OFFICE OF THE CITY AUDITOR

**PERFORMANCE AUDIT OF
HEALTH BENEFITS
ADMINISTRATION**

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**November 7, 2003
Report No. 403**

Memorandum

CITY OF DALLAS

November 7, 2003

Honorable Mayor and Members of the City Council
City of Dallas

We have conducted an audit of the health benefits provided to the employees and administered by the Human Resources Department (HR).

The cost of health benefits has been an area that has seen steadily increasing costs. When we reviewed the 2002 costs for health plans offered to employees and compared them to other entities, the rate charged to employees for the City PPO plan compared favorably while the rate for the HMO appears higher than most reviewed.

As a result of our inquiries, examinations, and reviews, we conclude that one factor that may be contributing to the increased cost of health benefits is the increased cost of administration of the health plan by HR. HRIS personnel were being paid from the funds designated for employee benefits. Although a small portion of their time is benefit related, the majority is for non-benefit-related activities. HR has acknowledged the use of these funds in the past year and now has agreed to fund the HRIS personnel from General Funds other than those designated for employee benefits. Related opportunities for improvement are included in this report.

Thomas M. Taylor

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City Auditor

c: Teodoro J. Benavides, City Manager

PERFORMANCE AUDIT OF HEALTH BENEFITS ADMINISTRATION

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EXECUTIVE SUMMARY

We have conducted a performance audit of health benefits administration by the Human Resource Department (HR) for the period October 1, 2000, through July 31, 2003. As a result of our inquiries, examinations, and tests, we conclude that improvements are needed in administering and monitoring health benefits administration. We have summarized our major findings below.

- HRIS personnel (with few benefit related duties) were being paid from the funds designated for the payment of employee benefits. In 2003, HR budgeted $544,203 for these personnel from funds designated for employee benefits. Nine additional HRIS employees have been included in the 2004 proposed budget.

- The City is paying Medicare Part A payments for only one employee, although there may be others who are qualified in accordance with approved resolutions. The City is providing payments for Medicare Part B for 21 active employees, which is not authorized by ordinance(s) or City Council.

- There are 4,490 active employees hired prior to mandatory Medicare participation who may not be eligible for Medicare coverage at federal expense. By resolutions, the City may be liable for the expense of providing Medicare Part A for these employees and their spouses.

- Monitoring of the health care benefits program needs to be enhanced to better utilize the performance reports of the outsourced claims administrator.

- The City health benefit contributions are incorrectly allocated across the designated RESOURCE funds. As a result, there are excess expenditures and revenues in some agency funds, which is not in compliance General Accepted Accounting Principles.

- HR budgeted funds for its outside consultant to conduct an audit; however, an audit has not been conducted. The timeliness of conducting such an audit has not been considered, and with the change to a new provider starting in 2004, the importance of a timely audit has increased.

INTRODUCTION

Authorization

We have conducted a performance audit of health benefits administration by the Human Resource Department (HR). We conducted this audit under the authority of Chapter IX, Section 2 of the Dallas City Charter and in accordance with the Annual Audit Plan approved by the City Council.

Scope and Methodology

We performed our audit in accordance with generally accepted government auditing standards and included tests of the accounting records and other audit procedures that we considered necessary in the circumstances. This audit was limited to health-related benefits as provided through the City's HR.

The objectives of our audit were to determine whether:

- Health benefit costs are comparable to other cities for similar coverage.
- There was competitive bidding for the administration of the Preferred Provider Organization (PPO) and the Health Maintenance Organization (HMO).
- There was adequate employee input for the benefit programs.
- The administration of health benefits is in compliance with applicable rules, ordinances, and laws.
- Claims are audited, monitored, and paid in accordance with the applicable contract terms and conditions.

Our audit covered October 1, 2000, through July 31, 2003, although we examined certain events and transactions occurring before and after that period.

To develop an understanding of relevant control structure policies and procedures, we reviewed financial records and applicable laws, ordinances, contracts, and requests for proposals.

Additionally, we interviewed the management and staff of HR concerning internal controls. We examined departmental reports, compared data of various reports, observed operating procedures, and analyzed historic results.

INTRODUCTION

We did not audit the claims administration performed by United Health Care (UHC). HR stated that it has an agreement with a consultant, the Hay Group, to conduct the claims audit. However, this audit has not been conducted as of this date. The Auditor's Office will confer with HR on the audit scope and methodology to be used by the Hay Group. The Auditor's Office will review the Hay Group's audit results upon its completion.

Overall Conclusion

As a result of our inquiries and analysis, we conclude that:

- Costs for the PPO plan are comparable to other cities for similar coverage. (See Exhibit One.)
- There was competitive bidding for the administration of the Preferred Provider Organization (PPO) and the Health Maintenance Organization (HMO).
- There was adequate employee input for the benefit programs.
- Compliance with policies and ordinances needs to be improved.
- Monitoring practices are inadequate.
- Reduction of cost related to outsourcing health benefits administration has not been achieved.
- Claims have not been audited.

Background

HR is responsible for health benefits administration and oversight.

Prior to 2001, the City self-administered the payment of health claims incurred under the Self-Funded Health Plan, while purchasing PPO and medical management services from outside vendors. HR performed a review concerning the outsourcing of claims administration and related programs. The determination was made that the programs could be administered at lower costs (resulting in better service to employees/retirees) and be more cost effective through improved medical management programs.

On June 14, 2000, the City Council approved outsourcing City claims administration and PPO and medical management services by authorizing a three-year contract with UHC of

INTRODUCTION

Texas, Inc. as the third party administrator (TPA). The contract (January 1, 2001, through December 31, 2003) was in the amount not to exceed $13,800,000 and contained two 12-month renewal options. The City chose not to exercise the renewal options. UHC is responsible for maintaining all books, documents, papers, accounting records, and other evidence pertaining to the benefits costs incurred.

As an alternative to the PPO, the City offers HMO coverage to employees and retirees. A three-year contract (January 1, 2001, through December 31, 2003) with two 12-month renewal options for HMO administration was awarded to CIGNA Healthcare. The only cost to the City is the amount allotted to each employee for health care coverage.

Additionally, HR coordinates with outside contractors to provide coverage for:

- Dental Plan
- Short Term Disability
- Life Insurance
- Prescription Drugs
- Vision Plan

OPPORTUNITIES FOR IMPROVEMENT

We identified certain policies, procedures, and practices that can be improved. Our audit was not designed or intended to be a detailed study of every relevant system, procedure, and transaction. Accordingly, the opportunities for improvement presented in this report may not be comprehensive of the areas where improvement may be needed.

1. The City's benefit administration costs are not decreasing even though claim processing has been outsourced.

A. Human Resource Information System (HRIS)[1] personnel are being paid from the Health Benefit Administration Fund.

In FY02, member services [Organization Code (Org) 5712] had no employees. However, in FY03, HR budgeted $544,203 for salaries and benefits from this Org. Currently, there are twelve HRIS employees paid under this Org: one Third Tier Executive and eleven Human Resource Assistants. As shown on page E-4 of the proposed 2004 budget, nine additional HRIS employees are anticipated. Inclusion of these HRIS costs distorts the true cost of employee health benefits administration and places a double expense on City Departments: (1) the department's budget FTE reduction due to perceived HRIS savings and (2) the department's increased cost allocations due to an increase in central services.

HRIS is used for only a portion of health care administration (the enrollment and the deductions used to pay for employee health care plans). The use of these funds does not appear appropriate in that the function is only indirectly concerned with health care administration.

B. Health benefit administration costs increased since the outsourcing of the PPO plan administration on January 1, 2001.

The health benefit administration was outsourced effective January 1, 2001. HR determined that the claims administration program could be obtained at a lower cost, could result in better service delivery to employees/retirees, and could ultimately be more cost effective in processing claims through improved medical management programs.

HR did not reduce its employee health benefit administration cost to reflect the outsourcing of PPO administration. To show the health benefit administration costs, we compiled data from RESOURCE, the City's accounting system, for fiscal years 2000 through 2003. The following table illustrates expenditures paid during these fiscal years. After two years of outsourced activities, the health benefit administration costs have increased by approximately $2 million. Part of

[1] HRIS is the Citywide system used for activities such as payroll, time accounting, and benefits enrollment.

this increased cost has been the payment of the HRIS personnel referenced above.

Health Benefit Administration Costs FY00 – FY03					
Org#	**Description**	**FY00**	**FY01**	**FY02**	**FY03 (Annualized projection based on 9 months actual)**
5710	**Benefit Administration**	**$936,925**	**$1,318,435**	**$2,487,381**	**$1,626,727**
5711	Claim Process	2,155,865	1,246,042	168,748	
5712	Member Services	449,660	275,874	5,679	504,033*
5713	Financial Services	177,333	168,407	1,474	
5719	Deferred Comp 401K/457	118,164	(1,372)	0.00	
7901	Health Fest	4,744	0.00	0.00	
7902	Wellness	208,592	38,813	245	
7920	Health Clinic	221,130	212,780	996	
7921	Care Service	156,244	(3,764)	116	
7933	Communications	25,424	0.00	0.00	
9947	Relocation				
	Total Fund 278 Expenditures	4,454,081	$3,255,215	$2,664,639	$2,130,760
	UHC Administration Fees	$0	$3,032,745	$4,656,292	$4,281,323
	Total Benefit Admin.	**$4,454,081**	**$6,287,960**	**$7,320,931**	**$6,412,083**

* $504,033 is included as the projected member services cost in the table above; however, HR budgeted $544,203 for this item.
Note: The above table does not include $109,155 in professional services fees; however, this amount was included in the HR table below.
$65,513 non-cash transaction is excluded from the above table, but was included in the HR table below.

The following table represents the HR budget briefing as presented to the City Council on June 4, 2003.

HR Presentation Data Summary Historical Revenue vs. Historical Cost (in Millions)			
	FY01	**FY02**	**FY03 – HR Projection**
Total Revenue	$69.4*	$71.7	$80.3**
Cost:			
PPO Active	$30.1	$29.3	$33.1
PPO Retiree	19.7	21.0	26.9
HMO	12.0	12.3	13.1
Total Admin.	*6.4*	*7.4*	*6.7*
Total Cost	$68.2	$70.0	$79.8
Revenue over Cost	$1.2	$1.7	$0.5

* The 2001 revenue includes $12.2 Fund Balance.
** The $80.3 FY03 Revenue includes $6.0 Fund Balance.

OPPORTUNITIES FOR IMPROVEMENT

Although benefit administration costs have increased, several programs have had funding significantly reduced. During FY01 and FY02, funding for Deferred Compensation, Health Fest, and Communication was eliminated, while Wellness and Health Clinic decreased over 99%.

Outsourcing should have decreased the cost of providing the internal health benefits functions. HR did not reduce its employee health benefit administration cost proportionately to reflect the outsourcing of PPO administration.

We recommend that the Director of HR:

A. Calculate the HRIS health benefits enrollment costs and assess health benefit administration accordingly. Funding for HRIS employees should be detailed separately in the HR departmental budget.

B. Identify the cause of the cost increase in Employee Benefit Administration Fund and take corrective action to improve the cost efficiency. Additionally, establish and implement policy and procedures that ensure that only expenditures related to employee health benefits are charged to employee benefit administration.

Management's Response:

A. The cost to provide benefits enrollment services extends beyond HRIS. The role of the HR Assistant is broader than HRIS or payroll. HR Assistants provide assistance with new employees as well as exiting employees regarding benefits issues. They assist with education and enrollment of employees and retirees during annual enrollment period. This program is shown as a separate ORG in the HR departmental budget.

   However, because the Auditor deems it necessary, Management will change the funding for this program to the HR General Fund Budget.

B. The statement is in error, as shown on the City Auditor's own chart on page 6, total benefits administration is projected to be less in FY03 than FY02. Additionally, it is budgeted to be less in FY04, than in FY03 or FY02. Based upon the Auditor's own chart, costs are decreasing, not increasing. The reprogramming of the HRIS employees to the General Fund, as stated above, will even further reduce administrative costs.

   Keep in mind that the administrative savings generated by outsourcing claims processing is dwarfed by the savings gained from higher network discounts, faster turnaround time, and reduced errors.

OPPORTUNITIES FOR IMPROVEMENT

Claims administration was outsourced for the following reasons:

- Savings in claims dollars (which does not show up in the RESOURCE line item for administration.) The success of this outsourcing initiative has already been proven because more efficient claims paying has allowed the City to reduce its Reserve for claims that have been incurred but not reported or paid. In fact the City was able to free up $5,000,000 excess reserve funds and use it help fund the benefits program.
- Savings from funds not spent. If the City had continued to internally process its own claims, it would have needed to make a multimillion-dollar investment in claims processing technology. By outsourcing this function, claims can be paid electronically, rather than manually. Firms whose core business is providing this service are performing this operation. This permits the City to use its resources to perform its core municipal functions.
- Receipt of higher network discounts. By using a third party administrator to perform the claims function, the City has access to that firm's preferred provider network; thus receiving better discounts. Higher provider discounts reduces actual claims costs.
- While healthcare costs have increased nationwide by 15 to 18%, the City has been able to maintain an increase of only 12 to 15%. Much of this savings can be attributed to being able to more efficiently and economically process and pay claims.

Management believes health benefits are being delivered in the most efficient and cost effective manner through its current method. Additionally, as stated above, Management has determined that expenditures are being appropriately charged.

Auditor's Comment:

Total benefit administration before outsourcing was $4,454,081; since outsourcing, it has not gone below that level. The total benefit administration cost was projected to be 43.96% more than the amount for 2000.

2. Payments for health care benefits are not in compliance with established ordinances.

A. The City is paying for Medicare Part A for one employee.

Medicare Part A is not consistently applied in accordance with City Ordinances. The City is not applying Medicare Part A payments for all eligible hires as

outlined in City Council approved Resolutions 80-1264 and 80-2407. Resolution 80-2407, Article IV, Section F, paragraph 3, states, "…or permanent employee or spouse of a permanent employee is entitled to Medicare 'A' by reason of age, but is not eligible for Medicare 'A' coverage at federal government expense through eligibility of a spouse or is ineligible because of inadequate Social Security coverage, his or her enrollment in Medicare 'A' will be paid from the Employee Health Benefit Plan Administration Fund." According to HR, the City is only paying total Medicare Part A premiums for one active employee because this individual is the only one who has pursued the Part A payments by the City. HR has made no effort to ascertain if other employees may be eligible for City paid Medicare Part A payments. The City's annual cost for Part A premium for this one individual is $3,792.

On April 30, 1980, City Council adopted Resolution 80-1264 coordinating the City's Employee Health Benefit Plan. The resolution states that the City shall pay Medicare A premiums for participants (in some cases the spouses of participants) not eligible for Medicare A at federal government expense. The participants' enrollment in Medicare A will be paid from the Employee Health Plan Administration Fund.

If it is the City's intent to pay for Medicare Part A, the policy should apply to all hires that are 65 years of age. These procedures should be well communicated to and understood by all employees. If the City elects to pay Part A for all active employees, the budgeted amount should be calculated, and the potential liability should be identified and communicated to the City Manager and the City Council.

B. The City Medicare Part B payments are without legal authority.

The City is paying Medicare Part B expenses. HR has stated that the City is only paying Part B premiums for twenty-one active employees. We requested HR to provide written authorization for making these payments; however, the data provided failed to support these payments. We were unable to locate an ordinance authorizing the City to pay Part B premiums for active employees.

The City Council passed Resolution 80-1264 addressing Medicare premiums, and then passed 80-2407 to clarify areas that pertained to City payments of Medicare premiums for participants. We were unable to locate a more recent ordinance relating to Medicare participation.

The Social Security Administration encourages individuals not to sign up for Medicare Part B if they or their spouse are working and have health coverage through their employer or union. Part B benefits may be of limited value to individuals as long as the City's group health plan is the primary payer of the

individual's medical bills. If an individual is employed and has medical insurance coverage, there are no penalties for late sign up.

We recommend that the Director of HR:

A. Determine if the City should pay the Medicare Part A premiums for eligible employees. If it is the policy to pay Medicare Part A premiums, establish and institute procedures to educate employees about the benefits and liabilities of Medicare Part A.

B. Immediately terminate the practice of paying the Part B premiums for active employees. Contact active employees for whom the City is paying the Part B premiums and make arrangements for the individuals to assume the payment responsibility should they desire to continue Part B.

Management's Response:

A. The Auditor states that payments are being made that are not in compliance with established ordinances. This inflammatory statement could lead the reader to believe massive payments are being made without legal authority. What the Auditor is referring to is the isolated incident of a $316 monthly payment for one employee. This mistake was made because of instructions given to staff on June 3, 1993 (see Exhibit Two). A benefits manager who reported to the Assistant Director of Benefits (now the City Auditor) wrote this memo. HR brought this item to the Auditor's attention so that it could be addressed. Once this individual retires, this practice will cease.

   The Auditor is in error when he states that the intent of Resolutions 80-1264 and 80-2407 was to pay Medicare Part A premiums for participants who would not otherwise be eligible for Medicare Part A.

   The intent was to provide this for **retirees**, not active employees. Active employees who reach the age of 65 continue to have the City's health benefits plan as its primary payor. As long as a person over the age of 65 is actively employed and receives health care benefits from his/her employer, there is no need to apply for Medicare. The master plan effective January 1, 2004 specifically includes all information regarding Medicare and the coordination with the City's plan.

   Management has already determined, and City Council has been informed and agreed, that Medicare Part A premiums for retirees and their spouses age 65 and over who are not otherwise eligible for Medicare Part A will be paid by the Employee Health Benefits Fund.

OPPORTUNITIES FOR IMPROVEMENT

Currently there are approximately 2,700 retirees over the age of 65, of which less than 200 (7%) are not otherwise eligible for Medicare Part A. The approximate annual cost to the City is $758K. The percentage of those approximately 2,100 retirees under the age of 65, who may not be eligible for Medicare, should be comparable or less than the current level. The approximately 4,500 current employees without a Medicare deduction have an even longer time to become eligible for Medicare. Using the current 7% figure, the City liability could increase to approximately $2.5M per year, based on current Medicare costs.

B. This is another item that HR brought to the Auditor's attention. The above-mentioned 1993 memo was the document instructing staff to make these payments. It is difficult to imagine the City Auditor, while Assistant Director of HR responsible for Benefits, would direct employees to make payments without legal authority.

The practice of paying Part B premiums for active employees who become 65 has ceased. To avoid confusion, 03-2582, the Ordinance approving the Master Plan for 2004, specifically rescinded Resolutions 80-1264 and 80-2407.

To put this into perspective, as of October 2003, there are only 16 employees for whom the City is paying Part B premiums ($11,300 annually). The City will continue to make their payments until they retire, at which time they will become responsible for the payment. HR Department has a procedure in place to monitor this group of employees to ascertain when they retire.

Of interest is the fact that the April 30, 1999 Performance Audit of the Employee Health Benefits Program (a 91 page document) did not question this practice.

It should also be noted that the City pays Medicare Part B premiums for eight retirees. As a result of a lawsuit involving the Employee Retirement Fund (ERF), the pension plan became obligated to pay Medicare Part B on behalf of 56 retirees. In 1992 ERF paid the Employee Benefits Fund $720,632 to fund these monthly payments. The number of retirees receiving this benefit is now 8.

Auditor's Comment:

If other employees were eligible under 80-2407, we believe that they should have received the same benefit that the individual employee was receiving. HR should not solely rely on past policies and procedures. The department should constantly be updating these procedures based upon changes in laws, ordinances, and policies.

OPPORTUNITIES FOR IMPROVEMENT

3. Monitoring of the health care benefits program is inadequate.

A. There is a lack of effective monitoring of the TPA.

HR has not conducted effective monitoring of the TPA health benefits administration. HR stated that staff has been reduced and there may not be enough employees to effectively monitor the health benefit functions. As a result of inadequate monitoring, the following has occurred:

1. Claims totaling $507,483 were paid beyond the claims filing periods. Prior to January 2002, the claim filing period was 18 months. After January 2002, the City reduced the period to 12 months, as stated in the June 4, 2003, HR briefing to the City Council.

   According to the January 1, 2002, UHC Health Benefit's Plan Options, page 34, the covered employee must give UHC written proof of loss within 12 months after the date the expenses are incurred. No benefits are payable for claims submitted after the twelve-month period. (Exception: if it is shown that it was not reasonable to submit the claim during the twelve-month period.)

   For the 2001 claims, $343,034 was paid after the 18-month period. As of April 2003, a total of $164,449 was paid past the 12-month period for the 2002 claims. The contract with UHC states that 90% of clean claims received in any contract year will be resolved or settled (and appropriate payments will be made to the Provider in question) within 10 business days. The contract allows for a 60-day period for claimants to file an appeal and a 60-day period for UHC to make a determination.

   Adherence to the time period should be enforced. Claims after stated time periods should receive strict scrutiny to determine if acceptable extenuating circumstances exist to justify the payments.

2. Reports on the TPA 2001 activities contained conflicting information (i.e., high claims, total claim costs, participant enrollment). UHC had to be contacted by HR for clarification. Conflicting information provides distorted information and does not allow for an objective review. Erroneous performance assumptions and decisions may be made because of misstated information.

3. UHC performance was not monitored to determine whether performance standards were being met. This inaction could lead to over payment and sub-standard service to members. By contract the health benefits contractor must meet detailed standards or be subject to financial consequences. Unacceptable contract compliance measurements may not be detected, resulting in poor performance and financial losses.

OPPORTUNITIES FOR IMPROVEMENT

4. A UHC health claims audit has not been conducted during the three-year TPA contract. HR staff had specified that the Hay Group would be responsible for conducting a claims audit of UHC. HR has also previously stated in the FY02 and the FY03 budgets that it would conduct a contract compliance and performance audit of the TPA. HR stated that it included $46,900 in its proposal for the claims audit with the Hay Group. It was agreed that the Hay Group would conduct the claims audit, and the Auditor's Office would review the Hay Group's work papers and reports.

   On December 18, 2002, after repeated requests, the Auditor's Office received the Hay Group's audit plan for UHC. The plan was an audit overview that was generic to most health care systems; it did not specifically address areas applicable to the City.

   Since that time several requests have been made to HR to provide a date for the commencement of the audit; however, as of this writing, a date has not been established. During a meeting on April 9, 2003, HR advised that it was going to institute a request for bid for a TPA of the PPO, so it was not a good time to conduct a claims audit. Since the new administrator is not going to be UHC, it is even more important to conduct an audit on a timely basis.

   Claims audits should be performed regularly to ensure that the contracted TPA is meeting contract requirements.

5. UHC contracts with National Health Care Resources for hospital audits. There are no provisions for disclosure of the hospital audit results to the City. HR did not have copies of any hospital audits and does not monitor this activity. HR is not aware of large claims hospital audit results and, therefore, is not able to address questionable claims.

6. HR has access to the UHC electronic reporting system, but has not effectively utilized these reports. According to HR staff, the generated reports are provided to the Hay Group for monitoring purposes. Two HR employees have access to this reporting system:

   - The Benefit Analyst used the reports to generate a spreadsheet to show the monthly usage by different employee categories and service types. Prior to terminating this practice in December 2001, the Benefit Analyst was able to recover $34,943 from the UHC performance guarantee.

   - The Benefit Accountant uses the payment report to reconcile the Resource Employee Benefit Fund liability account. Currently this reconciliation is the only usage of the UHC reports.

OPPORTUNITIES FOR IMPROVEMENT

According to the UHC proposal, UHC conducts various internal quality and accuracy audits; however, the audit results are used internally only and are considered proprietary. Although requested by the City Auditor through HR, they were not made available to the City.

Regular monitoring assists in ensuring that the health benefits program is being administered as contracted and that members are receiving the entitled health related benefits. Failure to monitor may result in undetected overpayments and breaches of contract. Procedures should be in place for regular monitoring and for scheduled audits.

To verify the performance results, an audit of claims processing should begin immediately. Regular monitoring should be undertaken. Additionally, claims processing audits should be scheduled. The City is relying on performance results that are provided by the vendor, and their accuracy and credibility has not been verified.

B. The City health benefit contributions are incorrectly allocated across different funds.

HR did not review the revenues reported on each health benefit fund in the financial system to ensure that they were correctly allocated. Therefore, revenue and fund balances for employee health benefits reported in the City's financial system are being carried inaccurately.

The following table reflects the City's health benefits' revenue and cost history as presented by HR in the June 2003 budget briefing.

Health Benefit Revenue vs. Cost Summary						
	PPO		HMO		Admin. Operation	
	FY01	FY02	FY01	FY02	FY01	FY02
City Contribution	23,233,049	33,246,315	7,647,823	10,090,257	3,397,198	4,787,128
Employee Contribution	6,543,666	6,806,479	3,920,081	4,632,325	2,785	
Retiree Contribution	9,580,329	10,216,378	799,426	944,403	8,285	
Other/Misc.	1,593,449	1,159,079	174,155		62,359	
Total Revenue	**40,950,493**	**51,428,251**	**12,541,486**	**15,666,985**	**3,470,627**	**4,787,128**
Claims (include Rx)	49,885,624	50,284,775	12,019,954	12,273,780		
Medicare	735,112	724,364				
Management Fees	3,141,902	4,656,293				
Misc. Special Serv.	2,240,839					
Operation Expenses					3,255,215	2,730,152
Total Cost	**56,003,477**	**55,665,432**	**12,019,954**	**12,273,780**	**3,255,215**	**2,730,152**
Revenue Vs Cost	**(15,052,984)**	**(4,237,181)**	**521,532**	**3,393,205**	**215,412**	**2,056,976**

OPPORTUNITIES FOR IMPROVEMENT

Our review of the Health Benefit Funds (based on the HR presentation) revealed the following:

- The PPO Fund has shown a loss of $15.1 million in FY01 and $4.2 million in FY02.
- The HMO Fund has shown excessive premium collection of $521,532 in 2001 and $3.4 million in 2002.
- HR uses Agency Funds (pass through funds) to manage the voluntary benefits and HMO medical insurance plan. *General Accepted Accounting Principles* (GAAP*)* 35.03 (2002 Miller Guide) states, "In an Agency Fund, the measurement focus is custodial, because the fund is not involved with performance of governmental services. An Agency Fund has no revenues or expenditures and, therefore, no fund balance or need to measure the results of operations for a period."

  This fund has various expenditure and revenue accounts. The FY02 ending balance of its expenditure was $19.1 million and revenue was $21.8 million.
- Employee Health Benefit Operation Fund had operating expenditures of $3.3 million and $2.7 million for FY01 and FY02 respectively; the City contributed $3.4 million in 2001 and $4.8 million in 2002 to this fund. As a result, the fund had a budget surplus of $215,412 in 2001 and $2.1 million in 2002.

According to HR, the City's payroll system allocates the City contribution for health benefits among different funds. The allocation percentages of the payroll system have not been updated since their inception ten years ago. Our calculation using the allocation percentages resulted in significant differences from the current fund situation. It appears that the payroll system is using different allocation percentages than the ones established ten years ago. HR did not renew and verify the allocation percentages used by the payroll system.

HR indicated the City contributions were considered one revenue source for the entire employee health benefit regardless of the destination of the contribution, and a change would have to be made in the payroll system to put all City contributions into one object code within PPO Fund 260.

Revenue and fund balances for employee health benefits reported in the City's financial system are inaccurate and misleading. Misleading information may result in incorrect decisions and strategy.

Maintaining excess expenditures and revenues in Agency Funds may complicate the fund structure and provide opportunities to conceal ineligible revenues and expenditures.

OPPORTUNITIES FOR IMPROVEMENT

We recommend that the Director of HR:

A. 1. Consult with UHC to determine whether there is a reasonable explanation for the $507,483 in payments after the claims filing period. If there is not a reasonable explanation, HR should seek a refund of the overpayment.

2. Establish and implement procedures to conduct annual audits of the TPA and its claims processing. If the Hay Group has not conducted the UHC claims audit by the end of FY03, HR should seek a refund of the $46,900, and HR should contract with another firm to conduct the audit.

3. Establish and implement procedures to randomly verify the performance results provided by the health benefits administrator.

4. Establish and implement procedures for an immediate claims audit of UHC.

5. Establish and implement procedures to receive and review hospital claims audits.

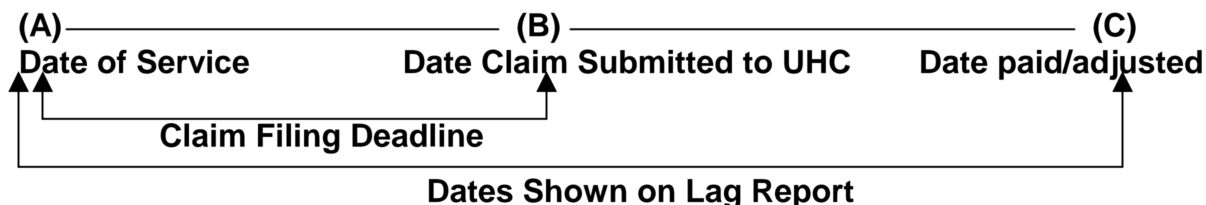
6. Establish and implement procedures to receive, review, and retain current TPA data.

B. Reconcile and apply the correct funding to each Employee Health Benefit Fund balance. Additionally, simplify the Agency Fund structure and ensure accounting practice is in compliance with GAAP.

Management's Response:

A. 1. **There have <u>not</u> been $507,483 in payments made beyond the claims filing period**. The Claim Lag Study reviewed by the City Auditor only measures the time claims are paid from the **date medical service was performed (A)** to the **date the claim was paid or an adjustment was made (C)**. **The report does not show the date that the claim was submitted to UHC (B), which is the date used to calculate the filing dead line.**

Below is an illustration, showing these three dates:



Claim filing deadline-

- Prior to 2002, the maximum amount of time allowed for filing a claim (A to B in above illustration) was 18 months; effective January 2002 the filing period was reduced to 12 months.
- There is no deadline imposed to pay claims after they have been submitted (B to C).

HR Department staff analyzed the $507,483 number the Auditor extracted from the lag report, which represented .7% of the $73,091,205 in medical claims processed and paid during that time period. They reviewed the actual claims detail of the six months having the highest totals ($344,238.) This comprised payments and/or credits made on behalf of 170 patients (see Exhibit Three). $211,235 of the $344,238 was generated from services rendered to one patient in May and June 2001. The claim was filed in August 2001, well within the filing deadline. The final payments/adjustments were not processed until November and December 2002.

The remaining $133,003 of the $507,483 is made up of approximately 250 separate payments or credits. These too were filed within the claim-filing deadline.

The Auditor misinterpreted the data and arrived at an erroneous conclusion. Based upon this inaccurate analysis, the Auditor has determined that monitoring is inadequate.

According to both UHC and the Hay Group, the City's benefits consultant, it is not uncommon for a claim to be received; either processed or denied during the appropriate time period; then have adjustments made after that time period.

There are a number of factors that could delay claim processing time, such as the need for additional documentation from the medical provider, a delay occurring while the primary carrier processes the claim, or because of the need for an internal medical review. In addition, previously processed claims could be in the process of being appealed, by either the participant or the provider.

The purpose of a lag report is to show the length of time required, in the aggregate, to pay claims. It is used to establish minimum cash reserve (IBNR) funding levels.

OPPORTUNITIES FOR IMPROVEMENT

There are several controls in place to ensure timely claim submission, below are examples of two:

- UHC's automated claims system contains a hard-coded system edit that compares incurred date with received date and rejects claims received after the filing limitation.
- UHC's network contracts require their contracted providers to submit claims within 90 days of the date of service in order to receive payment. If the network provider submits the claim late, the claim is denied and the provider is prohibited from balance billing the patient.

2. In 2002, HR contracted with The Hay Group as its benefits consultant. Hay's scope of services included the performance of a compliance audit of United Health Care. The department was forced to delay the 2002 audit because of having to implement a new call center and to bring its outsourced membership system in house. In 2003, Hay was scheduled to conduct the audit, however their expertise was required to assist with the Request for Proposal for a new claims processing and administration contract. A business decision was made that their time and expertise would be better used to in this manner.

   An extensive selection process was performed, resulting in a selection of a new vendor to perform claims administrative services. As a result, the following was accomplished:

   - An increase of $2,800,000 in network discounts
   - A reduction of $1,364,354 in claims processing costs
   - Minimal disruption with physicians
   - Full integration with prescription program to provide complete disease management capabilities
   - Fulltime onsite service representative

   HR has advised the Auditor that Hay Group would be available to perform the audit in early February. As an alternative, the Auditor's Office was given the option to perform its own audit.

   Like most City vendors, the Hay Group is paid only for services performed; the audit has not been performed, therefore $46,900 was not paid to the Hay Group. There is no need to request a refund.

3. The monitoring of United Health Care performance standards was included as part of the compliance audit to be conducted by the Hay Group in 2002; however, the audit had to be delayed. United Health Care has provided

documentation that indicates they met the performance standards outlined in the contract.

4. UHC contracts with a firm to perform hospital audits. This is done in order to ensure accuracy for itself and its clients. It contains proprietary information. The fact that HR Department does not get a copy of these internal UHC documents does not mean that HR is unable to address questionable claims. The Hay Group analyzes claim data on a monthly basis and is thus able to identify anomalies or major claim errors. HR Department will contact Humana, the new vendor for claims administration, and obtain a copy of their methodology for auditing hospital claims.

5. In 2001, when HR received access to UHC's system, the reporting capabilities were limited in nature. HR worked with UHC to get access to their expanded reporting system that provides more detailed claims data and membership information. HR provides monthly claims data and membership information to the Hay Group so that they may perform health plan projections and claims analyses.

   The City will receive full access to all electronic information gathered by Humana, the new claims vendor.

B. The fund structure has already been simplified. Accounting practices comply with accounting standards.

   The City's monthly contribution was received by the Benefits fund through an interface between the City's accounting system and its legacy payroll system. It was allocated based upon a percentage set up as an estimate of where the funds should go. A former Benefits Administrator put this system in place over ten years ago. Because it was programmed in the background, current HR staff did not know who controlled this process. After considerable research, HR Department isolated the background process, and finally was able to get it changed. HR Department brought this to the attention of the Auditor.

   The reason UHC's 2001 report contained conflicting information from that presented in its 2002 Executive Summary was that the 2001 report was prepared on a cash basis and the 2002 summary was prepared on an accrual basis. After it was determined what caused the confusion, corrected data was provided to the auditors.

Auditor's Comment:

The only way to verify that claims are being processed accurately and timely is to audit them, which HR stated it has not done. HR also stated that they had "included $46,900

in our proposal for this claim audit, and we will handle it within that cost structure" in the Hay Group contract. Further, HR was unable to provide documentation for accounting compliance assurance.

4. Ongoing assessments need to be made to forecast future health care issues.

The impact of Medicare Part A premiums is not known.

As identified in Opportunity for Improvement 2, the City's policy is to pay for Medicare Part A for retirees not otherwise eligible for federally paid coverage. HR has not assessed the possible financial impact if the City were to pay Medicare Part A premiums for additional eligible retirees and their spouses. There are 4,490 active employees hired prior to April 1, 1986, who may not have paid into the Medicare Plan. The total number of employees and spouses that the City may potentially pay Medicare Part A premiums for is not known by HR. HR has not attempted to determine the actual number of those employees who may not qualify for federally paid Medicare. We contacted the State's Social Security Administrator and were advised that such an inquiry of this group of employees would not violate Social Security Administration regulations.

Prior to mandatory Medicare payroll deductions and participation, the City opted for non-employee participation of those hired prior to April 1, 1986. This practice remains in effect at this time.

Using HRIS, we determined that of the 4,490 active City employees hired prior to April 1986:

- 58 employees are at least 65 years of age
- 8 individuals will turn 65 years of age during 2003
- 15 individuals will turn 65 years of age during 2004

Potential Impact If The City Were To Pay Part A During 2003/04 For Active Eligible Employees				
Eligible	No. Employees	Individual Payment	Monthly	Annually
Now	58	$316	$18,328	$219,936
2003	66	$316	$20,856	$250,272
2004	81	$316	$25,596	$307,152
Annual Recurring Total For the Group				**$307,152**

To maintain participation in the City's plan, all retirees eligible for Medicare must enroll in Part A and Part B. If an active employee desires to use Medicare as a secondary payer, the individual must enroll in Medicare Parts A and B. The City may be unable to determine its financial liability as it relates to Medicare Part A coverage for the 4,490

individuals. If the City assumes the entire liability for Medicare Part A premiums for these individuals at the time of their eligibility, the economic impact could be significant.

A financial benefit may exist for the City to pay Medicare Part A premiums, as Medicare will be the primary medical payer when the retirees reach age 65. The City's self-insured PPO will then only assume 80% of what is allowed and not paid by Medicare after deducible.

The 2001 plan provides that the City Manager may supply preferential rates and/or payment of all or part of Medicare A premiums to participants as follows:

1. Any participant who retired on or before July 1, 1980, and does not qualify under (2) through (5).
2. Any participant who retires on disability pension.
3. Any participant who retires with five or more years' service credit.
4. Any participant who is the surviving spouse of (1) above.
5. Any participant who is the surviving spouse of a participant who dies while actively employed.

These Medicare payment authorizations were not present in the 2002 and 2003 plans.

According to HR, the City is not paying the full amount of Part A for retirees who are 65 years of age and older. The $316 per month premium for Part A was included in the insurance premium rate calculation for retirees, as of 2003. Thus, all retirees are sharing in the cost of Part A within their insurance premium.

Sound financial decisions should be based on reliable supplied data; inaccurate data may have long lasting detrimental effects. On-going efforts should be maintained to accurately forecast financial projections and supply this information to the decision makers.

We recommend that the Director of HR:

- Consult with City Management and evaluate whether it is conducive for the City to continue paying Medicare Part A premiums for retirees.
- Determine the actual number of individuals that the City will pay Medicare Part A premiums for, should the Resolution remain unchanged.

Management's Response:

Ongoing assessments and projections are an important part of the HR process. Considerable time and effort is spent evaluating funding strategies, plan designs, and health care industry trends. The Auditor's statement implying this practice was not being performed is inaccurate.

OPPORTUNITIES FOR IMPROVEMENT

The impact of Medicare Part A premiums is known. It has been evaluated and a decision regarding its handling has been made. Please refer to an earlier response on this subject. As noted above and based upon the current participation percentage of 7%, if the 81 employees identified by the Auditor, the City's annual liability would be $22,752. (81 times .07 times $316 times 12)

Management has already evaluated and informed City Council regarding this. The approximate number of individuals has been calculated and the resulting funds have been budgeted for this purpose. The current resolution, 03-2582, states that retirees and spouses will apply for Medicare, and if not otherwise eligible because of employment, the City will pay their Part A premium on their behalf.

Auditor's Comment:

We disagree with the use of the 7% estimate. Supporting documentation was not provided to support this estimate. There are 4,490 employees and an unknown number of spouses that potentially qualify for City paid Medicare A premiums.

5. Opportunities to reduce the City's potential liability for Medicare Part A premiums has not been explored.

In compliance with existing ordinances, the City assumes a liability of Medicare Part A premiums for 4,490 employees hired prior April 1986 and others not qualifying for Medicare Part A at federal expense (and possibility some spouses). The City has not explored options for reducing this liability.

Section 218 Agreement of the Social Security Administration exists to provide Social Security and/or Medicare coverage for State and local government employees, hired before April 01, 1986, who are not eligible for free Medicare A. Section 218 allows local governments to make retroactive changes for the employees.

In order for an individual to qualify for the free Medicare Part A premium, the individual or the individual's spouse must have forty quarters of Medicare covered employment. The Part A premium is $174 monthly for those individuals having thirty to thirty-nine quarters of Medicare covered employment. The 2002 premium rate for those individuals having less than 30 quarters is $316 monthly.

If the City desires to enact Section 218, there must be a Council Resolution approving such action. Action may start new or be retroactive up to five years. Individual employees must be allowed to elect whether or not to participate in Medicare deductions. Each year retroactive requires 1.45% of individual's gross income for each year, by the City and by the individual.

OPPORTUNITIES FOR IMPROVEMENT

The 4,490 pre-1986 hired employees receive $228,634,608 in salary annually. The following table reflects the City's potential annual financial impact for the pre-1986 hires for 1.45% Medicare deductions.

Potential Impact to the City if Paying Contributions For Medicare Part A			
Individuals	Gross Income	City Percentage	Annual Contribution
4,490	$228,634,608	1.45%	$3,315,202

Add the additional annual contribution for each year retroactive, if all individuals elect to participate.

If the Medicare deduction were instituted, some of the pre-April 1, 1986, hired employees and others would be able to qualify for the 40 quarters requirement prior to their retirement.

Information relating to the potential financial impact to the City should be readily available to decision makers of the City. Employees should be knowledgeable about the possible effect of not having Medicare Part A available.

We recommend that the Director of HR:

- Make an inquiry of all pre-April 1, 1986, hired employees to determine possible employee or spousal Medicare Part A coverage.
- Determine actual impact to the City if the above resolution remains unchanged and the City accepts the liability of paying the premiums for Part A.
- Determine the actual City contribution for Medicare Part A for retirees and active employees.
- Re-compute retiree health care premiums to differentiate: one for those that qualify for Medicare and one for those do not.
- Establish an employee educational process regarding the possible effects of not having Medicare Part A available.
- Determine and present information to the City Council for a decision on providing affected employees the option of participating in Medicare through payroll deductions.

Management's Response:

Management will not be contacting employees hired prior to April 1, 1986 to inquire about their possible Medicare status. According to a representative of the federal government, such a survey would be in violation of an employee's right to privacy.

Opportunities to possibly reduce the City's potential liability for Medicare Part A premiums have been explored and evaluated, just not shared with the Auditor. City

OPPORTUNITIES FOR IMPROVEMENT

Management is familiar with Section 218 and its costs because an study of this program had been performed. Approximately 4,500 employees would be involved, 70% of who could retire within five years. Because it usually takes ten years to qualify for Medicare, a retroactive buy-in with Section 218 would not provide full eligibility for 70% of the group. To retroactively buy-in the remaining 30% would cost the City $9,500,000, payable at the time of agreement. In addition the City would then also contribute Medicare payroll taxes on behalf of these individuals.

Management will not be re-computing costs for retirees, differentiating between those who are eligible for Medicare and those who are not. The additional cost to pay Medicare Part A on behalf of those not otherwise eligible will continue to be spread across the entire retiree enrollment, just as all retiree claims costs are handled. This is the principal of insurance, the sharing of cost and risk. This method has been fully disclosed to City Council.

Auditor's Comment:

The State Social Security Administrator advised our office that there is not a privacy issue regarding individual inquiries to determine the Medicare coverage impact for the City of Dallas.

6. Incentives are not in place to encourage plan participants to report claim-processing errors.

There are no incentives (such as a percent of recovered overpayments) to the user for reporting inaccuracies that do not affect them directly (i.e., overpayment, payment for service not received).

Upon receiving a medical treatment invoice, UHC will start the claim processing, which involves a review of the treatment (services received for a diagnosed illness), the original charge, and the allowable amount.

In cases where an in-network provider is used, there is a contracted allowable amount for the service received. UHC then pays the provider 80% (if the users out of pocket - deductions have been met). The remaining 20% is the responsibility of the user.

If the provider is out-of-network, health care administrators rely on the Usual, Customary, and Reasonable (UCR) rate as a comparison to the amount charges. The following defines UCR:

- Usual – if it is the fee most frequently charged by a provider for the particular service or supply.

- Customary – if it is within the range of fees usually charged for the particular service or supply by providers or similar training and experience in the same locality.
- Reasonable – when it is usual and customary or, in the opinion of the administrator, is justified because of unusual circumstances, such as the complexity of a surgical procedure.

The administrator will pay the out-of-network provider 60% of the UCR allowable amount, and the remainder is the responsibility of the user.

After making a determination of the payment to the provider, UHC prepares an Explanation Of Benefits (EOB), a summary statement of service, date received, amount of the charges submitted, ineligible and approved benefits, and the amount to be paid to the provider by UHC and by the user.

The EOB is mailed to the user, with the expectation that the user will review it, compare it to actual services and charges, and notify UHC of any errors (i.e., overpayments, payment for treatment not received).

Rewards of sharing a percentage of the recovery of unauthorized payments will increase the user review of the EOB and encourage reporting inaccuracies.

We recommend that the Director of HR:

- Establish incentives to encourage users to review the EOB and report inaccuracies.
- Communicate incentives to plan participants, such as adding a notation to the UHC EOB statements.

Management's Response:

Management does not agree that it should establish incentives to encourage users to review their statements. This would create a process that would intrude upon a member's medical privacy in order to solve a problem that does not exist.

The EOB (Explanation of Benefits) is mailed to the plan participant, who should review it and notify the third party administrator (currently UHC) of any errors. If the participant has overpaid, UHC will reimburse the participant. It is the participant's responsibility to review the EOB to make sure deductibles and coinsurance amounts are correct.

The EOB is an easy to understand document, which the participants have regarded as a valuable tool, assisting them to take better control of their own health issues. One of the benefits of outsourcing claims processing is opportunity to have sophisticated claims

reporting technology that can communicate effectively with the participants. The few billing discrepancies that have arisen have been easily resolved.

Based on an actuarial overview of the City's claims experience, expenses are running well within normal expectations. If the aggregate numbers are in line, then the individual claims will be, in the aggregate, also in line. The City's consultant tracts aggregate claims expenses in order to identify trends and project future cash needs. This type of ongoing analysis would reveal major payment errors for which corrective action could be immediately taken.

7. A payment step in Medicare Part B processing may be eliminated.

The Employee Retirement Fund (ERF) and the Police and Fire Pension (PFP) through HR Risk Funds pay Medicare Part B premiums. Payments are submitted monthly to HR, which process the payments and submits them to the federal agency for the Social Security Administration. This procedure requires an extra step in processing the Medicare payments.

To reduce payment processing and improve time efficiency, this step could be eliminated by having payments made directly to the Federal agency by ERF and PFP.

We recommend that the Director of HR consult with ERF and PFP to establish procedures for ERF and PFP to pay Medicare premiums directly to the responsible agency.

Management's Response:

This was another item brought to the Auditor by HR. As time permits, this subject will be discussed with the two pension plans.

The rate employees are charged for the City's PPO plan appears average or lower while the rate for the HMO plan is higher.

Significant interest surrounds the cost of health care. To determine how the City of Dallas fares when compared to other governmental entities, we performed a survey of those entities' health care costs. The results are shown in the following tables.

2003 PPO Monthly Premium Contribution by Employee vs. Employer

	Employee Only			Employee + Spouse			Employee + Children			Employee + Family		
	Employee	Employer	Total	Employee	Employer	Total	Employee	Employer	Total	Employee	Employer	Total
Dallas	**23**	**193**	**216**	**216**	**216**	**432**	**65**	**313**	**378**	**258**	**336**	**594**
DISD	292	225	517	881	225	1106	720	225	945	1039	225	1264
Federal*	N/A			N/A			N/A			N/A		N/A
Ft. Worth	45	235	280	273	276	549	191	309	500	286	593	879
San ** Antonio	0	409	409	0	409	409	0	409	409	0	409	409
State***	N/A			N/A			N/A			N/A		

* The Federal Benefits Program does not offer PPO.
** San Antonio provides free health care to employees and dependents.
*** The State ERS does not offer PPO.

2003 HMO Monthly Premium Contribution by Employee & Employer

	Employee Only			Employee + Spouse			Employee + Children			Employee + Family			Avg.
Entity	Employee	Employer	Total	Employee	Employer	Total	Employee	Employer	Total	Employee	Employer	Total	Total
Dallas	**100**	**193**	**293**	**414**	**216**	**630**	**360**	**313**	**673**	**689**	**336**	**1025**	**655**
DISD	131	225	356	533	225	758	422	225	647	641	225	866	657
Fed**	75	225	300	N/A			N/A			194	541	735	517
Ft.W.	N/A			N/A			N/A			N/A			
S.A.*	18	409	427	35	409	444				52	409	461	444
State	0	307	307	176	483	659	118	425	543	294	601	895	601

* San Antonio has three HMO categories: employee, employee +1, and employee +2.
** Federal Employee Benefits program contains multiple HMO Plans; we selected a mid-range plan. In addition, Federal only has two categories: employee, or +family.

The 2003 HMO In-Network co-pay:

- **Dallas $30**
- DISD $15
- Federal Not Available
- San Antonio $10
- State $10

2002 to 2003 Total PPO Premium Increase (%)					
	Employee only	**Employee + Spouse**	**Employee + Children**	**Employee+ Family**	**Average**
Dallas	**22.73**	**13.39**	**8.62**	**10.77**	**12.89**
DISD	33.15	33.15	29.85	33.15	32.32
Federal	N/A	N/A	N/A	N/A	N/A
Ft. Worth	0.00	0.00	0.00	0.00	0.00
San Antonio	12.67	12.67	12.67	12.67	12.67
State	N/A	N/A	N/A	N/A	N/A

2002 to 2003 Total HMO Premium Increase (%)					
	Employee only	**Employee + Spouse**	**Employee + Children**	**Employee+ Family**	**Average**
Dallas	**19.30**	**28.25**	**49.75**	**32.19**	**39.32**
DISD	33.15	33.15	29.63	33.15	32.27
Federal	15.80			15.80	15.80
Ft. Worth	N/A	N/A	N//A	N/A	N/A
San Antonio	12.33	12.01	NA	11.70	12.01
State	11.96	12.45	12.36	12.57	12.41

There was a shift in member enrollment from the HMO to the PPO from 2001 to 2003. We noted a significant increase in the employee's premium for enrolling in the City's HMO plan, which would account for the migration to the PPO plan. The following tables reflect the three years of HMO and PPO enrollment.

City of Dallas Major Health Program Participation Summary					
	2001		**2002**		**2003**
	No. of Covered Lives	Annual Claim Cost	No. of Covered Lives	Annual Claim Cost	No. of Covered Lives
PPO	23,610	$33,606,933	24,746	$39,484,272	25,588
HMO	6,843	$8,997,924	5,943	$10,486,411	3,306

Note: The prescription drug cost is not included. Annual claim cost for 2003 not yet actualized.

City of Dallas PPO Participant Structure			
	2001	**2002**	**2003**
Active Employee	8,458	8,749	9,235
Active Employee Dependent	9,262	9,965	10,020
Retiree Over 65	2,727	2,655	2,690
Retiree Over 65 Dependent	822	960	879
Retiree Under 65	1,470	1,593	1,794
Retiree Under 65 Dependent	865	817	964
COBRA	6	6	5
COBRA Dependent	0	1	1
Totals	**23,610**	**24,746**	**25,588**

We recommend that the Director of HR conduct this assessment annually for Council presentation.

Management's Response:

The Auditor presented a comparison showing current employee/employer contributions for the above entities. There was no explanation of the level of benefits being provided by each entity for the given contributions (such as deductible, out of pocket maximums, etc.). The comparison reflects the fact that the City of Dallas plan is less expensive than that of the others shown in the survey.

The Auditor also listed the HMO co-pays for Dallas, DISD, San Antonio and the State of Texas; this shows the City's co-pay is $30, higher than the others. A brief calculation was performed to compute changes in plans or employer contributions.

Management believes the Benefits presentations that HR Department makes to Council are extremely effective and provide Council the information they need to make informed decisions. Management will continue to keep Council informed regarding this very important subject.

In conclusion, it was disheartening to see the Auditor focus on a few minor areas of the health benefits program, and be unwilling to applaud the larger and more important successes accomplished during the last three years, which included:

- Increased contributions from City and Members
- Outsourced claims administration to third party administrator (TPA) which
  - Improved customer service
  - Reduced claims backlog
  - Provided national PPO network & discounts
  - Introduced state of the art technology
- Outsourced COBRA billing and collection
- Increased monthly premiums from three to four rate tiers
- Added 65+ retirees to standard plan
- Coordinated with Medicare at 80% instead of 100%
- Included City's Medicare cost in determining retiree costs
- Eliminated dual coverage
- Increased out of pocket maximums, e.g.,
  - Pharmacy to $1500
  - Medical from $2000 to $2500 for individual in network (plus deductible)
- Redesigned pharmacy mail order
- Eliminated "Term Vesteds"—to participate as a retiree, employee must work for City until retirement
- Outsourced call center
- Introduced $1000 deductible plan
  - Preventive Care
  - "Buy back" option
  - Protection from financial catastrophe

- Added options for 65+ retirees
    - Stand alone Prescription Drug Benefit
    - Medicare Supplement (Medigap) Policies

There were more improvements and cost savings achieved during that time period than during the prior fifteen years. Management wonders whether this audit was impartial, or suffered from a conflict of interest caused by the Auditor's past role as fund administrator.

Currently there are five employees administering the City's health benefits plan, which covers approximately 30,000 employees, retirees, and dependents. That same group is responsible for the City's life insurance and voluntary benefits programs as well. Executive responsibility for this function is assigned to one of the two Human Resources Assistant Directors, who also is in charge of the Risk Management Division. This leveraging of City employees is accomplished because outsourcing is maximized. Claims processing, customer service call center operations, voluntary benefits, COBRA, Flexible Spending Account Administration, and life insurance claims are now all handled by outside vendors. HR, with assistance of its consultant, has been able to consistently offer comprehensive yet affordable health care program to its employees and retirees. This has continued even during difficult budgetary times.

Exhibit Two

Memorandum

DATE June 3, 1993

TO Jan Beggs
Claims Processing Manager

SUBJECT Medicare Premiums

Because we require people over 65, to join medicare in order to participate in our insurance programs, the City of Dallas pays for Medicare Part "A" (Hospital Coverage) for city retirees who are not otherwise qualified either by their own, or their spouses, contributions to the social security system.

In order to eliminate some confusion on the Medicare Premiums the City will pay for employees and retirees, I have put together the chart below:

Category	Part "A"	Part "B"
Active Employees (over 65)	YES	YES
Active Employees Spouses (over 65)	YES	YES
Retirees (over 65)	YES	NO
Retiree Spouses (over 65)	YES	NO

Requirements For Participation:

1) A minimum of five years of service with the city.
2) Participation in one of the City's Health plans, including the HMO plans.
3) Completion of the appropriate authorization forms.

Note that while the City writes a check for the Part "B" to Medicare Group billing for retirees, the money is deducted from their retirement checks and is not funded by the City.

Jack

Jack Liewehr
Benefits Financial Manager

c: Lonzie Greene Jr.
Debera Jones
Larry Low
Mike Taylor
Richard Tettamant

Exhibit Three

Attachment to Response to Health Benefits Audit
LAG REPORT—ANALYSIS OF BACKGROUND DETAIL*

Report Period-Months with highest totals	# Patients	# Non-Medicare Items (charges or credits)	Amount	# Medicare Items (charges or credits)**	Amount
Date of Service 2/2001 and Paid 11/2002	8	2	$67	12	$29,106
Date of Service 5/2001 and Paid 1/2003	13	8	$96,141***	10	$497
Date of Service 6/2001 and Paid 12/2002	22	10	$111,294***	13	$2,059
Date of Service 4/2002 and Paid 4/2003	55	43	$15,614	37	$12,295
Date of Service 3/2002 and Paid 3/2003	44	30	$4,086	40	$25,797
Date of Service 2/2002 and Paid 4/2003	28	24	$5,481	21	$41,801
TOTALS	170	117	$232,683	133	$111,555

*Prior to 2002, claims were required to be submitted within 18 months of date of service; effective 2002, claims were required to be submitted within 12 months of date of service.

** Claims are first submitted to Medicare for payment. After being processed by Medicare, claims are then submitted to UHC as secondary payor.

***$94,831—May 2001 services rendered for one patient who had exhausted Medicare benefits; therefore, Medicare notified UHC they would become primary. Claim filed by Medicare August 2001—final documentation was provided by Medicare and claims were paid by UHC November and December 2002.

***$116,404—June 2001 services rendered for above patient.

10/20/2003