchased for a lower cost using mail order.

Generic Substitution

As pointed out on page 65 of the audit, PEHP could save $439,000 annually in ingredient cost, if the generic substitution rate mirrored plans that offered employees much lower co-insurance for using generic drugs. The savings would result when the generic substitution rate increased. Three years ago, PEHP considered lowering the employees cost share for generic drugs to achieve the higher substitution rate. PEHP elected not to make the change when it was determined that by lowering the employees' cost share by 5% the plan's cost would increase $800,000 from cost-shifting away from the member. Between the employer and employee $439,000 dollars would be saved, but the employee would benefit from the savings, and the employer would pay out more. In the future, when PEHP changes co-insurance, the auditor's recommendation to have a four-tiered co-insurance structure will be considered.

Pharmacy Audits

The audit mentioned that PEHP has not performed formal audits of the Pharmacy Benefit Manager. It is important to note that PEHP's internal pharmacy manager receives monthly reports as well as an annual performance summary of the PBM. PEHP's staff closely follows the performance of the PBM. PEHP has recently initiated an external audit using a national pharmacy audit firm.

Mail Order Incentives
The audit recommends that PEHP consider limiting the day supply of drugs at retail stores to 30 days to encourage more use of the mail order house. The current policy of allowing a 90-day supply at retail has resulted from careful analysis made over several years. PEHP has consistently believed that the percentage cost share from the member allows them to make a market decision when purchasing drugs. On occasion their cost share at retail is lower than mail order. PEHP is also sensitive to the concerns of Utah pharmacists and recognizes that they pay Utah State taxes. Business sent out of state results in a loss of tax revenue to the State. By allowing a 90-day supply at both retail and mail order the Utah pharmacists can compete on an equal basis.

Member co-insurance

Three-tiered Co-payment Model
Exhibit A (see attached) shows the pharmacy experience for the two-and-a-half year period reviewed by the audit. You will note that if we had increased the members co-payment five percent, the program would have saved $1,595,000 from a cost shift. At the time, our 20% co-insurance was on the high side of co-payments required by most large employers for drug benefits. We determined a 20% co-insurance was competitive and did not make the increase required by the three-tiered model. It is important to note that the savings mentioned on page 66 of the audit would be from a *cost shift*, not from a *change in behavior*. Because fixed dollar single co-payments provide no incentive for employees to choose low cost alternatives, employers that use fixed dollar co-payments, would benefit the most by adopting the auditors tiered recommendation.

Four-tiered Co-payment Model
Exhibit B (see attached), also shows a cost-shift to the member of $1,219,000. We feel that the recommendation to go to a four-tiered model is an excellent suggestion. When that market moves to higher co-payments, PEHP will consider changing to the model recommended.

1. We recommend PEHP consider implementing a four-tier formulary and percentage co-payment structure: PEHP has had a percentage co-insurance structure since 1981. When PEHP changes its co-insurance in the future, PEHP will consider the auditor's recommendation to have a four-tier co-insurance structure.

2. We recommend PEHP develop more incentives to increase generic drug utilization: PEHP is currently reviewing lower co-insurance for generic drugs, and may consider a mandatory generic program.

3. We recommend PEHP continue to develop internal and external audit policies and procedures in order to conduct regular reviews of the current

pharmacy benefit manager. PEHP should consider implementing the following:

- **PEHP audit tests should occur at least once a year using the guidelines as outlined by PEHP's audit policy**
  - PEHP has been performing internal reviews since 1998 to ensure that the plan design and payments have been set up correctly at the PBM. PEHP runs quarterly data to evaluate the PBM's performance
- **External audits of PEHP's PBM should occur at least once during the contracted period, preferably before any contract renewal**.
  - PEHP has selected a national pharmacy audit firm to perform ongoing performance analyses of the PBM
- **PEHP should conduct a thorough analysis of their mail-order benefit**
  - With the assistance of a national consulting firm, PEHP will develop a program to incentivize and educate members to use the mail order option in the most effective way

November 7, 2003

Wayne L. Welsh
Legislative Auditor General
130 State Capitol
PO Box 140151
Salt Lake City, Utah 84114-0151

Mr. Welsh:

This letter is provided by the Children's Health Insurance Program (CHIP) in the Utah Department of Health in response to your Report No. 2003-09 "A Performance Audit of the Public Employees Health Program (PEHP) and Children's Health Insurance Program (CHIP)".

Children's Health Insurance Program (CHIP)
Response to the Recommendations in the Report

The Legislative Auditor General has made four observations in his report to which the program needs to respond.

(1) *Vaccine purchases.* Each fiscal year, CHIP orders discounted vaccines through the Vaccines For Children (VFC) program to immunize its enrolled children. The discounts, which are available to publicly funded programs, allow CHIP to purchase vaccines at a fraction of the cost commercial insurers pay for the same vaccines.

After CHIP purchases these vaccines, the VFC program sends the vaccines throughout the state to pediatricians and health clinics that have agreed to participate in the VFC program. Many healthcare providers have chosen not to participate in the VFC program. These providers purchase their vaccines at the prevailing commercial rate and then bill CHIP health plans for the cost of the vaccine.

One of CHIP's contracted health plans, Molina Healthcare of Utah, requires that all of its participating physicians enroll in the VFC program. Because of this policy, Molina is able to assume that all CHIP immunizations have been purchased through the VFC program and then doesn't pay immunization claims. Public Employees Health Program (PEHP), the other CHIP contracted health plan, does not require its providers to be enrolled in VFC. Consequently, PEHP pays claims for billed immunizations, assuming that the physician's office will not bill for vaccines purchased through VFC.

The auditor has quantified the cost of these billings at $32,400 per month. Though CHIP disagrees with the amount (based on immunization claim payment data supplied by PEHP), it does agree that the current process for paying immunization claims can be improved. CHIP will work with PEHP to implement tighter controls in the payment of claims and to educate physicians and health clinics on proper immunization billing practices.

(2) FY 2002 Contract with Molina Healthcare of Utah

The contract in effect between CHIP and Molina Healthcare of Utah for fiscal year 2002 did not include a profit-sharing cost settlement agreement. Prior years' contracts had included such a provision.

CHIP has agreed with Molina to restore the provision to the current contract.

(3) HMO plans in the rural areas

Since the inception of the CHIP program in fiscal year 1999, PEHP's Preferred Plan has been the only plan offering available for CHIP children living outside of Weber, Davis, Salt Lake and Utah counties. Effective December 1, 2003, Molina will begin offering a new health plan option for these children living outside the Wasatch Front. Additionally, CHIP has discussed with PEHP the possibility of offering the Exclusive Care plan to CHIP children living outside the Wasatch Front.

(4) Premium Collections

CHIP has been charging enrollees a premium as a condition of enrollment since February 2002. The collected premium dollars help offset medical claim expenditures, which in turn allows more children to be enrolled in the program. During that time, CHIP has worked continually to upgrade its information systems to effectively manage premium collections and past due balances.

After the completion of the auditor's fieldwork, CHIP implemented a new database that is significantly better at tracking past due balances on CHIP accounts. The new database system has allowed CHIP to determine that approximately thirty-four percent of CHIP accounts have a past due balance. This is significantly lower than the sixty-three percent figure reported from the auditor's sampling. In spite of the differences in figures, CHIP is committed to reducing the number of past due accounts and now has the information systems in place to pursue more aggressive collection policies.

The Children's Health Insurance Program appreciates this opportunity to respond.

Sincerely,

Michael Hales, Director
Children's Health Insurance Program