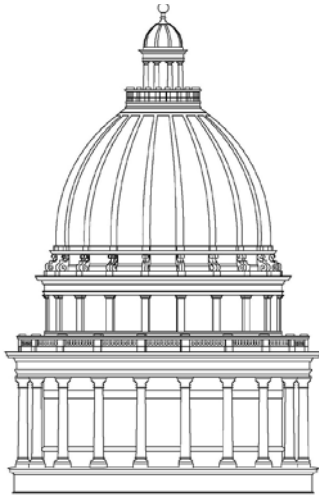
REPORT TO THE

UTAH LEGISLATURE

Number 2011-01



A Performance Audit Of PEHP's Business Practices

January 2011

Office of the
LEGISLATIVE AUDITOR GENERAL
State of Utah

STATE OF UTAH
Office of the Legislative Auditor General

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JOHN M. SCHAFF, CIA
AUDITOR GENERAL

January 18, 2011

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report, **A Performance Audit of PEHP's Business Practices** (Report #2011-01). A digest is found on the blue pages located at the front of the report. The objectives and scope of the audit are explained in the Introduction.

We will be happy to meet with appropriate legislative committees, individual legislators, and other state officials to discuss any item contained in the report in order to facilitate the implementation of the recommendations.

Sincerely,

John M. Schaff

John M. Schaff, CIA
Auditor General

JMS/lm

Digest of A Performance Audit of PEHP's Business Practices

Chapter I: Introduction

The 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, special service districts, and school districts. Utah Retirement Systems (URS) is an independent governmental agency and PEHP is a program within URS. Currently, PEHP provides health insurance coverage to state employees through six different plans.

Chapter II: PEHP Is Not As Competitive As in the Past

PEHP Does Not Compare Well Against Other Carriers in the Local Insurance Industry. We compared PEHP (using the state's insurance pool) to six major insurance carriers in Utah in terms of claim costs, contract rates with health providers, utilization, and administrative costs. The comparison showed the following:

- PEHP has higher medical, hospital, and pharmacy claim costs—the total cost paid by the employer and employee—than other carriers.
- PEHP's contract rates with health providers are not as competitive as rates of most carriers.
- PEHP has a higher utilization of office visits and the number of days spent in the hospital than other carriers.
- PEHP has lower claim administrative costs than all other carriers.

We completed this same comparison in *A Performance Audit of PEHP and CHIP* (number 2003-09) in 2003. That audit showed that PEHP was better managing the state's claim costs; by 2010, the state's claim cost has increased 114 percent since the 2003 audit.
PEHP should negotiate contract rates more aggressively with health providers before considering reducing health plan benefits to help control costs. We believe that a follow-up audit should be conducted in two years to determine if PEHP has adequately addressed the concerns discussed in this report.

Chapter III: PEHP Has Permitted a Poor Purchasing Process to Exist

PEHP's Procurement Process Demonstrates a Significant Lack of Adherence to Acceptable Purchasing Practices. PEHP's poor purchasing process inhibits their competitive procurement environment. Our concerns are based on an examination of the dealings that PEHP has had with 21 vendors representing more than $29 million in purchases over a five-year period. Some specific concerns regarding PEHP's weak procurement practices include the following:

- A lack of accurate and reliable records which identify specific contracts
- A failure to issue Requests for Proposal (RFP) or properly bid contracts as required by policy
- An absence of public advertisement or announcements of RFPs and bids
- Inadequate documentation of the evaluation process supporting the bid award
- A lack of strong management controls over contracts and terms of contracts

We have labeled PEHP's purchasing practices as poor because they have largely ignored previous audits by our office and the Utah Retirement System's (URS) internal audit division. Audit reports in 2003, 2005, and 2007 have identified concerns with PEHP's failure to properly bid contracts, lack of documentation, lack of contracts with current vendors, absence of a formal process for managing contracts, and a lack of adherence to URS' purchasing policies, which guides PEHP's purchasing practices.

Chapter IV: PEHP's Financial Practices Need to Improve

PEHP's Business Practices Have Caused Financial Problems in Individual Risk Pools. PEHP is financially solvent; the medical line of business increased reserves by $25 million in fiscal year 2010. However, seven medical risk pools had combined reserve deficits of $8.4 million. Three risk pools, including the state risk pool, may have $34.9 million of excess reserves that could be refunded to members and employers. We found that some of PEHP's business practices do not follow the self-funded insurance model.

- PEHP should prospectively quote administrative and reinsurance costs to employers at the beginning of a plan year.

- PEHP should allocate administrative costs to employer groups following industry best practices.
- PEHP reinsurance levels should be actuarially determined for each individual risk pool.
- PEHP should not pool reinsurance funds according to self-funded business practices. PEHP should conduct a cost-benefit analysis of the self-funded reinsurance model. If implemented, the $14.3 million in reserve should be reallocated to risk pools.

Consequently, some risk pools have paid more than their share of medical expenses for reinsurance coverage to offset expenses from other risk pools. Failure to resolve such issues led to the departure of employer groups, such as Utah County and Provo City. The Legislature should determine if the state risk pool should self-fund reinsurance or allow the current practice to continue where the state risk pool is a part of PEHP's reinsurance pool.

The ***Utah Code*** permits the Department of Insurance (DOI) to accept the financial audit by external auditors in lieu of the department's biennial audit. As a result, DOI last audited PEHP in 2003. We believe it is not sufficient for the DOI to accept the audited financial statements in lieu of an audit. Given the concerns addressed in this audit, PEHP should be audited biennially by the department.

Chapter V: PEHP's Pharmacy Program Requires Improvement

The Pharmacy Program Requires Adjustments to Ensure Members' Needs Are Being Met Fairly and Objectively. Prescription costs to PEHP have been declining since 2008 due to proactive cost-cutting efforts by PEHP. However, important decisions regarding the pharmacy benefit are made by the Pharmacy and Therapeutics (P&T) Committee regarding the prescription formulary (medication coverage), and therefore the pharmacy program require better processes and rules to ensure that PEHP's members' needs are fairly addressed. Specific conditions which should be addressed include:

- A concentration of responsibilities resides with the pharmacy director
- P&T committee lacks formal rules and policies in its administration
- Rebate process should be removed from the pharmacy program for appropriate separation of duties
- Transparent contract may be too costly for PEHP to obtain

Chapter VI: Appeals Process for Claims Review Needs to Be Strengthened

Additional external decision making is required to reduce unilateral decision making by the pharmacy director. Formal rules for the P&T Committee will reduce issues of independence, strengthen documentation of decisions, and promote greater overall safety for medication choices.

Appeals Process Needs Additional Controls. PEHP's claim appeals process consists of five levels of review. We found that PEHP needs to add additional controls to their appeals process to strengthen independence and objectivity for the first three levels of review. We found that:

- PEHP needs to establish a formal auditing process for the first level of appeals.
- The administrative review committee, which reviews the second level of appeals, needs additional clinical expertise.
- The administrative review committee needs a member advocate.
- The third level of appeals needs to be reviewed by an independent organization, outside of PEHP, with clinical expertise.

The appeals process helps protect PEHP by ensuring that members are receiving safe and effective care by their healthcare providers.

An appeals consultant reviewed 141 appeals and disagreed with the decisions made for eight appeals. The eight appeals represent a 5.7 percent disagreement rate. According to the appeals consultant, the disagreement rate is less favorable than the 3 to 5 percent rate that is considered acceptable in the industry. However, the disagreement rate was only slightly outside the acceptable range.

We observed that there is no formal tracking and trending of medical and pharmacy appeals. PEHP has experienced an extreme increase in the number of appeals submitted to PEHP in 2009 which has increased the workload of PEHP's staff involved in the appeals process. PEHP has not conducted an analysis determining the causes of the increase in appeals. We recommend that PEHP conduct such analysis going forward.

REPORT TO THE

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Report No. 2011-01

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Table of Contents

Chapter I
Introduction

The Public Employees Health Program (PEHP) is a non-profit, *self-funded** trust managed by the Utah State Retirement Board. In accordance with ***Utah Code* 49-20-401: "**[PEHP] shall: act as a self-insurer of employee benefit plans and administer those plans." The state must participate in the program on behalf of its employees; however, other employers, including political subdivisions and educational institutions, are eligible, but are not required, to participate in the program on behalf of their employees.

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, special service districts, and school districts. Currently, PEHP provides health insurance coverage to state employees through six different plans.

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

PEHP Is a Self-Funded Trust for The State and its Political Subdivisions

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.

Self-funded health plans are designed for employers to assume the risk for medical expenses incurred by their employees.

* Due to the technical nature of the subject matter, this report consists of highlighted words that are defined in the report's glossary in Appendix A.

Self-funding allows for reduced insurance costs because there is no profit margin built into premiums.

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 did not 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 costs spent on agent/broker fees and commissions, and administrative costs are lower.

Medical Benefits Are Available to State Employees and Their Dependents

PEHP offers six medical plans to state employees and their families.

Employees have the option to choose among six medical plans. Though there are other benefits offered, such as dental and life insurance, the focus of this audit is the medical benefit.

Membership in the various health programs offered through PEHP can change throughout the course of the year, due to job changes or other factors. However, the approximate membership of state employees for the State Medical Risk pool is about 73,000.

PEHP offers six medical plans for the state of Utah employees, three of which are high deductible high payment plans:

The Advantage Care health plan is provided through Intermountain Health Care.

- **Advantage Care.** Medical care is provided through Intermountain Health Care (IHC); PEHP contracts directly with all providers. Some employer groups require the use of panel physicians or no benefits are payable. Other employer groups offer a swing option and will allow up to fee schedule rates for off-panel use. There is freedom to move within the panel without referrals or a primary care physician.

- **Advantage Care High Deductible Health Plan.** Medical options are similar to Advantage care; however, all medical expenses are borne by the member until their deductible is met.

- **Summit Care.** Primarily a non-IHC based network that also includes Primary Children's Medical Center and all IHC rural facilities. PEHP leases this network from Wise Provider Networks. Some employer groups require the use of panel physicians or no benefits are payable. Other employer groups offer a swing option and will allow up to fee schedule rates for off-panel use. There is member freedom to move within the panel without referrals or a primary care physician.

The Summit Care health plan is a non-IHC based network, but includes Primary Children Medical Center.

- **Summit Care High Deductible Health Plan.** Medical benefits are similar to Summit; however, all medical expenses are borne by the member until their deductible is met.

- **Preferred Care.** Medical care is offered through all major hospitals within the state. PEHP contracts direct with all providers in this network. There is member freedom to move within the Preferred Care panel without referrals or a primary care physician. Swing option to non-panel providers is available with a higher out-of-pocket expense.

The Preferred Care health plan allows members to visit doctors with all major hospitals within the state.

- **Preferred Care High Deductible Health Plan.** Medical options are similar to Preferred; however, all medical expenses are borne by the member until their deductible is met.

The six plans give state employees options that best meet their benefit needs. Figure 1.1 shows the breakdown of membership amongst the six plans offered to State of Utah employees.

Figure 1.1 PEHP Offers Six Medical Plans. The Advantage and Summit Plans contain approximately 97 percent of the state medical pool as of December 2009.

Plan Type	Number of Members	Percent
Advantage	42,845	58.74%
Adv. HDHP	38	0.05
Summit	27,844	38.18
Sum. HDHP	38	0.05
Preferred	2,113	2.90
Pref. HDHP	57	0.08
Total	**72,935**	

Advantage and Summit Care plans account for 97 percent of all state membership.

According to Figure 1.1, the vast majority of members participate in the Advantage and Summit benefit programs. The State of Utah risk pool accounts for approximately 46 percent of the total membership of PEHP, the remaining 54 percent is primarily local government and education (total membership is approximately 161,000).

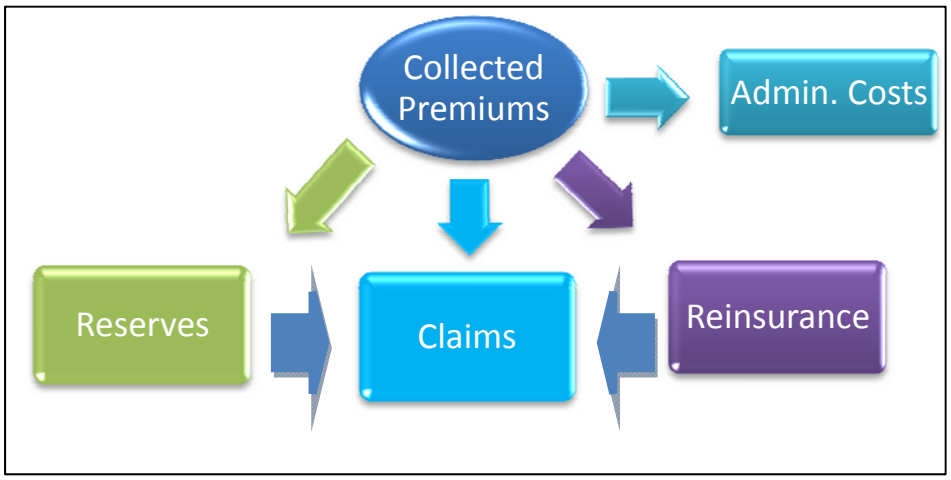
PEHP's Revenues are Premium-Based

Premiums received by employer groups cover claims costs and administration

PEHP serves various employee groups, known as risk pools, and receives premium equivalents from each risk group to cover administration and outstanding claim costs, as well as, setting aside monies for reserves and reinsurance. Figure 1.2 shows the relationship between the premiums received by PEHP and how the premiums are allocated.

Figure 1.2 PEHP Allocates Premiums to Cover Costs and Reserves. Premiums are used to cover administration and claims cost. Premiums are also placed in a reserve and used to pay for reinsurance.

Collected premiums are also allocated to reserves and reinsurance to pay for outstanding claims.



According to Figure 1.2, PEHP receives premiums from their employer groups and in turn allocates these monies into the areas shown in the figure. The premiums paid are allocated to pay for administration, claims, and reinsurance costs. Also, a portion of the collected premium is put in reserves to pay for unanticipated claims costs.

Premiums Fund Various PEHP Expenses

PEHP covers 230 employer groups or 11 risk pools. Premiums are the major form of revenue received by PEHP. Figure 1.3 shows the total balance of revenues and expenses for Fiscal Year 2010 for the state risk pool.

Figure 1.3 PEHP's State Pool Financial Summary for Fiscal Year 2010. PEHP receives its revenue from all of the employer groups' premiums. The premiums are used to pay for the various incurred expenditures.

PEHP's Medical Pool Operational Balance		
Category	**Amount**	**Percent of Total Expenditures**
Total Revenue	**$ 259,272,475**	
Health/ RX Claims Paid	(230,366,684)	96 %
Other Expenditures*	436,612	0
Admin Expense	(10,247,394)	4
Total Expenses	**(240,177,466)**	
Net Total (Reserves)	**$ 19,095,009**	

*Other expenditures include Reinsurance Premiums, Provisions for unpaid claims and claims incurred but not reported, Reinsurance Claims Paid, Network Access Fees, and Experience Dividends. The State of Utah received a $20 million reimbursement for Reinsurance Claims Paid, which leads to a positive "Other Expenditures" amount.

Of the $259 million PEHP received in premiums from the state and its members in fiscal year 2010, $230 million were used to pay for health and prescription claims, the remaining $19 million goes to reserves.

According to Figure 1.3, the state and its employees paid approximately $259 million in total premiums and approximately $230 million of the premiums were applied to pay for medical and prescription claims, which accounts for 96 percent of total expenditures for the state risk pool. The net total of $19 million excess revenue remained at year's end to cover unexpected claims. The state pool accounts for approximately 48 percent of PEHP's total revenue; total medical revenue is approximately $540 million. For 2010 only, the excess revenue amount of $19 million of increased reserve accounts for approximately 76 percent of the total increases the total reserves; total increases in revenue were approximately $25 million.

Premium Rates Have Increased But Remain Below National Trend

Premium rates for the state have increased 22 percent between fiscal years 2005-2009. Nationally premiums have increased by 29 percent.

PEHP's premium rates, which is the amount the employee and the employer pay together, for the state risk pool have increased approximately 22 percent for Advantage and Summit Care plans (for both single and family plans), from fiscal years 2005-2009. About 97 percent of the state's employees belong to one of those two plans. Compared to the state, the national average increased by 29 percent for plans similar to Advantage and Summit, from 2005-2009.

Only about three percent of the state's members are enrolled in Preferred Care. The state's Preferred Care plan compared to the national average was higher. The national average increased 19 percent, while the state's premium increased 47 percent, for the single plan. For the family plan, the national average increased 24 percent, the state's increased 47 percent.

When we examined the amount the member pays, there have been large increases since 2005. The amount the employee pays for his or her benefit in the state risk pool has increased by the following amounts from 2005 to 2010:

For the Summit and Advantage Care health plans, the employee's share of plans' cost have increased 223 percent for both single and family plans over a five year period.

- Summit and Advantage single employee plans: $77 to $249, an increase of 223 percent.
- Summit and Advantage family plans: $212 to $685, an increase of 223 percent.
- Preferred single employee plan: $289 to $1723, an increase of 496 percent.
- Preferred family employee plan: $797 to $4743, an increase of 495 percent.

The percentage the employee paid for the Summit and Advantage plans in 2005 was two percent of the total premium cost; in 2010, it was five percent of the total premium cost. For the Preferred plans, it was seven percent in 2005; in 2010, it was 27 percent of the total premium cost.

Audit Scope and Objectives

This audit was requested by two legislators who asked us to determine whether PEHP provides cost-effective programs to the state and its employees. We were asked to examine the following areas of PEHP:

We were asked to determine if PEHP is providing cost-effective programs to the state.

- Determine if appropriate procedures are followed in the procuring and managing of vendor services.
- Determine if PEHP is aggressively negotiating cost-effective provider contracts.
- Determine if the pharmacy benefit is providing safety, efficacy, and cost-effectiveness in administering this benefit.
- Determine if PEHP is effectively managing costs for the State of Utah members.

To complete this audit, we examined PEHP's financial records, performed an intrastate provider comparison study, collected a random sample of adjudicated claims, collected a sample of service providers and vendors that work with PEHP, and reviewed the pharmacy benefit contract and executive reports.

The audit report is organized as follows:

- Chapter II how PEHP compares to local insurance carriers.
- Chapter III investigates whether PEHP is fostering a competitive procurement environment.
- Chapter IV discusses the financial solvency of risk pools.
- Chapter V describes pharmacy benefit management practices.
- Chapter VI discusses the claims appeals process.

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Chapter II
PEHP Is Not As Competitive As in the Past

The Public Employees Health Program (PEHP) does not compare well against other carriers in the local insurance industry. We compared PEHP (using the state's insurance pool) to six major insurance carriers in Utah in terms of claim costs, contract rates with health providers, utilization, and administrative costs. The comparison showed the following:

- PEHP has higher medical, hospital, and pharmacy claim costs than other carriers.
- PEHP's contract rates with health providers are not as competitive as rates of most carriers.
- PEHP has a higher utilization of office visits and number of days spent in the hospital than other carriers.
- PEHP has lower claim administrative costs than all other carriers.

PEHP contract rates with health providers are not competitive; as a result, PEHP has higher claim costs than other carriers.

This comparison showed that member benefits were not richer than other local carriers. PEHP should negotiate contract rates more aggressively with health providers, before considering reducing health plan benefits to help control costs. We believe that a follow-up audit should be conducted in two years to determine if PEHP has adequately addressed the concerns discussed in this report.

A follow-up audit should be conducted in two years to determine if PEHP has adequately addressed the concerns described in this report.

We completed this same comparison in *A Performance Audit of PEHP and CHIP* (number 2003-09) in 2003. That audit showed that PEHP was better managing the state's claim costs at that time. Each section in this chapter reviews PEHP's current performance to what was found in the 2003 audit. The same methodology that was developed by actuaries in the industry to make a reasonable comparison among insurance carriers was used for both audits. The information requested from the carriers is shown in Appendix B. The time frame used for this comparison was calendar year 2009. We appreciate Altius Health Plans, Deseret Mutual Benefits Association, Educators Mutual Insurance Association, Select Health, Regence BlueCross BlueShield of Utah, and United Health Care for participating in this comparison.

Using the state's membership, PEHP was compared with local insurance carriers from the 2003 audit. The same methodology was used again for this audit.

PEHP Needs to Focus On High Claim Costs

A claim cost comparison showed that the state had higher claim costs than other carriers for all medical claims, including hospital and pharmacy claims. For the claim costs comparisons, we were able to compare the state's claim costs with the costs of five other local insurance carriers. (Due to low membership, one of the participating carriers was not included in the claims cost comparison for this report.) All claim costs were compared on a *per-member per-month*[*] (PMPM) basis. Most of the premium that the state and employees pay goes toward claim costs. Of the total expenditures for the state *risk pool* for fiscal year 2010, 96 percent were claim costs.

Ninety-six percent of the total expenditures for the state risk pool for fiscal year 2010 went toward claim costs.

This same comparison was completed in the 2003 audit of PEHP. The same five carriers participated in both audits. The results of that comparison showed the state's claim costs were lower than the average of the other carriers. Many inter-related factors could be responsible for PEHP's increase in claim costs; however, the age of the state's membership, and benefits offered to state members do not appear to be contributing factors.

When PEHP was compared with five local insurance carriers in 2003, the state's claim costs were lower than the average of the other carriers. They are now higher.

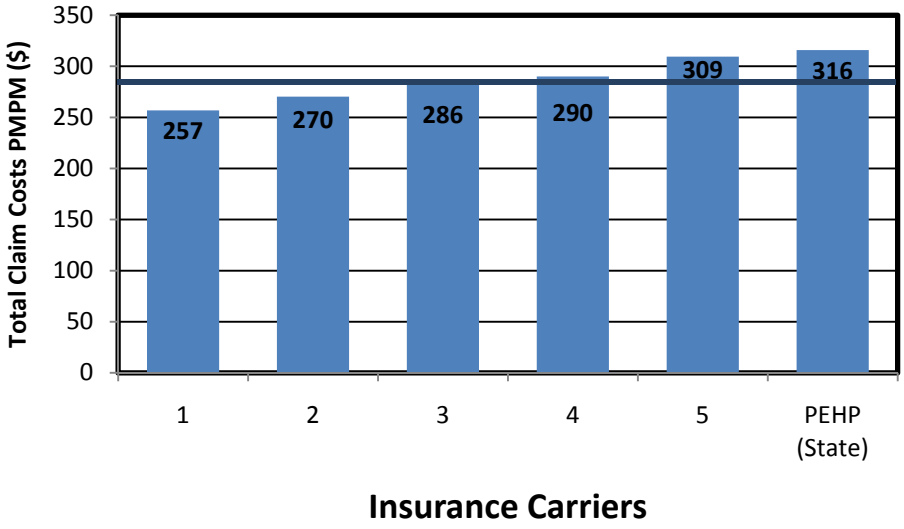
The State's Claim Costs Are Higher Than Other Insurance Carriers' Costs

The 2009 claim costs for the state's insurance pool at PEHP are higher than all other carriers that participated in the audit. Claim costs were analyzed using a weighted average of the *allowed amount*, which is the maximum charge that an insurance carrier will reimburse a provider for a given service or procedure on a (PMPM) basis. The maximum charge is the sum of what the insurance carrier pays and what the member pays. The PMPM is the cost for each enrolled member each month.

Figure 2.1 shows how PEHP compares with the local insurance industry. For this comparison all claims—medical, hospital, and pharmacy were reviewed.

[*] Due to the technical nature of the subject matter, this report contains highlighted words that are defined in the report's glossary in Appendix A.

Figure 2.1 Total Claim Cost Comparison. The average claim costs were $316 PMPM for the state, and $282 PMPM for all other local insurance carriers. (The average for the insurance carriers, excluding PEHP, is shown by the blue bar in all bar graphs in this chapter.)



The state's total claim costs exceed the average of the other local carriers by 12 percent.

Figure 2.1 illustrates that all of the state's claim costs at PEHP are higher than the other major insurance carriers in Utah. The state's total claim costs exceed the local carriers' average by $34 PMPM, or 12 percent.

The state's hospital claim costs are 38 percent higher than the average of other insurance carriers.

The State's Hospital Claim Costs and Pharmacy Claim Costs Are Also Higher than Other Carriers' Costs. The state's inpatient hospital claim costs are $72 PMPM, 38 percent higher than other carriers. The average cost for all other carriers was $52 PMPM. The state's pharmacy claim costs are $65 PMPM, while the average cost for all other carriers is $48 PMPM. That is a $17 PMPM difference, 35 percent higher than the average for all other carriers. Appendix C shows two separate graphs of how the state compares to the carriers for hospital and pharmacy claim costs.

The state's pharmacy claim costs are 35 percent higher than the average of the other insurance carriers.

Previous Audit Showed Lower Claim Costs

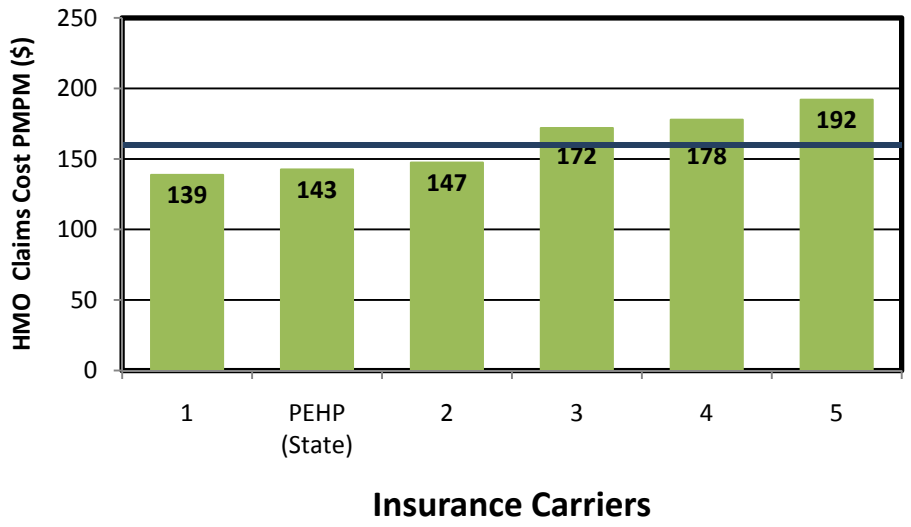
This same comparison was made in the 2003 audit of PEHP. The same major local insurance carriers that participated in this audit also participated in the 2003 audit. The comparison done in 2003 showed that the state's claim costs were about 13 percent lower than the average cost of the other local insurance carriers.

The insurance carrier comparison in 2003 showed that the state's claim costs were about 13 percent lower than the average cost of the other carriers.

Figure 2.1 above includes all membership for the state. Ninety-six percent of the state's members are enrolled in the Advantage Care and Summit Care health plans, while the remaining 4 percent are enrolled in the Preferred Care and high-deductible plans. As a result, most of the claim costs in Figure 2.1 reflect the costs for the Advantage Care and Summit Care health plans.

Figure 2.2 shows the total claim costs (including hospital and pharmacy) for the state's Advantage Care (then called Exclusive Care) and Summit Care memberships in 2003. These two plans were categorized as *health maintenance organizations* (HMO) type of health plans in 2003. For the 2003 audit, we did not combine all health plans together when we were reviewing total claim costs; we separated the HMO plans from the Preferred Care Plan. At that time, 45 percent of the state's membership was enrolled in those two plans.

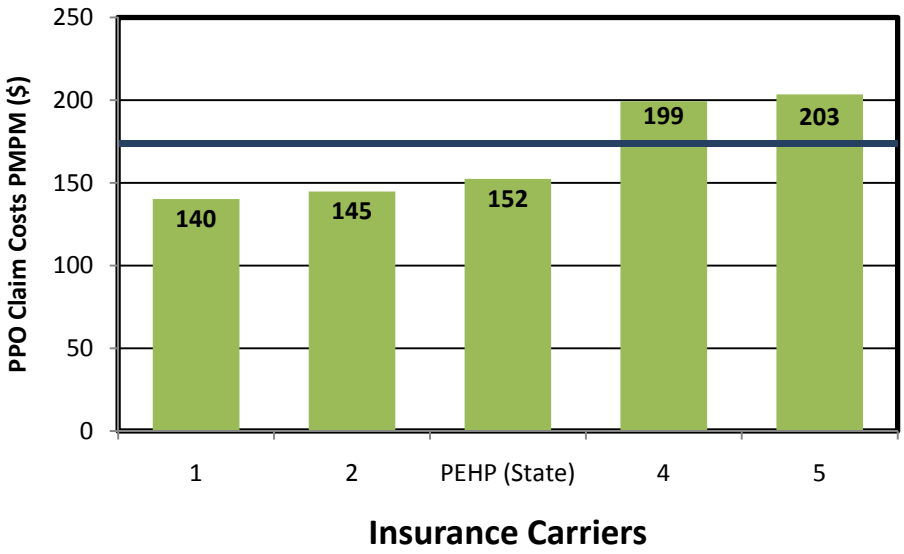
Figure 2.2 HMO Medical and Pharmacy Claim Costs Comparison from the 2003 Audit. At that time, the average claim costs were $143 PMPM for the state, and $166 PMPM for all other local insurance carriers.



In 2003, only one insurance carrier had lower medical and pharmacy claim costs than the state for the HMO plans.

As the figure illustrates, only one insurance carrier had lower claim costs than PEHP for the state members enrolled in the HMO plans. Also in 2003, 54 percent of the state's membership was enrolled in the Preferred Care, a *preferred provider organization* (PPO) type of a health plan. Figure 2.3 displays the medical claim costs for the state's membership enrolled in Preferred Care in 2003.

Figure 2.3 PPO Medical and Pharmacy Claim Costs Comparison from the 2003 Audit. At that time, the average claim costs was $152 PMPM for the state and $172 PMPM for all other local insurance carriers.



In 2003, the state's claim costs were $20 per-member per-month (PMPM) less that the average of the other carriers for the PPO claim costs.

In 2003, the state's PPO claim costs were in the middle of the other carriers that participated in the audit and were $20 PMPM less than the average of the other carriers. Since 2003, the state's claim costs have increased by about 114 percent.

It is difficult to make a precise comparison between carriers and plans, but the claim cost comparison shows that PEHP is not managing the state's medical costs as well as most of the other local insurance carriers are managing medical costs for their large employer groups.

Multiple Factors Influence Claim Costs

A variety of inter-related factors contribute to the rise in claim costs, such as technology advances and contract rates.

A variety of interrelated factors contribute to the rise in claim costs. Some factors, such as the underlying costs of providing medical services—market conditions, technology advances, inflation, etc., are not directly controlled by insurance carriers. For other factors, such as competitively negotiating contract rates, insurance carriers can monitor and develop strategies to help control costs.

Significant factors that can influence the increase in claim costs include the following:

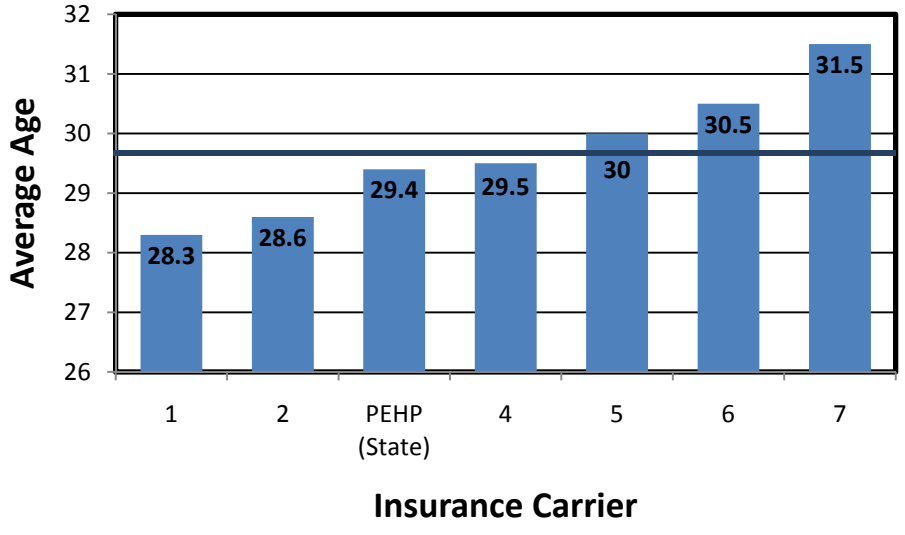
- The age of the enrolled members in employer groups
- The richness of the benefits offered to employer groups through plan design
- The negotiated contracts with health providers and facilities
- The use of services by enrolled members (utilization)
- The severity level of individual claims
- The underlying costs to provide medical services—market conditions, technology advances, inflation, research, etc.

For this audit, we looked at four factors that affect claim costs: age, benefits, contract rates, and utilization of services.

While it is not possible to analyze every factor that affects the rise in the state's claim costs, as part of this local carrier comparison, this audit did review four important factors: the age of the state's membership, richness of benefits, the contract rates with health providers (fee schedules), and utilization of services. Although PEHP does not control the age of the state's membership, PEHP can have an influence over the other three factors.

The Age of the State's Current Members Is Not a Contributing Factor to High Claim Costs. The age of the state's current members is younger than most other carriers. Figure 2.4 gives the average age for each of the participating carriers.

Figure 2.4 Age Comparison. The average age is 29.4 for the state and the average is 29.7 for all other local insurance carriers.



The average age of the state's membership is slightly younger than the average age of the membership of the other carriers.

Age of the state's membership does not appear to be a contributing factor to the state's high claim costs.

The average age of the state's membership is slightly younger than the average age of the membership of the other carriers. In the previous audit, the state's membership was slightly older than the membership

of other carriers. Older members often have higher-costing claims, and if the state's members were older this would help explain why the state's claim costs are high. This analysis shows that age does not appear to be a contributing factor to the state's high claim costs—as compared to costs of other local carriers.

State Members' Benefits Are Not Richer than Other Carriers' Benefits. Medical benefits are defined through health plan design. The medical benefits have been reviewed in terms of cost—as a ratio of the amount paid for a service or procedure by the insurance carrier versus the amount paid by the member. The benefits are richer the closer the ratio is to 100 percent. When reviewing the amount paid by the carriers, PEHP paid 82.7 percent of the allowed amounts, while the other carriers, on average, paid 84.8 percent.

Since state members' benefits are not as rich as other carriers, benefits are not contributing to the state's high claim costs in the carrier comparison.

This comparison shows that state members pay slightly more for medical services and procedures than members pay that are enrolled with other local carriers, because PEHP pays a lower percentage. Only one carrier had a lower percentage (80.6 percent) which indicates more restrictive benefits than PEHP. The results of this comparison show that the structure of benefits in the state's health plans' design do not appear to be a significant contributing factor to the state's high claim costs, as compared to costs of other local carriers.

Even though age and benefits do not to appear to affect the state's claim costs for this comparison, the next two sections of this chapter discuss two factors—contract rates and the use of medical services—that do contribute to the state's high claim cost.

PEHP Needs to Aggressively Negotiate Rates with Providers

A significant factor affecting claim costs is the contract rates that PEHP negotiates to pay health providers. We found that PEHP's contract rates are higher than most carriers' rates, and PEHP is not as competitive as we found them to be in the previous audit. As compared to other carriers, PEHP is not aggressively negotiating contract rates. These contract rates for different services or procedures are called *fee schedules*. We compared PEHP's fee schedules with fee schedules for six insurance carriers in Utah for 32 medical procedures

A significant factor affecting claim costs is the contract rates that PEHP negotiates with health providers.

or services. Other carriers are saving, on average, $1.4 million over PEHP for these selected fee schedules. Before reducing members' benefits to help control claim costs, PEHP should negotiate contract rates more aggressively.

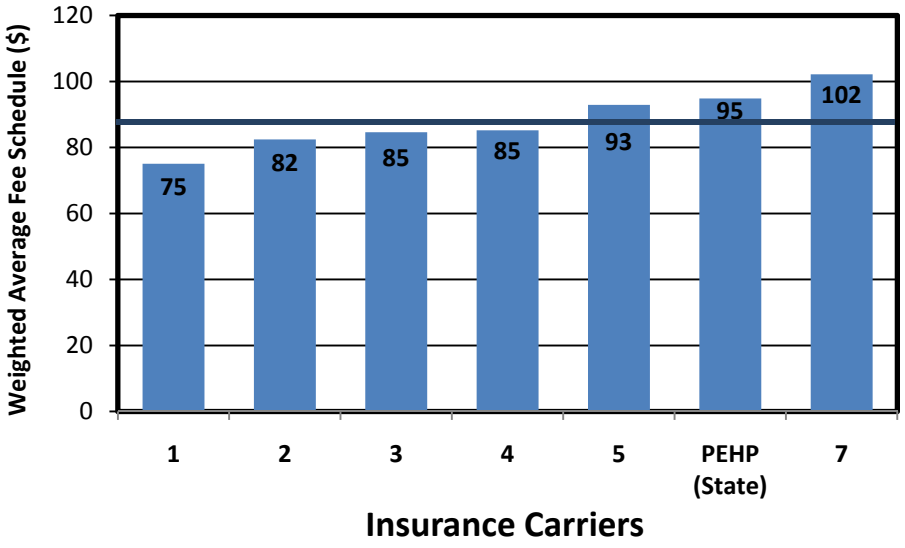
PEHP's Contract Rates Are Higher Than Most Insurance Carriers' Rates

PEHP's contract rates with health providers are not competitive; as a result, PEHP has higher claim costs than other carriers.

PEHP's contracted fee schedule rates with health providers for the state are higher than all but one of the major local insurance carriers' rates. Fee schedules are listings of the maximum dollar amount that insurance companies pay health providers for specified medical services and procedures. For this comparison, each carrier provided their fee schedule for 32 medical procedures. A copy of the fee schedule request, listing the 32 procedures, is in Appendix B.

This comparison applied the costs associated with each of the six local carriers' fee schedules to PEHP's state member utilization over a 12-month period for calendar year 2009. 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 state members. This weighted average fee schedule for the insurance carriers is shown in Figure 2.5.

Figure 2.5 Fee Schedule Comparison for 2009. The average of the fee schedules for selected medical procedures was $95 for the state and $87 for the other local insurance carriers.



For the sample of the fee schedules reviewed, PEHP's rates are 9 percent higher than the average of the other carriers.

PEHP's fee schedules of $95 in Figure 2.5 represent the Advantage Care and Summit Care plans, which consist of 97 percent of the state's membership. Preferred Care fee schedules were excluded, because only 3 percent of the state membership is enrolled in Preferred Care. However, Preferred Care fee schedules were a little higher than Advantage Care and the Summit Care plans.

The carrier with the lowest fee schedules is realizing a cost savings of $3 million over PEHP for 32 medical services reviewed.

Insurance companies periodically negotiate fee schedules with health provider groups. PEHP's negotiations with provider groups have not provided good cost savings for the State of Utah. For the 32 medical services considered, PEHP is only realizing a cost savings of $600,000 over the one carrier that had the highest fee schedules. The carrier with the lowest fee schedules is realizing a cost savings of $3 million over PEHP. This audit only reviewed 32 medical services and procedures, a small sample of services and procedures. If PEHP rates are as high for the other hundreds of services and procedures that exist, other local carriers are saving millions of dollars over PEHP.

The Previous Audit Found PEHP Rates to Be More Competitive

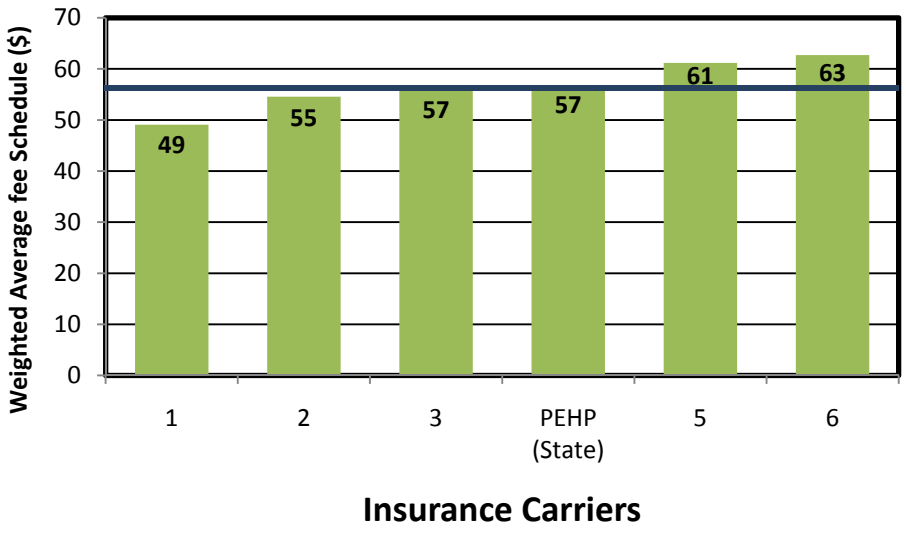
In 2003, PEHP was more competitive within the local insurance industry in procuring contract rates.

This fee schedule comparison was also made in the 2003 audit of PEHP. The same major local insurance carriers that participated in this study also participated in the 2003 audit, with the addition of one

carrier that participated in this audit. The comparison done in 2003 showed that PEHP was more competitive within the local insurance industry in procuring contract rates. Figure 2.6 shows the fee schedule comparison from the 2003 audit.

Figure 2.6 Fee Schedule Comparison from the 2003 Audit. In 2003, the average of fee schedules for selected medical procedures was $57 for the state, and it was also $57 for the other local insurance carriers.

In 2003, PEHP fee schedules were the same as the average of the other local insurance carriers.



In 2003, the fee schedules for the state were ranked fourth, among the six carriers, in terms of highest cost. This audit showed (in Figure 2.5) that the state was ranked sixth in terms of highest cost. Figures (2.5 and 2.6) also show the inflation in the cost of medical services. The fee schedule costs have increased $30 from the 2003 audit.

This study shows that when PEHP is compared to the local industry and to its performance from the 2003 audit, PEHP is not negotiating competitive contract rates with health provides, which results in high claim costs.

For 2009, the average fee schedules for selected physician visits was $54 for the other carriers, and $59 for PEHP.

PEHP Has the Second Highest Contract Rates for Physician Office Visits. We reviewed the primary care (new and established patient) office visits. Fee schedules that were submitted by each of the carriers showed that PEHP rates were higher than the other carriers, except for one. The average office visit fee schedules for the six carriers was $54, while PEHP's average was $59. For the number of office visits made by state members in 2009 for the four fee schedules submitted (see Appendix B for four office visits reviewed), the state

paid $457,000 more than the average cost paid by the other carriers. The high contract rates for these common medical services contribute to the state's high claim costs.

State Members Frequently Utilize Medical Services

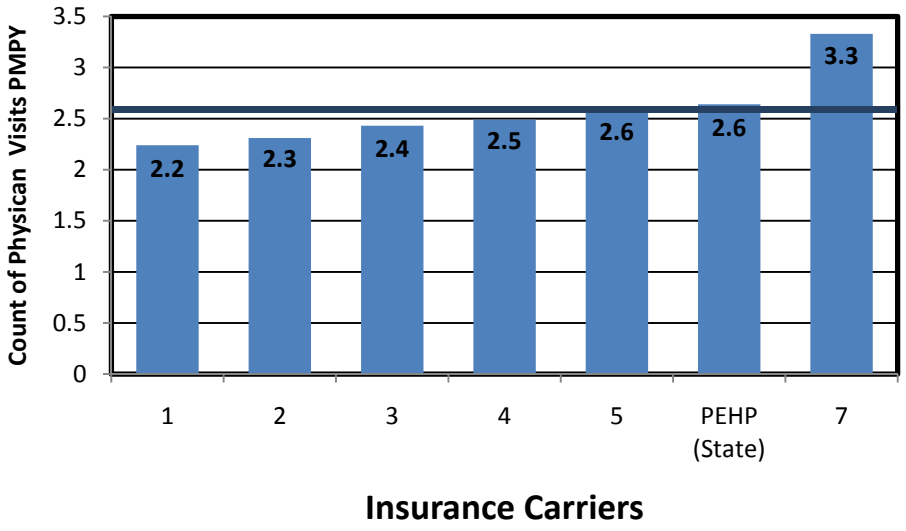
As part of this local carrier comparison, we compared how frequently state members utilized medical services compared to members enrolled with the other carriers. We found that state members visit the doctor slightly more frequently and spend more time in the hospital than most other employer groups' members. However, the count of medical claims has remained fairly constant for the state's medical risk pool for the last five years.

State Members Visit a Physician Slightly More Frequently

As part of the carrier comparison, we reviewed how many times during the year members visited their physicians. Figure 2.7 shows the average count of physician visits members made for each of the seven carriers for 2009.

For 2009, the state's average count of physician visits was slightly higher than other insurance carriers, except for one.

Figure 2.7 Physician Visits Comparison. State members made 2.6 visits to a physician in 2009. The average for all other carriers was also 2.6 visits in 2009.



High contract rates for physician visits combined with frequent physician visits, help explain the state's high claim costs.

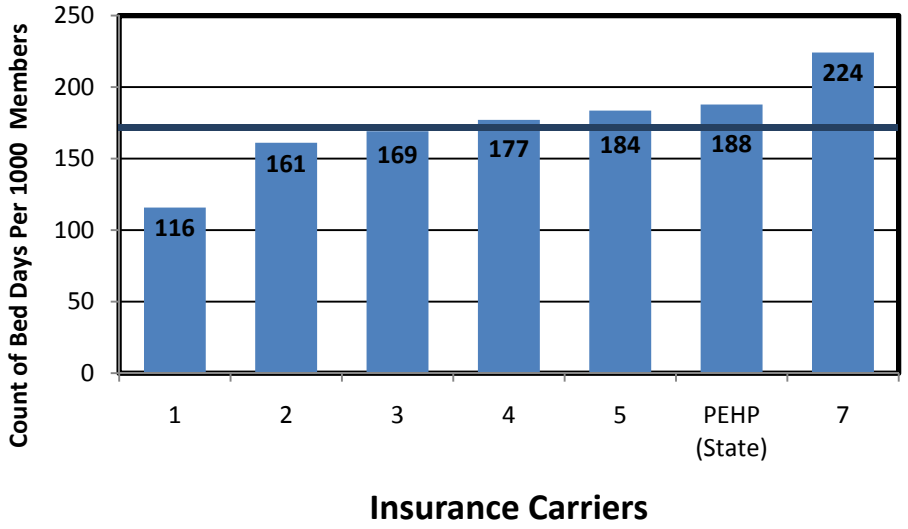
The state's average count of physician visits was the second highest when compared to the other insurance carriers. In the previous section of the report, we discussed that PEHP's contract rates for selected primary care physicians were higher than the rates for other carriers. These two factors combined, frequent visits and high rates, help explain why the state's claim costs are high. In the 2003 audit, state members made 2.2 visits to their physician in a year. The number of visits has increased by 18 percent.

The number of physician visits by state members has increased 18 percent since 2003.

State Members Hospital Stays Are Above the Average

We also compared state members' utilization of hospital days to utilization rates of members enrolled with other insurance carriers in 2009. Figure 2.8 shows the number of hospital bed days occupied per every 1,000 members.

Figure 2.8 Hospital Bed Days Comparison. For every 1,000 members, the average number of days spent in the hospital for the state members was 188. The average for other carriers was 172.



The state's average number of hospital bed days is the second highest in this carrier comparison.

The state's average number of hospital bed days is the second highest among the carriers, and 9 percent above the average of all other carriers. Hospitalization is an expensive medical service and contributes to the states high claim costs. The state's average number of hospital days has not changed from number reported in the 2003 audit. At that time, the average for state members was 188. The

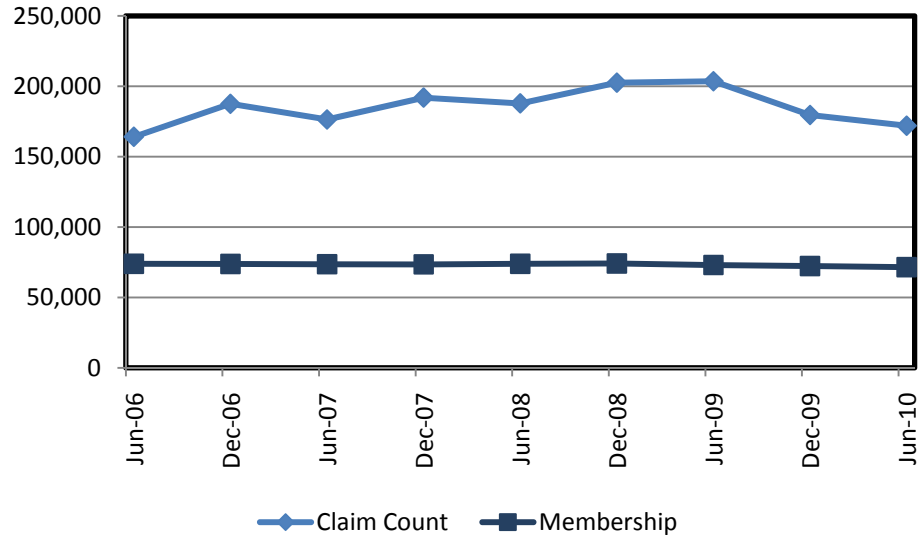
Hospitalization is an expensive medical service that drives high claim costs.

average of the other carriers in 2003 was 191, so their average has decreased by 19 bed days to 172.

Overall the Count of Medical Claims Has Only Slightly Changed

Even though utilization of office visits and hospital stays is high compared to other carriers, the overall total count of medical claims for state members has only slightly increased in the past four years. Since June 2006, the medical claims count trend shows an increase of about 5 percent, while state membership has only slightly decreased by 3 percent. Figure 2.9 illustrates the decrease in state membership compared to the number of medical claims filed for the last five years.

Figure 2.9 State Membership and Medical Claim Count. For the last four years, the average count of medical claims is 185,100. State membership is 71,500 as of June 2010.



Both medical claim counts and state membership have remained quite constant for the past four years. (June 06 – June 10)

Both medical claim counts and state membership have remained quite constant for the past four years. However, for about the same time period (Jan 06 – Dec 09) medical claim costs have increased 29 percent, from $159 million to $205 million. This indicates that the cost to provide medical services and procedures has increased, but utilization of services has not increased. Again, these trends show the need for PEHP to aggressively negotiate contract rates.

While the utilization of medical services has not increased, the cost to provide medical services has increased 29 percent since 2006.

Since utilization, or claim costs, is one of the factors that drive premium levels, PEHP looks at claim costs divided by premiums, the *loss ratio*, as a guideline to help determine if premiums need to be increased. When the loss ratio approaches 100 percent, PEHP has to consider increasing premiums to cover claims expense. Figure 2.10 provides the loss ratio for the state for the past five years.

Figure 2.10 State of Utah's Aggregate Loss Ratio. The loss ratio for the state has not exceeded 100 percent in the last five years.

The state's claim costs has not exceeded premium collected during the last five year period.

Year	Claims	Premium	Loss Ratio
2006	$ 195,832,261	$ 200,133,073	98%
2007	215,737,399	230,357,856	94
2008	231,210,973	256,387,075	90
2009	250,418,775	253,192,200	99
2010	239,262,477	254,674,644	94

The loss ratio for the state has been close to 100 percent for two of the last five years, but has not exceeded 100 percent. These loss ratios show that PEHP has been monitoring claim costs, and adjusting premium as needed to be able cover the increase costs of medical claims. PEHP has done a good job of monitoring the loss ratio for the state's insurance pool, and this indicates that PEHP can also monitor and focus on factors affecting the state's high claim costs.

PEHP's Administrative Costs Are Lower than Other Insurance Carriers' Costs

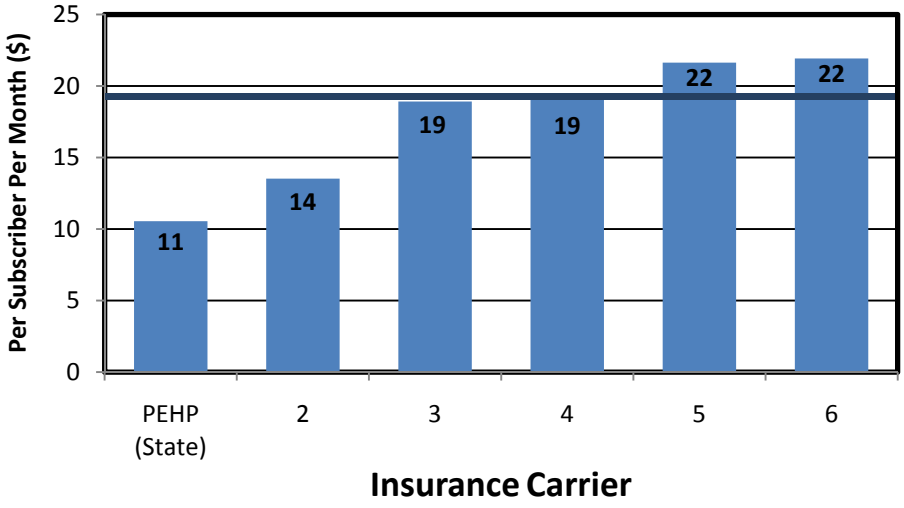
For the state, administrative costs consisted of 4 percent of the total expenditures for fiscal year 2010.

As part of the local carrier comparison, we also looked at administrative costs. Administrative costs are only 4 percent of the state pool's total expenditures for fiscal year 2010. PEHP's administrative costs were the lowest of the local insurance carriers participating in this audit. Administrative costs were reviewed on a *per-employee (also called a subscriber) per-month* basis (PSPM). Within the industry, administrative costs are commonly measured on a PSPM. PEHP's administrative costs are 42 percent less (PSPM) than the industry average. In the 2003 audit, PEHP's administrative costs were 66 percent less than the industry average.

In 2009, the state realized about $2.5 million in cost savings due to PEHP's low administrative costs, when compared to the other carriers. This savings has decreased by $3.5 million from the 2003 audit, because the average of other carriers' administrative costs has decreased by 49 percent, while PEHP administrative costs have only decreased by 15 percent. Figure 2.11 below shows the administrative costs on a PSPM for 2009.

PEHP's administrative costs are 42 percent lower than the industry average.

Figure 2.11 Administrative Cost Comparison. The PSPM for the state's administrative costs was $11, and the average for all other carriers was $19. (Note: One carrier did not participate in this comparison.)



On an annualized basis, the state realizes about $2.5 million in cost savings, when compared to other carriers, due to low administrative costs.

PEHP's low administrative costs, when compared with commercial insurance carriers' costs, are expected because PEHP self-funds their health plans. PEHP is not a for-profit insurance carrier like most of the carriers that participated in this audit. For this administrative cost comparison, shown in Figure 2.11, each carrier removed premium tax, commissions, and reinsurance charges.

Low administrative costs are expected because PEHP self-funds their health plans.

Having a low administrative overhead helps PEHP to control premiums rates, as was discussed in Chapter I. If PEHP administrative costs were similar to costs of other insurance carriers, the state's premium rates would be higher. However, PEHP appears to be controlling administrative costs.

Recommendations

1. We recommend that PEHP complete an in-depth study of the state's claim costs and develop strategies to contain costs.

2. We recommend that PEHP more aggressively negotiate contract rates with health providers.

3. We recommend that the Legislature request a follow-up audit in two years to determine if PEHP has adequately addressed the concerns discussed in this report.

Chapter III
PEHP Has Permitted a Poor Purchasing Process to Exist

We believe the Public Employees Health Program's (PEHP) procurement process demonstrates a significant lack of adherence to acceptable purchasing practices which inhibits their competitive procurement environment. Our concerns are based on an examination of the dealings that PEHP has had with 21 vendors representing more than $29 million in purchases over a five year period. Some specific concerns regarding PEHP's weak procurement practices include the following:

- A lack of accurate and reliable records which identify specific contracts,
- A failure to issue Requests for Proposal (RFP) or properly bid contracts as required by policy,
- An absence of public advertisement or announcements of RFP's and bids,
- Inadequate documentation of the evaluation process supporting the bid award, an finally
- A lack of strong management controls over contracts and terms of contracts.

We have labeled PEHP's purchasing practices as poor because they have largely ignored previous audits by our office and the Utah Retirement System's (URS) internal audit division. Audit reports in 2003, 2005, and 2007 have identified concerns with PEHP's failure to properly bid contracts, lack of documentation, vendor relations without a contract, absence of a formal process for managing contracts, and a lack of adherence to URS' purchasing policies, which guides PEHP's purchasing practices.

PEHP has allowed poor purchasing practices to continue after audits in 2003, 2005, and 2007 both by our office and URS.

PEHP Is Not Following URS' Purchasing Policies

In our review of the dealings that PEHP has with vendors (which may include service providers, consultants, etc.), we found that PEHP

We had concerns with 90 percent of PEHP's vendor dealings that we reviewed.

is not following many of the URS' purchasing policies. As a division of URS, PEHP is required to follow URS' purchasing policies. We reviewed the dealings that PEHP had with 21 vendors and found concerns with 19 (90 percent) of them. The remaining two contracts (10 percent) we found to be complete according to policy. Specific concerns we found were:

- Contractual relationships were not being formally established.
- Contracts were not competitively bid.
- Contracts were missing.
- Documentation was lacking.

As mentioned, these issues are a concern because we found large dollar vendor dealings established without sufficient protections under policy.

PEHP Is Exempt from Utah's Procurement Code

Utah Code 49-11-201(4) allows PEHP an exemption from "those acts which are applicable to state and other governmental entities under this code." URS has interpreted this as to include an exemption from Utah's procurement code. Consequently, PEHP does not utilize the Division of Purchasing and General Services when procuring goods and services. Although PEHP is exempt from Utah's procurement code, it is included in this report as one resource for best practices.

Still, URS maintains its own purchasing policies wherein purchases over $20,000 require a Request for Proposal (RFP), purchases between $10,001 and $20,000 require three written bids, and purchases between $2,001 and $10,000 require three written or three telephonic bids. URS' purchasing policies allow an exemption from these requirements if the purchases are from state contract vendors, office-approved vendors, and sole source vendors.

PEHP's Lack of Adequate Records Made Review Process Difficult

PEHP does not maintain an accurate and reliable master contract list.

PEHP does not have an accurate and reliable master contract list. In addition, because many of the dealings PEHP has with vendors are not governed by a contract, we believe any list of contracts would not accurately reflect their relationships with vendors. Therefore, we

could not determine the total number of vendor contracts from which to choose our sample.

To make our selections we reviewed the payment records of vendors paid over the last five fiscal years. Isolating vendors to review was a difficult process. We selected payments PEHP had made to several vendors then had to exclude ones that were not actual vendors or did not fit within the audit parameters. For example, we did not include network leases in the contract review because that is a part of our carrier review in Chapter II of this report. Finally, we reviewed 21 vendor dealings from fiscal years 2006 through 2010. We reviewed five years of payments to a single vendor starting at $2,000. The results of the review are discussed in the next two sections of this chapter.

PEHP's Vendor Selection Process is Inadequate

As stated previously, we have concerns with 19 of the 21 (90 percent) vendor dealings we reviewed. In 14 of the 19, we found PEHP is not following vendor selection policies for RFPs and bidding because they were not competitively bid. Also, we believe that PEHP should publicly advertise RFPs. In three of the 19, that were competitively bid, documentation did not adequately support the vendors chosen. Finally, in two of the 19 we found PEHP needs justification supporting the status of sole source vendors.

PEHP Is Not Following Policies For RFPs and Bidding

From fiscal years 2006 through 2010, we found 14 out of the 21 sampled dealings with vendors (67 percent) had not gone through the appropriate RFP or vendor selection process. One purpose of conducting RFPs and gathering bids is to help ensure a fair and competitive process for selecting vendors. The total value of these dealings over the last five fiscal years is almost $13.5 million. Although, PEHP has had a longer relationship with most of these vendors, we only captured the last five years. Figure 3.1 shows the breakdown by issue and vendor expenditure.

We found 67 percent of the vendor dealings we reviewed had not gone through the appropriate RFP or selection process.

Figure 3.1 PEHP Failed to Have Required RFPs or Bids with 14 Vendors.

Vendor	Issue	PEHP Expenditure: FY 2006 - 2010
A	No RFP	$ 5,257,263
B	No RFP	2,008,170
C	No RFP	1,861,656
D	No RFP	1,461,870
E	No RFP	1,358,071
F	No RFP	750,215
G	No RFP	161,886
H	No RFP	160,956
I	No RFP	128,613
J	No RFP	112,203
K	No RFP	73,364
L	No RFP	67,780
M	No bids were taken	18,350
N	No bids were taken	8,636
Total		$ **13,429,033**

PEHP has a current working relationship with 13 of the 14 vendors shown in Figure 3.1. The relationship with vendor L ceased in 2009. Vendors M and N did not require an RFP since the expenditure was less than $20,000. However, they both should have been subject to the process of written or telephonic bids.

Our review found a lack of RFPs and bidding as required by URS policy, both of which are essential to ensure competitive pricing.

PEHP has determined vendors B and M in Figure 3.1 to be office-approved vendors. URS created office-approved vendors to relieve the burden of going through the bidding process every time a certain vendor's products or services are desired. URS' purchasing policies state that an office-approved vendor "is effective for two years." After two years the vendor may be reinstated "for up to two additional year periods." At the end of the four-year period, the vendor must be rebid in order to continue the relationship.

PEHP has used vendor B since 2002. Vendors B's status as an office-approved vendor expired in 2009 but is still being used and has never been rebid. Vendor M's status as an office-approved vendor was reinstated in February 2010; however, no bids were taken to determine if the vendor offers competitive pricing.

PEHP Should Publicly Advertise RFPs

Pursuant to URS' purchasing policies, PEHP is supposed to advertise RFPs to select vendors. Compared to the ***Utah Code,*** the *Utah Administrative Code*, and other states' RFP publication practices, we find URS' purchasing policies on RFP advertisement to be weak. This could include any products or services, including consultants, software products, medical services, etc.

We believe purchasing best practices dictate a more open advertisement of RFPs than PEHP currently conducts.

The URS policies state that PEHP's purchasing committee is responsible for conducting a "commercially reasonable inquiry into the existence and identity of potential vendors." However, "commercially reasonable" is not defined in policy.

In addition, the policies state that copies of RFPs are to be distributed to "selected vendors." We were told by a PEHP representative that PEHP could advertise in the newspaper but it is not a customary practice. We did not find any evidence of newspaper publications RFPs submitted by PEHP. We were told vendors are subjectively selected and contacted directly.

Although PEHP is exempt from the procurement code, we believe best practices dictate the open advertisement of bids. ***Utah Code*** 63G-6 explains that the underlying purpose of the procurement code, among other things, is to "foster effective broad-based competition within the free enterprise system."

Although PEHP is exempt from the Utah procurement code, its purpose is to "foster effective broad-based competition within the free enterprise system."

For state agencies that are subject to Utah's procurement code, *Utah Administrative Code* R33-3 requires procurements in excess of $50,000 to be publicized in any or all of the following: a newspaper of general circulation, a newspaper of local circulation in the area pertinent to the procurement, industry media, or a government internet website or publication designed for giving public notice. Utah state agencies use BidSync to publish procurements. BidSync is an Internet program that publishes state, local, and federal RFPs and bids. PEHP does not publish their RFPs on BidSync.

We contacted six other states' public employee health program to learn how they advertise for RFPs. Figure 3.2 shows that these states advertise RFPs in ways that PEHP does not.

Figure 3.2 In Contrast to PEHP, All Six States We Contacted Advertise Their RFPs in a Major Publication. Three of the states (Alabama, Louisiana, and Wyoming) even involve a third party in publishing their RFPs.

States' Self-Funded Health Insurance Group*	RFP Advertisement
Alabama	Consultant lists in newspaper and direct vendor contact
Louisiana	State Purchasing advertises in newspaper
Minnesota	State's weekly publication
Montana	Major newspapers and direct contact with vendors
West Virginia	State's purchasing bulletin and direct vendor contact
Wyoming	Newspaper, consultant group participates, direct vendor contact
Utah	Direct vendor contact

** These states were chosen because their employee health insurance is a self-funded program, such as PEHP.*

Publicly advertising RFPs opens the door to a broader-base of competition.

Relying on direct vendor contact in place of publicly advertising their RFPs limits PEHP's ability to ensure adequate competition. We believe PEHP needs to expand their advertisement of RFPs to attempt to capture any potential vendors that are not receiving notice of RFPs directly from PEHP.

Documentation for the Evaluation Process Is Not Adequate

PEHP records for three vendor dealings we reviewed that went through an RFP or bid process reveal little evidence of the RFP process or why the vendor was selected.[†] Figure 3.3 shows inadequate documentation justifying these three contract awards.

[†] This section does not apply to the 14 vendors discussed previously because they were not bid, nor does it apply to two vendors that PEHP has determined to be sole source vendors (as discussed later in this chapter).

Figure 3.3 PEHP Does Not Have Adequate Documentation to Support Selected Vendors.

Vendor	Contents of Record	PEHP Expenditure: FY 2006 – 2010*
O	Financial analysis but no discussion or evaluation of vendors	$ 7,224,976
P	Handwritten note justifying selection	4,217,334
Q	No evidence of 3 written bids	17,825
Total		**$ 11,460,135**

** According to PEHP, the actual commission paid to vendor P is 10% of the total expenditure, or $421,733.The remainder, 90%, was paid as a premium for the product which the vendor sells as a broker.*

In Figure 3.3, the amounts paid to vendors O and P were over $20,000. Therefore, both bids required an RFP. Vendor O alone totals over $7 million, clearly a significant amount to justify strong documentation supporting the selection process. Evidence supporting why the vendors were chosen from the RFP includes only a handwritten note, a financial analysis showing the selected vendor offering the biggest savings but providing no further discussion, and an e-mail declaring the purchasing committee's vote for a particular vendor. The Committee does not keep minutes, so the votes could not be tabulated. The third contract (vendor Q) involved an expenditure of less than $20,000. Therefore, we should have found evidence of three written bids in the records, but there was no evidence of three written bids. All we found was a letter denying the contract to another vendor.

Strong support documentation is needed to justify the selection of a vendor.

The state's Division of Purchasing and General Services has published an RFP manual on their website. Although exempt from state purchasing, PEHP should be adhering to similar best practices. Some of those steps mentioned in the manual include the following:

- Establishing a selection committee
- Pre-determining the criteria for selecting a vendor
- Using a decision matrix or scoring sheet to rank vendors' proposals
- Documenting the evaluation and award recommendation

PEHP could improve their RFP process by using a decision matrix or scoring sheet to rank vendors' proposals.

Using a pre-determined set of weighted criteria to score proposals can help PEHP ensure the most sought-after attributes are given the most weight on selection. By appropriately documenting the scoring

and evaluation of RFPs, PEHP can justify why a vendor is selected and ensure the parameters required under the RFP have been met. To their credit, PEHP provided us with a newly created scoring matrix that they report they will be using for future RFPs.

Documentation legitimizes the contract's validity when challenged.

Documentation is important because it legitimizes the contract's validity in the challenge of any conflicts of interest or inappropriate contract awards. For example, when awarding a contract from an RFP, agencies subject to Utah's procurement code are required by the *Utah Administrative Code* R33-3-2 to make a brief justification statement "showing the basis on which the award was found to be most advantageous to the state taking into consideration price and the other evaluation factors set forth in the Request for Proposals." They must also advertise the rankings of the proposals, their final scores and the written justification statement.

PEHP does not image and retain original bid responses for a set period of time as required by URS policy.

After an RFP is conducted, URS' purchasing policies require the purchasing committee to "generally award the contract to the lowest responsive vendor who meets the requirements and criteria set forth in the RFP," giving the committee "discretion to award the bid to any entity that is not the lowest bidder based on selection criteria." PEHP is also required to retain copies of the original bid responses, to be imaged and kept "for a period equal to the term of the contract or seven years, whichever is longer." We found no evidence of imaged bid responses and scant information about the reason vendors were selected, as discussed above.

Sole Source Status of Vendors Must Be Justified

Two of the 21 vendors we reviewed have been categorized by PEHP as sole source vendors. Comparing them, once again, to the state's purchasing policies, we found URS' policies regarding sole source vendors to be lacking. For example, we found no documentation justifying the vendors' status as sole source or evidence that PEHP followed a process to determine the vendors' status as sole source. PEHP also does not advertise sole source procurements, thus preventing other vendors from competing.

By not advertising sole source procurements, PEHP is preventing other vendors from competing.

PEHP has used these two vendors for a long period of time and neither has been rebid to see if other options exist. Figure 3.4 shows the contract dates and expenditure amounts for each contract.

Figure 3.4 PEHP Needs Documentation Justifying Sole Source Vendor Status.

Vendor	Original Contract Date	PEHP Expenditure: FY 2006 - 2010
R	2002	$ 2,168,784
S	2000	380,000
Total		**$ 2,548,784**

URS' purchasing policies defines a sole source vendor as a "vendor which is the only source of a product or service or a vendor which, due to extensive existing interfaces with or modifications to existing URS systems infrastructure, is deemed to be the only practical source to supply the product or service." The URS purchasing policies do not state if or when a vendor deemed as sole source must be researched or rebid to make sure they are still a sole source.

We believe URS' purchasing policies should require a periodic redetermination of a vendor's sole source status.

The State of Utah also uses sole source vendors; however, *Utah Administrative Code* R33-3 requires that for sole source procurements exceeding $50,000, public notice shall be given: "The notice shall be published at least 5 working days in advance of when responses must be received in order that firms have an adequate opportunity to respond to the notice." URS' purchasing policies do not require PEHP to advertise sole source contracts.

The state's Division of Purchasing and General Services suggests four questions to ask regarding a sole source, which PEHP could implement:

1. Can program requirements be modified so that competitive products or services may be used?
2. Is the product available from only one source and not merchandised through wholesalers, jobbers or retailers?
3. Must items be interchangeable or compatible with in-place items?
4. Item/Service is unique and possesses specific characteristics that can be filled by only one source.

In short, we believe PEHP needs a more aggressive process for determining a vendor's status as sole source. This could include advertising to solicit other vendor's comments and creating a

PEHP needs to be more aggressive in determining a vendor's status as sole source.

questionnaire to be completed and retained internally when reviewing new vendors for sole source products and services.

In addition to improving their process for the selection of vendors, PEHP needs to improve contract management. This is discussed in the next section.

PEHP Needs Adequate Contract Controls

Perpetual contract terms, missing contracts for some service years, and no contract at all are major concerns effecting PEHP's ability to effectively manage their dealings with vendors.

Of the 21 vendor dealings we reviewed, we had contract management concerns with 15 of them, totaling about $18 million. We believe these 15 need to be better managed. The remaining six from the 21 vendor dealings we reviewed were adequate in regards to this discussion. In addition, we found that PEHP does not adhere to formal processes for managing the physical contracts. Perpetual contract terms, missing contracts for some service years, and no contract at all are major concerns that effect PEHP's ability to effectively manage their dealings with vendors.

Current Contracts Need Better Management

We had concerns with 15 vendors relating to how contracts are managed. Contracts need periodic review to ensure they are competitive. This does not appear to be occurring at PEHP. Specifically, we found:

Contract management concerns include: a lack of renegotiating long-term contracts and no contract in place or physically missing contracts.

- Eight of the 15 contracts have not been renegotiated or rebid in many years, if at all. The terms of these contracts essentially allow for the contracts' perpetual existence. An example of language allowing for the perpetual existence of contracts was "this agreement shall be renewed each successive year without notice" and "shall continue until otherwise terminated."
- Six of the 15 vendors do not have a contract, but should.
- One vendor's contracts are physically missing. (In addition, one of the eight discussed in the first bullet above is also missing a contract.)

These contract management concerns are further detailed in Figure 3.5.

Figure 3.5 Fifteen Vendor Dealings Need Better Contract Management.

Vendor	Contract Date	Contract Termination Language
A	2004 & 2009	Perpetual
B	2004	Perpetual*
C	2006	Perpetual
D	2004	Perpetual
E	2002	Perpetual
F	No contract	-
G	No contract	-
H	No contract	-
I	2006 & 2010	One year
J	No contract	-
K	No contract	-
L	No contract	-
P	2004	Perpetual
Q	2002	Perpetual
S	2000	Perpetual

**Technically, vendor B's term is not perpetual. But, as schedules are added, the contract term is extended. The most recent schedule extended the termination date to 2014, but then it automatically renews for successive one-year periods. From 2004, that is a 10 year contract term, assuming the contract is renegotiated in 2014 and PEHP does not exercise the one-year successive periods.*

In addition to vendor A never being bid and the terms being perpetual, the 2004 contract terminated in 2007 with no contract replacing it until 2009. However, PEHP continued the relationship from 2007 to 2009 as though it were governed by a contract. Vendor I is physically missing contracts. We found a contract for vendor I for 2006 and 2010 but could not find contracts for the years in between; however, the vendor was paid during those years.

PEHP is allowing large-dollar, perpetual contracts without periodic rebidding.

Referring back to Figure 3.1, the amounts paid to most of these vendors is quite significant yet PEHP does not tightly control the contractual relationship between themselves and these vendors. Allowing a potentially never-ending contractual relationship without a requirement to rebid is not acceptable.

Best practices for contract management suggest periodic review of contracts. The general criteria we recommended to PEHP in our 2003 audit of PEHP are still relevant today:

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.

In general, purchasing best practices dictate contracts should be reviewed every three years.

URS' purchasing policies do not state when contracts should be renegotiated or renewed. However, in their definition of an "Office-approved Vendor," they make it clear that after four years maximum, bidding is required. This suggests that URS finds it necessary to remain competitive.

The ***Utah Code*** does not specify the period of time for contract length. ***Utah Code*** 63G-6-417 states, "A contract for supplies or services may be entered into for any period of time considered to be in the best interests of the state." We spoke with a representative from the Division of Purchasing and General Services who said contract length depends on the product or service. For example, it does not make sense to have a long-term contract for technology products because it changes quickly. The Department of Technology Services told us they usually rebid their contracts for master license agreements every three to five years and never have perpetual contracts.

However, the ***Utah Code*** does provide some guidance on an appropriate time to rebid provider networks. Although the ***Utah Code*** is limited on the authority it provides to PEHP, ***Utah Code*** 49-20-401 requires PEHP to conduct an RFP every three years for their provider networks for the purpose of:

***Utah Code* requires PEHP to rebid their provider networks every three years.**

(i) stimulating competition for the benefit of covered individuals;
(ii) establishing better geographical distribution of medical care services; and
(iii) providing coverage for both active and retired covered individuals;

Therefore, we believe PEHP should ensure the contracts they have in place are still competitive. They can do this by going out for bids and allowing contract terms that are in the best interest for the state, limited as appropriate for the product or service, while remaining competitive.

Better Recordkeeping System for Contract Management Needed

PEHP is not following policy regarding contract recordkeeping. In order to mitigate risk, PEHP needs to improve recordkeeping and develop a more reliable master contract list that is regularly updated and reviewed by management.

PEHP needs one point of control for managing all contract issues.

More specifically, PEHP needs one point of contact for contract issues. Throughout the audit, we found it very difficult to locate both contracts and those responsible for contract management. In some cases, it was even difficult to find out if PEHP had contracts. Several times we were told that no one knew if there was a contract in place for a particular vendor.

In addition to there not being an accurate master contract list, PEHP's purchasing agent does not have copies of all contracts, as required by URS purchasing policies. Although PEHP is directed by URS policies, there appears to be a disconnect between URS policies and how those policies are applied at PEHP.

To summarize, PEHP needs better practices for managing contracts. PEHP should ensure contracts are being competitively bid. In order to be competitive, PEHP must widely advertise the RFPs. PEHP should also ensure the terms of the contract encourage competition and are in the state's best interest. Finally, PEHP should have a central contact for all contract management and maintenance.

Recommendations

1. We recommend PEHP follow URS policy in the following areas:

    - Conducting competitive RFPs and bids when selecting vendors
    - Imaging and retaining contract documentation
    - Keeping a master contract list and having a point of contact for all contracts

2. We recommend PEHP follow best practices in the following areas:

    - Publicly advertising RFPs to allow open competition
    - Using a decision matrix or scoring sheet to evaluate proposals in an RFP
    - Retaining documentation of why vendors are chosen in an RFP or when bids are taken
    - Retaining documentation when a vendor is declared as sole source

3. We recommend PEHP strengthen contract controls in the following areas:

    - Ensuring there is a contract in place for each vendor
    - Requiring contract terms to have a definite end, possibly allowing a limited extension
    - Ensuring there is another RFP or rebidding at the end of the contract

4. We recommend URS strengthen the following policies:

    - Requiring public advertisement of RFPs
    - Requiring contract terms to be explicit and definite of contract expiration
    - Setting parameters for when a sole source vendor needs to be reviewed.

Chapter IV
PEHP's Financial Practices Need to Improve

Although the Public Employees Health Program (PEHP) is financially solvent, business practices have caused financial problems within individual *risk pools*[*]. We found seven medical risk pools that had combined reserve deficits of $8.4 million. Three risk pools, including the state risk pool, may have $34.9 million of excess reserves that could be refunded back to members and employers. We found that some of PEHP's business practices are not following the *self-funded* insurance model and PEHP has spread medical expenses and risk among risk pools. The Legislature should determine if the state risk pool should self-fund reinsurance or allow the current practice to continue where the state risk pool is a part of PEHP's reinsurance pool.

Not all of PEHP's business practices are following the self-funded insurance model. As a result, medical expenses, risk pools and reinsurance funds are negatively impacted.

Consequently, some risk pools have paid more than their share of medical expenses for *reinsurance* coverage to offset the expenses from other risk pools. According to best practices, PEHP should not pool reinsurance funds for the medical risk pools and the $14.3 million reinsurance reserve should be reallocated to each individual risk pool. To address the concerns identified in this chapter, the Utah Department of Insurance should increase their oversight of and involvement with PEHP.

Some Risk Pools Run Substantial Deficits While Others Have Significant Reserves

PEHP is financially solvent and the medical line of business increased reserves by $25 million during the 2010 fiscal year. However, PEHP failed to follow ***Utah Code*** and allowed seven risk pools to incur reserve deficits of $8.4 million. As a result, reserves from healthier risk pools have been used to cover other risk pools' deficits. We were unable to evaluate if risk pools had adequate reserves because PEHP did not actuarially determine risk pool reserve

PEHP, as a whole, is financially solvent, but seven risk pools have been allowed to incur reserve deficits of $8.4 million.

[*] Due to the technical nature of the subject matter, this report consists of highlighted words that are defined in the report's glossary in Appendix A.

levels. However, if PEHP's 60-day benchmark reserve level is actuarially sound, three risk pools have over $34.9 million of excess reserves.

PEHP Is Financially Solvent

As a whole, PEHP is financially solvent. Figure 4.1 shows the overall financial operations and reserve balances for fiscal years 2009 and 2010.

Figure 4.1 Revenue, Expense, and Reserve Totals for 2009 and 2010 Fiscal Years. PEHP collects over a half-billion dollars worth of ***premiums*** to cover the costs of its insured members each year.

Insurance benefit expenditures were $550 million in the 2010 fiscal year.

	2010	2009
Revenues	$ 608,794,842	$ 598,755,123
Insurance Benefits	(550,469,905)	(568,770,800)
Administrative Expense	(23,205,127)	(23,083,981)
Net Gain/Loss	35,119,810	6,900,342
Contingency Reserve	**$ 146,361,961**	**$ 111,242,151**

From fiscal year 2009 to 2010, revenues (premiums, investment income, and federal subsidies) have increased by $10 million. Expenses (insurance benefits, ***claims*** review expenses, and network access fees) decreased by $18 million, and administrative expenses were consistent, as expected. As a result, overall reserves have increased by $35 million.

PEHP divides its insurance programs into six service areas or business lines: medical, dental, long-term disability, term life, retiree life, and death benefit. During this audit, we only reviewed the medical line of business which is subdivided into risk pools. Each participating employer or agency in PEHP's medical programs is either a single member or part of a risk pool—a pool of funds set aside to be used for defined expenses. The size of the employer group determines whether the agency can be a single risk pool or be part of a multi-employer risk pool. The medical line of business has 11 risk pools and encompasses about 89.5 percent of PEHP's total expenses (this includes the Medicare supplement and reinsurance).

PEHP's medical line of business encompasses about 89 percent of PEHP's total expenses.

The medical line of business, as a whole, is also financially solvent, and the reserves have increased by $25 million from $74.1 million in

fiscal year 2009 to $99.1 million in fiscal year 2010. However, our review of the individual risk pools within the medical line of business shows that not all the risk pools are financially solvent. This indicates that excess reserves of the financially sound risk pools, such as the state's risk pool, are covering the deficits of the other risk pools. The next section of the report discusses the financial position of the individual medical risk pools.

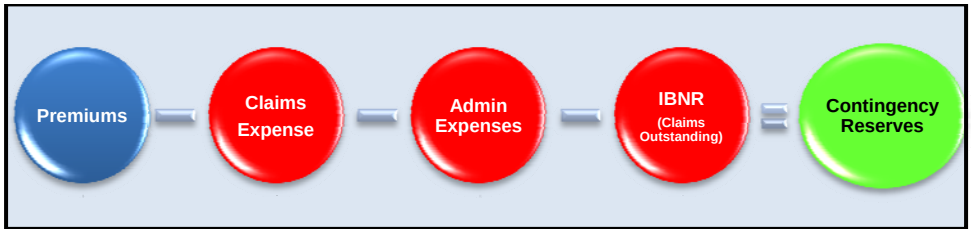
PEHP's medical risk pools' reserves have increased by $25 million during the past fiscal year.

Multiple Risk Pools Should Not Have Reserve Deficits

According to ***Utah Code***, PEHP should maintain risk pool reserves at adequate levels and require risk pools to cure any reserve shortfall. In addition, industry experts state that self-funded risk pools should not incur deficits. As a result of not following these practices, the reserves from healthier risk pools have subsidized other risk pools' deficits.

After reviewing each of the 11 risk pools within the medical line of business, we observed seven medical risk pools, or 64 percent, that had a *contingency reserve* deficit (insufficient funds to cover all expenses and *liabilities*) for the fiscal year ending in 2010. Four of the seven risk pools have had a contingency reserve deficit for multiple years. Figure 4.2 explains how contingency reserves are calculated for each of the medical risk pools.

Figure 4.2 Calculation of Contingency Reserves. Contingency reserves are calculated by subtracting claims, expenses and liabilities from premiums collected.



Contingency reserves are calculated by taking the difference between premiums and expenses.

A risk pool has a contingency reserve deficit when it has not paid sufficient premiums to PEHP to cover all of its expenses (claims, reinsurance, and administrative costs) and incurred but not reported (*IBNR*) claims. IBNR claims are an actuarial estimation of claims that have occurred but have not yet been reported to PEHP. If PEHP

does not collect enough premiums in a given year, risk pools incur a deficit. Figure 4.3 shows the contingency reserves for the past five fiscal years for each of the 11 medical risk pools.

Figure 4.3 Medical Claims Contingency Reserves for the 2006-2010 Fiscal Years. At the end of the 2010 fiscal year, 7 out of 11 medical risk pools had contingency reserve deficits.

Medical Risk Pools:	2006	2007	2008	2009	2010
State of Utah	$20,702,332	$34,301,501	$48,838,921	$41,986,627	$ 61,081,636
SL County	4,261,923	2,477,102	1,869,392	61,283	(591,459)
SLC	1,162,446	(1,343,639)	(2,618,052)	(4,952,596)	(4,074,077)
Dept of Health	(2,319,724)	(1,539,429)	(2,316,877)	2,778,623	1,938,270
LGRP[1]	2,873,052	8,659,204	14,617,505	17,503,367	23,114,506
Utah Behavior Health Network	(387,044)	66,902	49,754	157,936	-
Provo City[2]	102,870	(558,281)	(24,849)	(368,309)	(437,554)
Utah County[2]	254,226	(394,360)	(942,034)	(1,244,677)	(1,410,917)
USBA	1,552,157	2,513,864	3,488,878	5,039,124	6,992,231
Jordan SD[3]	795,054	(549,268)	(550,526)	(401,287)	(96,321)
Nebo SD	620,024	2,266,845	1,979,942	385,211	(1,693,955)
Ogden SD	(1,124,932)	(1,833,706)	(507,364)	66,574	-
Canyons SD[3] [4]	-	-	-	-	(106,810)
Total	**$28,492,384**	**$44,066,735**	**$63,884,690**	**$61,011,876**	**$84,715,550**

[1] Local government risk pool
[2] Provo City and Utah County terminated their medical insurance with PEHP effective January 1, 2009. However, they remain on PEHP's accounting books because they still have deficits.
[3] These risk pools have a different agreement with PEHP than the other risk pools. PEHP bills them every week for claims expenses and once a month for administrative expenses.
[4] PEHP started offering insurance to the Canyons School District in the 2010 fiscal year.

The contingency reserve deficit for the seven risk pools was $8.4 million at the end of the 2010 fiscal year.

Some risk pools have steadily increased their reserves throughout the years while other risk pools have transitioned from a positive reserve balance to a deficit. The State of Utah risk pool and the local government risk pool (LGRP) have significantly increased their respective reserves from $20.7 million and $2.9 million to $61.1 million and $23.1 million during the past five years. Conversely, the Salt Lake County, Salt Lake City, Provo City, Utah County, Jordan School District and Nebo School District risk pools have accumulated a deficit since the 2007 fiscal year.

The total contingency reserve deficit amount for the past fiscal year came to $8.4 million. However, some risk pools have deposited additional funds with PEHP. After accounting for the deposits, the

Canyons and Jordan School District risk pools do not have a contingency reserve deficit and the overall contingency reserve deficit is $6.7 million.

Risk pools with positive reserves (State of Utah, Department of Health, LGRP, and the Utah School Boards Association (USBA)) have covered the remaining deficits with their reserves. PEHP management allowed reserve deficits by not collecting enough premiums from risk pools to cover costs. Consequently, these deficits create an unfunded liability for PEHP and the risk pools. In two instances, risk pools have left PEHP without reimbursing PEHP for their medical insurance expenses.

Reserves from some risk pools have been used to pay for other risk pools' deficits.

Two Risk Pools Left PEHP with Contingency Reserve Deficits. Effective January 1, 2009, two risk pools (Utah County and Provo City) terminated their groups' insurance benefit with PEHP. These risk pools had contingency reserve deficits after their association with PEHP ended. However, both risk pools claimed that PEHP's financial statements did not represent an accurate financial position of their risk pool. PEHP disputes this claim and believes the risk pools owe the amounts found on PEHP's financial statements.

In 2008, Utah County and Provo City risk pools left PEHP with outstanding deficits.

During the course of the audit, we tried to work with PEHP and the two risk pools to determine their actual amount owed, but PEHP's contracts with the risk pools do not establish deficit reimbursement procedures or administrative and reinsurance rates (Refer to the concern of fluctuating administrative percentages in Figure 4.5 and the concern that PEHP does not quote actual reinsurance costs at the beginning of the plan year as discussed on page 48 of the report.) We believe that PEHP should have taken a more active approach curing the deficits throughout the 2007-2010 fiscal years. As of the release of this audit, the Provo City and Utah County reserve deficits are still unresolved.

PEHP Violated *Utah Code* by Allowing Deficits to Continue. According to ***Utah Code*** 49-20-402(1), PEHP should require all risk pools to resolve their reserve deficits. The specific language is as follows:

> The reserves in a risk pool in a given fiscal year shall be maintained at the level recommended by the program's consulting *actuary* and approved or ratified by the board. If the reserves drop below that level, covered employers in the risk pool are required to cure any deficiency in the reserve.

PEHP should comply with statute and not allow risk pools to run reserve deficits.

As seen in Figure 4.3, PEHP allowed risk pools to run multiple-year reserve deficits. The practice of allowing risk pools to run reserve deficits is not consistent with ***Utah Code***. When the contingency reserve deficit first occurred, PEHP should have increased premium rates (and/or reduced benefits) the following year to resolve those deficits.

PEHP Is Not Following Their Contracts Pertaining to Cash Deficit Penalties. If risk pools run a deficit, PEHP charges them a penalty fee equal to the interest earned on PEHP's investment funds. However, PEHP is not following the process established in their contracts with risk pools.

When we reviewed a sample of original contracts between the risk pools and PEHP, we found that the contractual course of action PEHP can take against risk pools with deficits is to

(1) assess a late charge of 1 percent per month (roughly 12.7 percent APR) of the total amount due calculated from the date the rate payment was due, or
(2) terminate the group's medical and/or dental coverage.

We recommend that PEHP charge the contractual late fee or adjust their contracts to concur with their current late fee assessment.

PEHP has not exercised either of these two options, and risk pools paid a late charge lower than their contractual commitment. We recommend PEHP either adjust the content in their contracts to come into agreement with their current practice or adhere to and enforce the language in their contracts.

Excess Risk Pool Reserve Levels Should Be Actuarially Determined

Statute requires PEHP to actuarially determine adequate risk pool reserve levels, which they have not done.

Utah Code requires PEHP to actuarially determine reserve levels for risk pools. However, PEHP has not complied with this statute. Reserve requirements in ***Utah Code*** 49-20-401(1)(i) direct PEHP to "maintain reserves sufficient to liquidate the unrevealed claims liability and other liabilities of the employee benefit plans as certified by the

program's consulting actuary." Instead of using actuarially determined reserve levels for each individual risk pool, PEHP has a 60-day reserve benchmark for all risk pools.

The 60-day reserve benchmark was implemented because of a federal requirement that allows the federal government to request a refund of federal funds if reserves are in excess of 60 days worth of working capital. Three of the nine operating risk pools exceeded this target at the end of the 2010 fiscal year.

Rather than having a 60-day reserve benchmark, PEHP should establish minimum reserve levels that meet the requirements described in ***Utah Code*** 49-20-401(1)(i). Reserves that exceed actuarially determined levels could be refunded back to the employer groups.

If reserves exceed the actuarially determined amount, PEHP should refund the excess reserve back to risk pools.

Excess Reserves Could Be Refunded. If reserves are built above the actuarially determined levels, state statute directs the URS board to consider refunding excess premiums. ***Utah Code*** 49-20-402(2) states:

> If substantial excess reserves are accrued above those required by this chapter [actuarially determined reserves], and the board determines that a refund is appropriate, a refund shall be made: (a) to covered employers. . . ; or (b) directly to covered individuals.

Without actuarially determined reserve levels, we question how the URS board can comply with this statute. Hypothetically, if the 60-day reserve limit is actuarially sound, then three risk pools could be refunded the amounts shown in Figure 4.4.

Figure 4.4 Hypothetical Example of Reserve Refunds. Using a 60-day benchmark, we found that three risk pools have excess reserves of $34.9 million.

Medical Risk Pools	2010 Fiscal Year Premiums	Reserves on 6/30/2010	60 Day Reserve	Possible Refund Amount
State of Utah	$254,560,324	$61,081,636	$41,846,000	**$19,235,636**
LGRP	62,683,368	23,114,506	10,304,000	**12,810,506**
USBA	24,924,596	6,992,231	4,097,000	**2,895,231**
Total	**$342,168,288**	**$91,188,373**	**$56,246,000**	**$34,942,373**

Three risk pools have an estimated $34.9 million of reserves in excess of 60 days worth of working capital.

The example in Figure 4.4 shows that there is likely substantial money that could be refunded back to the risk pools of the State of Utah, the LGRP, and the USBA. However, for an actual amount, the reserve requirements need to be actuarially determined. If a reserve refund is appropriate, PEHP could reduce excess reserves by offsetting future premium increases or enhancing current benefits for members. The next section compares PEHP's processes to insurance industry best practices.

PEHP Is Not Following Insurance Industry Best Practices

PEHP should follow insurance industry best practices and determine administrative and reinsurance costs at the beginning of a plan year for the risk pools. Providing these costs to employers at the beginning of the plan year helps to control risk and deters costs from shifting among the risk pools. This process would also help employers better manage their budgets, and could help reduce future reserve deficits. Additionally, PEHP should not pool reinsurance funds for all the medical risk pools and the pooled reserves of $14.3 million should be reallocated to risk pools.

PEHP Should Establish Fixed Administrative Rates at the Beginning of the Plan Year

PEHP is not following industry best practices and should prospectively determine administrative costs.

Insurance carriers, both self-funded and *fully insured*, establish actual fixed administrative costs at the beginning of a risk pool's plan year. Conversely, PEHP quotes estimated administrative rates at the beginning of a plan year then charges the actual administrative costs to risk pools at the end of the fiscal year. PEHP should follow industry best practices and establish actual fixed costs at the beginning of the plan year. This practice will provide an internal control for PEHP and assure risk pools that administrative costs are not being shifted between risk pools.

Establishing fixed administrative costs at the beginning of a plan year can also improve relations between PEHP and their employer groups and increase employer group retention. Four employer groups have left PEHP in the past five years. One of the reasons they have

chosen to terminate their relationship with PEHP is because PEHP does not establish fixed costs at the beginning of a plan year.

The employer groups (which are the political subdivisions of the state) establish budgets at the beginning of the financial year and are required to operate within the budgeted parameters. Some employer groups have told us they are unable to pay for unexpected year end expenses because their budgets have already been approved and spent for that year. As a result, the retrospective model of determining actual costs is a contributing factor to risk pool deficits.

Risk pools have been unable to pay for unexpected costs at the end of their plan year.

The following example shows that PEHP's administrative cost quote can be misleading to employer groups. We reviewed the actual administrative costs as a percentage of premiums for four risk pools during the past five fiscal years. Although PEHP states that administrative costs will typically be four to five percent of premiums collected, Figure 4.5 shows four risk pools with administrative costs that have exceeded the 5 percent level at least once during the past five years.

Figure 4.5 Examples of Administrative Costs as a Percentage of Premium. The administrative cost analysis included all administrative costs and claims review expenses. Administrative rates in excess of five percent are highlighted in red.

Employer Group	2006	2007	2008	2009	2010
Dept. of Health	4.3%	4.2%	5.1%	4.2%	4.7%
Provo City	5.0%	7.6%	3.1%	5.1%	-
Utah County	7.1%	4.9%	6.2%	4.6%	-
Nebo SD	2.3%	3.3%	4.0%	5.7%	6.2%

Some risk pools' administrative expenses have been higher than PEHP's quoted amount. Risk pool administrative costs should not fluctuate from year to year.

The highest administrative cost as a percentage of premiums was 7.6 percent and some risk pools' percentages fluctuated significantly from year to year. We question how risk pool administrative rates can be so volatile from one year to the next. The financial impact of higher than expected administrative costs can be significant. For example, the Provo City risk pool had $126,000 in additional administrative expenses above the 5 percent level in 2007.

The risk pools that experienced higher-than-expected administrative costs were not notified until after the fiscal year ended.

Part of this delay can be contributed to the complex method PEHP uses to allocate administrative costs among the risk pools. This concern is discussed in the next section of the report.

PEHP Administrative Cost Allocation Should Follow Industry Practices

After reviewing PEHP's yearly administrative expense allocation model, we believe that the current model is too complex and should follow industry best practices. Other insurance carrier's administrative costs are usually allocated to employer groups using one of the following methods:

Other insurance carriers generally allocate administrative costs on a per-employee-per-year basis.

- **Per-Employee-per-Year.** The total administrative cost is divided by the total number of employees.
- **Percentage of Claims per-Year.** The total administrative cost is divided by the number of claims, and the administrative cost is based as a percentage of total claims for each employer group.

PEHP's current method of determining administrative costs is complex and involves many steps.

Both of these methods can allocate administrative costs prospectively (at the beginning of the plan year). The most common approach is the per-employee-per-year method. The method that PEHP uses to allocate administrative costs is done retrospectively. It is complex because it is a multistep process that involves a weighted allocation of general administrative expenses, employee workload surveys and direct allocation of expenses to the risk pools.

Administrative costs are a fixed cost and employer groups should see fairly consistent rates from year to year, assuming workload does not change. However Figure 4.5 shows that administrative rates fluctuate up and down for each employer group and that different administrative rates exist for different employer groups. By allocating administrative costs prospectively using industry best practices, PEHP will improve their administrative cost accountability to the risk pools which will incentivize PEHP to keep administrative costs low.

PEHP's reinsurance is similar to a fully insured health plan, which spreads costs among all the risk pools. As a result, some risk pools reinsurance is being paid by healthier risk pools.

PEHP's Reinsurance Practices Are Not Consistent with Industry Standards

PEHP's model of providing reinsurance is not aligned with industry best practices for self-funded insurance plans. PEHP does

not quote actual reinsurance costs at the beginning of a plan year, and PEHP comingles reinsurance premiums among risk pools. Also, PEHP does not actuarially determine reinsurance levels. Consequently, some risk pools reinsurance expenses are being paid by healthier risk pools' reinsurance premiums. The purpose of a self-funded risk pool is to control the risk within a pool and according to the self-funded model, PEHP should require individual risk pools to cover costs within each individual risk pool.

Reinsurance helps to limit the loss that PEHP's employer groups, such as the state, could experience in certain circumstances including unusually high medical claims or a disaster. For medical coverage, reinsurance is used to cover the following:

- individual claims above a certain dollar amount, called specific *stop-loss coverage*
- the total dollar amount for an entire risk pool that exceeds an established level, called aggregate stop-loss coverage

A portion of the premium that PEHP collects from employers goes toward reinsurance costs. Specific concerns with PEHP's stop-loss coverage are discussed next.

PEHP Should Not Pool Reinsurance Reserves. Reinsurance should be kept separate for each risk pool under the self-funded model. PEHP spreads reinsurance risk among all the risk pools by having one pool dedicated for reinsurance costs. Once medical expenses are spread among all the medical risk pools, the risk pools are no longer acting as self-funded plans. Pooling is a concept that is used for fully insured plans. Insurance companies that administer fully insured plans spread risk among all risk pools and profit from excess risk pool premiums. The Legislature should determine if the state risk pool should self-fund reinsurance or allow the current practice to continue where the state risk pool is part of PEHP's reinsurance pool.

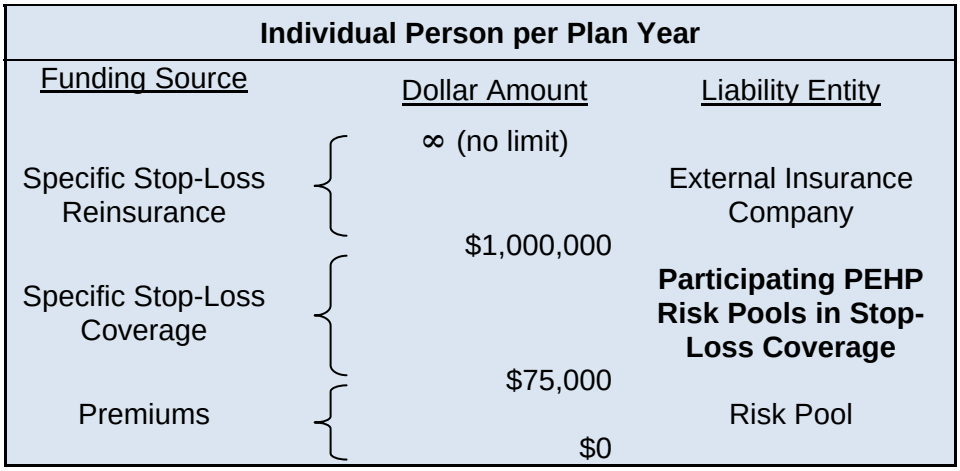
PEHP should only administer reinsurance on a self-funded basis, which means not pooling reinsurance costs.

Specific Stop-Loss Coverage Levels Need to Be Actuarially Determined. PEHP's specific stop-loss coverage levels are the same for all pools regardless of their size. Specific stop-loss coverage reimburses the risk pools for individual claims in excess of $75,000 during the plan year. However, this reinsurance level should be actuarially determined based on the size and the health of the risk

PEHP should actuarially determine specific stop-loss levels for each risk pool.

pool. A large risk pool, such as the state, would not have the same level as a smaller risk pool according to best practices. Figure 4.6 diagrams the current specific stop-loss structure for PEHP risk pools.

Figure 4.6 PEHP's Current Specific Stop-Loss Model. Risk pools share costs when individual claims exceed $75,000 during a plan year.



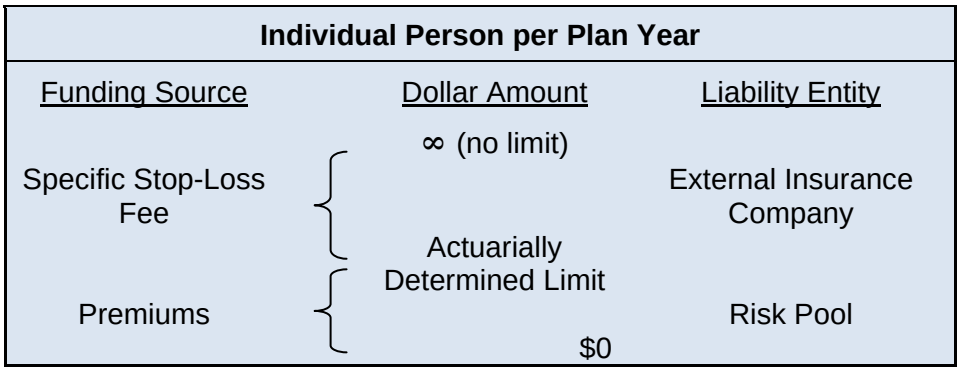
PEHP's specific stop-loss coverage levels are the same for every risk pool regardless of their size and medical coverage needs.

All individual claim amounts in excess of $75,000 are paid by employer groups participating in the reinsurance pool. If an individual claim exceeds $1 million in medical expenses during a plan year, PEHP has reinsurance with an external insurance company that would cover the costs of the claim by reimbursing PEHP's stop-loss coverage reserve. Some of the larger risk pools' stop-loss levels are too low, according to industry experts, due to the large number of members in the pool.

Risk pools should be liable up to an actuarially determined limit. Any individual claims above the limit should be covered by external reinsurance.

To align current practices with the industry self-funded model, PEHP should require that all risk pools specific stop-loss reinsurance deductibles be actuarially determined. Individual claims above the actuarially determined deductible should be covered by external reinsurance. PEHP should conduct a cost benefit analysis of pooling stop-loss coverage or obtaining coverage through an external reinsurer for each risk pool. Figure 4.7 is an example of a self-funded specific stop-loss model.

Figure 4.7 Insurance Industry Self-Funded Specific Stop-Loss Model. The risk pool's specific stop-loss level should be actuarially determined based on risk pool characteristics and desired assumption of risk.



PEHP should structure their stop-loss coverage following a self-funded model.

PEHP should structure their specific stop-loss coverage based upon the self-funded model and keep reinsurance claims and premiums separate for each risk pool. In other words, to insure against high specific claims, each risk pool would obtain its own stop-loss coverage from an external reinsurer. In addition, the specific level where reinsurance coverage begins for risk pools should be actuarially determined. In the next section we discuss aggregate stop-loss coverage which insures against high overall risk pool claims.

Aggregate Stop-Loss Coverage Should Follow the Self-Funded Model. Self-funded risk pools have aggregate stop-loss coverage to protect against high claim costs for a risk pool as a whole. For some risk pools, PEHP uses the reinsurance pool to pay for a risk pool's actual costs that exceed 20 percent of cost projections. A risk pool's aggregate stop-loss coverage ends when a risk pool's actual costs exceed 35 percent of cost projections. These percentage levels vary depending on the risk pools' assumption of risk and contractual agreement with PEHP. Figure 4.8 is an example of PEHP's current aggregate stop-loss model.

Figure 4.8 Example of PEHP Aggregate Stop-Loss Model. Aggregate stop-loss coverage pays for claims above and beyond estimated plan year costs.

Risk Pool per Plan Year		
Category	Percent of Expected Claims	Liability Entity
Excess Aggregate	∞ (no limit)	Risk Pool
	135%*	
Aggregate Stop-Loss Coverage		**Risk Pool Reinsurance Reserves**
	120%*	
Expected Annual Claims		Risk Pool
	0%	

**These levels vary among risk pools.*

PEHP has structured aggregate stop-loss coverage to cover a risk pool's total claim costs that exceed cost projections.

Rather than following the model in Figure 4.8, PEHP should adjust their aggregate model so that aggregate stop-loss coverage follows self-funded best practices. Combined risk pool reinsurance reserves should not be used for aggregate coverage because each risk pool should manage their own aggregate risk. According to insurance experts, very large risk pools, such as the state, would most likely not need aggregate stop-loss coverage. If smaller risk pools decide aggregate stop-loss coverage is needed, the appropriate aggregate stop-loss structure should be similar to that shown in Figure 4.9.

Larger risk pools may not need aggregate stop-loss coverage.

Figure 4.9 Insurance Industry Self-Funded Aggregate Stop-Loss Model. Usually aggregate reinsurance is obtained from an external reinsurance company and no reinsurance risk pool would be needed.

Risk Pool per Plan Year		
Category	Percent of Expected Claims	Liability Entity
Aggregate Stop-Loss Coverage	∞ (no limit)	External Insurance Company
	Actuarially Determined Limit	
Expected Annual Claims		Risk Pool
	0%	

Aggregate stop-loss coverage should be offered by an external insurance company.

As was the case with specific stop-loss coverage, PEHP should not spread the aggregate reinsurance liability among risk pools and should actuarially determine aggregate stop-loss levels.

Reinsurance Expenses Have Been Spread Among Risk Pools and Reinsurance Reserves Should Be Reallocated. During the past five fiscal years, some risk pools have paid more than their share of stop-loss premiums; these payments have compensated for other risk pools' medical expenses. This occurred because PEHP combined the large individual claims among risk pools. Figure 4.10 displays the specific stop-loss expenses and premiums paid by risk pool.

Figure 4.10 Stop-Loss Premiums and Expenses During the Past Five Fiscal Years. The majority of risk pools paid more stop-loss premiums than they expended. However, the Utah School Boards Association (USBA) and Utah Behavior Healthcare Network's (UBHN) stop-loss expenses were shared among other risk pools.

Medical Risk Pools:	FY 2006-2010 Reinsurance Premiums	FY 2006-2010 Reinsurance Claims	Difference
State of Utah	$ 89,780,307	$ (85,737,231)	$ 4,043,076
SL County	12,602,289	(12,157,787)	444,502
LGRP	22,451,333	(17,283,577)	5,167,756
Nebo SD	6,091,957	(5,406,243)	685,714
Ogden SD	1,143,598	(1,025,046)	118,552
Provo City	1,344,966	(794,307)	550,659
Quasi*	904,497	(0)	904,497
USBA	9,060,915	(12,527,343)	(3,466,428)
SLC	9,305,882	(8,203,164)	1,102,718
UBHN	1,332,382	(2,266,302)	(933,920)
UCIP	566,181	(475,769)	90,412
Utah County	951,521	(616,274)	335,247
Total	**$ 155,535,828**	**$ (146,493,043)**	**$ 9,042,785****

** The Quasi risk pools existed only during the 2006 fiscal year.*

*** The reinsurance reserve increased by over $5.1 million during this time period. The rest of the excess premiums paid for expenses including claims review and administrative expenses.*

Because costs are spread among all risk pools under PEHP's current reinsurance model, most risk pools have paid more premiums than needed to cover their claims.

Figure 4.10 clearly shows that PEHP's stop-loss coverage is not structured as a self-funded model. The figure shows that USBA's and UBHN,'s reinsurance costs are being covered by the other risk pools.

Since reinsurance reserves are not needed in the self-funded model, we recommend that PEHP refund the $14.3 million reserve back to risk pools.

Under a self-funded stop-loss model, the risk pool or the reinsurer would assume all risks, and a joint reserve among risk pools would be unnecessary. As stated in the first footnote of Figure 4.10, the reinsurance reserve increased by over $5.1 million during the past five fiscal years. PEHP has built their reinsurance reserves to over $14.3 million with excess reinsurance premiums from risk pools. If PEHP follows the self-funded model for all risk pools, PEHP should reallocate the $14.3 million to the individual risk pools that have contributed to the reinsurance reserve.

PEHP Could Benefit from Department of Insurance Oversight

Utah Code Title 49 is the legal framework that directs PEHP. As part of Title 49, the Utah Department of Insurance (referred to as the department) has PEHP oversight responsibilities. ***Utah Code*** 49-20-405 states:

According to statute, the Department of Insurance has oversight responsibilities of PEHP.

> The Insurance Department shall biennially audit the Public Employees' Trust Fund [PEHP] and programs authorized under this chapter and report its findings to the governor and Legislature, but the commissioner may accept the annual audited statement of the programs under this chapter in lieu of the biennial audit requirement (emphasis added).

The ***Utah Code*** permits the department to accept the financial audit by external auditors in lieu of the department's biennial audit. As a result, the department only completed one audit of PEHP in the past 10 years (2003). Since the 2003 audit, the department has not audited PEHP but plans are in place to audit them in the near future.

The Department of Insurance should not accept the audited financial statements in lieu of an audit.

We believe it is not sufficient for the department to accept the audited financial statements in lieu of a department audit. Given the concerns addressed in this audit, PEHP should be audited biennially by the department-seven risk pools in 2010 have reserve deficits and some business practices do not follow industry standards. In other words, we are concerned that without future audits, financial concerns will likely continue.

The department should have the same authority over PEHP that it has over other insurance carriers. Currently, if concerns are identified in the PEHP audit, the department can only report findings to the Governor and the Legislature. In contrast, if problems are found in a Utah insurance carrier audit, the department has three options:

- Require the carrier to create an action plan to become compliant with laws.
- Take over the management of the carrier to force compliance.
- Close the carrier.

Furthermore, the department does not have enforcement authority over PEHP, as it does with other local insurance carriers. We believe that the department should be able to hold PEHP accountable to standards that are similar to those applied to other Utah insurance carriers. The Legislature should amend the ***Utah Code*** to give the Department of Insurance the authority to require PEHP to comply with applicable state laws if concerns arise during a departmental audit.

Recommendations

1. We recommend that PEHP adhere to ***Utah Code*** and not allow risk pools to run reserve deficits.

2. We recommend that PEHP either adjust the language in their contracts to charge risk pools with deficit late fees equal to market returns or adhere to the current language found in their contracts.

3. We recommend that PEHP adhere to ***Utah Code*** and develop actuarially sound reserve requirements for each risk pool. We also recommend that if reserve levels exceed the required amount, the URS board should approve a refund back to the risk pool or reduce future premiums to lower the excess reserves.

4. We recommend that PEHP prospectively quote administrative rates at the beginning of a plan year and allocate administrative costs based on industry best practices.

5. Regarding reinsurance, we recommend that PEHP:

    - Prospectively quote reinsurance rates
    - Actuarially determine stop-loss deductible levels by risk pool
    - Examine the cost benefit of external reinsurance by each risk pool

6. We recommend the Legislature determine if the state risk pool should self-fund reinsurance or allow the current practice to continue where the state risk pool is a part of PEHP's reinsurance pool.

7. We recommend that the Department of Insurance perform a biennial audit of PEHP rather than accepting audited financial statements in lieu of an audit.

8. We recommend the Legislature amend ***Utah Code*** 49-20-405 and grant the Department of Insurance the authority to require PEHP to comply with a written improvement plan if issues arise in the biennial audits.

Chapter V
PEHP Pharmacy Program Requires Improvement

The pharmacy program requires adjustments to ensure members' needs are being met fairly and objectively. Prescription costs to PEHP have been declining since 2008 due to proactive cost-cutting efforts by PEHP. However, important decisions regarding the pharmacy benefit are made by the *Pharmacy and Therapeutics (P&T) Committee*[*] regarding the prescription *formulary* (medication coverage), and therefore requires better processes and rules to ensure that PEHP's members' needs are fairly addressed. Currently, the concentration of responsibilities that reside with the pharmacy director results in unilateral decision making; additional external decision making is needed. We also looked at the contract PEHP has with its *pharmacy benefit manager (PBM)* and discuss the cost and benefits of a transparent contract.

PEHP needs to strengthen the Pharmacy and Therapeutics (P&T) Committee over medication coverage and, control some unilateral decision-making by the pharmacy director.

Due to the complex and technical nature of pharmaceuticals, we retained the expertise of a pharmacy consultant from the consulting firm CAZMA, LLC, to help examine the administration of the pharmacy benefit. In conjunction with the pharmacy consultant's expert opinion, we utilized the findings of our independent field work to arrive at the conclusions put forth in this chapter. While we quote the consultant extensively, we have also included CAZMA's full report in Appendix D.

Prescription Costs Have Been Decreasing Since 2008

The pharmacy program is a significant part of PEHP's medical benefit costs, approximately $114 million, or roughly 25 percent, of all medical and pharmacy costs. PEHP offers the pharmacy benefit to approximately 140,000 members (not including retirees), which includes employees and their dependents, and all risk pools, with a

The pharmacy program accounts for about $114 million of the $456 million medical and pharmacy costs.

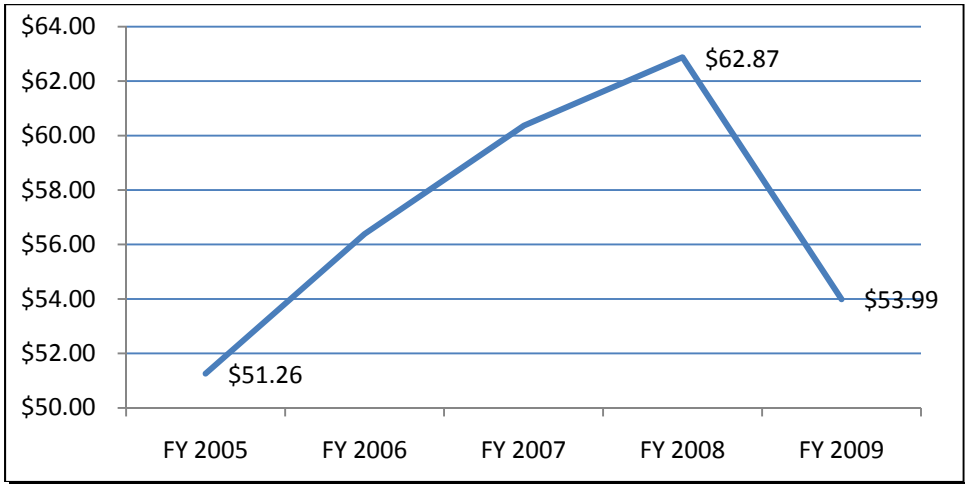
[*]Due to the technical nature of the subject matter, this report consists of highlighted words that are defined in the report's glossary in Appendix A.

total of 1.4 million annual drug claims at an estimated cost of $74 million, paid out by PEHP. The State of Utah employee pool has approximately 71,000 members (employees and dependents). The focus of this chapter will be on the State of Utah employee pool.

Aggressive cost-cutting measures have led to a sharp decrease in prescription costs.

PEHP has been able to decrease prescription costs since fiscal year 2008. The cost trend for medications was steadily increasing from fiscal year 2005 to fiscal year 2008. In 2008, PEHP hired a new pharmacy director who has effectively implemented cost-saving methods. Figure 5.1, shows how the average prescription costs (the costs that PEHP has paid not including the members' co-pay) for the State of Utah risk pool have changed since 2005.

Figure 5.1 After Increasing for Some Time, State Prescription Costs Have Recently Decreased. The dollar amounts indicate the average prescription cost that PEHP pays (without member co-pay). This cost includes all generic, preferred, non-preferred, and specialty drugs.



According to Figure 5.1, the average cost of prescriptions had steadily increased from 2005 until 2008 at which point prescription costs sharply declined. (Note that the cost averages in Figure 5.1 do not reflect any *rebates* that may accompany some medications.) In fiscal year 2008, the average prescription cost was $63; however, it decreased to $54 by 2009, which equates to a 14 percent decrease, and roughly, a $9.9 million savings. In 2005, the average prescription cost was approximately $51, and in 2009, the average cost was about $54. However, using a present value adjustment, the 2005 average cost was equivalent to $56 in 2009 dollars. In other words, the 2009 average

Since 2008 PEHP has saved $9.9 million in prescription costs.

prescription cost was $2 less than what was effectively being paid in 2005. This translates into savings of about $1.7 million.

The new director was able to reduce costs beginning in fiscal year 2009 by implementing the following:

- Controlling which prescriptions PEHP will cover
- Creating a three *tier prescription system* based on cost wherein the lower tier equals lower prescription costs
- Reclaiming funds owed by the PBM
- Increasing the amount of rebates received on preferred drugs
- Increasing the use of generic medications
- Increasing the members' share of the prescription costs through $100 prescription deductible, which is a cost-shifting measure

Controlling prescription coverage, a three tier system, rebates, and increased generic use have positively impacted cost savings.

Despite PEHP's ability to keep prescription costs from increasing, there are still concerns that PEHP needs to address to ensure that the pharmacy program is operating effectively. Also, Chapter II shows that prescription claim costs are higher when compared to local carriers.

P&T Committee Process Is Deficient

PEHP is responsible for deciding which prescriptions they will allow members to access. The pharmacy program utilizes a P&T committee to determine how the pharmacy benefit will be administered. However, we believe the current system is flawed due to independence issues such as: the same vantage point being carried through the entire process; also, the pharmacy director is responsible for choosing who is on the committee, which could bias the choices of the committee. Also, there are no formal policies or procedures in place to manage this committee. Finally, the committee's formulary decisions lack documentation. Addressing the concerns in this process can strengthen the credibility of the committee.

P&T committee lacks formal rules and policies.

The pharmacy director has the authority to initiate change to the formulary (a list of all prescription drugs covered by PEHP), which is a unique responsibility when compared with other states that have similar plans. We contacted other states and they claimed not to have attempted to control their formularies and have required their PBMs to manage their formularies, due to the complex nature of managing a formulary. One state expressed that PBMs have a large number of

The Pharmacy Benefit Manager (PBM) administers all pharmacy benefits in other states that we contacted.

pharmacists more able to assess the safety and effectiveness of their formulary. Additional reasons as to why these other states did not have formulary control include the following:

- One person does not have the expertise to manage a formulary for a large population
- Too costly to hire the right personnel to perform pharmacy benefit management.
- A lack of pharmaceutical expertise at the state's disposal
- A pharmacy benefit manager has greater resources to more effectively manage the formulary

We recognize that PEHP appears to be utilizing an innovative approach in the delivery of pharmacy benefits to its members. Formulary control, cost-containment of prescription costs, and the managing a P&T committee—which are generally performed by the pharmacy benefit manager—have greatly assisted in the positive administration of the pharmacy benefit to PEHP members. However, PEHP must exercise prudent formulary management to assure that issues of safety and effectiveness are addressed on behalf of members. Having a strong P&T committee can greatly improve the success of formulary management.

P&T Committee Performs Crucial Role in Establishing Pharmacy Benefit

The P&T committee determines what will be covered and the rules of administering the formulary.

The P&T committee is an interdisciplinary committee charged with determining a safe, effective, and cost-effective way to administer the prescription benefit to PEHP's members. The P&T committee is tasked with performing the following duties:

- Add or remove medications from the list of prescriptions covered by PEHP
- Review of specific medication categories, such as antipsychotics, stimulants, etc., and discuss utilization trends both in PEHP and industry-wide
- Determine the safety, effectiveness, and cost-effectiveness of medications as they pertain to members
- Discuss and determine rules in the dispensing of various medications

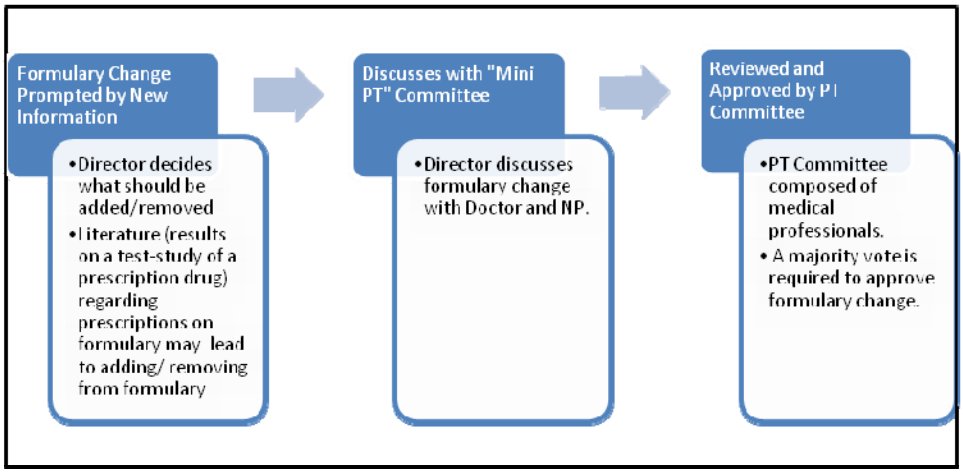
The pharmacy director currently manages the committee, which is composed of 10-13 members, 4 of which are employees of PEHP. The remaining members are independent doctors and pharmacists, some of which are invited by the pharmacy director. The biggest role the P&T committee plays is determining which medications will be covered by PEHP. The formulary is the list of medications that PEHP allows its members to access, and it is this list that is controlled and changed by the P&T committee.

Of the 10-13 members of the P&T committee, 4 are employed by PEHP.

The process by which the P&T committee receives recommendations to make changes to the formulary is initiated by the pharmacy director. First, the pharmacy director elects to add or remove a drug to the formulary; the director will distill information regarding the drug from various sources, such as medical publications. Second, the pharmacy director will then discuss this addition in a meeting with PEHP's medical director (a medical doctor), pharmacy assistant, and nurse practitioner (NP)—a group known as the "mini" P&T committee. Third, if formulary changes are approved, they will be sent to the P&T Committee for final approval. Figure 5.2 outlines the process.

The mini-P&T committee recommends changes to formulary for P&T committee.

Figure 5.2 The Process to Change the Formulary. Formulary changes are proposed by the pharmacy director and follow the process below.



Mini-P&T committee reviews formulary issues that arise between P&T committee meetings.

In Figure 5.2, the second step in the process, the mini-P&T committee meeting is used to handle formulary issues that may arise between P&T meetings. The pharmacy consultant's concern with step two in this process is that "there seems to be little dissension amongst the committee members." These same individuals vote on the full P&T committee, which means any changes approved by the mini-P&T would likely be four guaranteed votes at the P&T committee.

Mini P&T carries the same perspective to P&T committee which can provide an unfair voting advantage to PEHP, the consultant recommend that the P&T committee be discontinued.

The same viewpoint carried to the P&T committee can give an unfair advantage to PEHP if it wishes to make changes that may not be in the best interest of the member. The consultant recommends that mini P&T meetings should be discontinued and that a standardization process be created to handle issues that arise in the P&T committee meetings.

PEHP Lacks P&T Committee Policies and Procedures

The lack of formal policies for the P&T committee can lead to issues of independence and can potentially affect members unfavorably. Inadequate documenting of the decisions reached by the P&T committee can also weaken the integrity of the committee.

Questions of Independence Exist in P&T Committee's Execution of Duties. The pharmacy director manages, prepares, and presents most of the information for the P&T committee meeting. The pharmacy director and medical director aid in selecting who is on

the committee, the directors' ability to choose committee members could affect the independence of the committee and potentially bias the choices of the committee. Our consultant states:

> There are no rules established as to how the committee should be formed, who should be on the committee, who can and cannot vote for changes, or what happens if there are not enough members in attendance.

The committee has no formal rules regarding how it is to be formed and who can vote.

This current condition of the P&T committee is not consistent with other agencies. For example, the P&T committee standards for the Utah State Hospital outline who can participate on the committee, as well as the participants' duties and responsibilities. We were unable to compare what is done by PEHP with other states; all the states contacted claimed that their PBMs handle all P&T committee activities. Dealing with medications requires expertise and thoughtful deliberation. Therefore, it is critical that standards are in place to ensure that the safety of PEHP members is not compromised.

According to our consultant:

> [The impact of not formally creating standards for the P&T committee could result in] inconsistent and inappropriate administration of the P&T committee, undermining credibility of the committee and its structure. Examples could include: unqualified member representation, lack of term limits on committee members and nondisclosure of "conflict of interest" by members with outside interests with pharmaceutical manufacturers.

Lack of standards for the P&T committee may result in unqualified members serving and lack of term limits.

Currently, P&T committee members are required to sign a conflict of interest form. However, the consultant believes the form can be strengthened:

> [The conflict of interest form] is lacking in essentials needed for protections of the health plan against outside influence of pharmaceutical manufacturers… [Strengthening the conflict of interest form can help prevent] inappropriate formulary placement of medications by members with financial interests outside that of the health plan.

Tightening the conflict of interest form will help prevent inappropriate influence from manufacturers.

P&T Committee Lacks Clear Documentation Regarding Formulary Change Decisions. The P&T committee does have minutes published for each meeting. But, according to the consultant, the details of these minutes should be improved to assure proper consideration is applied to the very serious nature of approving and removing medications from the formulary.

Though discussion was observed during the meeting, the credibility of the committee can be strengthened by documenting more in-depth discussion of the following:

Documentation of formulary decisions can be enhanced to ensure safe and effective review is occurring.

- Decisions regarding medications
- Dissension amongst committee members (if it occurs)
- Committee vote counts (detailing members for and against)

If documentation is not strengthened, the credibility of the P&T committee can be questioned. Furthermore, it can expose PEHP to the possibility that the P&T committee may not be performing sufficient consideration of medication safety and effectiveness in its decision-making process.

Pharmacy Operational Functions Require Strengthening

The pharmacy director has the authority to make key decisions alone, with minimal input from the program staff and without oversight from senior management. The consultant states that the concentration of power with the pharmacy director results in "unilateral decision making". As a result, very little outside influence of decision making is seen. Creating a framework for unbiased decision making is important. PEHP needs to adjust pharmacy benefit rules to assure that members get their prescription needs met. The pharmacy director should not have the sole responsibility to make pharmacy benefit rules. PEHP should determine whether processing rebates in the pharmacy program could be a potential conflict of interest for PEHP.

The pharmacy director has the authority to design benefit rules and has very little outside influence in the decision-making process.

Some Benefit Rules Appear to Be Too Rigid

The pharmacy director has the responsibility to choose specific prescription drugs, ***specialty medications and injectibles*** that require a pre-authorization in order to be covered by the pharmacy benefit. These medications should be chosen due to their high potential for safety issues, adverse reactions, misuse, and/or cost. However, our consultant states: "the ***prior-authorization*** criteria are very cumbersome with generally 18-24 criteria per drug being required before approval of a medication is obtained" (an example of preauthorization criteria is in Appendix E). The consultant also points out that PEHP is inflexible in regards to some higher-cost but medically-necessary medications.

PEHP's Pharmacy Pre-authorization Criteria Is Cumbersome. Unlike the lengthy pre-authorization criteria at PEHP, the State Plan of North Carolina, as an example, has pre-authorizations for a couple of drugs that only have 2-3 criterions. Though preauthorization serves a vital purpose to protect PEHP and its members, there needs to be a balance between cost containment and reasonably meeting members' needs. A continual independent review by PEHP of the criteria developed by the pharmacy director is needed to determine whether the rules are too strict or are justified.

Preauthorization criterion should be independently reviewed for its reasonableness.

PEHP Needs Greater Flexibility Regarding Necessary Medications. According to the consultant, another example of inflexibility lies with how PEHP treats some medications. Some medications, if changed to a generic, may have an unhealthy effect on the member. In many other health plans, the brand name medication will be dispensed at a generic co-pay after medical necessity is verified with the physician, meaning that the member either cannot take the generic or has tried and failed (with adverse effect) to take it. This flexibility is stated in the master policies of other health plans. However, this is not the case with PEHP, where the member must pay the tier three rates (most expensive covered rate).

Other health plans are more flexible in dispensing brand drugs at generic rates if it is deemed medically necessary.

The potential impact of these requirements, which are established by the pharmacy director, is that members could potentially forgo gaining approval for needed medications and choose not to take medication. As a result, PEHP will have to address the financial impact of costly hospitalizations or more intense, involved care. The

other impact is that members will pay more for brand medications that are deemed medically necessary when they cannot take the generic equivalent.

PEHP Should Consider Removing Rebate Process from Pharmacy Program

Rebates are reimbursements provided by the manufacturer to the Pharmacy Benefit Manager (PBM) for the use of their brand name medications. These rebates are generally passed on to PEHP. Rebates are generally used as incentives by manufacturers to get their medications covered on pharmacy plans. PEHP received over $8 million in rebates for fiscal year 2009. The pharmacy program is responsible for the $8 million, which poses oversight issues, as well as conflict of interest issues.

Rebates processed by a department apart from pharmacy can reduce potential influence by the manufacturer to place medication on the formulary.

Setting control mechanisms within the rebate area will minimize the ability for pharmaceutical manufacturers to peddle influence with PEHP and seek medication placement on the formulary. The ability of manufacturers to influence PEHP to place their medication on the formulary can also be reduced if the rebate process is handled by an internal section, which is independent from the clinical department.

The pharmacy program is able to negotiate rebate deals with manufacturers, making it possible for the program to receive inappropriate payments from a manufacturer for putting particular medications on the formulary. While we do not believe this is occurring, we are concerned that senior management's oversight involvement appears to be limited in this process. If greater oversight is not implemented, opportunities for fraudulent activity will still exist.

Fully Transparent PBM Contract Would Be More Costly

We were asked to review the level of contract transparency PEHP has with its current pharmacy benefits manager (PBM).

The current contract lacks full transparency due to the following factors:

- There is no disclosure of *spread pricing* that the PBM could be engaged in with retail pharmacies and manufacturers. (Spread pricing is the difference between the price charged to PEHP for a pharmaceutical item and the cost the PBM pays for the item.)
- The ability of PEHP to audit the PBM is limited.
- Rebates are not explicitly defined.

PEHP's PBM is not transparent because there is no disclosure of spread pricing, restrictive auditing of PBM, and rebates are not clearly defined.

According to the consultant, a transparent contract would allow PEHP to clearly see and understand the PBM's business practices and pricing arrangements with retail pharmacies and pharmaceutical manufacturers. The consultant states transparency has its benefits, chiefly, the ability to comprehensively audit the PBM, which would allow PEHP to more effectively compare services, evaluate costs and determine if the PBM is acting in PEHP's best interest. Transparent contracts have not been industry standard and have only increased in demand over the last four to five years. Most of the states contacted claimed to have a fully transparent contract.

However, there is a trade-off for procuring a more transparent contract- higher pharmacy costs. Generally, this means much higher fixed costs, such as administration costs. For example, if PEHP currently pays their PBM $1 per each claim processed and PEHP decides to pursue a transparent contract, the PBM could hypothetically charge as much as $7 for each claim processed. In fiscal year 2009, the average number of claims per member was approximately 10, so, hypothetically, if PEHP were to choose a fully transparent option, it could potentially increase costs by approximately $4.2 million. PEHP strives to be a cost-conscious provider and so procuring a fully transparent contract may not be in their best financial interest.

A transparent contract can potentially cost more to PEHP in higher fixed costs.

PEHP Is Considering Transparency in Latest Procurement Process with PBM. PEHP is in the process of procuring a PBM because the contract with the current PBM is expiring. As part of their request for proposals, they are modeling different contract arrangements, one of which is a transparent contract, to see whether this will fit their business needs. The consultant remarked that health plans that are cost-driven, such as PEHP, may find that transparent contracts are too costly.

PEHP is including the cost of a transparent contract, in their current bid.

Recommendations

1. We recommend PEHP create a Pharmacy and Therapeutics (P&T) committee oversight document which outlines the following:

    - Schedule of meetings
    - Committee composition, selection and credentials of individual members
    - Procedure for approval/acceptance of committee members
    - Conflict of interest statements and continued reiteration at each meeting
    - Signature and date required on committee minutes

2. We recommend PEHP revise the current Pharmacy and Therapeutics Committee Agreement to include disclosure provisions on the acceptance of monies by individual members of the committee by pharmaceutical manufacturers.

3. We recommend PEHP provide greater oversight to the pharmacy program by taking the following actions:

    - Reviewing the role and responsibilities of the pharmacy director and better defining the director's duties as it pertains to the P&T committee.
    - Independently reviewing pre-authorization and co-pay criteria to assure rules are safe, effective, and fair; and, amending the Master Policy to reflect these changes.

4. We recommend PEHP consider having the rebate function handled by an internal section which is independent from the Clinical Department.

Chapter VI
Appeals Process for Claims Review Needs to Be Strengthened

The Public Employees Health Program's (PEHP's) appeals process for reviewing denied medical and pharmacy claims needs to improve. An appeals process is a standard method to provide members and healthcare providers assurance that claims are being adjudicated appropriately according to health plan policies. This process also helps protect PEHP by ensuring that members are receiving safe and effective care by their healthcare providers. We found that PEHP needs to add additional controls to their appeals process to strengthen independence and objectivity. Specifically, a formal auditing process needs to be established, and internal and external clinical expertise is needed. However, our appeals consultant found that most appeals have been adjudicated appropriately. Also, PEHP does not have a formal process in place to track and trend appeals to promote continuous improvement within the organization.

PEHP needs to add additional controls to their appeals process to strengthen independence and objectivity.

For this audit, we hired an appeals consultant, Wolcott and Associates Inc., with the expertise to review denied medical and pharmacy claims that have been submitted for appeal. The appeals consultant reviewed PEHP's appeal policies and procedures, conducted interviews with personnel involved in the appeals process, and reviewed a random sample of appeals that were adjudicated through the appeals process.

We hired a consultant with the expertise to review denied medical and pharmacy claims that have been submitted for appeal. Our pharmacy consultant also reviewed pharmacy appeals.

We also hired a pharmacy consultant, CAZMA, LLC, who reviewed the appeals process as it related to the pharmacy appeals. In conjunction with the two consultants' expert opinion, we utilized the findings of our independent field work to arrive at the conclusions described in this chapter. While we refer to the consultants' findings throughout the chapter, we have also included Wolcott and Associates Inc.'s, full report in Appendix F, and CAZMA's full report in Appendix D.

Appeals Process Needs Additional Controls

Additional controls in the appeals process will help promote member safety and ensure appeals are evaluated consistently and objectively.

PEHP's claim appeals process consists of five separate levels of review. We reviewed four of the five levels of appeal and found that additional controls are needed for the first three levels of review. Additional controls will help better promote member safety and ensure that appeals are evaluated consistently and objectively at each level in the appeals review process. Specifically, PEHP needs to establish a formal auditing process for the first-level of appeals. The administrative review committee, which reviews the second-level of appeals needs additional clinical expertise. The third-level of appeals needs to be reviewed by an independent organization, outside of PEHP, with clinical expertise to review the claims.

PEHP has five levels of appeals for members and healthcare providers to request a review of claim payments which have been denied. The five levels of review are briefly described in Figure 6.1.

Figure 6.1 PEHP's Five Level Appeal Process. Three of the five levels of PEHP's appeal process are outlined in statute.

Level	Reviewer(s)	Description
1	Benefit Specialists	A team of benefit specialists approve or deny the appeals based on the benefits outlined in the master policy. If a clinical review is needed, the pharmacy appeals are reviewed by a clinical pharmacist, and medical appeals are reviewed by the medical director or the medical director's staff.
2	Administrative Committee	A seven member committee, consisting of PEHP employees, reviews all second-level appeals on a weekly basis. They vote to uphold or overturn the first-level decision.
3	URS Executive Director	According to ***Utah Code*** 49-11-613(1)(c) members/providers can request a ruling by the executive director.
4	Hearing Officer	According to ***Utah Code*** 49-11-613(2) members/providers have the right to appeal to a hearing officer. Once a decision is rendered by the hearing officer, it is presented to the Utah Retirement Board for approval or denial.
5	Utah Court of Appeals	***Utah Code*** 49-11-613(7) states that the decision of the retirement board may be submitted for judicial review.

PEHP has five levels of appeals for members and healthcare providers to request a review of denied claim payments.

Most appeals are resolved at the first-level. Looking at the trend for the past five years, we found that only about 4 to 6 percent of all appeals are resubmitted for an administrative review. For example, 5,308 appeals were submitted to PEHP in 2009, and 312, or 6 percent, were resubmitted for an administrative review. Less than 1 percent of all appeals are resubmitted to the executive director for review, and less than 0.5 of a percent are resubmitted to a hearing officer. We are not aware of any appeals that have been submitted to the court of appeals within the scope of this audit for the past five years.

Our appeals consultant conducted an evaluation of the five-level appeals process and found that improvements need to be made in the first three levels. In addition, our pharmacy consultant, CAZMA, also reviewed the appeals process—as related to the pharmacy appeals and found similar concerns. Concerns with each level of appeal (one through three) are discussed separately below.

The consultants found that improvements need to be made in the first three levels of the appeals process.

First-Level Appeals Need To Be Audited Consistently

An audit process should be established at the first-level of appeals, since most appeals are resolved at the first-level.

No formal auditing process has been established to systematically review appeal decisions made at the first-level. It is important to have an audit function at the first-level of appeals, since most appeals are resolved at this level. In 2009, only 6 percent were resubmitted for the second-level review. An audit function at the first-level helps provide assurance to members and health care providers that appeal decisions are made in accordance with benefit policies. PEHP can utilize the audit results for continuous improvement within the organization.

An audit function would be beneficial for training purposes, to make sure reviewers are following current policies.

The appeals consultant recommends that PEHP establish a formalized audit process that reviews a statistically valid sample of first-level appeals. Industry best practices require an audit of appeals. Other local insurance carriers that we contacted also have a process in place for auditing appeals. According to the appeals consultant, an audit function would be beneficial for training purposes, to make sure that reviewers and claim adjustors are following current policies. Additionally, it could result in a reduction of the number of appeals that are submitted to PEHP for reconsideration.

Not having turnaround schedules for processing appeals could result in serious harm to the member and increased liability cost to the health plan.

Acceptable Turnaround Time Guidelines to Process Appeals Need to Be Established. For the first-level of appeals, as well as the second and third-levels, PEHP has not established in policy acceptable turnaround time guidelines for processing medical and pharmacy appeals. This is a member safety issue. Not having established turnaround schedules could result in serious harm to the member and/or increased liability cost to the health plan for additional care to the member.

Decisions to approve or deny an appeal should be completed within 30 calendar days.

In accordance with industry standards, the appeals consultant stated, PEHP should send an acknowledgement letter to each member or provider that makes an appeal for each level within five to seven calendar days of receipt of the complaint. The appeals consultant also stated that the decision to approve or deny an appeal should be completed within 30 calendar days of receipt of the appeal (not 30 days after the acknowledgement letter has been sent). Also, a letter should be sent to the member regarding the decision within five calendar days of when the decision was made.

We looked at how long it took to process all appeals for calendar year 2009 for the first three levels of review.

- **First-Level**—13 percent of the appeals took longer than 30 calendar days to process.
- **Second-Level**—25 percent of the appeals took longer than 30 calendar days to process.
- **Third-Level**—Appeals took less than 30 calendar days to process.

This review shows that PEHP is not meeting industry standards to process appeals for the first and second-levels. Other local carriers we contacted also have a general policy to process appeals within 30 calendar days. However, a few appeals may exceed the 30 day guideline if additional information is being gathered to properly adjudicate the appeal. One local carrier only allows two percent of their appeals to exceed the 30 calendar day policy. In contrast, for the first-level appeals in 2009 at PEHP, after 45 calendar days, 2 percent had not been adjudicated. For the second-level appeals, 10 percent had not been adjudicated within 45 calendar days.

PEHP is not meeting industry time standards to process appeals for the first and second-levels.

In addition, the pharmacy consultant stated that for first-level pharmacy appeals, urgent appeals should be reviewed within 72 hours, and non-urgent appeals should be reviewed within seven days. The length of time taken to process appeals should be included in the audit function.

Second-Level Appeals Need Clinical Expertise

Both the appeals consultant and the pharmacy consultant are concerned that the administrative review committee has only one committee member with clinical expertise. The pharmacy consultant stated, "Membership is skewed, with the committee being comprised of primarily administrative personnel . . ." Clinical expertise is needed at this level in the appeals process to determine if prescribed therapies and procedures are safe for members and if insurance coverage is appropriate.

According to the pharmacy consultant, "Membership [of the administrative review committee] is skewed, the committee being comprised of primarily administrative personnel."

The administrative review is handled by a seven-member committee who reviews appeals and votes whether to approve or deny the claims. The following PEHP employees are voting committee:

- The director
- The medical director
- The member services director
- The provider relations director
- The long-term disability and general services director
- The compliance director
- The marketing manager

The medical director is the only voting member of the administrative review committee with clinical expertise. However, the medical director cannot vote on an appeal if the medical director's department reviewed the appeal when it was first submitted at level one. This includes pharmacy appeals, because the pharmacy program is part of the medical director's department. We observed the administrative appeals committee meetings for three months, which was 12 committee meetings; during that time frame, the medical director was not eligible to vote on 60 percent of the appeals that were reviewed.

The medical director is the only voting member of the administrative review committee with clinical expertise.

To help remedy this imbalance, the appeals consultant recommends that the pharmacy director have a voting position on the administrative review committee. With this change, PEHP would be following industry best practices. Other local carriers we contacted also have clinical pharmacists to help adjudicate pharmacy claims. The appeals consultant recommends that the pharmacy director should abstain from voting on pharmacy appeals that were already reviewed by the pharmacy director or the pharmacy director's staff submitted at level one. However, the medical director could vote on the pharmacy appeals.

The pharmacy director at PEHP should have a voting position on the administrative review committee.

Also, when a medical appeal is being reviewed at the second-level, the medical director should continue to abstain from voting, but the appeals consultant stated that the pharmacy director could vote on those medical appeals. This arrangement would allow at least one committee member with clinical expertise to vote on each appeal reviewed by the committee. PEHP should reevaluate the structure of the administrative review committee, and consider if additional members of that committee should have clinical expertise.

A Member Advocate Should Be Involved in the Appeals Process. The appeals consultant and the pharmacy consultant also

observed that there is no member advocate at any level of the appeals process. Having a member advocate included in the appeals process is also an industry standard. Other insurance carriers we contacted also include a member advocate in their appeals process. The appeals consultant recommends that a member advocate have a voting position on the administrative review committee. Typically, the member advocate is a retiree of a health plan that is administered by PEHP. It would be beneficial if the member advocate had expertise in healthcare and/or human services.

A member advocate should have a voting position on the administrative committee, similar to other insurance carriers we contacted.

Administrative Committee Meetings Review Complex Claims. We observed administrative review committee meetings for three months, and saw that some appeal cases can be very complex. Sometimes we observed conflict, and difficult decisions had to be made during the committee meetings. We observed some inconsistency in the decision-making process:

- An appeal was denied because the prescribed treatment was not following Food and Drug Administration (FDA) guidelines, but another appeal was approved, even though the treatment was not following FDA guidelines.
- An appeal was denied because the claim did not follow policy, but another appeal was approved, even though it did not follow policy.

We also observed that members of the administrative committee were not given copies of internal policies governing medications and medical procedures to help guide decisions of a clinical nature. After a committee meeting we asked for a copy of some of the internal policies so we could review a decision that was made. We observed those internal policies governing medications and medical procedures were not formally approved by the pharmacy and therapeutic (P&T) committee. Having another clinician and member advocate on the administrative review committee, as well as providing approved policies may help reduce some of the inconsistencies in the decision-making process.

Third-Level Appeals Need Outside Clinical Expertise

The third-level of appeals presents a potential lack of independence according to the appeals consultant. The purpose of having a multi-level appeals process is to promote an independent and objective review at each level. Currently, the third-level of the appeals process is a review by the executive director of the Utah Retirement Systems (URS). However, the executive director can request information from the medical director and/or the medical director's staff in order to assist in the review, even though the medical director has already provided an opinion on the appeals at previous levels in the appeals process. In most cases, the medical director has provided a memo regarding the basis of the second-level decision, which can be reviewed by the executive director.

The purpose of having a multi-level appeals process is to promote an independent and objective review at each level.

The pharmacy consultant noted that the same viewpoint is carried through each step of the appeals process—that of the medical director and pharmacy director. It should be noted that for the sample of appeals the appeals consultant reviewed, the third-level review upheld 100 percent of the decisions made at the second appeal level. In the past five years, the executive director has reviewed 144 medical appeals and has only disagreed with the decision made at the second-level nine times, or 6 percent of the time.

At PEHP, the same viewpoint is carried through each step of the appeals process; that of the medical director and pharmacy director.

The appeals consultant recommends that the third-level appeals consist of an independent review organization (IRO), which should include at least one specialist in the field for the procedure or services being appealed (e.g., oncology, orthopedics, endocrinology, etc.) The results of this review should be presented to the executive director for the final decision regarding the appeal. The pharmacy consultant also agrees with the appeals consultant, outside clinical expertise should be utilized at the third appeal level.

The appeals consultant recommends that the third-level appeals consist of an external independent review organization (IRO).

Having an IRO is an industry standard and will help provide an independent clinical opinion for the appeals. Other local insurance carriers we contacted include an external clinical review in their appeals process. One local carrier contracts with 100 different specialists to help insure appeals are properly reviewed. An IRO review process can be utilized by PEHP to help make future changes to medical policies and procedures, which could help reduce the number of appeals. In addition, the changes to the third-level appeals process would help

Having an IRO is an industry standard, and will help provide an independent clinical opinion for the appeals.

PEHP and URS be within established guidelines under Healthcare Reform, which requires an IRO review during the appeals process.

Most Appeals Were Appropriately Adjudicated

The appeals consultant reviewed a statistically valid random sample of appeals that were adjudicated in 2009, for levels one through four, in the appeals process. The conclusions of this review substantiate the need to make changes to the appeals process discussed in the previous section of the report. The consultant reviewed 141 appeals and disagreed with the decisions made for eight appeals. The eight appeals represent a 5.7 percent disagreement rate. According to the appeals consultant, the disagreement rate is less favorable than the 3 to 5 percent rate that is considered acceptable in the industry. However, the disagreement rate was only slightly outside the acceptable range. Also, the consultant noted that for the sample of appeals reviewed, the governance of the review process at each level of review followed PEHP's established policies.

The appeals consultant reviewed 141 appeals, and disagreed with the decision made for eight appeals, or 5.7 percent, which is slightly higher than industry norms.

The main purpose of this review was to determine if the appeal decisions are in compliance with PEHP's established policies and procedures. The appeals consultant was provided with the information that decision-makers used to adjudicate each of the selected appeals in the random sample (for levels one through four in the appeals process). The consultant reviewed each appeal to determine the following:

- The nature and validity of the appeal
- That each appeal was evaluated for compliance to the appeals process at each level, if applicable
- That sufficient documentation existed to properly adjudicate each appeal
- That the decision for each appeal was in compliance with appeal policies

The main purpose of the appeals consultant review was to determine if the appeal decisions are in compliance with PEHP's established policies.

The documentation for each appeal was reviewed to determine the level of communication between the participant and PEHP, and to establish that the participant was provided information regarding the elevation of the appeal to the next level.

The appeals consultant disagreed with the decision that was made for eight of the appeals. Five of those disagreements, or 63 percent, were at the first appeal level. This result supports the recommendation that PEHP should establish a formalized audit function at the first-level, as discussed in the previous section. Two of those disagreements were at the third appeal level, and one disagreement was at the fourth appeal level.

Of the 141 appeals reviewed, the appeals consultant found that 12 additional appeals, or 8.5 percent, lacked enough information regarding the basis for PEHP's decision. Four of these 12 appeals were at level three, the executive director's review. The remaining eight appeals did not include any notes regarding the basis for the reversal of the original decision. Also, based on the consultant's review of the documentation for each appeal, the denial letters did not always contain supporting documentation of the medical policy or the plan policy utilized as a basis for denial.

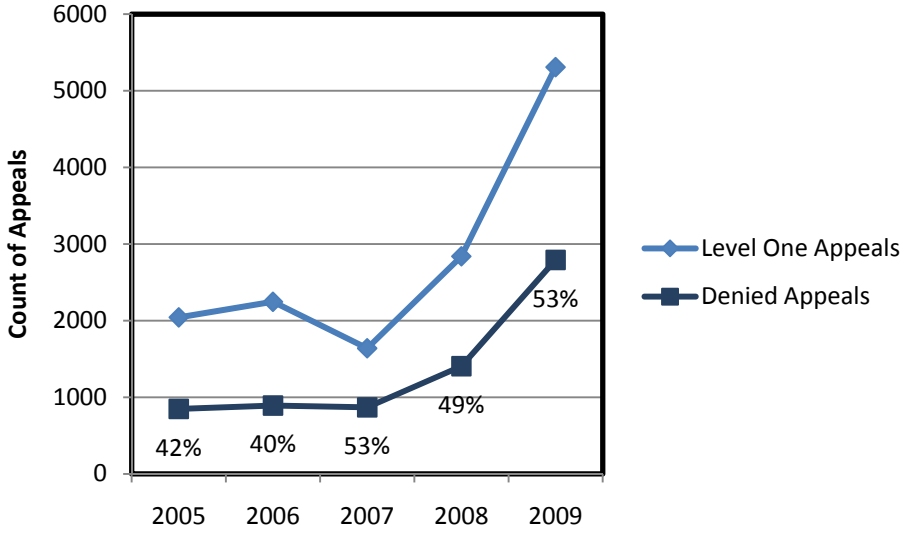
PEHP Should Monitor Appeals

We observed that there is no formal tracking and trending of medical and pharmacy appeals. In 2009, PEHP experienced an extreme increase in the number of appeals submitted. As a result, this has increased the workload of PEHP's staff involved in the appeals process. An analysis determining the causes of the increase in appeals has not been conducted by PEHP.

Appeal approval and denial rates should be reviewed consistently to help determine if the appeals process is functioning properly.

The pharmacy consultant also mentioned that PEHP does not track medical and pharmacy appeal trends. According to the pharmacy consultant, appeal approval and denial rates should be reviewed consistently to help determine if the current appeals process is working and current benefit policies are being followed. For example, abrupt changes in denial rates, may indicate a problem in the appeals process. Figure 6.2 shows the number of first-level appeals and their denial rates over the past five years.

Figure 6.2 Count of Appeals Submitted to PEHP. Appeals submitted to PEHP have dramatically increased the past two years.



The number of appeals entering PEHP has increased 160 percent during the last five years.

Figure 6.2 shows that the number of appeals entering PEHP has increased 160 percent during the last five years. We were told by PEHP staff that the large increase in appeals submitted to PEHP in 2008 and 2009 is likely due to internal policy changes made by a new medical director and pharmacy director that PEHP hired. However, PEHP has not completed an analysis of the increase in appeals counts. PEHP should be reviewing the count of appeals and denial rates for all appeal levels.

Overall, denial rates appear to be fairly consistent for level one appeals.

The denial rate for the level one appeals shown in Figure 6.2 averaged 48 percent over the five-year period. The highest denial rates were in 2007 and 2009, at 53 percent, and the lowest denial rate was in 2006, at 40 percent. Overall, denial rates appear to be fairly consistent for level-one appeals.

PEHP Should Better Utilize Appeal Data. PEHP categorizes each appeal reviewed according to the nature of the appeal. PEHP has established 10 different types of appeals. Figure 6.3 shows the 10 types of appeals and the percentage of the 2009 appeals placed in each category.

Figure 6.3 Appeals Submitted to PEHP by Type. Almost 20 percent of the appeals submitted in 2009 challenged that the claim met benefit guidelines.

Appeal Category	Percentage
Claim was for a non-covered service	19.3%
Claim was included in another procedure	14.9
Claim was over benefit limitation	13.1
Claim was not preauthorized	13.0
Claim was not filed timely	11.3
Claim was out of network	10.6
Claim was not medically necessary	2.3
Claim was experimental or investigational	1.4
Claim was for a pre-existing condition	.5
Claim was cosmetic purposes	.2
Appeals not categorized	13.6

It appears from our audit, that PEHP underutilizes this information. By closely monitoring trends, PEHP may be able to determine what changes could be made within the organization, or with external relationships to help reduce the large increase in appeals being submitted to PEHP. For example, 10.6 percent of all appeals submitted in 2009 were for claims that were out-of-network. PEHP could use this information to consider different approaches of informing members about health plan benefits. From the reviewed appeals, it appears that not all members understand that it is their responsibility to make sure that a provider or facility is covered by their individual health plan.

PEHP should begin monitoring trends, so they may be able to make improvements within the organization, and improve external relationships.

The pharmacy consultant also mentioned that there is no "keeper" of all appeals that enter PEHP. We agree with this conclusion. For this audit, we were not able to go to one source to gather the number of appeals and rulings for each level of appeal. Without a gatekeeper for all appeals that enter PEHP, no formal tracking and trending can take place.

There is no gatekeeper for all of the appeals that enter PEHP.

Recommendations

1. We recommend that PEHP establish a formalized audit function at level one of the appeals process.

2. We recommend that PEHP make the following changes to the administrative review committee at level two of the appeals process:

    - Add two voting positions to the committee—the pharmacy director and a member advocate.
    - Evaluate the structure of the committee to insure adequate clinical expertise is assigned to the committee.

3. We recommend that PEHP hire an independent review organization at level three of the appeals process.

4. We recommend that PEHP establish turnaround schedules for processing appeals for appeal levels one through three.

5. We recommend that PEHP establish a formal process to track and analyze appeals submitted to PEHP.

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Appendices

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Appendix A

Glossary

Actuary: A qualified statistician who deals with the financial impact of risk and uncertainty.

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

Claims: Expenses resulting from individuals utilizing their medical benefits.

Contingency Reserve: Risk Pool funds held by PEHP to cover all claims and expenses accrued by risk pool members.

Employer Group: An entity with a current group benefits agreement in effect with a health plan to provide covered health care services to its employee-subscribers and eligible dependents.

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

Formulary: A list of drugs covered by a health plan. 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.

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 or do not typically benefit when premiums exceed cost.

Health Benefit Plan: Sets of benefits that employers have established (in conjunction with PEHP) for their employees.

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.

IBNR: Incurred but not reported claims. The IBNR totals are estimates and represent an actual financial liability.

Insurance Carrier: A company that offers insurance policies to the public, either by selling directly to an individual or through another source such as an employee's benefit plan.

Liabilities: A future obligation to be fulfilled.

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.

Per-Subscriber Per-Month (PSPM): A monthly count of eligible employees in a plan.

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

Pharmacy and Therapeutics (P&T) Committee: An interdisciplinary committee charged with promoting rational, cost-effective use of pharmaceutical and other therapeutic products, and patient safety as it relates to pharmaceutical and other therapeutic products.

Preauthorization: Some medical procedures and facilities, specific prescription drugs, specialty medications and injectibles that require PEHP's approval because of the high potential for safety issues, adverse reactions, contraindications, misuse, opportunity to use first line therapy, and cost.

Preferred Drug List (PDL): A brief list of the most commonly prescribed medications.

Preferred Provider Organization (PPO) Plan: Retain many 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.

Premiums: Agreed upon fees paid for coverage of medical benefits for a defined benefit period. Premiums can be paid by employers, employees, or shared by both the insured individual and the plan sponsor.

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.

Rebates: A discount given by the manufacturer after the drug is dispensed.

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

Risk Pool: One or more employee groups which share premiums, expenses, liabilities and risk.

Self-Funded Plan: 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.

Specialty Drugs/Injectables: Typically bio-engineered medications that have specific shipping and handling requirements or are required by the manufacturer to be dispensed in a controlled environment (physician's office/hospital).

Spread Pricing: The difference or margin between the price charged to the plan sponsor for an item and the cost the PBM pays for the item.

Stop-Loss Coverage: A form of reinsurance for self-insured employers that limits the amount the employers will have to pay for each person's health care (individual or specific limit) or for the total expenses of the employer (group or aggregate limit).

Tier-System: Depending on type of drug, a list of medications structured by cost. For example:

Tier 1: $10 generics
Tier 2: $20 brands

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Appendix B

Legislative Audit Request

Time Frame: January 2009 to December 2009 (with run out through March 31, 2010)
Book of Business
Fully insured, large commercial groups (for groups 51 or more)
Only include Utah members and exclude retired members
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. Inpatient Hospital Claims Only (Remove all members with claims over $100,000)

	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, substance abuse, 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 (1) per subscriber per month basis, (2) per member per month basis

Remove:

- Premium tax
- Commissions and all broker related costs
- Reinsurance charges
- Rebates
- Marketing and Advertising Expenses

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+		

7. Comparison by CPT Code

If you have multiple fee schedules please provide three most common

Fee Schedules as of July 2009

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			
	99202	New office/0utpatient visit			
	99213	Established patient 15 minutes			
	99214	Established patient 25 minutes			
Medical Services	90806	Individual pychotherapy 45-50 minutes			
	92004	New patient eye exam, comprehensive			
	92557	Comprehensive audiometry threshold evaluation			
	93005	Electrocardiogram, tracing			
Inpatient	99223	Initial hospital care			
	99232	Subsequent hospital care			
Surgery	29881	Knee arthroscopy/surgery			
	30520	Repair of nasal septum			
	47563	Laparo cholecystectomy/graph			
	66984	Cataract removal & insertion lens			
	49650	Laparoscopy, repair initial inguinal hernia			
	59400	Normal vaginal delivery			
Lab	80053	Comprehensive metabolic panel			
	84443	Thyroid stimulating hormone (TSH)			
	81002	Urinanalysis nonauto w/o scope			
	85025	Blood count, complete			
Pathology	88304	Surgical pathology, gross microscopic examination (level 3)			
	88305	Surgical pathology, gross microscopic examination (level 4)			
Radiology	71020	X-ray exam of chest, two views			
	72100	X-ray exam of lower spine			
	70210	X-ray exam of sinuses			
	73562	X-ray exam of knee, three views			
	73610	X-ray exam of ankle, three views			
	70552	MRI exam of brain with contrast			
	70551	MRI exam of brain without contrast			
	72148	MRI exam of lower spine			
	74160	CT exam of abdomen with contrast			
	74150	CT exam of abdomen without contrast			

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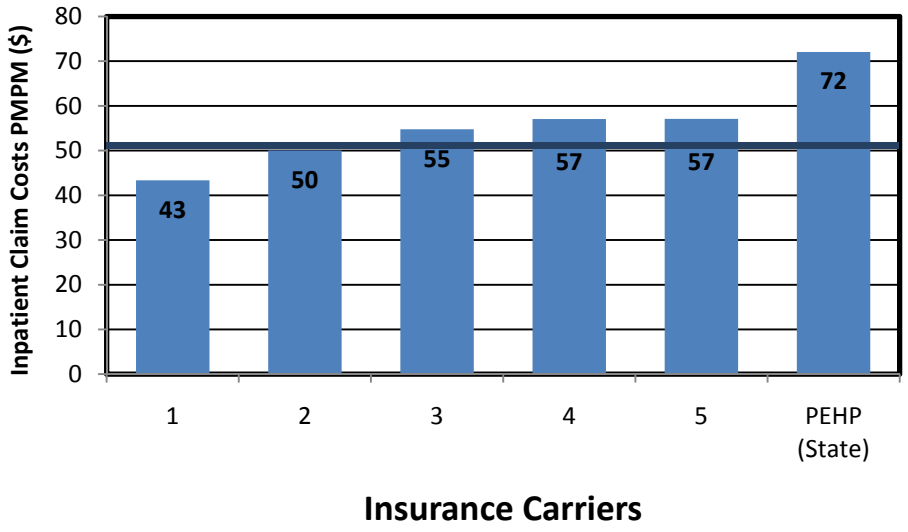
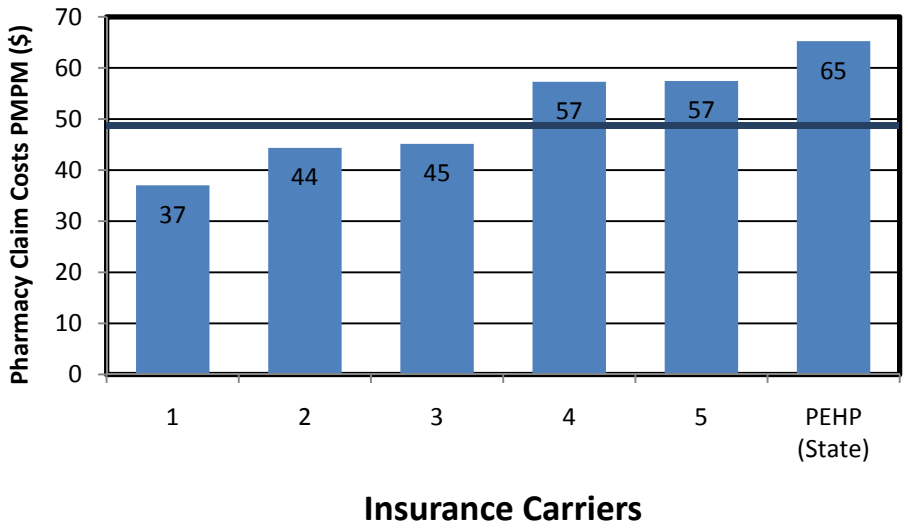
Appendix C

Hospital Claim Cost Comparison. The average claim costs were $72 PMPM for the state, and $52 PMPM for all other local insurance carriers.



Pharmacy Claim Cost Comparison. The average claim costs were $65 PMPM for the state, and $48 PMPM for all other local insurance carriers.



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Appendix D

Utah Public Employee Health Plan
Legislative Audit

Pharmacy Program

Presented by

Carole A. Zikowski, R.Ph.,MBA
President

CAZMA, LLC

Report of Findings And Recommendations

November 28, 2010

Introduction

The Public Employee Health Plan (PEHP) for the State of Utah, is responsible for insuring the pharmacy benefit for approximately 140,000 members, 1.4 million annual drug claims with an estimated cost of 74 million dollars.

This report describes the audit of the Pharmacy Benefit Program of the Public Employee Health Plan (PEHP) for the State of Utah.

The focus of this audit was on the State Employee pool of members that accounts for approximately 75,000 state employee members.

The review was concentrated on the following business processes as they relate to the provision of the pharmacy benefit:

Formulary Management Review

- Review of categories and classes including number of drugs in each category
- Drug list review
- Tier placement review
- Availability of medications consistent with national practice guidelines for primary chronic diseases
- Availability of most or all drugs within certain drug categories allowing for patient variability
- P&T committee oversight for clinical appropriateness including practices and policies for formulary management activities, such as prior authorizations, step therapies, quantity limitations, generic substitutions and other drug utilization activities that affect access.
- Evidence that clinical decisions by the P&T committee are based on scientific evidence and standards of practice, including peer reviewed medical literature, well-established clinical practice guidelines and pharmacoeconomic studies as well as other accepted sources of appropriate information.
- Documentation of P&T procedures
- Consideration of medication therapeutic advantages in terms of safety and efficacy as they relate to formulary status and tier placement.

Pharmacy and Therapeutics Committee (P&T) Audit

- Membership – adequate clinical specialty representation

- Experts if membership has specific population needs
- Conflict of interest review
- Meeting administration
- Documentation of meeting outcomes i.e. meeting minutes

Pharmacy Appeals Audit

- Documentation of Pharmacy Appeals process – internal policy and procedure review
- Review of Appeals cases for evidence of handling consistency

Documentation Review

The documentation review included the following materials:

- Prior Authorization Drug Listing
- Copy of Drug Formulary
- Copy of MAC Lists
- Copy of group set-up conditions – days' supply allowed per fill, refill percent rate, etc.
- Copy of Rebate Reports (most recent 2 calendar years)
- Copy of AWP sourcing and calculation procedures
- Copies of client billing statements for the most recent 12 calendar months
- Copy of Mail Service program description and procedures
- Copy of Customer Service activities or conditions for group – PA placement by PBM, etc.
- Copy of your standard set of management reports for the most recent calendar year.

The main elements which guided the review strategy included:

Formulary Management, P&T Committee & Pharmacy Appeals Review

- Insure that formulary and P&T processes are consistent with best practices.
- Insure that formulary and P&T processes are driven by consideration for access to medically necessary medications.
- Insure that formulary and P&T processes allow for flexibility in unusual medical circumstances.
- Insure that formulary and P&T processes allow for maximum clinical and cost-effectiveness.

Methodology

Documentation Review including:

- P&T committee meeting minutes for 1 year prior to audit
- Formulary changes for 1 year prior to audit
- Copies of all current plan year formularies
- Documentation of all UM program protocols, including prior authorization, step therapy and appealsprocess

Business Process Review including:

- Internal policy and procedure review
- Member and Prescriber communications
- Onsite interviews

Formulary Management Review

Review of categories and classes, drug list, tier placement including number of drugs in each category

ISSUE
No complete formulary listing of PEHP was provided. The formulary document provided was a Preferred Drug List (PDL) list only. This listing is not organized by medication class and therefore difficult to ascertain whether meds in all medication classes are appropriately available for the various population groups.

IMPACT

1. Ease of use/readability by provider (physician or pharmacy) or by beneficiary is compromised. This can result in delay of care or lack of proper access to care.

2. Complicates and provides an inefficient process for the health plan's continual review of formulary appropriateness.

RECOMMENDATION
Provide members and providers with a formulary that is organized by drug class. A very good example of a clear format which organizes by drug class, identifies preferred and non-preferred within each category is:

http://www.bcbsnc.com/assets/services/public/pdfs/formulary/printable-formulary-guide.pdf

http://www.shpnc.org/pdf/PreferredPrescList.pdf

Formulary Changes

ISSUE
Other than postings on the website, it is unclear how members' are notified of interim changes to the PDL. This is of importance since it seems that drug placement can and does change any time throughout the year. Documentation of letters being sent to the members on formulary changes regarding new generics was provided however, no policy exists on when a member will be notified and how they will be notified.

IMPACT
Without formal policy and procedures on department workflow and operations, medication access can become inconsistently delivered to the provider network and/or beneficiary.

RECOMMENDATION
Develop a policy and procedure on member communications documenting in what circumstances and how members will be notified on formulary changes.

Availability of medications consistent with national practice guidelines for primary chronic diseases

ISSUE
Evaluation of this type is not feasible based on current format of formulary. It appears there is decent representation of most therapeutic classes (rough count of 800 drugs on the formulary).

The plan preferred formulary listing contains only those medications at Tier 2, it cannot be ascertained what is on the medication formulary at Tier 3.

IMPACT
National practice guidelines are established after research, thought and consideration of the disease state that is being treated. By not following these guidelines, the impact could be a formulary that promotes inappropriate drug use for the identified disease state.

RECOMMENDATION
A formulary organized by drug class, as provided would make this type of review possible.

As an example, CAZMA reviewed and compared 2-drug classes based on the referenced formulary of Blue Cross Blue Shield of North Carolina. The results are listed below:

ENDOCRINE (Diabetes/Hormones/Contraceptives)

BCBS NC	PEHP
Insulin Therapy - Tier 2	Same
Apidra/Solostar	
Humalog, Humalog Mix	
Humulin N	
Humulin R	
Lantus/Solostar	
Levemir	
Novolin N, Innolet	
Novolin R, Innolet	
NovoLog, NovoLog Mix	
Diabetes Agents - Tier 1= generic only	Same except for:
acarbose (Precose)	
chlorpropamide (Diabinese)	
glimepiride (Amaryl)	No age edits on chlorpropamide
glipizide (Glucotrol/XL)	
glipizide/metformin (Metaglip)	
glyburide (DiaBeta, Micronase)	
glyburide, micronized (Glynase)	
glyburide/metformin (Glucovance)	
metformin (Glucophage/XR)	
nateglinide (Starlix)	Metformin - QL
tolazamide (Tolinase)	
tolbutamide (Orinase)	
Tier 2	
Actoplus Met	Actoplus Met - QL
Actos	Actos - QL
Avandamet	
Avandaryl	
Avandia	Avandia - NC
Byetta	Byetta - PA, QL
Duetact	Duetact - QL
Janumet	Janumet - QL
Januvia	Januvia - QL
Onglyza	Onglyza - NC
Tier 3	
Actoplus Met XR	Actoplus Met XR - NC
Fortamet	Fortamet - NC
Glumetza	Glumetza - NC
Glyset	
Prandimet	Prandimet - NC
Prandin	
Riomet	Riomet - NC

Symlin/Pen	
Victoza	Victoza - NC

*QL = Quantity Limit **NC = Not Covered ***PA = Prior Authorization

Cholesterol-Lowering Agents

BCBS NC	PEHP
Tier 1= generic versions only*	
cholestyramine (Questran)	
colestipol (Colestid)	
fenofibrate/micronized	fenofibrate - QL
gemfibrozil (Lopid)	
lovastatin (Mevacor)	lovastatin - QL
pravastatin (Pravachol)	ravastatin - QL
simvastatin (Zocor)	simvastatin - QL
Tier 2	
Crestor	Crestor - QL
Lipitor	Lipitor - QL
Niaspan	
Simcor	Simcor - QL
Tricor	Tricor - NC
Vytorin	Vytorin - QL
Zetia	Zetia - NC
Tier 3	
Advicor	Advicor QL (tier 2)
Altoprev	Altoprev QL (tier 2)
Antara	Antara - NC
Caduet	
Fenoglide	Fenoglide (tier 2)
Lescol/XL	Lescol XL - NC
Lipofen	Lipofen - NC
Livalo	Livalo - NC
Lovaza	
Triglide	Triglide - NC
Trilipix	Trilipix - NC
Welchol	Welchol - QL (tier 2)

*QL = Quantity Limit **NC = Not Covered ***PA = Prior Authorization

Availability of most or all drugs within certain drug categories allowing for patient variability

ISSUE

Based on information obtained and provided, it is unclear.

IMPACT

Lack of clear availability for a medication could result in delay or lack of care to the beneficiary.

RECOMMENDATION
Perform a one-time review by class as referenced above on all drug classes.

Pharmacy & Therapeutics (P&T) Committee

P&T committee oversight for clinical appropriateness including practices and policies for formulary management activities, such as prior authorizations, step therapies, quantity limitations, generic substitutions and other drug utilization activities that affect access.

ISSUE 1

Based on the materials submitted for review, decision support documentation for the PEHP P&T committee, was very limited. No P&T minutes were provided from 2010. However, a complete P&T committee agenda packet was made available for review while onsite for the PEHP departmental visit in October that proved existence of such clinical oversight.

IMPACT

Lack of proper documentation gives the impression that appropriate review of the medications is not occurring. This undermines the credibility of the committee, the clinical appropriateness of PEHP and the clinical rules they place on medication use and approval.

RECOMMENDATION

Standardize the medication review process for consistency and auditability purposes. An example of Pharmacy & Therapeutics administration can be found at:

http://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter6.pdf

ISSUE 2

There is nothing indicating that votes are taken on any coverage issues and signature and dating of the minutes.

IMPACT

Again, this undermines the creditability of the committee and PEHP organization; potentially allow for decisions of the committee to be dominated by a few members.

RECOMMENDATION

Re-format P&T minutes to include the information provided above. Samples of P&T Minutes are noted below:

http://www.gatewayhealthplan.com/documents/minutes/PT2009-06_final.pdf

http://www.tricare.mil/pharmacy/pt_cmte/May%202010%20PT%20signed%20minutes%201.pdf

ISSUE 3

According to provided policy, additions and deletions to the PDL can be made by pharmacy at any time and not reviewed by the P&T Committee for 3 months. This is a very unusual set of circumstances and does not represent current clinical oversight standard of practice by P&T committees over health plan drug decision making.

IMPACT

Again this could result in a total loss of control over health plan formulary, with no real oversight in place to require otherwise.

RECOMMENDATION

Define specifications within policy and procedure on Formulary changes and the clinical rules for if and when it is appropriate for a medication to be added without clinical review.

Evidence that clinical decisions by the P&T committee are based on scientific evidence and standards of practice, including peer reviewed medical literature, well-established clinical practice guidelines and pharmacoeconomic studies as well as other accepted sources of appropriate information.

ISSUE

Through review of a complete P&T agenda packet while onsite at PEHP, it was determined that scientific evidence is presented to support decision making; however, no supportive documentation or evidence was available in the committee minutes to determine whether this is the case.

IMPACT

With no documentation to support the decisions of the P&T Committee there is no integrity on the scientific evidence or standards of practice presented and discussed. If appropriate evidence and standards were not used, a result could be sub therapeutic or inappropriate medication therapy for the health plan population.

RECOMMENDATION

Adopt standardized decision making criteria, an example is provided below.

- *Greater efficacy than other options or Effective treatment for unmet need*

- *Safety or side effect advantage over other options*
- *Improved adherence potential*
- *Significant cost advantage over other options*
- *Convenience Simpler dosing, packaging, route of administration*
- *No additional value*
- *No clinical advantage over other options*

Documentation of P&T procedures

ISSUE 1
The information provided on the PEHP P&T structure and procedures are limited.

IMPACT
The result could be inconsistent and inappropriate administration of the P&T Committee, undermining credibility of the committee and its structure. Examples could include: unqualified member representation, inconsistent meeting dates and times, lack of term limits on committee members and nondisclosure of "conflict of interest" by members with outside interests with pharmaceutical manufacturers.

RECOMMENDATION
Adopt P&T oversight document which outlines the following:

- Schedule of meetings
- Committee composition, with credentials of individuals members
- Procedure for approval/acceptance of committee members
- Remuneration for outside P&T committee members
- Conflict of interest statements and continued re-iteration at each meeting
- Signature and date required committee minutes

ISSUE 2
The "Pharmacy and Therapeutics Committee Agreement" is lacking in essentials needed for protections of health plan against outside influence of pharmaceutical manufacturers.

IMPACT
This could result in the inappropriate formulary placement of medications by members with financial interests outside that of the health plan.

RECOMMENDATION
Revise current "Pharmacy and Therapeutics Committee Agreement" to include disclosure provisions on the acceptance of monies by individual members of the committee by pharmaceutical manufacturers.

Also as mentioned above, "Conflict of Interest" statements should be reiterated at each P&T meeting.

Consideration of medication therapeutic advantages in terms of safety and efficacy as they relate to formulary status and tier placement.

ISSUE
There is a lack of clear documentation the P&T Committee has based its decisions in light of this consideration.

IMPACT
1. The creditability of the P&T committee could be questioned.
2. The P&T Committee may not be performing sufficient consideration of medications safety and efficacy in its decision making process resulting in a potential safety issue for members.

RECOMMENDATION
P&T committee adopt standardization in decision making criteria. Again to reiterate, an example of such standardized criteria is provided below. The P&T committee should then specifically document the committee's consideration of each medication reviewed based on these criteria.

- *Greater efficacy than other options or Effective treatment for unmet need*
- *Safety or side effect advantage over other options*
- *Improved adherence potential*
- *Significant cost advantage over other options*
- *Convenience Simpler dosing, packaging, route of administration*
- *No additional value*
- *No clinical advantage over other options*

Issues of Control

PEHP

As with any small health plan, PEHP has a limited number of personnel overseeing the benefit provision of its membership. However, with that also come the issues of lack of oversight and too much control going to a limited number of personnel making key decisions.

This is illustrated in the pharmacy department. Key decisions are made by the Director of Pharmacy alone, with minimal input from the small departmental staff and without oversight or input from the broader PEHP organization.

Director of Pharmacy

The Director of Pharmacy for PEHP, Robert Jaramillo has done an outstanding job during his 2 years of employment at PEHP. He has numerous accomplishments in the management and administration of the pharmacy benefit for the health plan and an excellent record of cost containment in formulary product selection.

In addition, he has monitored and tracked disparities within the health plan Pharmacy Benefit Manager (PBM) contract, recovering approximately $2 million in inappropriate billings.

Your excellent drug costs are a result of good departmental management, specifically with tight control over the medication formulary.

Lastly, he has built and has continually improved the overall Pharmacy department's operations.

ISSUE

There is a concentration of power in the position of the Pharmacy Director resulting in unilateral decision making. Very little outside influence of decision making is seen. It is important that there is a balance specific to the Director's decision making and that controls are put into place that oversee and that create a framework for unbiased, cooperative decision making.

IMPACT

Without appropriate oversight of decision making, results can be limited to the purview of the isolated, identified individual. This creates potential for poor decisions, conflict of interest issues or even out-right fraud. While this may not be a current problem, it could become one in the future.

Secondly, decisions could be made by the Pharmacy department impacting other departments of the organization without their input.

Lastly, in the event the Director left PEHP there would be a huge lack of understanding regarding the role and responsibilities of the Director of Pharmacy versus the roles and responsibilities of the rest of the organization**.**

RECOMMENDATIONS

Place limits on the control/power Director of Pharmacy has within organization.

1. The roles and responsibilities of the Director of Pharmacy versus the roles and responsibilities of the rest of the organization need to be evaluated, developed and better defined.

2. Work to include as oversight, other departments and their representatives within PEHP. Examples could include:

- Limiting functions surrounding rebates and rebate process (as outlined in "Rebates" section of this document).
- Limit functions surrounding any/all pharmacy related executive reporting (for example, all pharmacy data reporting should be a function or have oversight by the information management department of the organization and not that of the pharmacy department).
- Fraud, Waste & Abuse (FWA) – The FWA functions needs to be controlled and performed by the FWA department. Pharmacy should be limited to only providing utilization reports and fielding questions of the FWA department. This is outlined in "Fraud, Waste and Abuse" section of this document.

Pharmacy Appeals Audit

The appeals process is one that transcends across several departments depending upon the level of review the medication request is undergoing.

PROCESS REVIEW

The Pharmacy department has a high number of appeals, averaging 129 per month based on the limited amount of customer service statistics provided for review. With approximately 600-700 prior authorizations requested per month, this calculates to an appeals rate of approximately 18-22% of all prior authorization requests.

After a small review, the majority of the reviewed appeals were denied based on PEHP's strict drug use criteria.

***ISSUE 1* - 1st Level Pharmacy Appeal process**

- No timeline of review is described for a medication needed on an emergency basis, rather a "will meet when able to schedule time" is noted.

IMPACT

The impact is a member safety issue with the potential result being that a seriously ill member will not be able to obtain a needed medication within a reasonable timeframe. This could result in serious harm to the member and/or increased cost liability to the health plan for additional care to the member.

RECOMMENDATION

Create timeline for review of 1st Level appeals. Suggested timeline is:

- 72 hours for urgent or expedited appeals
- 7 days for non-urgent appeals

***ISSUE 2* - 1st Level Pharmacy Appeal process**

- There is no mention in the Pharmacy Department Appeals process of the members/physicians appeal rights being communicated to the member in the 1st Level Pharmacy Appeal denial letter.

IMPACT

A member may not be aware of the potential for further appeal beyond the 1st level.

RECOMMENDATION

Policies and procedures should properly reflect the operations of the health plan. Update all policies and procedures, at least annually within the department.

ISSUE 3 - 1st Level Pharmacy Appeal process

- Prior authorization (PA) criteria very complicated and onerous. While difficult to obtain a prior authorization, it makes it especially difficult to gain approval for a pharmacy appeal. The overall impression is that someone would just give up before jumping through all the criteria hoops. The author has serious concerns that a member requiring treatment would not have proper access to medical or pharmacy approvals.

IMPACT

The result could be:

- Increased financial liability to the plan for the additional care a member would require as a result of; lack of or delayed medical or pharmacy treatment.
- Increased financial liability to the member for paying out of pocket for a treatment not approved by the health plan.
- Patient Safety issues.

RECOMMENDATION

Revise appeal process and outline within new process exceptions that would override written criteria.

ISSUE 4 - 1st Level Pharmacy Appeal process

- Pharmacy's appeal is labeled as a Process, not a Policy and Procedure. This would be appropriate if referenced as part of the overall health plan appeals policy and procedure, but it is not.

IMPACT

Without proper policies and procedures and clear and concise due process members and providers can find the process confusing and overly burdensome. This potentially can result in lack of follow through and missed pharmacy and medical treatment.

RECOMMENDATION

Revise Pharmacy Appeals Policy and Procedure.

ISSUE 5 - 1st Level Pharmacy Appeal process

- Same viewpoint is carried through the Pharmacy appeals process – that of the Pharmacy Director. Very little discussion and/or research appears to be conducted on Level 1 Pharmacy Appeals.

IMPACT

Members' may not have access to needed medications.

RECOMMENDATION
Due to size of plan and limited pharmacy personnel, consider use of outside review for appeals.

ISSUE 6 - 1st Level Pharmacy Appeal process
There is no tracking and trending of Pharmacy Appeals

IMPACT
The lack of ongoing data analysis of pharmacy appeals process gives an illusion of little to no problems associated with the current process. There exists the potential for needed revisions of outdated clinically considerations that are not occurring.

RECOMMENDATION
Develop process for tracking and trending of Pharmacy Appeals.

ISSUES - Overall Appeals Process for PEHP is as follows:

- Level 1 Pharmacy Appeal; coordinated and handled within pharmacy however there is no mention of a Level 1 appeal or a Pharmacy appeal within Medical Master Policy.
- The nomenclature used within policies and procedures for appeals are not congruent between the pharmacy and medical sides of the appeals.
- There is no, one policy and procedure where all of the levels of appeals are presented.
- Administrative Claims Review Committee – Membership is skewed; with the committee being comprised of primarily administrative personnel with little to no clinical representation. In addition, the Administrative Claims Review Committee Policy states that the Medical Director cannot vote on an appeal if the voting member directly manages the personnel responsible for the original denial. In this example the Medical Director cannot vote on any appeal generated through the pharmacy department. This is particularly concerning when the Medical Director is one of a small number of people in the plan with clinical expertise.
- There is no member advocate on above committee or anywhere within the appeals process.
- Same viewpoint is carried through the entire appeal process – that of the Pharmacy Director and Medical Director. Very little discussion on each appeal is made.
- In review of appeals, not all appeal requests were from physicians some were from the members. Greater detail should be referenced within the policy and procedure on the appropriate authoring of such appeals.

- There is no “Keeper” of all the appeals that enter the plan. There is a coordinator that attempts to keep appeals once they are at a Level 2.
- There is no tracking and analysis of the appeals that are sent to the plan for appeal consideration.
- There is no timeframe documented within the P&P on appeals stipulating the turnaround time on an appeal request.
- Communication detail on the appeal to the member is very limited.
- The policy and procedure reviewed for the Administrative Claims Review Committee was not signed or contained a date of annual review.

IMPACT

The impact is that you could have a dysfunctional appeals process that truly does not best serve any benefit for the members.

RECOMMENDATIONS

1. While, somewhat outside the scope of this Pharmacy Audit; CAZMA suggests a total and complete overhaul of the Appeals process for PEHP is needed. Included in this would be the Pharmacy Appeals process also.
2. The following offers insight into the process for a state based employer plan and its website communication to members on its appeals process.

   http://statehealthplan.state.nc.us/appeal-decision.html

   http://admin.state.nh.us/hr/documents/anthemleveloneappeal.pdf

3. Examples of appeals processes with levels of appeal rights is as follows:

   http://humanresources.vermont.gov/sites/dhr/files/pdf/benefits_compensation/DHR-Pharmacy_Clinical_Appeals_Process.pdf

   http://www.aetna.com/healthcare-professionals/policies-guidelines/dispute_process_qrg.html

4. If health plan medical personnel are not able to vote as part of the committee then more clinical expertise should be sought out for appeal reviews.
5. Consider use of “outside” Medical Director for Level 3 Appeals.
6. Consider defining within the Appeals P&P, the type of appeal and who is appropriate to author the appeal request. In example, a clinical appeal should be authored by the physician and an administrative appeal can be authored by the PEHP member.

Documentation Review

Prior Authorizations & Benefit Rules

The plan has a robust list of medications on Prior Authorizations. Per review of the area, the pharmacy helpdesk receives approximately 600-700 requests monthly.

PROCESS REVIEW: Prior Authorizations
The process for handling prior authorization requests is tightly controlled by the pharmacy department, specifically the Prior Authorization Technicians.

- PA forms can be downloaded from the PEHP website or faxed to the physician from the Customer Service Pharmacy Technicians.
- All medication requests (approvals and denials) are handled by the Pharmacy Technicians based on PA Criteria approved by the P&T Committee for the medication. No reviews are forwarded to a Pharmacist for a more clinical review.
- Notification letters are sent to the prescribing physician in the case of approved requests for medications and a letter is sent to the physician with a copy to the member with medication requests that are denied.
- All requests, letters and corresponding documentation are tracked and stored within the PEHP computer system.
- The vast majority of requests are handled within a 24-hour timeframe. However, no departmental policy exist citing specifications on turn-around timeframes.
- Monthly internal departmental audits are performed by the Manager, Pharmacy Technicians; audit scores range from 97-100% accuracy for review and handling of medication requests.
- Medical/Pharmacy Drugs: Currently, PEHP is working on defining the various channels of drugs that overlap the medical and pharmacy departments of the plan and how to operationalize requests and authorizations for such: The channels of distributions of such drugs are as follows:
    - Mono Channel: Self- Administered
    - Dual Channels – Oncologists
    - Medical Only

ISSUE 1
While there is great management of drug costs within PEHP, it must be noted that there is a fine line between cost containment and drug appropriateness. The PEHP medication criteria are overly rigid. The prior authorization criteria are very cumbersome with generally 18-24 criteria per drug being required before approval of a medication is obtained.

Another example of the tight PEHP formulary management, which is a copayment issue exists with narrow therapeutically indexed medications. A drug is commonly referred to

as having a narrow therapeutic index when small variances in blood levels cause changes in the effectiveness or toxicity of that drug; examples include Coumadin® and Synthroid ®. Generally, it is seen with other health plans that the brand name medication will be dispensed at a generic copay after medical necessity is verified with the physician that the member cannot take, or has tried and failed (with adverse effect) the generic formulation. This is not the case with PEHP, where the member must pay the Tier 3 – non-preferred copayment for the clinically required medication. This is something that is typically addressed and stated within the Master Policies of the health plan.

IMPACT

Both situations described above can lead to the following impacts:

Members will forego gaining approval for needed medications that will in-turn result in greater financial impact to PEHP through costly hospitalizations or more intense, involved care for the member.

Members will pay more for brand medications that are medically necessary when they cannot take the generic equivalent.

RECOMMENDATION

1. Evaluate all prior authorization criteria for appropriateness. The following are examples of prior authorization criteria for medications that seem reasonable in terms of criteria for approval of the medication.

   http://statehealthplan.state.nc.us/pdf/Provigil.pdf

   http://statehealthplan.state.nc.us/pdf/cns-stimulants.pdf

2. Part of the thought process behind why the criterion is so strict is so that a Pharmacy Technician would be able to handle the request simply based on the answers to the criteria questions. This would allow for a procedure to be followed with no real clinical insight into the appropriateness of the medications in the treatment of the specific patient. For this reason, consider transitioning all pharmacy technician denied requests to a clinical pharmacist for review. This would provide greater clinical oversight of PEHP medication requests and would strengthen the clinical creditability of the department.

3. Approval and denial letters are signed by the “PEHP Clinical Department”. Consider changing letter signature to “PEHP Pharmacy Department” or a signature line from the Director of Pharmacy.

ISSUE 2
There is no noted policy and procedure on turn-around time for medication requests – prior authorizations.

IMPACT
The impact could be a safety issue to the member due to delayed care.
RECOMMENDATION
Revise Pharmacy policy and procedure on the handling of Prior Authorizations to include the following:

Turn-around timeframe for all medication requests

- Suggested timeframe for non-urgent requests; 72 hours
- Suggested timeframe for all urgent, expedited requests; 24 hours

ISSUE 3
There is a high degree of medication cost savings if a pharmacy managed program on Medical/Pharmacy medications is developed within the organization. However, a strong clinical review component will need to be developed for these types of medication requests. This is due the serious disease states and complicated medical histories of the patients involved.

Again, care and consideration should be used in the development of these criteria, with it not being too overly rigid and allowing appropriate use when needed.

IMPACT
Oversight of this type of program will require reviews to be conducted by a pharmacist and not that of a pharmacy technician. This is due to the detailed clinical review each request will require.

With regard to medical/pharmacy claims, this author's experience with other plans audits has shown a high degree of "off-label" use. This can result in high cost drug expenditures for these medications due to inappropriate "off-label" drug use.

RECOMMENDATION

Develop a pharmacist based strong clinical review program for medical/pharmacy claims.

Consider the appropriateness of off-label use of medical/pharmacy medications.

Drug Formulary

PEHP has a comprehensive, robust drug formulary for use by its membership.

The PEHP formulary is aggressively managed by the following underlying principles and set-up in its operations:

Prior Authorizations
The PEHP formulary contains approximately 75 retail medications and 200 specialty medications that require a specific set of criteria to be met before authorization for the drug will be granted. The use of prior authorizations can promote both safety to the member and a cost savings to the health plan.

Quantity Limits
Limits on drug quantity sets a limit based on either a defined days' supply or a maximum number of repeated courses of a medication. Amounts or prescription fills over the set quantity limits requires prior authorization. Again, this promotes safe and effective use of medication therapy.

Administrative Management
Administratively, the formulary is managed using the following procedures.

PROCESS REVIEW: *Drug Formulary*

- Weekly Formulary Management
    - Weekly drug additions are handled by the Pharmacy department.
        - Weekly listing provided by PEHP PBM, based on changes made by First Data Bank.
        - Listing is reviewed for appropriateness; with simple package size, or product line extensions being approved for change.
        - More, extensive changes to the formulary of either 1). Will result in a large cost impact to the plan or 2). A "negative" change, meaning will be removed from the formulary with impact to the membership is forwarded to the next P&T Committee meeting for review.
        - Add/change forms are then completed and submitted to PEHP PBM by the plan for formulary file processing.

- P&T Committee

- A quarterly-meeting, comprised of “provider volunteers”, as well as the PEHP Pharmacy Director, Clinical Pharmacist, Clinical Account Manager from PBM and PEHP Medical Director.
- All negative changes are administered bi-annually, to cut down on member satisfaction and mailing costs associated with notification.

- Mini P&T Committee Meetings
  - Weekly meeting held to handle issues that arise between P&T meetings.
  - Includes: Medical Director, Nurse Practitioner, Clinical Pharmacist and Pharmacy Director.
  - Again, limited dissention between individuals.

ISSUES

As previously stated, there is no policy and procedure on the structure, components, expertise level, voting rights, etc. associated with the administration of the P&T Committee.

In review of the minutes, there seems to be little dissension amongst the committee members (P&T and mini P&T committees), with most decisions being “unanimous”.

The departmental policy addresses the addition/deletion of a drug from the PEHP PDL but does not address those not on the PDL. Nor does it address any standards for inclusion or exclusion of a medication onto the PEHP formulary, as previously cited.

IMPACT

The impact of the noted issues is that you can get a formulary that is not in the best interest of the beneficiary. Simply, the member cannot obtain the right drug at the right time.

RECOMMENDATIONS

1. Authoring of a P&T oversight document which includes the following:
   a. Schedule of meetings
   b. Composition of committee
      i. Rotating membership, with term limits – in example - expiring every 2 years.
      ii. Expertise and credentials
   c. Procedure for approval of committee members
   d. Remuneration
      i. Conflict of interest statements (which should be re-iterated at each meeting).
   e. Reference to Employee Code of Conduct and Business Ethics.
2. Seek new P&T Committee membership through the following:
   a. Physician Provider Network (PEHP Account Representatives, Newsletter articles)

b. Local, Regional, State Universities
c. Local branches of healthcare organizations (American Health Association, Allergy & Asthma Foundation, etc.).

3. Discontinue Mini P&T Meetings
    a. Create standardization of process to handle issues that arise in between P&T Committee meetings.
4. Develop policy and procedure on the handling of medications removed from the market by the Federal Drug Administration (FDA).

Rebates

PROCESS REVIEW: *Rebates*

- PEHP receives 100% of all rebates received by their PBM.
- There is no dollar amount guarantee on rebates since the formulary is managed and maintained by PEHP. Therefore, it is difficult to estimate an appropriate amount of rebate dollars the plan should expect to receive based on their formulary.
- The PEHP contract states that they can carve out select rebate agreements, as long as PEHP's PBM does not have a current rebate agreement in place with the drug manufacturer. Therefore, PEHP currently has Wyeth and Pfizer as carved-out rebates.
- Drug utilization data is compiled by the Pharmacy department and per specifications of the carve-out agreements are sent to the respective company for rebate payment.
- Currently, rebates once received are placed in with the employee reserve risk pools and are not returned to each group.
- PEHP Pharmacy is currently attempting to gain cost and procedure control of Specialty Rebates but with current employee share it is difficult considering copay structure of the medications – Tier 2: 20% copay with $150 max and Tier 3: 30% copay with $275 max.

ISSUES

- Rebate terms are not explicitly defined in the PBM contract. It is not defined if the plan portion is 100% of net or gross rebates.

- Lack of proper oversight issues could arise if the entire rebate process remains within the pharmacy department for handling and processing.

IMPACT

1. Considering the large amounts of money surrounding rebates, the impact of limited checks and balances within the rebate area is the possible diversion of funds.

2. Setting control mechanisms within the rebate area will minimize the ability to pedal influence with pharmaceutical manufacturers and medication placement on the PEHP formulary.
3. There is potential for manufacturing influence on medication placement on the PEHP formulary.
4. Potential for conflict of interest on the part of PEHP personnel.

RECOMMENDATIONS

1. For the rebate process, develop an auditing mechanism and robust policy and procedures. This would allow for the creation of multiple checks and balances within the process and handling of rebates.
2. Remove certain portions of the rebate process from the pharmacy department, specifically auditing, accounting and processing of rebates.

3. Consider, requesting as part of any carve-out rebate contract agreement a reportable by the drug manufacturer any monies paid to any PEHP employees during the contract timeframe. This would alleviate any possible conflict of interest occurring between a PEHP employees and contracted drug manufacturers.

Fraud, Waste & Abuse (FWA)

PROCESS REVIEW: *Fraud, Waste & Abuse (FWA)*

- Currently, all FWA activities involve anonymous reports coming into the FWA tip-line and then being investigated
- There is current discussion to have the pharmacy department generate screening reports from the PBM data and distribute to FWA Investigator.
- High abuse medications such as combination narcotic agents, containing acetaminophen, have had maximum quantity limits set per day on acetaminophen quantities.

ISSUES

Very limited FWA activities surrounding pharmacy is performed at the plan.

No P&P on pharmacy departments' role and responsibility in detecting FWA.

IMPACT

PEHP lacks the ability to develop a comprehensive plan to detect and prevent healthcare fraud, without the pharmacy departments' involvement in FWA.

RECOMMENDATIONS

1. Develop a comprehensive Pharmacy FWA program that focuses on the detection of all aspects of fraud including review of the following:
    a. Member
    b. Physician Provider
    c. Pharmacy Provider
2. Pharmacy should be instrumental in the development of these reports with direct delivery to the FWA area for investigation.
3. A good source of information related to the development of such a program is found under Chapter 9 of the CMS Medicare guidelines. This document can be found at:

    http://www.umdoctors.com/documents/FWA%20Medicare%20Manual_Chapter9.pdf

Maximum Allowable Cost (MAC) List

Due to sensitivity of proprietary information, the Medco MAC list used by PEHP was not provided for review.

Group Set-Up Conditions & Mail Service Program

Conditions reviewed all seemed appropriate as described through the Master Medical Policy. The days' supply allowed per fill, refill percent rate, pharmacy coverage rules, etc. are consistent with the marketplace.

PBM Contract Review

The current contract held between PEHP and their PBM vendor is considered a traditional PBM contract agreement. A traditional PBM contract provides the PBM with revenue sources in addition to administrative fees. Sources of revenue for a PBM can include; spread pricing (the difference between what the PBM bills the client and what the PBM pays the pharmacy), and retaining a portion of the manufacturer rebates generated from the health plan's drug utilization.

Over the course of the last several years, there has been more emphasis and calling for transparent and/or pass-through rate pricing on PBM contracts. A PBM contract is considered transparent if the PBM is willing to disclose all revenue streams (e.g., network spread pricing, rebates, formulary management fees, data sales, etc.). A pass-through contract rate defines one source of revenue by the PBM, usually that of a flat, fixed administrative fee, paid either per member, per month (PMPM), or per claim to the

PBM. There are advantages and disadvantages to each PBM contract type, all of which must be reviewed in detail and considered in comparison to the health plan specifics in order to find the appropriate contract type for the plan.

Generally, pass-through PBM agreements work best for plans or employer groups with leadership that understands the PBM industry and has the staff for proper oversight of the PBM.

ISSUE
Transparent versus Traditional PBM Contract

IMPACT of a Traditional Agreement
Advantages: Low administrative fees
Consistent discount levels

Disadvantages: Non-disclosed revenue streams

The impact of a Traditional PBM agreement is that the plan could realize potentially, higher non-fixed costs to the health plan. Results could be higher drug costs, due to the pricing spread mentioned above between the network pharmacies and the PBM and/or an undisclosed retention of the rebates by the PBM on the clients' drug utilization.

An example of such non-disclosure for PEHP as described above under the "Rebates" section of this report is that the rebate terms are not explicitly defined in the PBM contract. Specifically, there is no distinction of the plan portion of rebates and if it is 100% of the net or gross rebate total.

IMPACT of a Transparent Agreement
Advantages: Medium to moderate administrative fees
Consistent discount levels

Disadvantages: No power over or access to arrangements PBM has with subcontractors (pharmacies).

IMPACT of a Pass-Through Agreement
Advantages: Access to all PBM contracts (both in contract terms and physical review/auditing rights)
Pass-through of all pricing terms

Disadvantages: Higher administrative fees

The results of PEHP having a transparent agreement with your PBM would be higher fixed costs by way of higher administrative fees. This could potentially have large cash flow impact to PEHP both in its initial set-up within the plan and subsequently if the plan were to have a large influx of membership.

Executive Report

The PEHP Executive Report features drug cost statistics and comparisons on drug utilization on a detailed level for:

- Pharmacy Retail
- Pharmacy Mail-Order
- Specialty Pharmacy
- Therapeutic Drug Category

PROCESS REVIEW: *Executive Report*

This report and the cost detail associated are standard for the industry.

As reported in the 2009-10 Novartis Facts and Figures, Pharmacy Benefit Report; the national average for prescription utilization is 12.7 scripts per member, per year (PMPY), the State of Utah is one of the lowest in drug utilization at 10.6 PMPY, and PEHP prescription utilization is 11.29 PMPY.

The average cost for a PEHP prescription as noted in the Executive report, is $62.98. The national average for a prescription per the report notes a cost of $108.12 for a Commercial group. This illustrates effective cost management within the PEHP Pharmacy Program.

Conclusion

The PEHP Pharmacy program is a well-run, aggressively managed pharmacy benefit. This is extremely important, considering the ever present rise of prescription drug costs, the vastly widening selection of expensive Specialty pharmaceuticals and the inappropriate and off-label use of medications that is commonplace within the medical community.

Organizational Structure

In health plans of any size, issues concerning process, workflow and appropriate oversight require organizational development and planning. It is imperative that the proper checks and balances are placed procedurally that protect not only the organization but also the employee against potential for inappropriate activities.

PEHP with its limited number of personnel is seen as a plan with “growing pains” concerning staffing and organizational structure. Each new key staff member brings new ideas and decision making for the organization, it is important that there be a continued review of the roles and responsibilities.

Benefit Structure

There exists a fine line between cost containment, effective drug utilization and proper drug mix. While, it is difficult to maintain such tight formulary management, it is not impossible. To maintain a clinically effective program, the program should allow for proper drug utilization and inhibit inappropriate drug use.

One key factor instrumental in maintaining the balance is a clinically strong P&T Committee. Committee members should have the appropriate expertise and be clinically engaged in the decisions made by the committee for the health plan.

Secondly, prior authorization and appeal requests should have clear and consistent, appropriate criteria, guidelines and processes for the handling of such requests. Likewise, guidelines for use should be fair balanced and allow for those individuals requiring the medication to obtain the medication.

Lastly, communication to the member, physician and pharmacy providers should be strong and most up to date. Ease of readability should be paramount when deciding format.

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Appendix E

PEHP
Prior Authorization Criteria

Authorized by: __Cynthia Jones, MD_____ Initial Approval Date: __April 25, 2008_____
Revision No: _____ Revision Date: _____ Pages: 2

Opana® ER *(oxymorphone)*

How supplied: 5 mg Tablet. 7.5 mg Tablet. 10 mg Tablet.
15 mg Tablet. 20 mg Tablet. 40 mg Tablet.

FDA-APPROVED INDICATIONS

Opana® ER is indicated:

A. For the relief of moderate to severe pain in patients requiring continuous, around-the-clock opiod treatment for an extended period of time. Opana ER is not intended for use as an as needed analgesic. Opana ER is not indicated for pain in the immediate post-operative period (12-24 hours following surgery) for patients not previously taking opiods because of the risk of over sedation and respiratory depression requiring reversal with opiod antagonists. Opana ER is not indicated for pain in the post-operative period if the pain is mild or not expected to persist for an extended period of time.

DOSE

The recommended dose of Opana® ER is:

A. It is suggested that patients who are not opiod-experienced being initiated on chronic around-the-clock opiod therapy be started with Opana ER 5 mg every 12 hours. Thereafter, it is recommended that the dose be individually titrated, preferably at increments of 5-10mg every 12 hours every 3-7 days, to a level that provides adequate analgesia and minimizes side effects under the close supervision of the prescribing physician. Patients receiving Opana may be converted to Opana ER by administering half the patient's total daily oral Opana dose as Opana ER, every 12 hours. For conversion from other opiods to Opana ER, physicians and other healthcare professionals are advised to refer to published relative potency information. In general, it is safest to start the Opana ER therapy by administering half of the calculated total daily dose of Opana ER in 2 divided doses, every 12 hours.

COVERAGE POLICY

Opana® ER is covered for members who meet the following criteria:

A. Patient has no history of substance abuse.
B. **AND** patient must sign an opiate agreement with PEHP that states that the patient will take the medication according to the provider's recommendations, he/she will not request any early refills due to lost or stolen medications or use of their medication inappropriately, he/she will agree that all pain management will be done solely by the prescribing physician that has been trained as a pain specialist and any attempt to get medication from another provider (clinic) will cease the pre-authorization granted by PEHP, and any illegal activity will cause the pre-authorization to become null and void, the patient will receive their medication from only one pharmacy and if he/she seeks pain management from any emergent or urgent source the pre-authorization will also cease.
C. **AND** diagnosis is documented as chronic severe pain.
D. **AND** the prescribing physician has been trained as a pain specialist or has obtained a consult.
E. **AND** the prescribing physician will use Opana ER according to the manufacturer's guidelines and will not recommend dosage greater than twice a day and treat breakthrough pain with immediate release pain medications.
F. **AND** the patient's pain management is being administered solely by the requesting provider's office. *(The patient's prior authorization will be locked into only one physician).* .
G. **AND** the patient has had an adequate trial and failure with at least two of the following immediate release medications: codeine, hydromorphone, meperidine, methadone, morphine, oxycodone, and/or hydrocodone and the patient's pain is still unmanageable.
H. **AND** the patient has had an adequate trial and failure with maximum tolerated doses of a morphine controlled release medication MS Contin® or morphine SR in combination with an immediate release opiod therapy (e.g., oxycodone, codeine, hydrocodone, methadone, morphine, hydromorphone or meperidine) and pain is still unmanageable.
I. **AND** the patient has had an adequate trial with maximum tolerated doses of Oxycontin in combination with immediate release opiod therapy (e.g., oxycodone, codeine, hydrocodone, methadone, morphine,

hydromorphone or meperidine) and pain is still unmanageable.

J. **AND** the patient has had an adequate trial and failure with maximum tolerated doses of generic fentanyl transdermal patch with immediate release opiod therapy (e.g., oxycodone, codeine, hydrocodone, methadone, morphine, hydromorphone or meperidine) and pain is still unmanageable.
K. **AND** the patient will receive Opana ER therapy in combination with immediate release opiod therapy for breakthrough pain.
L. **AND** if the patient has had previous therapy with Opana ER, the patient must have not violated PEHP's pain contract.

AUTHORIZATION PERIOD
Initial authorization: 1 year. 2 tablets per day.
Extended authorization: 1 year. 2 tablets per day.

These authorizations should be entered as Card/Direct Only in Medco CWS.

PROCUREMENT
Retain Pharmacy: (PBM)

NON COVERAGE
Opana® ER is NOT covered for members who meet the following criteria:

A Patient has a history of substance abuse.
B. Patient will not sign an opiate agreement with PEHP.
C. The diagnosis is NOT documented as chronic severe pain.
D. The prescribing physician has NOT been trained as a pain specialist or received a consult.
E. The patient's pain management is NOT being administered solely by the requesting provider's office.
F. The patient has NOT had an adequate with at least two of the following immediate release medications: codeine, hydromorphone, meperidine, methadone, morphine, oxycodone, and/or hydrocodone.
G. The patient has NOT had an adequate trial and failure with maximum tolerated doses of a morphine controlled release medication MS Contin® or morphine SR in combination with an with immediate release opiod therapy (e.g., oxycodone, codeine, hydrocodone, methadone, morphine, hydromorphone or meperidine) and pain is still unmanageable.
H. The prescribing physician has prescribed Opana ER in a dosage regimen that requires the drug to be dosed greater than twice a day.
I. The patient has NOT had an adequate trial with maximum tolerated doses of Oxycontin in combination with immediate release opiod therapy (e.g., oxycodone, codeine, hydrocodone, methadone, morphine, hydromorphone or meperidine) and pain is still unmanageable.
J. The patient has NOT had an adequate trial and failure with maximum tolerated doses of generic fentanyl transdermal patch with immediate release opiod therapy (e.g., oxycodone, codeine, hydrocodone, methadone, morphine, hydromorphone or meperidine) and pain is still unmanageable.
K. If the patient has had previous therapy with Opana ER and the patient has violated PEHP's pain contract.
L. The patient is NOT receiving immediate release opiod therapy in combination with Opana ER for breakthrough pain.

REFERENCES:

1. Opana ER. Package Insert. Endo Pharmaceuticals Inc. Chadds Ford, PA 2007. http://www.endo.com/PDF/OPANA_ER_PI.pdf (April 22, 2008).
2. Opana ER. Clinical Pharmacology. Gold Standard Inc. 2008. http://classic.clinicalpharmacology-ip.com/. (January 30, 2008).
3.

Prepared by: rj (April 22, 2008)

Appendix F

WOLCOTT & ASSOCIATES, INC.

November 16, 2010

Mr. John Schaff
Auditor General
Office of the Legislative Auditor General
State of Utah

Dear Mr. Schaff:

The purpose of this letter is to present our findings regarding the performance of an audit of healthcare claims adjudicated through the appeal process for the Office of the Legislative Auditor General of the State of Utah. In addition, our findings regarding the evaluation of the appeal process are included in this report.

SCOPE OF SERVICES

We reviewed the appeal policies and procedures documentation. In addition, we conducted interviews, during a site visit to PEHP, with the personnel responsible for management of the appeal process.

Based on our review, this report has been provided to the Office of the Legislative Auditor General regarding our analysis of the process and recommendations we believe would improve the appeals process at PEHP. This has been based on the "best practices" as determined through our many reviews of appeals processes at major insurance companies and TPAs.

Our services also included a statistically valid random audit of claims that had been adjudicated through the appeals process at PEHP.

The sample was selected so as to permit us to express, with 95% confidence, the frequency of error/discrepancy in the population with a precision of + or - 3%. Our sample size was141 appeals. The selection was made to include appeals adjudicated through each level of the appeal process (90 in level 1, 29 in level 2, 18 in level 3 and 4 in level 4 and 0 in level 5, as there were no appeals in level 5). Due to the fact that level 4 appeals (14 for 2009) are handled by a hearing officer, which is independent of PEHP and the State of Utah, the records were not easily obtainable.

APPEAL PROCESS

Prior to our review of claims, we reviewed the appeal policies and procedures manual. In addition, we conducted interviews with the personnel responsible for management of the appeal process.

Levels of Appeals

PEHP has established five levels of appeals for members to request review of claim payments. Our interviews consisted with personnel involved at levels 1 through 3.

The five levels are briefly described below.

- **Benefit Specialists Review** - The Benefit Specialists will review each claim that is presented for an appeal. The master policy is reviewed for qualification of benefits. If a clinical review is required, assistance is requested from the medical director and/or pharmacist at PEHP.

- **Administrative Review** - A seven member committee reviews all 2nd level appeals on a weekly basis. The seven members consist of PEHP management, including the medical director. However, if the medical director has reviewed the case prior and upheld the denial, they cannot vote, but can discuss at the committee meeting.

- **URS Executive Director Review** - The appeals are reviewed by the Director of URS and a decision is rendered. The Director may consult PEHP management for information regarding the appeal. This may include medical director, pharmacy director, etc.

- **Hearing Officer Review** - The member may request a hearing officer to review the appeal. The hearing officer is retained by URS in accordance with administrative hearing rules. Legal counsel represents PEHP and the member has a right to legal representation. Once a decision is rendered by the hearing officer, it is presented to the Utah Retirement Board for approval or denial.

- **Court of Appeals** - The Board decision may be appealed to the Utah Court of Appeals.

Recommendations

Based on our review, including interviews conducted with personnel in levels 1 through 3, and experience with other insurance companies/TPA appeal procedures, we recommend the following for enhancing the appeals process at PEHP.

- There is no established turnaround time guidelines for processing appeals and rendering the decision.

  We recommend, based on industry standards, that an acknowledgment letter be sent to the member within 5-7 calendar days of receipt of the complaint. Furthermore, we recommend, based on industry standards, that the decision to uphold denial or reverse original decision be completed within 30 calendar days, of receipt of the denial, with a letter sent to the member regarding the decision within 5 calendar days. These turnaround time guidelines should be established for level 1 through level 3 appeals.

- We noted that there is no audit function for the first-level of appeals.

  We recommend that an established audit function be developed based on a percentage of benefit specialist reviews performed on a daily or weekly basis. We believe this audit function would be beneficial for training purposes for claim examiners. This could reduce the number of appeals that are submitted to PEHP for reconsideration.

- Currently, there is no member advocate at any level during the appeals process.

  Based on industry standard, we recommend that a member advocate have a voting position on the administrative review committee (level 2). Typically, the member advocate is a retiree of a plan that is administered by PEHP. It would be beneficial if the advocate has a background in healthcare and/or human resources.

- The pharmacy director does not maintain a voting position on the administrative review committee. However, the director is consulted during the review process, but is not present, for discussion, during the administrative review committee meetings.
  Based on industry standard, we recommend that the pharmacy director have a position on the administrative review committee. For those situations where the pharmacy director has had direct involvement, they may recuse themselves and the medical director could be the substitute voting member of the committee. Furthermore, for those situations where the medical director has had direct involvement, the pharmacy director could be the substitute voting member of the committee.

- Currently, the third-level of the appeals process, the review consists only of the Executive Director of URS. The Director can request information from the medical director of PEHP, in order to assist in the review. In most cases the medical director has provided a memo regarding the basis of the 2nd level decision. This process presents a potential lack of independence between the 2nd and 3rd level of appeals. It should be noted that all the 3rd level appeals reviewed upheld the decision at the 2nd appeal level.

We recommend that the third-level of appeals consist of an independent review organization (IRO), which should consist of at least one specialist in the field for which the services are being appealed (i.e. oncology, orthopaedics, endocrinology, etc.). The results of this review should be presented to the Executive Director for final decision regarding the appeal.

Furthermore, the results of the IRO review process should be utilized by PEHP for future changes to medical policies and procedure, which could further reduce the number of appeals.

In addition, the changes to the third-level appeal process would assist PEHP/URS to be within established guidelines under Healthcare Reform, which requires an IRO review during the appeal process.

APPEAL AUDIT

Our services included a statistically valid random audit of claims that have been adjudicated through the appeals process at PEHP.

The sample was selected so as to permit us to express, with 95% confidence, the frequency of error/discrepancy in the population with a precision of + or - 3%. Our sample size was141 appeals. The selection was made to include appeals adjudicated through each level of the appeal process (90 in level 1, 29 in level 2, 18 in level 3 and 4 in level 4 and 0 in level 5, as there were no appeals in level 5). Due to the fact that level 4 appeals (14 for 2009) are handled by a hearing officer, which is independent of PEHP and the State of Utah, the records were not easily obtainable.

The work plan included: (1) a thorough review of the appeal process policies and procedures at each level and (2) test work conducted on a sample of previously processed claims to (i) determine the extent of compliance with established policies and procedures and (ii) identify errors in claim payments under the plan. Each phase of our work plan is described below.

Valid Claims

We reviewed all documentation regarding the appeal and verified that the appropriate processes were applied during the appeal process.

Test Work

Electronic copies were provided for each selected appeal. Each appeal documentation was compared to the policies outlined in PEHP's appeal process manual. Steps in the test work process include:

- **Nature of Appeal** - Appeal documents were reviewed to determine the nature of the appeal and its validity.

- **Appeal Process** - Each claim and its appeal was reviewed and evaluated on the compliance to the appeal process at each level, if applicable. We reviewed each appeal and evaluated the review level (management, medical professionals, etc.) as outlined in the appeal process manual.

- **Documentation** - Each selected claim was evaluated to determine that all appropriate material needed to properly adjudicate the claim was available prior to actual payment. Documents were also evaluated to determine that sufficient documentation existed based on the nature of the appeal and the compliance to the appeal process.

- **Appeal Decision** - Each selected claim was reviewed and evaluated based on the decision making process as outlined in the appeal policies. Documentation was reviewed as to the level of communication between the participant and PEHP and the appropriateness of the decision. In addition, we reviewed the documentation, in order to establish that the participant was provided information regarding the elevation of the appeal to the next level.

Results

We identified 8 appeals, of the 141 reviewed, that we disagreed with PEHP's decision. We identified 12 appeals, of the 141 reviewed, that did not contain enough information for a complete analysis to be performed. Our analysis is presented in the Exhibit attached to this report.

The 8 appeals, for which we disagreed with PEHP's decision, represents 5.67% disagreement rate. It should be noted that, in 3 cases, we believe it would have been beneficial for a specialist in the area regarding the appeal to render their opinion regarding the services. The rate of disagreement is less favorable than the 3% to 5% rate for which is deemed acceptable in the industry.

The 12 appeals, for which there was not enough information regarding the basis for PEHP's decision, represents 8.51% lack of information rate. It should be noted, that 4 of the appeals were at the Executive level. The information regarding the first 2 levels did not get filed with executive level appeals data. The remaining 8 did not include any notes regarding the basis for the reversal of the original decision.

Recommendations

Based on our review results, we present the following recommendations.

- We believe that all documents filed for the appeal should be maintained at each level of appeals. It appears that the executive level appeals (3rd level) do not always contain all of the information from the 1st and 2nd levels. This will be important during the IRO review process, which is detailed in the recommendations under the appeals process.

- The rate of disagreement of the appeal decision (5.67%) substantiates the recommendation regarding the IRO review process, which is detailed in the recommendations under the appeals process. This provides an independent review of the cases. Currently, the majority of cases are based upon the recommendation of the medical director and/or pharmacy director. It should be noted that the pharmacy director does not have a voting position on the committee. We have recommended that this process be changed.

- Based on our review of the documentation for each appeal, the denial letters did not always contain supporting documentation of the medical policy or master plan policy utilized as a basis for denial. This was especially consistent when an outside source was utilized for benefit determination.

  Therefore, we recommend that if an outside source is utilized for the basis of benefit determination that it be included in the letter to the participant/provider.

  Furthermore, we believe a copy of the claim in question should be included in all post-treatment appeals.

* * * * *

We appreciate this opportunity to be of service to the Office of the Legislative Auditor General for the State of Utah.

Yours truly,

WOLCOTT & ASSOCIATES, INC.

Marie K. Pollock
President

MKP:bkw

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Agency Response

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JEFFREY L. JENSEN
Director

January 12, 2011

The Utah State Legislature:

Public Employees Health Program (PEHP), a division of Utah Retirement Systems, is pleased to submit our responses to the Auditor General's Report No. 2011-01 **A Performance Audit of PEHP's Business Practices**. We appreciate the open and candid discussions with the auditor about the recommendations offered in this report.

PEHP takes seriously its charge to provide high quality and cost effective benefits to Utah's public employees. The recommendations in this report will help PEHP to improve processes to become more effective in fulfilling its charge. Upon reading our responses, you will note that we have already begun or are committed to addressing the recommendations made.

For nearly 34 years PEHP has partnered with the state of Utah and many other public entities to provide employee benefits. We take pride in consistent satisfaction survey ratings of over 80% from public employees and over 90% from their employers, demonstrating customer satisfaction with PEHP.

We strive to provide the widest choice for our health plan members at the best price. For example, in order to better control our claims costs, PEHP concluded negotiations in the past few days to increase certain hospital discounts by 33%. This is in addition to renegotiating more competitive rates for laboratories and diagnostic centers and implementing a cost-conscious physician payment strategy. As noted in the report, new controls and oversight in the pharmacy benefit have saved $9.9 million in the past two years. PEHP will continue to seek opportunities to control costs, balanced with providing the maximum in member choice and overall value, leveraging our very low administrative costs.

As healthcare costs continue to escalate, the audit report notes that the state's costs have increased at a lesser rate than national averages over the last five years.

PEHP recognizes the challenges inherent in the current healthcare delivery – and financing – system. Changes are unavoidable. With both state and federal efforts to

reform the healthcare delivery system, the future landscape is uncertain, not just for PEHP, but for all participants in the system.

With this uncertainty, we take the audit recommendations as a further opportunity to evaluate the business model we have traditionally employed as it relates to the current market as well as the future healthcare services delivery mechanism. We constantly strive to add value to our business practices. For example, our self-insuring of high-cost claims has saved $60 million over commercially-purchased policies for participating employers.

We note that the consultants employed by the auditor, while making recommendations for improvement in our processes, also recognize PEHP's achievements. The pharmacy consultant says: "The PEHP Pharmacy program is a well-run, aggressively managed pharmacy benefit. This is extremely important, considering the ever present rise of prescription drug costs." And the appeals consultant notes an agreement rate of over 94% of early level appeals.

In summary, the recommendations contained in the auditor's report are valuable tools to make PEHP even better. Our history of providing value, our dedicated employees, and our commitment to improve provide a solid base on which to consider and implement the recommendations made in this report.

Sincerely,

Jeffrey L. Jensen, CPA

PEHP Director

PEHP RESPONSE TO AUDITOR GENERAL REPORT 2011-01
"A Performance Audit of PEHP's Business Practices"

PEHP recognizes the role of the Legislative Auditor General in reviewing PEHP operations and welcomes this opportunity to respond to the Legislative Audit. PEHP has reviewed the audit and is studying ways and means to implement the recommendations. PEHP takes the recommendations seriously and recognizes that some recommendations produce a quick return on investment while others may take longer to reflect a return. PEHP is committed to improve its operations to provide the most cost efficient and effective insurance possible to the state and local governments.

In response to the recommendations listed in Chapter II:

As healthcare costs continue to escalate, the audit report notes that the state's costs have increased at a lesser rate than national averages over the last five years.

PEHP understands that the reimbursement rates or discounts it has with the provider community plays a significant part in the total cost of health care for our clients. PEHP, at least annually, performs an analysis of market reimbursement rates mainly by internally reviewing claims in which PEHP is the secondary payer on a claim to which one of our competitors is the primary payer. This analysis provides us with comprehensive benchmark information and allows us to identify opportunities to improve our competitiveness by requesting similar discounts.

The landscape for negotiating provider contracts, especially facility (e.g., hospital), has changed significantly since the Auditor General's 2003 audit. Instead of being permitted to "lease" established networks of facilities and physicians, PEHP and certain other payers have been required to negotiate separate arrangements with facilities, physicians, labs, etc. PEHP has a particular challenge in this new environment. PEHP has statutory responsibility to stimulate competition which has been best accomplished by offering competing networks. This has prevented PEHP from obtaining the lowest reimbursement rates offered.

Early in 2010, PEHP identified that our hospital discount rates with a large hospital chain were not at the same level as other payers in the market. We engaged the hospital chain in intense negotiations during 2010 to correct this concern. We are pleased to report that negotiations were finalized very late in December 2010 and will result in 33% better discounts for the State beginning January 1, 2011. Due to this timing, the impact of these new rates was unable to be reflected in the Auditor General's analysis. Some terms of the new reimbursement agreement may impact some of PEHP's risk pools in being able to take advantage of the deeper discounts. PEHP is continuing discussions with the hospital chain on this point.

PEHP obtained 33% better discounts for Advantage Care Network hospital claims beginning in 2011

PEHP has analyzed its reimbursement rates in the market. The 32 medical procedures codes (out of approximately 10,000) used to asses PEHP's competitiveness is a small sample size and the majority of the codes are procedures performed by primary care physicians. These codes are billed the most frequently and are commonly analyzed.

PEHP RESPONSE TO AUDITOR GENERAL REPORT 2011-01
"A Performance Audit of PEHP's Business Practices"

PEHP believes that primary care services are undervalued in the Utah market and is promoting a strategy of encouraging more care at the primary care level by paying more than some of our competitors. This strategy supports cost control through the formation of medical homes, accountable care organizations and similar payment reform efforts. Payment reform is key to controlling healthcare costs.

Additionally, as our employer groups have transitioned from PPO plans and networks to HMO plans and networks, we have found the need to adjust our physician reimbursement levels to reflect discounts more appropriate for the HMO networks. The 2009 rates surveyed in the audit reflect the first steps in our phased adjustment plan to align our physician rates to HMO competitive levels as employed by many of our competitors. In 2010, our physician increase was limited to 1%, which was below the average market increase to providers. In 2011, our physician fee schedule changes will continue our strategy. We will continue to monitor our fee schedules versus our competitors and relative to our reimbursement strategy.

PEHP realizes the impact that competitive discounts have in the total cost of health care for our employer groups. PEHP performs annual competitive market research to identify opportunities for improvement. PEHP has identified areas of improvement within its facility and physician contracts. We are and have implemented steps to correct any imbalances.

In the matter of utilization, PEHP faces a unique challenge of insuring only public employees and their families. Recent studies have shown that the risk score, the statistic which indicates how likely the member will incur medical costs during the next year, is higher at every age cohort for public employees and their families than those employed by private companies. Public employees exhibit a much higher prevalence of chronic disease than those of private employers. This results in higher utilization and in higher costs. PEHP offers Disease Management, Wellness, and Care Management programs to deter costs.

1) *"We recommend that PEHP complete an in-depth study of the state's claims cost and develop strategies to contain costs."*

PEHP constantly monitors State claims costs and regularly presents the data to state decision makers to develop strategies to contain costs. PEHP will continue its studies and complete a more in-depth study of the state's claim costs and develop strategies to contain costs.

2) "We recommend that PEHP more aggressively negotiate contract rates with health providers."

PEHP will press to receive the rates offered to others. PEHP has a continued practice of reviewing rates in the market and making adjustments to ensure we are competitive and in concert with reimbursement strategy.

3) *"We recommend that the Legislature request follow-up audit in two years to determine if PEHP has adequately addressed the concerns discussed in this report."*

PEHP will cooperate with a continued review to determine if it has adequately addressed the concerns raised in this report.

In response to the recommendations listed in Chapter III:

PEHP has already begun to change its purchasing practices based upon the audit and is committed to reflect best practices in its procedures.

1) *"We recommend PEHP follow URS policy in the following areas:*
   - *Conducting competitive RFP's and bids when selecting vendors*
   - *Imaging and retaining contract documentation*
   - *Keeping a master contract list and having a point of contact for all contracts"*

PEHP will continue to conduct competitive RFPs and bids when selecting vendors. PEHP will improve documentation, imaging and retention practices and keep a master contract list having a point of contact for all contracts.

2) *"We recommend PEHP follow best practices in the following areas:*
   - *Publicly advertising RFP's to allow open competition*
   - *Using a decision matrix or scoring sheet to evaluate proposals in an RFP*
   - *Retaining documentation of why vendors are chosen in an RFP or when bids are taken*
   - *Retaining documentation when a vendor is declared as sole source"*

PEHP will publicly advertise RFPs and improve upon practices to increase open competition. PEHP will use a scoring sheet to evaluate responses and increase documentation of why vendors are chosen. Documentation for sole source status will be improved and retained.

3) *"We recommend PEHP strengthen contract controls in the following areas:*
   - *Ensuring there is a contract in place for each vendor*
   - *Requiring contract terms to have a definite end, possibly allowing a limited extension*
   - *Ensuring there is another RFP or rebidding at the end of the contract"*

PEHP will ensure there is a contract in place for each vendor. Each contract shall have a defined term with possible limited extensions. PEHP will conduct a new RFP at the end of contracts.

4) *"We recommend URS strengthen the following policies:*
   - *Requiring public advertisement of RFP's*
   - *Requiring contract terms to be explicit and definite of contract expiration*

- *Setting parameters for when a sole source vendor needs to be reviewed"*

PEHP and URS have begun efforts to revise purchasing policies which will address the above recommendations.

In response to the recommendations listed in Chapter IV:

PEHP, as pointed out by the auditor, is solvent. PEHP's goal is to administer benefits in a cost efficient manner and this goal has been met. The auditor has made several recommendations intended to improve our financial processes and practices.

PEHP was created by the Legislature in 1976 and given a unique set of operational guidelines. We acknowledge that our unique nature makes it difficult to categorize PEHP for some comparative and benchmarking purposes for our current and potential employer groups as well as for reviewers. Our financial practices are a reflection of PEHP's statutory charter. That some of our financial practices are now being examined and questioned in light of changes (market shifts, health care reform efforts, ever-increasing costs of health care, etc.) is to be expected.

One important value PEHP brings our employer groups is a significant savings in administrative costs. As noted in Chapter II of this report PEHP's administrative costs are 27% lower than the next lowest carrier and 50% lower than the highest. Based on these percentages PEHP has saved participating groups in the range of $24 to $44 million dollars in administrative costs during the five year period the audit covers.

PEHP's reinsurance program has been a cost efficient method of providing reinsurance to the risk pools choosing to participate. Based on a recent study of commercial reinsurance rates, using our cost effective reinsurance model has saved participating groups approximately $60 million in reinsurance costs over the 5 year period.

Individual risk pools have agreed to be self-insured and may accrue liabilities with their benefits plans, characterized as deficits on PEHP's books. Each risk pool stands on its own in terms of its claims and contributions (or premiums). Risk pools with surpluses may provide cash flow support for other risk pools but receive interest as payment. In order to stay true to the trust concept PEHP applies sound trust accounting principles to assign interest income or costs to the appropriate risk pool.

1) *"We recommend that PEHP adhere to Utah Code and not allow risk pools to run reserve deficits."*

PEHP agrees that current Utah Code does not allow risk pool reserve deficits and that reserve deficits should be avoided. We will work with the risk pools to assure that deficits are promptly recognized by PEHP and are resolved in a manner to eliminate any on-going deficit position.

2) *"We recommend that PEHP either adjust the language in their contracts to charge risk pools with deficits late fees equal to market returns or adhere to the current language found in their contracts."*

PEHP will comply with the recommendation.

3) *"We recommend that PEHP adhere to Utah Code and develop actuarially sound reserve requirements for each risk pool. We also recommend that if reserve levels exceed the required amount, the URS board should approve a refund back to the risk pool or reduce future premiums to lower the excess reserves."*

PEHP will refine the process for developing reserve requirements. We estimate it will take up to six months to develop the actuarial sound methodology. Actuarially sound reserve requirements will likely be expressed in a range of acceptable levels. PEHP will evaluate excess reserves and recommend the Board make refunds when appropriate. PEHP currently considers the excess reserve level when developing rate renewals.

4) *"We recommend that PEHP prospectively quote administrative rates at the beginning of a plan year and allocate administrative costs based on industry best practices."*

PEHP can see the benefits of prospectively quoting administrative rates. PEHP is organized as a trust fund under Utah Code. In order to stay true to the trust concept we have used sound trust accounting principles to allocate costs to the participating risk pools. We will explore ways that PEHP can offer prospective administrative rates.

5) *"Regarding reinsurance, we recommend that PEHP:*
   - *Prospectively quote reinsurance rates*
   - *Actuarially determine stop-loss deductible levels by risk pool*
   - *Examine the cost benefit of external reinsurance by each risk pool"*

PEHP can see the benefits of prospectively quoting reinsurance rates. PEHP is organized as a trust fund under Utah Code. In order to stay true to the trust concept we have used sound trust accounting principles to assign costs to the participating risk pools. We will explore ways that PEHP can offer prospective reinsurance rates in accordance with the recommendations.

6) *We recommend the Legislature determine if the state risk pool should self-fund reinsurance or allow the current practice to continue where the state risk pool is a part of PEHP's reinsurance pool*

PEHP is willing to assist the Legislature in this analysis.

7) *"We recommend that the Department of Insurance perform a biennial audit of PEHP rather than accepting audited financial statements in lieu of an audit."*

PEHP is open to review by the Department of Insurance. An annual audit of PEHP is performed by an auditing firm that specializes in the insurance industry: this report is then reviewed by the State Auditor and the Department of Insurance.

8) *"We recommend the Legislature amend Utah Code 49-20-405 and grant the Department of Insurance the authority to require PEHP to comply with a written improvement plan if issues arise in the biennial audits."*

PEHP is willing to work closer with the Department of Insurance. PEHP has implemented all previous recommendations made by the Department of Insurance during their reviews of PEHP.

In response to the recommendations listed in Chapter V:

PEHP is pleased that the auditor's consultant acknowledged that "The PEHP Pharmacy program is a well-run, aggressively managed pharmacy benefit. This is extremely important, considering the ever present rise of prescribing drug costs."

The consultant's views align with PEHP's recent efforts. For the past several years, pharmacy costs have increased for managed care organizations by double digits due to manufacturers raising prices, introduction of new medications, increased utilization and the practice of using more expensive drug therapies when lower cost generics and brand name medications are available. In 2008, PEHP proactively made the decision to change our pharmacy management program to help manage these yearly trends and hired a professional pharmacy director.

PEHP has saved groups $9.9 million in pharmacy costs since 2008. PEHP was able to accomplish these savings by:

- establishing a four tier pharmacy benefit that encouraged members to use low cost generics,
- re-negotiating the PBM contract to obtain medications at a lower cost,
- increasing collected manufacturer rebates by 400% and ensuring that 100% of all rebates are passed back to the employers,
- actively managing the drug formulary and rebates for the benefit of both members and employers, and
- developing thorough pre-authorization criteria to enhance member safety and control costs.

"The PEHP Pharmacy program is a well-run, aggressively managed pharmacy benefit." Groups have saved $9.9 million in pharmacy costs since 2008.

PEHP has modified the pharmacy homepage, showing member formulary information by alphabet, specific disease, and formulary suggestions. Additionally PEHP provides targeted direct mailings whenever a formulary change is made.

PEHP has policies and procedures allowing members to receive a preferred drug list copayment when their provider can document that a non preferred drug is needed when the patient has tried all formulary alternatives, have a direct allergy or no other medication is available to treat the member.

The pharmacy department will continue to monitor PEHP's prescription drug benefits by reviewing pre-authorization requirements, improving drug pricing contracts as well as providing PEHP members with a viable formulary.

PEHP actively manages the formulary through the efforts of the PBM's Pharmacy and Therapeutics (P&T) Committee and a local P&T Committee, which is an advisory group, made up of physicians, pharmacists and nurses from the Wasatch Front. These experts help PEHP ensure that the medical standard of care within the State of Utah is reflected in the formulary. Providers who are experts in their field of oncology, psychiatry, internal medicine and family practice were chosen by the Medical Director, Pharmacy Director and Director of Provider Relations.

1) *"We recommend PEHP create a Pharmacy and Therapeutics (P&T) committee oversight document which outlines the following:*
   - *Schedule of meetings*
   - *Committee composition, selection and credentials of individual members*
   - *Procedure for approval/acceptance of committee members*
   - *Conflict of interest statements and continued reiteration at each meeting*
   - *Signature and date required on committee minutes"*

PEHP will develop a policy that governs the advisory role of the Pharmacy and Therapeutics Committee in accordance with this recommendation.

2) *"We recommend PEHP revise the current Pharmacy and Therapeutics Committee Agreement to include disclosure provisions on the acceptance of monies by individual members of the committee by pharmaceutical manufacturers."*

PEHP will develop a comprehensive form governing the behavior of members serving on the local P&T Committee in accordance with this recommendation.

3) *"We recommend PEHP provide greater oversight to the pharmacy program by taking the following actions:*
   - *Reviewing the role and responsibilities of the pharmacy director and better defining the director's duties as it pertains to the P&T committee*
   - *Independently reviewing pre-authorization and co-pay criteria to assure rules are safe, effective, and fair; and, amending the Master Policy to reflect these changes."*

The Medical Director provides oversight to the pharmacy program and directly supervises the Pharmacy Director. The Pharmacy Director's role with the P&T Committee will be reviewed and better defined as recommended. PEHP will review its

formulary actions to ensure they reflect industry standards and meet the needs of employers while ensuring the safety of members.

4) *"We recommend PEHP consider having the rebate function handled by an internal section which is independent from the Clinical Department".*

Rebates will be audited by the Financial Assurance Department.

In response to the recommendations listed in Chapter VI:

PEHP believes that its appeals process has allowed for the successful adjudication of appeals from members and providers alike. PEHP employees with a high level of expertise, and from a variety of disciplines, review our appeals at the various levels, providing the most comprehensive review possible.

PEHP is pleased that the review of its appeals process performed by the consultant confirms our belief. We feel that the consultant's finding that more than 94% of our appeals were adjudicated correctly at levels one through four demonstrates that our process is effective. We also recognize that the auditor's recommendation can help the process become even better.

1) *"We recommend that PEHP establish a formalized audit function at level one of the appeals process."*

PEHP will establish a formal audit function at level one of the appeals process.

2) *"We recommend that PEHP make the following changes to the administrative review committee at level two of the appeals process:*
   - *Add two voting positions to the committee, the Pharmacy Director and a Member Advocate*
   - *Evaluate the structure of the committee to insure adequate clinical expertise is assigned to the committee."*

PEHP will immediately add the Pharmacy Director to the Administrative Review Committee and will consider the addition of a member advocate. PEHP notes that the Affordable Care Act (PPACA) currently requires PEHP to comply with new appeals processes so this recommendation will be considered in light of federal requirements.

3) *"PEHP should hire an independent review organization (IRO) at level three of the appeals process. "*

PEHP expects to contract with a company offering clinical expertise in order to comply with the PPACA which will bring PEHP in line with the recommendation.

4) "We recommend that PEHP establish turnaround schedules for processing appeals for appeal levels one through three."

PEHP will establish turnaround schedules for processing appeals levels one through three.

5) "We recommend that PEHP establish a formal process to track and analyze appeals submitted to PEHP."

PEHP will establish a formal process to track and analyze appeals.