

Office of the State Auditor
Performance Audit Division



State of Mississippi

PHIL BRYANT
AUDITOR

A Performance Review of The State and School Employees Life and Health Insurance Plan

March 28, 2000

Office of the State Auditor
Performance Audit Division

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Phil Bryant
State Auditor

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STATE OF MISSISSIPPI
OFFICE OF THE STATE AUDITOR
PHIL BRYANT
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March 28, 2000

Department of Finance and Administration, Office of Insurance
State and Public School Employees Health Insurance Management Board
Members of the Mississippi Legislature
State and Public School Employees
All State Agencies, Boards, and Commissions

Ladies and Gentlemen:

The Office of the State Auditor has completed *A Performance Review of The State and School Employees Life and Health Insurance Plan*. The results of this review are presented to you in the report published herein. This review was initiated based on the request of the Department of Finance and Administration, Office of Insurance pursuant to requirements of Section 25-15-11, Mississippi Code of 1972, Annotated.

Since the State and Public School Employee Life and Health Insurance Plan (Plan) is an extremely important government program protecting the health of thousands of state employees and public school employees, the significance of this report cannot be overstated.

The Plan is in financial crisis. Over the last three completed fiscal years (1997, 1998 and 1999), a June 30, 1996 Plan surplus of \$70.6 million has decreased \$93.2 million creating a Plan deficit of \$22.6 million at June 30, 1999. The deficit has grown to approximately \$36 million in March, 2000. These deficits have occurred despite the fact Plan premiums were increased during these three years by 10%, 4.5% and 9%, respectively. The State and Public School Employees Life and Health Insurance Management Board and the State Legislature must act soon to resolve this financial crisis.

It is our hope the information included in this report will be beneficial to state and public school employees in understanding the condition of their life and health insurance plan and to state officials and policy-makers in the administration of this vital program.

Sincerely,

A handwritten signature in cursive script, reading "Phil Bryant".

Phil Bryant
State Auditor

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Office of the State Auditor Division of Performance Audit

A Performance Review of The State and School Employees Life and Health Insurance Plan

Executive Summary

March 28, 2000

Purpose of Review

The Department of Finance and Administration, Office of Insurance (DFA-Insurance), requested the State Auditor's Office conduct a performance review of the State and School Employees Life and Health Insurance Plan (Plan). The letter requesting this review is in compliance with Section 25-15-11, Mississippi Code of 1972, Annotated, which states, in part (page 1):

“Annually, the board [State and School Employees Health Insurance Management Board] shall request, and the Department of Audit shall conduct, a comprehensive audit of the State and School Employees Life and Health Insurance Plan.”

Scope

Due to the number and scope of other financial and compliance audits of the Plan conducted annually, the State Auditor's Office

limited the scope of the performance review to summarization and analysis of the other audits conducted on the Plan. (page 1)

Actuarial Report

The Office of the State Auditor's analysis of the June 30, 1999 Actuarial Report, prepared by Wm. Lynn Townsend, FSA, MAAA, indicated several important matters, such as (page 2):

1. There was a significant improvement in claims payment timelines during calendar year 1999.
2. The funding status has changed from a surplus of \$70.6 million in fiscal year 1996 to a deficit of \$22.6 million in fiscal year 1999.
3. A comparison of claims to premiums shows that in fiscal year 1996 premiums exceeded claims by \$3.2 million while in fiscal year 1999 claims exceeded premiums by \$17.9 million.
4. The plan is experiencing a 12-14 % annual increase in the average number of prescriptions per member, and annual increases in the average cost of

prescriptions in excess of 13 %. Drug benefit claims grew from \$36 million in calendar year 1997 to \$50 million in calendar year 1998. Drug benefit claims for the first half of calendar year 1999 have totaled \$32 million.

Deficit Health Plan Financial Condition Worsening

At June 30, 1999, the Plan's liabilities exceeded its assets by \$22 million. Since the average decrease in the Plan's surplus in each of the last three fiscal years was \$31 million and its current financial trend is to disburse more funds than it receives, changes must occur in the Plan's financial structure or its current serious financial condition could worsen. (page 7)

The Plan is able to continue operations despite this deficit due to the cash flow generated from current premium collections and investment income. The approximate two month lag between the date a claim is incurred to the date it is filed and paid has helped allow the Plan to continue processing claims without interruption. Nonetheless, the current level of premium receipts is insufficient to fund the current and projected level of claims and Plan expenses. (page 7)

Due to the \$22 million deficit, the State and Public School Employees Health Insurance Management Board must take some action to resolve this financial crisis. These possibilities include, but are not limited to, the following:

- increase receipts through higher health premiums;
- increase participant deductible and co-

payment amounts;

- decrease participant benefits;
- reduce utilization;
- find an alternative funding source to supplement premium increases or utilization reduction; or
- apply a combination of these actions.

(It is important to note that any decision regarding alteration of the Plan is at the sole discretion of the Board and State Legislature. Any possible resolutions included in this report should not be accepted as a recommendation or directive of the Auditor's Office.) (page 7)

The growing cost of new drugs is creating a substantial financial drain of the Plan. The increase in retail pharmacy payments created a large percentage of the financial drain on the Plan and must be addressed. (page 8)

The Board has already addressed the growing deficit issue by authorizing increases in the Plan premiums for fiscal years 1999 and 2000, and projecting increases for 2001. However, state policy-makers should immediately address the Plan's financial condition and take any additional steps necessary to place this important government program on sound long-term financial ground. (page 8)

Benefit Changes for 2000 and Proposed Future Changes

The state has increased health benefit premiums 8 of the last 11 years at an average annual increase of over 6% and projects another premium increase in FY 2001 of 14%-20%. (page 13)

Plan Subsidization of Some Participant Categories

Charges for premiums to operate the Plan are made by participant category (active employee, spouse, children, family, COBRA, early retirement, retirement spouse, and Medicare retirement). Increases in Plan premiums per participant are not necessarily based on utilization within these categories. This results in the subsidization of certain categories with higher claims per participant by other categories with lower claims per participant.

Some subsidization of other premium classes is necessary by the active employee premium class because federal and state laws restrict increases to the COBRA and early retirement premium classes. However, rather than continuing or increasing subsidization of premium classes incurring higher claims, DFA- Insurance should revisit the basis for setting the current health benefit premium structure.

Benefit Changes

The following insurance benefit changes were implemented for calendar year 2000 (page 13):

- single AHS state network;
- application of in-network and out-of-network out-of-pocket provision;
- out-of-area benefits;
- revision to carve out benefits;
- revision to outpatient pre-certification;
- addition of speech therapy as a covered service;
- addition or licensed clinical workers and professional counselors as covered providers;
- addition of outpatient cardiac rehabilitation benefits;
- addition of wellness/preventive coverage;
- prescription drug deductible;
- pharmacy co-payment amounts and generic differential; and
- delete plan provision to annually restore \$1,000 benefit after \$1,000,000 lifetime maximum exhausted.

The Board has identified several problem areas with the current health benefit plan and has developed proposed changes in its January 1999 *State and Public School Employee Health Insurance Plans Strategic Plan* (page 20).

Planned actions to be taken during 1999 through 2003 to address some of these problem areas are similar to actions being taken by most large employer and state employee health benefit plans and will need to be reviewed and revised annually based upon external and internal changes. These planned actions include the following (page 20):

- establish a State-specific provider network;
- study various options for the Plans

-
- for years 2000 and forward;
 - expanding preventive care services;
 - providing incentives for participants to stay healthy or use cost-effective providers;
 - developing a benefit structure similar to the federal employees' health plan; and
 - developing a benefit structure with co-pays instead of co-insurance.
 - consider implementing a disease management program;
 - continue improvements in communication to participants through quarterly newsletters, annual updates to the Summary Plan Description, other publications, and videos;
 - develop the capacity to electronically transfer premium billing information and payments; and
 - continue competitive bidding for all vendors under the Plans.

These planned actions reflect a commitment to maintaining an affordable health benefit plan for both the State and the Plan participants, while allowing participants a choice of benefit options that meet their needs. (page 21)

Claims Audit

The Office of the State Auditor's analysis of the calendar year 1998 Claims Audit, performed by William M. Mercer, Inc., indicates DFA- Insurance should closely monitor the performance of BlueCross in meeting their contractual obligations in the

claim administration services for the Plan. The Claims Audit pointed out unacceptable levels of compliance in three of four categories. Blue Cross did not meet contractual obligations in pay error frequency, dollars mispaid and claim turnaround time. Blue Cross incurred the maximum performance penalties of 10 % of annual administrative fees for 1998 claims and the maximum of 10% of runout fees for runout claims. The total performance penalty paid by BlueCross was \$962,021. (page 22)

If the performance of Blue Cross does not satisfactorily improve, DFA- Insurance should evaluate their course of action considering various methods of penalties for non-compliance with contractual obligations. This may include increased financial penalties or other penalties up to and including the appointment of a new claim administrator. An actuarial report, dated September 7, 1999, based on a review of the experience through June 30, 1999 of the State and School Employees Life and Health Insurance Plan was prepared by Wm. Lynn Townsend, FSA. This report stated "*Based on the review of recent claims activity and confirmed by separately prepared BlueCross performance reports, it is clear that there has been a significant improvement in the claims payment timelines during calendar year 1999.*" (page 23)

The entire report can be obtained from the Office of the State Auditor by calling 601-364-2888.

Introduction

Purpose of Performance Audit

The Department of Finance and Administration, Office of Insurance (DFA- Insurance), requested the State Auditor's Office to conduct a performance audit of the State and School Employees Life and Health Insurance Plan (Plan). The letter requesting this audit is in compliance with Section 25-15-11, Mississippi Code of 1972, Annotated, which states, in part:

“Annually, the board [State and School Employees Health Insurance Management Board] shall request, and the Department of Audit shall conduct, a comprehensive audit of the State and School Employees Life and Health Insurance Plan.”

Scope

In addition to an annual audit by the State Auditor's Office as part of publication of the state's Comprehensive Annual Financial Report, statutory authorization by the PEER Committee to contract compliance audits of the Plan's third party administrator, and this annual performance audit, DFA-Insurance also contracts an actuarial report every six months and an annual claims audit, and periodically contracts audits of the pharmacy network and the utilization management vendor.

Due to the number and scope of other financial and compliance audits of the Plan conducted annually, the State Auditor's Office limited the scope of this performance audit to summarization and analysis of the other audits conducted on the Plan. The oversight provided by these required and elective audits should provide the Plan sufficient audit coverage.

Actuarial Report

Report Summary

The Department of Finance and Administration (DFA) contracted with Wm. Lynn Townsend, FSA, MAAA (Townsend) to prepare an actuarial report based on a review of the experience through June 30, 1999 of the State and School Employees Life and Health Insurance Plan (Plan).

The Office of the State Auditor's analysis of the Actuarial Report indicates several matters of importance. These matters are summarized below.

29. There was a significant improvement in claims payment timeliness during calendar year 1999.
2. The funding status has changed from a surplus of \$70.6 million in fiscal year 1996 to a deficit of \$22.6 million in fiscal year 1999. [Emphasis added]
3. A comparison of claims to premiums shows that in fiscal year 1996 premiums exceeded claims by \$3.2 million while in fiscal year 1999 claims exceeded premiums by \$17.9 million. [Emphasis added]
4. Drug benefit claims grew from \$36 million in calendar year 1997 to \$50 million in calendar year 1998. Drug benefit claims for the first half of calendar year 1999 have totaled \$32 million. The plan is experiencing a 12 -14 % annual increase in the average number of prescriptions per member and annual increases in the average cost of prescriptions in excess of 13 %.

These matters indicate serious problems in the Plan that are being addressed by DFA. Townsend's report presented two scenarios (See detail of scenarios on pages 28 and 34) attempting to solve Plan problems. Possible solutions include premium increases, deductible increases and handling of prescription drug claims with methods more cost beneficial to the Plan.

Actuarial Report Results for

Outstanding Claims Liability and Claims Processing

"There has been a significant improvement in the claims payment timelines during calendar year 1999."

Townsend stated "Beginning with the announcement of the Plan's intention to change claims administrators in June 1997, and continuing throughout CY98 and the early part of CY99, the Plan has experienced significant claims backlogs that have made the accurate evaluation of the outstanding claims liability extremely difficult."

The report further stated “Based on the review of recent claims activity, and confirmed by separately prepared BCBS performance reports, it is clear that there has been a significant improvement in the claims payment timelines during calendar year 1999. [emphasis added] The extent to which current payment timeliness approach historical standards is difficult to say, however, because much of that improvement, particularly to old claims, has occurred only in the last few months. Therefore, the current estimate of the outstanding claims liability has been based on claims completion data developed from recent claims activity, and not on the use of historical claims completion data.” Townsend said “In my opinion, an appropriate estimate of health insurance claims outstanding as of June 30, 1999 is \$53.6 million, prior to margin, and \$60.6 million after adding a \$7.0 million margin for claims fluctuations and expenses.”

Plan’s Current Funding Status

Townsend compared the Plan’s current funding status with the funding status of prior periods. The following table shows the results of this comparison.

Table 1

Comparison of Funding Status (In Millions)				
	June-96	June-97	June-98	June-99
Plan Assets	120.7	92.7	92.8	42.7
Less Plan Liabilities	50.1	52.1	84.5	65.3
Plan Surplus (Deficit)	70.6	40.6	8.3	(22.6)
Annual Increase (Decrease) in Surplus		(30.0)	(32.3)	(30.9)

Source: Fy 1999 Actuary Report prepared by Wm. Lynn Townsend, FSA, MAAA

Plan's Premium Versus Claims

Incurred health insurance claims are estimated to have exceeded premiums by \$17.9 million in fiscal year 1999. The following table compares premiums to claims for the last four fiscal years.

Table 2

Premium Versus Claims Incurred (In Millions)				
	FY96	FY97	FY98	FY99
Premiums	230.8	240.1	270.4	293.1
Claims Incurred	227.6	261.2	288.5	311.0
Gain (Loss) Prior to Expenses	3.2	(21.1)	(18.1)	(17.9)
Loss Ratio (Claims/Premium)	98.6 %	108.8 %	106.7 %	106.1 %

Source: Fy 1999 Actuary Report prepared by Wm. Lynn Townsend, FSA, MAAA

Drug Benefit Costs

Cost increases in prescription drug benefits from CY97 to the first half of CY99 were troublesome according to Townsend. Drug benefit claims grew from \$36 million in CY97 to \$50 million in CY98. Drug benefit claims incurred in the first half of CY99 have already totaled \$32 million. The plan is experiencing a 12 - 14 % annual increase in the average number of prescriptions per member, and annual increases in the average cost of prescriptions in excess of 13 %.

Townsend recommended that the State perform a comprehensive review of the drug benefit plan and implement necessary changes, over and above the co-pay increases already planned, as soon as possible. Changes to consider [some which have since been adopted] listed by Townsend were a calendar year deductible, introduction of a "performance" drug list with higher copays for non-performance brand drugs, and a 20 % coinsurance rate assigned to drugs above a certain cost level.

Plan Projections

The following plan projections were taken verbatim from the executive summary of Townsend's report. Appendix A consists of the detailed figures of scenario one and appendix B consists of the detailed figures of scenario two.

Plan Projections

As a result of higher than expected cost levels and higher than expected future cost increases, the premium rates on the State Plan will have to be increased significantly. This Report includes two different sets of projections to assist the State in budgetary planning.

Scenario 1.

These projections illustrate the effect of a 15 % active employee rate increase on July 1, 2000. In this scenario, dependent and retiree rate increases were based on the same set of rate increases that were included in the Calendar Year 1998 Actuarial Report for those premium classes. Note that the rates for those premium classes should be re-evaluated during the Calendar Year 1999 Actuarial Report and should reflect any benefit revisions beyond those currently planned. This set of projections does not restore the Plan's funding position. Additional rate increases, beyond those illustrated in this scenario, are recommended unless the State takes additional action to reduce benefit costs.

[See appendix A for scenario one computation details]

Scenario 2.

Because of rapidly declining asset levels, a separate set of projections was prepared illustrating the effect of an "off-anniversary" active employee rate increase of 3 % on January 1, 2000, followed by 12 % increases on July 1, 2000 and July 1, 2001. This set of projections includes an assumption that drug card benefits are reduced by an annual rate of \$5.5 million beginning January 1, 2000. This could be accomplished through the introduction of a \$50 drug card deductible benefit along with other modest drug benefit changes. This set of projections includes dependent and retiree rate increases that are based on the current premium class structure, but limited to a maximum annual increase of 15 %. Note that this set of projections, based on the current assumptions for medical care trend, restores the Plan's funding to approximately a "breakeven" position at the end of fiscal year 2002.

[See appendix B for scenario two computation details]

Deficit Health Plan Financial Condition Worsening

Health Plan Disbursements Increasing Much Faster Than Receipts

While administrative expenses have decreased slightly from \$12.2 million in FY 97 to \$11.6 million in FY 99, amounts paid during this period by DFA- Insurance for state and school employees health and life insurance claims increased \$72 million, or 27%, and from FY 97 through FY 99 Plan disbursements have exceeded receipts by \$74 million.

Plan disbursements for administrative expenses, cost containment fees and network fees remained relatively constant from fiscal year 1997 to 1999 (\$19.5 million in FY 97 to \$19.1 million in FY 99), and administrative expenses actually decreased slightly from \$12.2 million in FY 97 to \$11.6 million in FY 99.

However, Plan disbursements for claims during this period increased dramatically (27%) from \$270 million in FY 97 to \$342 million in FY 99. See Table 3, page 8, for more information on excess Plan disbursements over (under) receipts. See Table 4, page 9, for information on specific Plan disbursements.

Major Causes For Increases in Plan Disbursements

The \$72 million growth in Plan disbursements over the past three years resulted primarily from increases in the following payment types: hospital charges per day; outpatient payments per service and per employee; and retail pharmacy payments. Retail pharmacy payments, particularly new drugs, account for a substantial portion of recent increases in Plan disbursements.

Increased costs for hospital costs per day, outpatient payments per service and per employee, and retail pharmacy payments have greatly contributed to the \$72 million growth in Plan disbursements over the past three years.

Retail pharmacy payments are the largest contributing factor in increased disbursements. A major reason for increased retail pharmacy payments is the high cost of new drugs. In 1998, the average price per prescription for new drugs was \$71.49, more than twice the average price of \$30.47 for previously existing drugs.

Examples of some new drug costs for active employees are: \$941.95 per prescription for Enbrel (arthritis); \$2,303.48 per prescription for Genotropin (growth hormones); and \$1,408.64 per prescription for Synagis (monoclonal antibody). The total paid for all new drugs by the Plan for active employees and retirees in calendar 1999 was \$4.1 million and \$2 million, respectively.

Health Plan's Deficit Is Growing At An Alarming Rate

From fiscal year 1997 through 1999, the Plan's financial condition deteriorated \$93.2 million (from a \$70.6 million surplus in 1997 to a \$22.6 million deficit in 1999) and the current financial trend indicates possible additional deterioration.

See Table 5, page 12, for more detailed information on Plan surpluses/deficits.

Conclusion

At June 30, 1999, the Plan's liabilities exceeded its assets by \$22 million. Since the average decrease in the Plan's surplus in each of the last three fiscal years was \$31 million and its current financial trend is to disburse more funds than it receives, changes must occur in the Plan's financial structure or its current serious financial condition could worsen.

The Plan is able to continue operations despite this deficit due to the cash flow generated from current premium collections and investment income. The approximate two month lag between the date a claim is incurred to the date it is filed and paid has helped allow the Plan to continue processing claims without interruption. Nonetheless, the current level of premium receipts is insufficient to fund the current and projected level of claims and Plan expenses.

Due to the \$22 million deficit, the State and Public School Employees Health Insurance Management Board must take some action to resolve this financial crisis. These possibilities include, but are not limited to, the following:

- **increase receipts through higher health premiums;**
- **increase participant deductible and co-payment amounts;**
- **decrease participant benefits;**
- **reduce utilization;**
- **find an alternative funding source to supplement premium increases or utilization reduction; or**
- **apply a combination of these actions.**

(It is important to note that any decision regarding alteration of the Plan is at the sole discretion of the Board and State Legislature. Any possible resolutions included in this report should not be accepted as a recommendation or directive of the Auditor's Office.)

The growing cost of new drugs is creating a substantial financial drain on the Plan. The increase in retail pharmacy payments created a large percentage of the financial drain on the Plan and must be addressed.

The Board has already addressed the growing deficit issue by authorizing increases in the Plan premiums for fiscal years 1999 and 2000, and projecting increases for 2001. However, state policy-makers should immediately address the Plan's financial condition and take any additional steps necessary to place this important government program on sound long-term financial ground.

Background Information on Plan's Operation

The Department of Finance & Administration, Office of Insurance (DFA-Insurance), categorizes disbursements from the State and School Employees Life and Health Insurance Plan (Plan) in four groups:

- **Claims/Refunds** - Claim/Refund disbursements are payments made by DFA-Insurance to pay approved health and life insurance claims, to refund certain health premiums and to make payment under the Patient Audit Incentive Program;
- **Administrative expenses** - Administrative disbursements are payments made by DFA-Insurance to manage and administer the Plan;
- **Cost Containment Fees** - Cost containment fees are payments made by DFA-Insurance to third parties that help manage the utilization and appropriateness of medical services to ensure maximum effectiveness and efficiency; and
- **Network Fees** - Network fees are payments made by DFA-Insurance to third parties to provide participant access to provider networks, usually at negotiated lower fees than are normally charged individual health care recipients.

Excess Disbursements Over Receipts

Cumulatively, for the three-year period from fiscal year 1997 through fiscal year 1999, the Plan expended more funds than it received or Plan disbursements exceeded receipts. These excess disbursements over receipts for the three year period total \$74.7 million. With the knowledge of the Legislature, the Board establishes the health benefit premium rates. Table 3, page 9, shows excess disbursements (over) under receipts for fiscal years 1997 through 1999.

Plan Disbursements For Claims

Plan disbursements increased significantly from fiscal year 1997 to 1999. Disbursements rose from \$290.1 million in FY 97 to \$361.9 million in FY 99, an increase of 25% over three years. Table 4, page 9, shows Plan disbursement for fiscal years 1997 through 1999.

Table 3

State and School Employees Life and Health Insurance Plan Excess Disbursements over Receipts	Fiscal Year 1997	Fiscal Year 1998	Fiscal Year 1999	Total
Total Receipts	\$264,500,147	\$290,729,593	\$312,238,080	\$867,467,820
Total Disbursements	290,119,108	290,175,592	361,888,332	942,183,032
Excess Receipts Over (Under) Disbursements	(\$25,618,961)	\$554,001	(\$49,650,252)	(\$74,715,212)

Source: Department of Finance & Administration, Office of Insurance

Table 4

State and School Employees Life and Health Insurance Plan Cash Receipts and Disbursements	Fiscal Year 1997	Fiscal Year 1998	Fiscal Year 1999
<i>Total Receipts</i>	\$264,500,147	\$290,729,593	\$312,238,080
<i>Disbursements</i>			
Claims/Refunds			
Medical Claims	\$264,847,068	\$261,461,201	\$335,471,437
Life Insurance Claims	5,616,331	6,664,831	7,154,500
Premium Refunds	135,919	197,453	87,888
Patient Audit Incentive Program	3,957	2,285	2,671
Total Claims/Refunds	\$270,603,275	\$268,325,770	\$342,716,496
Administrative Expenses			
State Administrative Expenses	\$1,173,813	\$1,185,264	\$1,022,242
Foster Higgins & Co (Mercer) - Audit	96,589	101,605	99,462
Coopers & Lybrand - Consultant	389,961	291,804	214,495
Lynn Townsend - Actuary	115,333	85,998	92,257
Phelps Dunbar - Legal	0	22,648	0
Blue Cross Blue Shield (BCBS)	0	4,964,279	10,402,444

State and School Employees Life and Health Insurance Plan Cash Receipts and Disbursements	Fiscal Year 1997	Fiscal Year 1998	Fiscal Year 1999
BCBS Performance Penalty	0	0	(962,021)
Lamar Life	267,757	142,538	149,962
Centra Benefit Services	9,678,669	7,735,266	0
Centra Performance Penalty	0	(175,742)	175,742
Medstat Data Base Service	326,622	336,138	355,060
Trustmark Bank Charges	99,921	29,081	27,553
MSU - Health Plan Satisfaction Survey	0	0	14,000
Transfer to PEER Committee	46,253	0	0
Total Administrative Expenses	\$12,194,918	\$14,718,879	\$11,591,196
Cost Containment Fees			
BCBS - FMP Hospital Savings Fees	\$184,870	\$0	\$0
Centra - Cost Containment Code Review Fees	1,156,128	594,871	0
Centra - Hospital Bill Audit	0	62,165	0
Cost Care - Utilization Review	2,546,648	3,438,066	4,736,953
Total Cost Containment Fees	\$3,887,646	\$4,095,102	\$4,736,953
Network Fees			
PCS - Pharmacy Network	\$902,315	\$1,148,729	\$1,136,478
BCBS - Pharmacy Network	400,105	2	0
BCBS - Key Provider Network	919,728	1,025,435	1,236,175
MS Physicians Care Provider Network	444,175	402,245	341,723
Baptist & Physicians Central Services Network	102,059	106,213	96,930
Health Choice/Health Connection Provider Net	18,712	22,918	31,612

State and School Employees Life and Health Insurance Plan Cash Receipts and Disbursements	Fiscal Year 1997	Fiscal Year 1998	Fiscal Year 1999
MS Health Partners Provider Network	2,262	0	0
Managed Health Care Provider Network	1,451	1,544	769
Centra - Network Repricing	642,462	328,755	0
Total Network Fees	\$3,433,269	\$3,035,841	\$2,843,687
Total Disbursements	\$290,119,108	\$290,175,592	\$361,888,332
Net Increase (Decrease) To Plan Assets	(\$25,618,961)	\$554,001	(\$49,650,252)

Source: Department of Finance and Administration, Office of Insurance

For the three year period, total disbursements increased \$71.8 million from \$290.1 million in FY 97 to \$361.9 million in FY 99. Following is a description of changes in specific disbursement categories over this period:

- **Administrative expenses decreased \$545,462, or 4%, from \$12.2 million in FY 97 to \$11.7 million in FY 99;**
- **Cost containment fees increased \$849,307, or 22%, from \$3.9 million in FY 97 to \$4.7 million in FY 99;**
- **Network fees decreased 647,842, or 19%, from \$3.4 million in FY 97 to \$2.8 million in FY 99; and**
- **Claims/Refunds increased \$72.1 million, or 27%, from \$270.6 million in FY 97 to \$342.7 million in FY 99.**

While Administrative Expenses and Network Fees both decreased approximately \$500,000 and Cost Containment Fees increased approximately \$800,000 over this three year period, amounts disbursed for Claims/Refunds sharply increased \$72.1 million.

Plan Surpluses/Deficits

Excess disbursements over receipts over the last three fiscal years has caused the financial status of the Plan to move from a \$70.6 million surplus at June 30, 1996 to a \$22.6 million deficit at June 30, 1999.

See Table 5, page 12, for more information on Plan deficits.

Table 5

Comparison of Funding Status (in millions)	June 30 1996	June 30 1997	June 30 1998	June 30 1999
Plan Assets	120.7	92.7	92.8	42.7
less Plan Liabilities	50.1	52.1	84.5	65.3
Plan Surplus/(Deficit)	70.6	40.6	8.3	(22.6)
Annual Increase (Decrease) in Surplus		(30)	(32.3)	(30.9)

Source: State of Mississippi's State & School Employees Life & Health Insurance Plan Actuarial Report Fiscal Year 1999

Benefit Changes For 2000 and Proposed Future Changes

Large Annual Increases in the State's Health Benefit Premiums Is Common

While the state has increased health benefit premiums 8 of the last 11 years at an average annual increase of over 6% and projects another premium increase in FY 2001 of 14% - 20%, Mississippi had the lowest or second lowest health benefit premiums in a comparison with surrounding states prepared by DFA- Insurance.

Prior Premium Increases

The state has increased Plan premiums several times over the last few years to meet increased cost and utilization. See Table 6, page 13, for a listing of previous Plan premium increases.

Table 6

State and School Employees' Health Insurance Plan Summary of Active Employee Rate Increases 1986 through 1999			
Year	Increase	Year	Increase
1986	0.0%	1993	5.0%
1987	0.0%	1994	0.0%
1988	0.0%	1995	0.0%
1989	6.0%	1996	0.0%
1990	10.0%	1997	10.0%
1991	20.0%	1998	4.5%
1992	25.0%	1999	9.0%

Note: This rate increase history is equivalent to an annualized rate increase of 6.1% for the last 14 years and an annualized rate increase of 3.8% for the last 6 years.

Source: DFA- Insurance

Plan premiums have increased eight times in the 14 year period from 1986 through 1999 for an average annual increase of over 6%. In the last 11 years from FY 89 through FY 99, the state has increased Plan premiums eight times for an average annual increase over 7%. Increases in Plan premiums have been made each of the last three fiscal years from 1997 to 1999 for an average annual increase of over 7%. (This compares to a 25% increase in disbursements)

Proposed Premium Increases

In addressing the Plan's current financial condition, the Board is projecting premium increases for FY 2001 from 12.2% for active employees to 15.2% for families with one Medicare. See Table 7, page 14, for a listing FY 2001 proposed premium increases.

Table 7

State and School Employees' Health Insurance Plan Comparison of Monthly Premium Rates by Class			
Premium Class	FY 2000 Rates	Projected FY 2001 Rates	Percent Increase
Active Employee	\$167/172	\$193	13.9%
Spouse	162	193	19.1%
Full Family	243	290	19.3%
Special Family/Children	121	145	19.8%
Non-Medicare Retiree	186	222	19.4%
Medicare Retiree	113	130	15.0%
Non-Medicare Spouse	186	222	19.4%
Medicare Spouse	113	130	15.0%
Full Family	263	316	20.2%
Family (1 Medicare)	164	197	20.1%

Source: DFA- Insurance

Comparison of Premiums With Surrounding States

DFA-Insurance compared (See Table 8, page 15) health benefit monthly premiums with five surrounding states: Alabama; Arkansas; Florida; Louisiana; and Tennessee. The four coverage categories of health premiums used in the comparison were employee, family, retiree, and retiree and spouse. Mississippi has the lowest health premiums in three of the four categories (employee, family and retiree) and the second lowest in the other category (retiree and spouse).

Table 8

State Employee Health Benefit Plans Mississippi & Surrounding States Monthly Premiums				
State	Employee Coverage	Family Coverage	Retiree Coverage	Retiree & Spouse
Alabama	\$357	\$521		\$110
Arkansas	371	591	\$294	588
Florida	224	508	119	238
Louisiana	227	447	136	256
Tennessee	205	513	205	307
Mississippi	172	415	113	226

Source: DFA- Insurance

Based on this comparison, Mississippi's employee health benefit monthly premiums compare favorably with surrounding states. However, this comparison of monthly premiums does not take into consideration the difference in benefits offered by the states and must be evaluated in that light.

The Plan Subsidizes Some Participant Categories At the Expense of Other Categories

Charges for premiums to operate the Plan are made by participant category (active employee, spouse, children, family, COBRA, early retirement, retirement spouse, and Medicare retirement). Increases in Plan premiums per participant are not necessarily based on utilization within these categories. This results in the subsidization of certain categories with higher claims per participant by other categories with lower claims per participant.

Some subsidization of other premium classes is necessary by the active employee premium class because federal and state laws restrict increases to the COBRA and early retirement premium classes. However, rather than continuing or increasing subsidization of premium classes incurring higher claims, DFA- Insurance should revisit the basis for setting the current health benefit premium structure.

The Board proposed premium increases for 2001 (Table 7, page 14) ranging from 13.9% for active employees to 20.2% for family with one Medicare.

Table 9, page 16, shows Plan premiums rates and average monthly claims for calendar year 1998. Premiums collected exceeded claims paid per employee in two of the eight premiums classes (active and children). Therefore, active employees and children subsidize the other categories. This is not that unusual except for the degree of subsidization.

In the other six premium categories (spouse, family, COBRA, early retirement, retirement spouse and Medicare retirement and spouse), claims paid per employee exceeded premiums charged. These

Table 9

State and School Employees' Health Insurance Plan Monthly Claims and Premium Rates by Class For Calendar Year 1998			
Premium Class	Claims	Premiums	Excess Premiums over (under) Claims
Active	\$134	\$150	\$16
Spouse	274	147	-127
Family	233	221	-12
Children	87	110	23
COBRA	451	149	-302
Early Retirement	358	169	-189
Retirement Spouse	327	169	-158
Medicare Retirement & Spouse	119	104	-15

Source: DFA- Insurance

six premium categories are subsidized by the active employee and children premium categories. The four premium classes where claims paid per employee greatly exceeded (large amount of subsidization) premiums charged by DFA- Insurance are: spouse - \$127; retirement spouse - \$158; early retirement - \$189; and COBRA - \$302.

The proposed premium increases do not address the large disparity for claims paid and premiums charged in four of the eight premium classes.

Problems Resulted When Single Provider Network Created for 2000

A degree of difficulty could have been expected when the state changed from multiple health care provider networks by creating a single provider network for 2000. However, actual problems encountered resulted in much inconvenience for Plan participants: 1) Plan participants lacked provider coverage in northeast and coastal Mississippi when negotiations with hospitals bogged down; and 2) Plan participants were not provided information on authorized providers until very late in 1999, resulting in a lack of important information for Plan participants in completing cafeteria health plans.

Due to the inability to obtain fixed pricing with multiple networks and the confusion to Plan participants and providers related to multiple networks, DFA-Insurance contracted for a new single network of health providers in 2000 for Plan participants.

The concept of changing the strategic direction of the plan began in 1997, and in 1999 the Health Insurance Management Board issued a Request for Proposals for a Direct Contracting Administrator to establish a single provider network for the Plan. Advanced Health Systems, Inc. (AHS), a subsidiary of Blue Cross Blue Shield of Mississippi, was selected in 1999 as Direct Contracting Administrator.

In building the new network AHS has offered a contract to every hospital and physician in the state. While many health care institutions and providers have joined the AHS Network, some health care institutions and health care providers have chosen not to participate. In north Mississippi a major medical center did not join the network until late 1999 causing inconveniences, and on the coast a major medical center has yet to join. However, AHS continues to negotiate with this medical center and health care providers and expand the network scope.

In our opinion, while the goal of converting from multiple provider networks to a single provider network was well conceived, AHS not anticipating problems in negotiation with hospitals and providers resulted in major inconveniences to Plan participants.

See Appendix C for DFA-Insurance's summary of the selection and implementation of the Direct Contracting Administrator.

DFA- Insurance Efforts To Reduce Utilization Should Be Expanded

In its five year strategic plan to address problems with the state and school employees health plan, DFA- Insurance includes expanding preventive care services and providing incentives for participants to stay healthy or use cost-effective providers. Finding ways such as these to reduce utilization is the only real alternative to continuing the fourteen year trend by the state of increasing health benefit premiums an average of 6.1% per year.

Background

The Department of Finance and Administration, Office of Insurance (DFA- Insurance) annually publishes the *State of Mississippi State and School Employees' Health Insurance Plan, Summary Plan Description*. This health insurance information is provided to all state and school employees and retirees. This summary describes administration of the Plan as follows:

“The State and School Employees’ Heath Insurance Management Board administers the State and School Employees’ Heath Insurance Plan. The Department of Finance and Administration provides for the day-to-day management and administration of the Plan through the Office of Insurance.

The State and School Employees’ Heath Insurance Plan is self-funded by the State of Mississippi. The State contracts with various vendors to provide the services necessary to operate the Plan. The Claims Administrator, Blue Cross & Blue Shield of Mississippi, processes medical claims and maintains eligibility records. The Pharmacy Benefit Manager, PCS Health Systems, processes retail pharmacy claims. UNICARE/Cost Care, the Utilization management Program, determines medical necessity for inpatient admissions and certain outpatient services, as well as provides case management services.

The cost of maintaining the Plan is paid jointly by the State and you [state employee], through contributions that go into the insurance fund. The State pays the total cost of your [state employee] participation as an eligible Employee. If you [state employee] elect coverage for your eligible Dependents, you pay for the cost of their participation through payroll deductions. Retirees and COBRA Participants pay for the cost of their coverage and that of their Dependents.”

In January 1999, the Plan had over 188,000 participants located in all 82 counties. See Table 10, page 19, for listing of total participants by county.

Table 10

Plan Participants By County January 1999					
County	Number	County	Number	County	Number
Adams	1,896	Itawamba	1,201	Pike	2,415
Alcorn	1,875	Jackson	5,355	Pontotoc	1,536
Amite	530	Jasper	1,127	Prentiss	1,686
Attala	1,457	Jefferson	1,083	Quitman	605
Benton	408	Jefferson Davis	769	Rankin	11,687
Bolivar	3,783	Jones	5,236	Scott	1,707

Plan Participants By County January 1999					
County	Number	County	Number	County	Number
Calhoun	804	Kemper	631	Sharkey	410
Carroll	526	Lafayette	5,420	Simpson	2,269
Chickasaw	1,035	Lamar	4,816	Smith	971
Choctaw	679	Lauderdale	5,504	Stone	1,363
Claiborne	653	Lawrence	979	Sunflower	2,488
Clarke	993	Leake	1,255	Tallahatchie	1,061
Clay	1,022	Lee	3,208	Tate	1,536
Coahoma	2,090	Leflore	2,518	Tippah	1,035
Copiah	1,495	Lincoln	2,553	Tishomingo	943
Covington	1,471	Lowndes	3,145	Tunica	313
DeSoto	2,159	Madison	6,842	Union	1,292
Forrest	4,851	Marion	1,536	Walthall	661
Franklin	645	Marshall	1,103	Warren	2,389
George	1,106	Monroe	1,731	Washington	3,226
Greene	942	Montgomery	873	Wayne	1,103
Grenada	1,162	Neshoba	1,168	Webster	851
Hancock	1,040	Newton	1,972	Wilkinson	443
Harrison	8,262	Noxubee	584	Winston	1,192
Hinds	27,178	Oktibbeha	7,357	Yalobusha	1,004
Holmes	1,325	Panola	2,014	Yazoo	1,494
Humphreys	646	Pearl River	2,231		
Issaquena	40	Perry	807	Total	188,771

Source: DFA- Insurance

Plan Problem Areas and Proposed Changes

The Board has identified several problem areas with the current health benefit Plan and has developed proposed changes in its January 1999 *State and Public School Employee Health Insurance Plans Strategic Plan*:

“In light of the trends in the health care delivery system and in employee benefit plans, and based on an examination of cost and utilization data, survey results, and comments from Plan participants and others, several problem areas have been noted in the State and Public School Employees’ Plans:

-
- *Excessive growth in claims;*
 - *Lack of certain services, particularly preventive/routine care;*
 - *Low coverage for rehabilitative services;*
 - *High out-of-pocket costs;*
 - *Need for choice of benefit options;*
 - *A family deductible related to multiple individual deductibles rather than a specific dollar amount;*
 - *Need to define value of Plan vendors;*
 - *Rapidly growing utilization of outpatient services;*
 - *Need for preventive management of high cost cases;*
 - *Need for continued improvements in communication to participants;*
 - *Complications of coordinating multiple vendors;*
 - *Complexity of the Plans;*
 - *Need to react quickly to impact of federal changes;*
 - *Discount arrangements that don't control for cost shifting;*
 - *Complicated and error-prone premium billing and payment system;*
 - *and Need to comply with future GASB reporting requirements.*

Planned actions to be taken during 1999 through 2003 to address some of these problem areas are similar to actions being taken by most large employer and state employee health benefit plans and will need to be reviewed and revised annually based upon external and internal changes. These planned actions include the following:

- *Establish a State-specific provider network;*
- *Study various options for the Plans for years 2000 and forward:*
 - *Expanding preventive care service;*
 - *Providing incentives for participants to stay healthy or use cost-effective providers;*
 - *Developing a benefit structure similar to the federal employees' health plan; and*
 - *Developing a benefit structure with co-pays instead of co-insurance.*
- *Consider implementing a disease management program;*
- *Continue improvements in communication to participants through quarterly newsletters, annual updates to the Summary Plan Description, other publications, and videos;*
- *Develop the capacity to electronically transfer premium billing information and payments; and*
- *Continue competitive bidding for all vendors under the Plans.*

These planned actions reflect a commitment to maintaining an affordable health benefit plan for both the State and the Plan participants, while allowing participants a choice of benefit options that meet their needs."

The Office implemented the following insurance benefit changes for 2000:

- **Single AHS state network;**
- **Application of in-network and out-of-network out-of-pocket provision;**
- **Out-of-area benefits;**
- **Revisions to carve out benefits;**
- **Revisions to outpatient pre-certification;**
- **Addition of speech therapy as a covered service;**
- **Addition of licensed clinical workers and professional counselors as covered providers;**
- **Addition of outpatient cardiac rehabilitation benefits;**
- **Addition of wellness/preventive coverage;**
- **Prescription drug deductible;**
- **Pharmacy co-payment amounts and generic differential; and**
- **Delete plan provision to annually restore \$1,000 benefit after \$1,000,000 lifetime maximum exhausted.**

See Appendix D for detailed descriptions of 2000 insurance benefit changes.

Claims Audit

General Information

The Department of Finance and Administration (DFA) entered into an administrative service contract (Contract) with Blue Cross Blue Shield of Mississippi (Blue Cross). The State contracted with Blue Cross to provide claim administrative services for the State and Public School Employee's Health Insurance Plan (Plan). The Contract provided the following performance standards:

- 97 % of all claims will be paid correctly.
- 99.5% of all dollars will be paid correctly.
- An accuracy rate of 95 % in procedural and statistical matters will be achieved.
- 90 % of clean claims (claims not requiring investigation) will be paid in 14 calendar days.
- 80 % of all claims will be paid in 20 calendar days.
- 90 % of clean run-out claims will be paid in 14 calendar days.
- 80 % of all run-out claims will be paid in 40 calendar days.

The firm of William M. Mercer, Incorporated (Mercer) was selected to perform an audit of the claims performance by Blue Cross. This is the most recently completed claims audit. The purpose of the audit was:

To perform a statistically valid quality review of a sample of 1998 plan year claim transactions and runout claims incurred prior to January 1, 1998 processed by Blue Cross Blue Shield of Mississippi for the State and Public School Employee's Health Insurance Plans and to review procedural issues identified in the last audit.

The audit covered claims incurred and paid January 1 through December 31, 1998 and runout claims incurred prior to January 1, 1998 and paid between July 1 and December 31, 1998.

Audit Conclusions

Based on the results of the Mercer report, DFA needs to closely monitor the performance of Blue Cross in meeting their contractual obligations in the claim administration services for the Plan. The audit of the contract by Mercer pointed out unacceptable levels of compliance in three of four categories.

Blue Cross did not meet contractual obligations in pay error frequency, dollars mispaid and claim turnaround time. Mercer stated that *“based on these standards and results, it appears that Blue Cross has incurred the maximum performance penalties of 10 % of annual administrative fees for 1998 claims and the maximum of 10 % of runout fees for runout claims.”* The total performance penalty paid by Blue Cross was \$962,021. Mercer further stated in their report that *“because of the lack of meeting expectations, consideration should be given to a mid-year audit to confirm that the backlog reduction and quality improvement efforts currently in place are producing the required results.”*

If the performance of Blue Cross does not improve, DFA should evaluate their course of action considering various methods of penalties for non-compliance with contractual obligations. This may include increased financial penalties or other penalties up to and including the appointment of a new claim administrator. However, it should be noted, an actuarial report, dated September 7, 1999, based on a review of the experience through June 30, 1999 of the State and School Employees Life and Health Insurance Plan was prepared by Wm. Lynn Townsend, FSA. This report stated *“Based on the review of recent claims activity and confirmed by separately prepared Blue Cross performance reports, it is clear that there has been a significant improvement in the claims payment timeliness during calendar year 1999.”*

Audit Results

Mercer’s report said “Blue Cross did not meet [performance] expectations for claim administrative services in three of the four major categories of evaluation.” Table 11, page 23, shows results of compliance with these four major categories.

Table 11

Four Major Categories of Contract Evaluation				
Category #	Description of Evaluation Category	Actual %	Contract %	Meets Contract %
1	Correct Payment of Claims	94.11 %	97 %	NO
2	Correct Dollar Amounts Paid	95.16 %	99.5 %	NO
3	Accuracy of Procedural and Statistical Matters	97.17 %	95 %	YES
4	Claim Turnaround Time:			
4a	Clean Claims (paid in 14 calendar days)	54 %	90 %	NO

Four Major Categories of Contract Evaluation				
Category #	Description of Evaluation Category	Actual %	Contract %	Meets Contract %
4b	All Claims (paid in 20 calendar days)	57.8 %	80 %	NO
4c	Clean Runout Claims (paid in 14 calendar days)	40.5 %	90 %	NO
4d	All Runout Claims (paid in 40 calendar days)	**	80 %	NO

Source: Information taken from report of William M. Mercer, Incorporated

**** - Blue Cross's report for runout claims does not calculate at 40 days but 78.2 % of all claims were paid in less than 45 days, not meeting the standard of 80 %.**

Claim Office Procedures Update

Mercer in a prior audit reviewed the claim payment procedures at the Blue Cross claim office in Jackson, Mississippi in August, 1998 for the 1997 calendar year. Mercer's current report referred to the prior years audit of claim office procedures stating "We found them to be typical of those we usually find in Blue Cross plans and other claim administrators. With the exception of effectively counting and controlling the backlog, auditing hospital bills over \$10,000 in a timely fashion, and reauditing the quality assurance auditors, we found the claim office to be as expected."

Mercer, as part of the current 1998 calendar year claim audit, reviewed and followed up on their prior year audit findings concerning claim office procedures. Mercer's current report summarized their review of claim office procedures by stating "Based on improved supervisory controls and success in reducing the backlog, we believe that substantive improvement has occurred since the last audit. However, substantial improvement still must occur in order to meet expectations of the State service contract." Auditing hospital bills over \$10,000 has been implemented by BlueCross and they are in the process of implementing a program for reauditing the quality assurance auditors.

Summary of Blue Cross's Response to Claims Audit

Portions of Blue Cross's response to Mercer report.

Introduction

We believe the 1998 Mercer audit was conducted in a fair manner and generally yielded accurate results. We are taking the opportunity in this document to comment on some of

the key findings. Our intent is to provide additional information and context on the issues and not to deflect accountability for our performance. In addition, this document includes an update on our performance improvement initiative that began in late November 1998 and is still underway.

Comment on Key Findings

Claims Accuracy Performances - *While two of the three accuracy measures for the full year 1998 sample do not meet contractual standards, we are encouraged by the improvement we demonstrated in the full year audit when compared with the 1998 mid year audit. Assuming a high degree of statistical accuracy in both the mid year and full years audits, we conclude that our accuracy numbers significantly improved in the final six months of 1998 in order to yield the improved full year results. Although the payment and financial accuracy numbers are not in contractual compliance, the improvement shows our commitment and ability to improve claims payment accuracy.*

Claims Turnaround Performance - *We accept accountability for not meeting turnaround standards for regular (non run-out) 1998 claims. For run-out claims, we believe our performance closely approached the agreed-to standard of 80 % paid within 40 days. Since January 1, 1999, claims turnaround performance has been a major improvement focus, and recent performance has been exceeding claims turnaround standards.*

Major Sources of Error

Bill Audit - *We accept our share of accountability for the delayed start of the bill audit program, however, 1998 bill audits are now underway. We intend to fulfill our contractual commitment for 1998 claims and therefore have chosen to disagree with these errors. Although no time constraints are called out in the contract, we do agree that bill audits must be conducted in a timely manner in order for the program to have maximum effect.*

Semi-Private Room Rates - *We acknowledge that rates more than one year old were used to calculate hospital inpatient reimbursement. Since the mid-year audit, we have made a good faith effort to request updated rates using written surveys sent to all providers.*

Inpatient Educational Training - *We agree that the summary plan description (SPD) clearly delineates education therapy/training as a covered benefit for hospital inpatient stays under 30 days.*

Prompt Pay Discounts - *We did fail to consistently capture prompt discounts in 1998. In 1999, prompt pay discounts are no longer part of any network contract and therefore no further changes have been put in place for claims incurred during 1999.*

Other Miscellaneous Issues from Report

Lack of Turnaround Report - We have been providing monthly turnaround time reports since April 1998 to DFA that outline claims processed within various timeliness ranges.

Reaudit of Quality Assurance Auditors - We acknowledge the recommendation and are in the process of implementing such a program.

Performance Improvement Update

Reduce the backlog of claims to be processed - *We have seen dramatic decrease in overall claims inventory since December 1998. The overall claims in process and hardcopy inventories have been maintained within target ranges through March 18, 1999.*

Improve claims processing productivity and turnaround time - *In order to ensure that appropriate claims inventory levels are maintained and that claims are processed in a timely manner, we have taken steps to improve the individual productivity of our base claims processing resources.*

Provide Outstanding Customer Service - *Our performance in providing responsive customer service has been excellent. We have implemented numerous process improvements and tracking mechanisms in our customer service department and have also provided significant additional training to our customer service representatives.*

Improve Quality/Accuracy - *Having reduced the claims backlog and created the ability to meet claims turnaround goals, Blue Cross is currently working to improve claims payment accuracy. Starting in late February 1999, accuracy-improvement initiatives have begun that should contribute to accuracy improvement in March and April 1999.*

Summary

Mercer summarized their claim audit report on the Plan in their executive summary of said report as follows:

“In summary, while we believe improvement should be forthcoming, the immediate results do not meet expectations and Blue Cross needs to rapidly improve in the areas of pay error frequency, dollars mispaid and turnaround time. We also believe Blue Cross should implement prior instructions not to use semi-private room data that is more than one year old and to implement the hospital bill audit program immediately. Finally, because the results do not meet expectations, we believe consideration should be given to a mid-year audit to confirm that the backlog reduction and quality improvement efforts currently in place are producing the required results.”

All of the information listed in this section of the report by the Auditor is based on a review of the report dated February 1999, performed by William M. Mercer, Incorporated on the contract between the Department of Finance and Administration and Blue Cross Blue Shield of Mississippi. Some of the important issues in the report have been summarized for review.

More information can be obtained from a reading of the complete Mercer report available at DFA or Blue Cross. This includes among other items more detailed information regarding audit findings and responses by Blue Cross to said findings.

APPENDICES

**Can be obtained from
the Office of the State Auditor upon request
at 601.364.2818**