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Report To

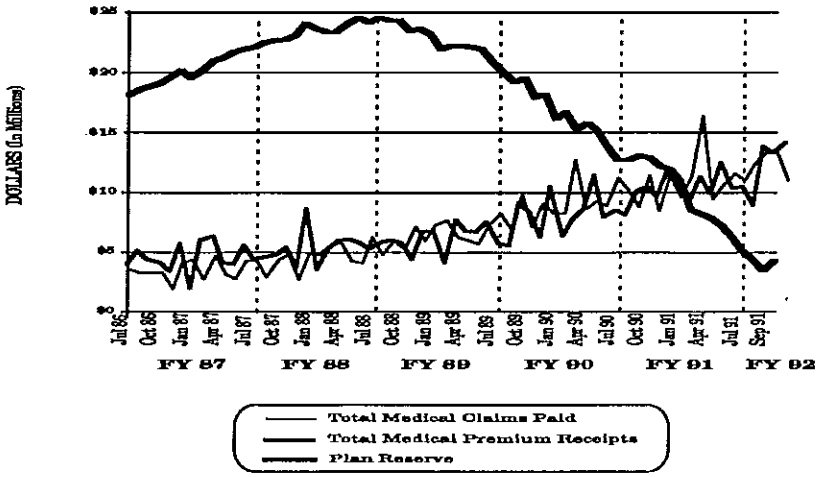
The Mississippi Legislature

REVIEW OF THE STATE OF MISSISSIPPI'S EMPLOYEE HEALTH INSURANCE PLAN

December 17, 1991

For the past four years, Department of Finance and Administration (DFA) managers have postponed making necessary, but politically unpopular, business decisions to manage the State Employees' Health Plan. DFA also did not develop an adequate system to monitor the position of the reserve fund regularly and analyze claims data and usage patterns upon which to base management decisions.

DFA allowed the Plan to become financially unsound with only $3 million in cash reserves at October 31, 1991, far short of the industry standard ($17.9 million, which represents the claims liabilities owed by the Plan) and well below the May 1988 $25 million reserve. This depletion of reserves occurred because DFA failed to follow the recommendations of its actuarial consultants to raise premiums. As a result, the state or state employee Plan members will have to finance large premium increases in one year rather than smaller increases over a period of several years.



The PEER Committee

PEER: THE MISSISSIPPI LEGISLATURE'S OVERSIGHT AGENCY

The Mississippi Legislature created the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER Committee) by statute in 1973. A standing joint committee, the PEER Committee is composed of five members of the House of Representatives appointed by the Speaker and five members of the Senate appointed by the Lieutenant Governor. Appointments are made for four-year terms with one Senator and one Representative appointed from each of the U. S. Congressional Districts. Committee officers are elected by the membership with officers alternating annually between the two houses. All Committee actions by statute require a majority vote of three Representatives and three Senators voting in the affirmative.

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REVIEW OF THE STATE OF MISSISSIPPI'S EMPLOYEE HEALTH INSURANCE PLAN

December 17, 1991

The PEER Committee

Mississippi Legislature

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Joint Committee on Performance Evaluation and Expenditure Review

PEER Committee

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December 17, 1991

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MEMBERS OF THE MISSISSIPPI STATE LEGISLATURE

At its meeting of December 17, 1991, the PEER Committee authorized release of the report entitled **Review of the State of Mississippi's Employee Health Insurance Plan**.

Representative Jerry Wilkerson, Chairman

This report does not recommend increased funding or additional staff.

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REVIEW OF THE STATE OF MISSISSIPPI'S EMPLOYEE HEALTH INSURANCE PLAN

EXECUTIVE SUMMARY

INTRODUCTION

In response to legislative concerns, the PEER Committee reviewed Mississippi's Employee Health Insurance Plan (hereafter referred to as the Plan), as administered by the Department of Finance and Administration. PEER examined trends in the Plan's collections, expenditures and cash balances and assessed its financial stability. The report presents responses to the legislative concerns in question-answer format.

Background

The Legislature created a health and life insurance plan for employees of the state of Mississippi effective July 1, 1972. The Plan was originally created to provide major medical insurance coverage of $40,000 per insured member, with the state paying fifty percent of the employee's premium and the employee paying dependent coverage. Currently the major medical insurance is a maximum of $1,000,000 with the state paying one hundred percent of the employee's coverage. At June 30, 1991, the Plan covered 50,931 employees composed of 5,789 retirees and 45,142 active employees. Total membership in the Plan was 88,073 at June 30, 1991, including an additional 37,142 dependents covered.

The state employee health plan is financed by premiums collected from Plan members and from the state, which pays one hundred percent of the employee premiums as a fringe benefit. During fiscal year 1991, the Plan collected $69.5 million in premiums, $46.6 million paid by the state and $22.9 million paid by Plan members. Premiums collected under the Plan are used to pay claims for health care costs and to pay the administrative costs of operating the fund.

The Plan is administered by the Department of Finance and Administration, a claims administrator (Blue Cross & Blue Shield of Mississippi), and a utilization review organization (Healthmarc, Inc.). DFA oversees the Plan by monitoring the insurance program; setting premium rates and benefits; maintaining the reserve fund; providing customer service, including handling complaints and appeals of Plan members, corresponding with agencies and retirees, and compiling a newsletter; and selecting a claims administrator and utilization review firm.

Overview

For the past four years, Department of Finance and Administration managers have postponed making necessary, but politically unpopular, business decisions to manage the State Employees' Health Plan. DFA allowed the Plan to become financially unsound with only $3 million in cash reserves at October 31, 1991, far short of the industry standard ($17.9 million, which represents the claims liabilities owed by the Plan). This depletion of reserves occurred because DFA failed to follow the recommendations of its actuarial consultants to raise premiums to protect the fund reserve. As a result, the state or state employee Plan members will have to finance large premium increases in one year rather than smaller increases over a period of several years. In addition, DFA did not develop an adequate system to monitor the position of the reserve fund regularly and analyze claims data and usage patterns upon which to base management decisions.

Rising health care costs nationwide have greatly affected the increase in Plan costs. Although DFA could have more aggressively contained program costs, DFA's Plan changes implemented in January 1990 and its utilization review and other cost containment efforts contributed to a slower growth in cost increases during FY 1991.

Recent actions by the Board of Trustees of Institutions of Higher Learning to withdraw from the Plan would affect the Plan by increasing the premiums which would have otherwise been paid by non-IHL state employees. Another effect would be an undetermined increase in overall administrative costs. At its December 1991 meeting the IHL Board voted to accept a Blue Cross & Blue Shield contract effective January 1992. Subsequent to this meeting, the Commissioner of Higher Education, in response to Governor-elect Kirk Fordice, contacted board members asking them to rescind their action and not withdraw from the state health plan.

Blue Cross reimburses a lower dollar amount of some health claims than do other commercial insurance companies. DFA could require Blue Cross to reimburse a greater dollar amount for each cost incurred, but that would ultimately increase the claims costs and raise state Plan premiums. Finally, the Plan's present level of benefits in terms of deductibles and stop loss limits is similar to levels provided to state employees in other states.

FINDINGS

Has the Department of Finance and Administration properly managed the State Employee Health Insurance Plan?

- **For the past four years, DFA management has postponed making necessary, but politically unpopular, business decisions to manage the State Employee Health Insurance Plan.**

During the first four months of fiscal year 1992, Plan expenses exceeded income by $1,710,086. The Plan is projected to continue to lose money based on the current premium and benefit levels. Because of the currently low levels of cash held by the Plan and because the Plan will continue to lose money if no changes are made, additional funding is needed. Despite the most recent twenty percent increase in premiums instituted in July 1991, DFA will be forced to revise premiums and perhaps benefits levels again before the end of fiscal year 1992, perhaps as early as January 1992.

If DFA had monitored the plan properly, more closely heeded the advice of actuarial consultants, and been willing to make difficult and politically unpopular decisions (such as raising premiums) which are necessary to manage the Plan in a businesslike manner, current financial problems could have been avoided altogether or reduced in magnitude. Because DFA has not managed the Plan closely enough, the state and the employees will have to make drastic increases in funding to the plan during one year, rather than over a period of years.

Is the insurance fund financially sound?

- **DFA allowed the State Health Plan to become financially unsound with only $3 million in cash reserves at October 31, 1991. The Plan's reserves fall short of $17.9 million, which represents the estimated claims liabilities owed by the Plan.**

The health plan reserve equals the cash accumulated from premiums collected which exceed claims paid and administrative expenses during an accounting period. According to insurance industry experts, the typical amount for a claim reserve is two and one-half times the average claims paid per month. The reserve needed to protect a health plan is based upon the estimated amount of claims which have been incurred by health plan members but not reported to the plan administrator. The Plan's reserve fund has ranged from its current low of $3 million to a high of $25 million in May 1988. Based upon the industry standard for reserve funds, the Plan should currently have a minimum reserve amount of $17.9 million to pay claims.

The depletion of the health plan reserves was caused by mismanagement by DFA officials charged with the responsibility of managing the Plan. Although these officials knew the reserve was depleting, they chose the easiest course of action, which was to postpone needed premiums increases. As a result of DFA's mismanagement, the health plan presently is financially unsound.

What caused the financial problems?

- **DFA failed to follow the recommendations of its actuarial consultants to raise premiums in order to protect the fund reserve. As a result, the state or state employee Plan members will have to fund large premium increases in one year rather than a number of smaller increases over several years.**

From June 1987 to March 1991, DFA paid $121,775 to William M. Mercer, Incorporated, actuarial consultants, for reviewing the claims experience of the state employee health plan. Specifically, Mercer was responsible for *"determining appropriate funding levels, identify*[ing] *trends in medical costs and benefits, and estimate*[ing] *future reserve levels."*

Mercer consistently recommended premium increases over the past four years to maintain the Plan's financial position and bolster the reserve. Instead, DFA chose to implement smaller and less frequent premium increases, thus depleting the reserve. DFA officials have stated that one of their biggest concerns was the effects of higher premiums on employees. As a result DFA purposely chose not

to raise premiums as much as recommended by Mercer and consequently weakened the reserve. While a concern for the welfare of the employees certainly must be a part of the administration of the health plan, the actual result of DFA's decision to decrease the reserves was ultimately to affect the employees of the state adversely. Had DFA acted in accordance with actuarial recommendations, the dramatic financial impact on both the employees and the state would have been minimized.

- **DFA has not developed an adequate system to monitor the position of the reserve fund regularly and analyze claims data and usage patterns upon which to base management decisions.**

Because of increasing costs of health insurance, the management of health care is becoming increasingly more important. As a result, trends in the claims paid and premiums received and changes in the way the health plan is used by members must be analyzed carefully in order to make the most informed decisions.

DFA has no data base of information on state employees such as types and amounts of claims paid, claims usage, and demographics. As a result, DFA is dependent upon Blue Cross to provide pertinent information. Blue Cross provides several regular reports to DFA on claims paid and claims usage, but often these reports include meaningless or contradictory information. In other instances DFA has not promptly followed up on potential problems brought to its attention. For instance, Mercer, in an October 1990 report, stated that hospital service prices for state employees have risen faster than for other Blue Cross accounts in Mississippi and that state employees have over-utilized hospital services in comparison to other Blue Cross business in Mississippi and national trends. DFA has not pursued this finding to clarify the problem or determine the solution.

Has the Department of Finance and Administration aggressively developed measures to maximize fund assets and contain program costs?

- **DFA has allowed Blue Cross to hold refunds due to the health plan for quarterly periods, rather than remitting the funds to DFA on a daily basis. As a result DFA has lost the opportunity to earn approximately $78,168 in interest for the health plan since October 1989.**

In October 1989, DFA contracted with Blue Cross to enter into Fair Market Price agreements with hospitals in order to reduce the cost of hospital care. Blue Cross contracts directly with hospitals for a competitive price, with subsequent savings from the pricing agreements being passed along to the Plan.

Blue Cross is responsible for refunding the reimbursement obtained from the hospital to DFA. From that amount Blue Cross deducts its administrative fee of approximately $55,000 per month for several cost containment programs. Beginning March 1991, DFA officials required Blue Cross to remit the discounts on a quarterly basis. As a result of DFA's new quarterly remittance policy, Blue Cross has the use of Plan funds on which it can earn interest. If DFA had required Blue Cross to refund the discounts as soon as they were received by Blue Cross, the Plan would have had the opportunity to earn approximately $78,168 in interest on the funds since October 1989.

- **Because the premium structure is set at the same level for employees in all risk categories, the state subsidizes certain employee groups within the plan.**

In the insurance industry, individual premiums are structured so that at-risk and older individuals will be charged higher premiums for their coverage. As a result, individuals who are more likely to use their insurance plans tend actually to pay more for their coverage. In a group plan, premiums are sometimes structured so that costs are spread more evenly among the plan members. For instance, in the State Plan, retirees under sixty-five and non-retirees must pay the same premium ($102 as of July 1, 1991, for single coverage). Because the premium structures of the State Plan are set at the same level for employees in all risk categories, the state subsidizes certain subgroups of state employees.

Recently DFA commissioned a consulting actuary to study the claims experience of different employee groups within the Plan. Because the employees of the Board of Trustees of Institutions of Higher Learning (IHL) have taken steps to withdraw from the State Health Plan, the study included a separate analysis of IHL employee claims experience. The actuary reported that during FY 1990 and FY

1991, premiums paid by the state for individual coverage for IHL active employees subsidized state retirees (including both IHL and other state retirees) and also subsidized active state employees to a lesser extent. The State of Mississippi also has been subsidizing premiums for dependent coverage for its employees.

- **Rising health care costs contributed to the increased Plan claims expenditures. State claims expenditure trends show that the January 1990 Plan changes contributed to the lower rate of cost increases in FY 1991. It also appears that DFA's utilization review cost containment efforts may have contributed to the lower rate of cost increases occurring in FY 1991.**

In recent years medical costs have risen dramatically, outpacing the general rise in inflation. As expected, the State Health Plan has been affected by these nationwide trends in increasing health care costs. State Health Plan claims paid rose 11.7% in FY 1988, 16.5% in FY 1989, and 21.2% in FY 1990. Fortunately, from FY 1990 to FY 1991 the state plan cost increases slowed to an 11.8% rate, from $70 million to $79 million. The Plan changes in January 1990 contributed to the lesser increase in costs. These changes consisted of increasing the deductibles from $100 to $150 for employees with salaries of less than $15,000 and to $200 for employees paid $15,000 or more. DFA also increased the stop losses from $1,000 to $1,500.

Although PEER did not review Healthmarc's operations specifically to determine the efficiency of that company's operations, it appears that DFA's use of managed care, such as that provided by Healthmarc, has been beneficial in reducing the state's overall health costs. DFA chose Healthmarc as its utilization review firm based on a consultant's recommendations. But because DFA pays Healthmarc $1.1 million in annual fees, DFA should closely monitor this utilization review contract in future to determine whether it is cost beneficial or whether another utilization review firm could provide comparable or better services at a lower price.

- **DFA has not implemented a cost-reduction drug program which could save the state and its employees an estimated $1,000,000 annually.**

Payments for prescription drugs total over ten percent of the benefits paid by the Plan. Consequently DFA must attempt to keep the costs of drugs under control. One method of keeping drug costs in line is through a mail-order prescription drug program. Seventeen of the fifty states currently use mail-order drug programs as cost containment measures. Savings are generated through mail-order programs when insured parties order routine drug purchases through the mail at discount prices. The process reportedly results in lower costs to the state employee health plan and also financial advantage to the plan members.

DFA has considered mail-order programs since before October 1989. According to an October 5, 1989, memo from the former Office of Insurance Director to the former DFA Director, a mail-order drug program would result in savings of over $1,000,000 per year. However, two years after DFA first began considering the drug programs, DFA still has not taken action to include such a program in the plan, primarily because of objections raised by pharmacists in states which adopted such a program.

- **Delinquent payments of twelve state agencies decreased the Plan's reserve by more than $700,000 at September 30, 1991, money which is badly needed during the present Plan funding shortfall.**

Blue Cross bills state agencies to receive premium payments at the first of each month or, in cases of some larger agencies, at the first and fifteenth of each month. According to a DFA study of delinquent accounts dated October 23, 1991, twelve state agencies were consistently nineteen to thirty-five days delinquent in their payments, with the total for these twelve agencies averaging $1,408,602. The four agencies having the largest amount of delinquent premiums, the Highway Department, the Department of Human Services, the University of Southern Mississippi, and the Department of Public Safety, had average monthly delinquencies of $1,269,302 ranging from twenty-six to thirty-five days late. If all September 1991 payments due from the twelve agencies had been received and deposited by September 30, then the premium income for September 1991 would have increased by $705,305.

MISS. CODE ANN. § 25-15-15 allows DFA to *"establish and enforce late charges and interest penalties or other penalties for the purpose of requiring the prompt payment of all premiums for life and health insurance."* DFA has not established a late penalty to penalize state agencies for late payments. The agencies therefore have less incentive to pay on time. As a result the Plan has not received much needed premium payments in a timely man-

ner and has lost the opportunity to earn interest on the delinquent payments.

- **DFA has lost approximately $670,195 in interest which could have been earned on a healthy reserve.**

As previously stated, the industry benchmark for a healthy claims reserve is two and a half times the average claims paid out in a month. In May 1990, Plan reserves fell below the industry standard and have continued to decline ever since. PEER determined that if DFA had maintained reserves at the level of the industry standard, $670,195 in interest would have been earned on these reserves from May 1990 to September 1991. This interest would now be a part of the state plan reserves and could reduce the amount by which premiums must be raised in the future.

How would the state Plan be affected if the Board of Trustees of Institutions of Higher Learning withdraws its employees from the Plan?

- **The Plan would be affected to some degree if the Board of Trustees of Institutions of Higher Learning withdraws its employees from the Plan.**

At the November 1991 meeting of the Board of Trustees of the Institutions of Higher Learning (IHL), the Board gave IHL the permission to withdraw its employees from the state health plan if the standards of MISS. CODE ANN. 25-15-21 were met. The CODE states that IHL may establish a separate health insurance group for institution employees. It also states that the separate group must operate under the same rules as set forth for the total employee group health plan and that *"the total cost* [of the separate group] *shall not exceed the cost that would have been incurred under the state plan if it had not chosen such action."*

If IHL employees withdraw from the State Plan, the Plan could be affected to some degree. In the short term, IHL premiums would be lower than State Plan premiums. Overall administrative costs charged to the state and its employees would be higher after separation of the two groups, although the amount cannot presently be estimated by DFA or IHL officials.

How does the state Plan compare to other state health plans and to commercial health plans?

- **Mississippi state employee health coverage is similar to the state employee health plans in the other forty-nine states.**

PEER reviewed a state employee health plan survey for the fifty states compiled by the Martin E. Segal Company, health plan consultants. PEER determined that other state plans are similar to the Mississippi Plan in the following ways:

-- 34 of 50 states have self-insured plans;

-- 26 of 50 states have contracted with utilization review companies and another 20 states use their claims payors to conduct utilization review activities such as concurrent review and pre-certification;

-- 23 of 50 states use Blue Cross and Blue Shield for their insured and self-insured plans; and,

-- 32 of 50 states' executive branches operate or administer their plans.

PEER also found that the practice of subsidizing retiree costs was not unique, with 38 of 50 states subsidizing retiree coverage to some extent.

- **Blue Cross reimburses a lower dollar amount on some health claims than do other commercial insurance companies. DFA could require Blue Cross to reimburse a greater dollar amount for each cost incurred, but that would ultimately increase the cost of state Plan premiums.**

Because of numerous complaints about the level of Blue Cross's allowable charges, PEER reviewed the allowable charges established by Blue Cross and compared them to allowable charges of other insurance plans. Allowable charges, also known as UCR's (usual, customary and reasonable), are the reimbursement amounts allowed by the insurance company for covered services. Companies base UCR's on a profile of actual charges by physicians and hospitals for services in a given area. Depending on the insurance company, the UCR is usually set at the 70th to the 90th percentile of the local customary profile.

Because UCR's are considered confidential by insurance companies, PEER could not compare Blue Cross's reimbursement rates to those of other companies. However, the consensus of insurance experts interviewed by PEER was that Blue Cross tends to have lower overall allowable charges and therefore reimburses at lower amounts than other commercial insurance companies. Although there is merit to the complaint that Blue Cross's allowable charges tend to be lower than for other insurance companies, Blue Cross's lower allowable charges keep down the overall cost of the Plan. Therefore requiring Blue Cross to increase its allowable charges would increase the overall premiums of the state health insurance plan.

RECOMMENDATIONS

1. DFA's Executive Director should take immediate steps to restore financial stability to the state employees' health plan. Items which the DFA Director should consider include:

   - Increases in current premiums. (DFA's insurance actuary recommends an immediate twenty-four percent increase, assuming DFA makes no other changes in the plan.)

   - Increases in current deductible levels. (Insurance experts told PEER that deductible levels for most health plans range from $250 to $500.)

   - Phased-in revision of premiums to experience-based levels to lessen cross-subsidies of various groups contained in the health plan

   - Evaluation of current services offered by the state health plan

   - Implementation of more aggressive cost-containment programs

2. DFA should establish an "Insurance Reserve Fund" account in the state treasury as provided for in MISS. CODE ANN. § 25-15-15 (1972). Assuming DFA implements a premium increase, the department could utilize any excess cash generated by the higher premiums to fund the reserve account. As a minimum reserve level, DFA should maintain an amount generally equal to two and a half times the monthly claims paid. DFA should attempt to reach the recommended reserve level by December 1994.

3. In the future, DFA insurance management should more carefully consider the advice of its paid insurance actuary. Following the issuance of actuary reports, DFA's Executive Director should require the Insurance Office Director to compile a written response with recommended action steps. If DFA management deems that the actuary's advice is no longer needed, the department should terminate the consulting contract, thereby reducing its annual costs by approximately $40,000.

4. Within existing resources, DFA should reorganize its Office of Insurance to include a staff person who would be responsible for the following analytical duties:

   - forecasting monthly claims payments, premiums receivable and reserve levels of the health plan to lessen dependence on expensive actuarial consultants for decision-making;

   - analyzing claims utilization data to determine what medical procedures are being used more often and to identify the present and potential problems in health care coverage;

   - tracking monthly projections to determine if the fund income and expenditures are in line with expected results;

   - reassessing financial results to determine what decisions should be made to get unfavorable deviations in line with projected results;

   - analyzing Healthmarc, Fair Market Pricing and other programs to determine whether the programs are actually saving the plan money;

   - performing all background work and collection of data and liaison with Blue Cross & Blue Shield to eliminate time spent by actuarial consultants in obtaining needed data and other information;

   - assisting the DFA Office of Insurance Director in evaluating the financial provisions of all Health Plan Contracts, including Blue Cross contracts, to insure

that the state plan obtains favorable terms; and,

- analyzing claims data to provide information for management decision-making.

5. The DFA Office of Insurance should perform a cost/benefit analysis to determine whether it would be cost beneficial to develop an internal data base of information. The data base, which would lessen DFA's reliance on Blue Cross to provide special reports, should include claims amounts by type, utilization indicators, and demographic and other information.

6. DFA should immediately obtain updated cost savings proposals from various mail-order and prescription management programs and select the most advantageous programs for implementation.

7. DFA should revise its contract with the plan administrator, Blue Cross, as soon as possible so that Blue Cross will charge DFA only for the discounted amount of the hospital services under the Fair Market Pricing agreement. The effect will be a remittance of Fair Market Price refunds to DFA on a daily basis.

8. In order to encourage prompt payment of premiums by state agencies and retirees, DFA should adopt an interest penalty of one percent per month on the balance of delinquent premium payments.

9. The Legislature should require the Department of Audit to conduct a separate, full-scope audit of the state employee health plan each year. In addition, the Legislature should require the DFA Executive Director to submit an annual report to the Legislature which fully describes the health plan; presents the plan's financial condition for the calendar year; lists recommendations made by DFA's insurance actuary and actions taken by the department on those recommendations; lists the claims experience for employee subgroups and the corresponding loss ratios of the subgroups; and describes plan revisions made by DFA.

10. DFA should review the current administrative contract with Blue Cross to determine if Blue Cross is providing the best service which can be expected of the State Health Plan claims processor at the best cost obtainable.

11. The Legislature should consider repealing MISS. CODE ANN. Section 25-15-21 (1972), which allows the Board of Trustees of Institutions of Higher Learning to establish a separate group health plan for its employees. Regardless of legislative action on the repeal of this section, the IHL Board should not withdraw from the state plan and establish a separate plan.

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REVIEW OF THE STATE OF MISSISSIPPI'S EMPLOYEE HEALTH INSURANCE PLAN

INTRODUCTION

Authority

At its July 30, 1991, meeting, the PEER Committee, in response to a legislative request, began a review of the State of Mississippi Employee Health Insurance Plan (hereafter referred to as the Plan), as administered by the Department of Finance and Administration. The Committee acted in accordance with MISS. CODE ANN. Section 5-3-57 (1972).

Scope and Purpose

PEER reviewed the status of the State Employee Health Insurance Plan to determine whether the Plan is financially sound. PEER determined the current financial condition of the Plan and examined trends in the Plan's collections, expenditures and cash balances.

Method

While conducting this review, PEER:

- reviewed Department of Finance and Administration (DFA) monthly health and life insurance plan financial statements and other pertinent records;
- reviewed the reports of DFA's actuarial consultants for the health plan, William M. Mercer, Incorporated, of Charlotte, North Carolina;
- interviewed DFA staff members, Blue Cross & Blue Shield executives and staff members, actuarial consultants from two national firms, and state Department of Insurance and Department of Treasury staff;
- interviewed officials and reviewed premium levels of commercial insurance companies;
- reviewed state statutes and administrative contracts entered into by DFA; and,
- reviewed health insurance industry literature.

Overview

For the past four years, Department of Finance and Administration managers have postponed making necessary, but politically unpopular, business decisions to manage the State Employees' Health Plan. DFA allowed the Plan to become financially unsound with only $3 million in cash reserves at October 31, 1991, far short of the industry standard ($17.9 million, which represents the claims liabilities owed by the Plan). This depletion of reserves occurred because DFA failed to follow the recommendations of its actuarial consultants to raise premiums to protect the fund reserve. As a result, the state or state employee Plan members will have to finance large premium increases in one year rather than smaller increases over a period of several years. In addition, DFA did not develop an adequate system to monitor the position of the reserve fund regularly and analyze claims data and usage patterns upon which to base management decisions. Fortunately the Director of the DFA Office of Insurance hired in September 1991 appears to have begun to address some of these matters.

DFA has not always aggressively developed measures to maximize fund assets and contain program costs as follows:

- DFA has allowed Blue Cross to hold refunds due to the Plan for quarterly periods, rather than remitting the funds to DFA on a daily basis. As a result, DFA lost the opportunity to earn approximately $78,168 in interest for the Plan since October 1989.

- DFA has not implemented a cost-reduction drug program which could save the state and employees an estimated $1,000,000 annually.

- DFA has allowed premium delinquencies which decreased the reserve by more than $700,000 as of September 1991.

- DFA has lost approximately $670,195 in interest which could have been earned had the reserve maintained a healthy level (two and a half times monthly claims paid, an industry standard).

Rising health care costs nationwide have greatly affected the increase in Plan costs. Although, as stated above, DFA could have more aggressively contained program costs, PEER determined that DFA's Plan changes implemented in January 1990 and its utilization review and other cost containment efforts contributed to a slower growth in cost increases during FY 1991. Also, a recently commissioned actuarial study dated December 1991 outlined subsidies by the state to different employee subgroups which occurred because DFA uses a flat premium rate for all subgroups.

Recent actions by the Board of Trustees of Institutions of Higher Learning (IHL) to withdraw from the Plan would affect the Plan by increasing the premiums which would have otherwise been paid by non-IHL state employees. Other effects will be an as yet undetermined increase in overall administrative costs. At its December 1991 meeting, the IHL Board will vote whether to accept a Blue Cross and Blue Shield contract effective January 1992.

Finally, the present level of benefits in terms of deductibles and stop loss limits is similar to levels provided to state employees in other states, and Blue Cross reimburses a lower dollar amount of some health claims than do other commercial insurance companies. DFA could require Blue Cross to reimburse a greater dollar amount for each cost incurred, but that would ultimately increase the claims costs and raise state Plan premiums.

BACKGROUND

Purpose and Scope of the State Employee Health Insurance Plan

The health and life insurance plan for employees of the state of Mississippi (hereafter referred to as the Plan) was created by the State Legislature effective July 1, 1972, with the enactment of Chapter 523, *General Laws of 1971*. PEER's review will not address the life insurance plan for two reasons: (1) the legislative request was directed toward the health insurance plan, and (2) the life insurance plan is only a small portion of the total health and life fund. Because the reserves of the life and health funds are commingled, any references in this report to reserves will include both health and life reserves. Any other mention of the Plan will be a reference to the health plan only.

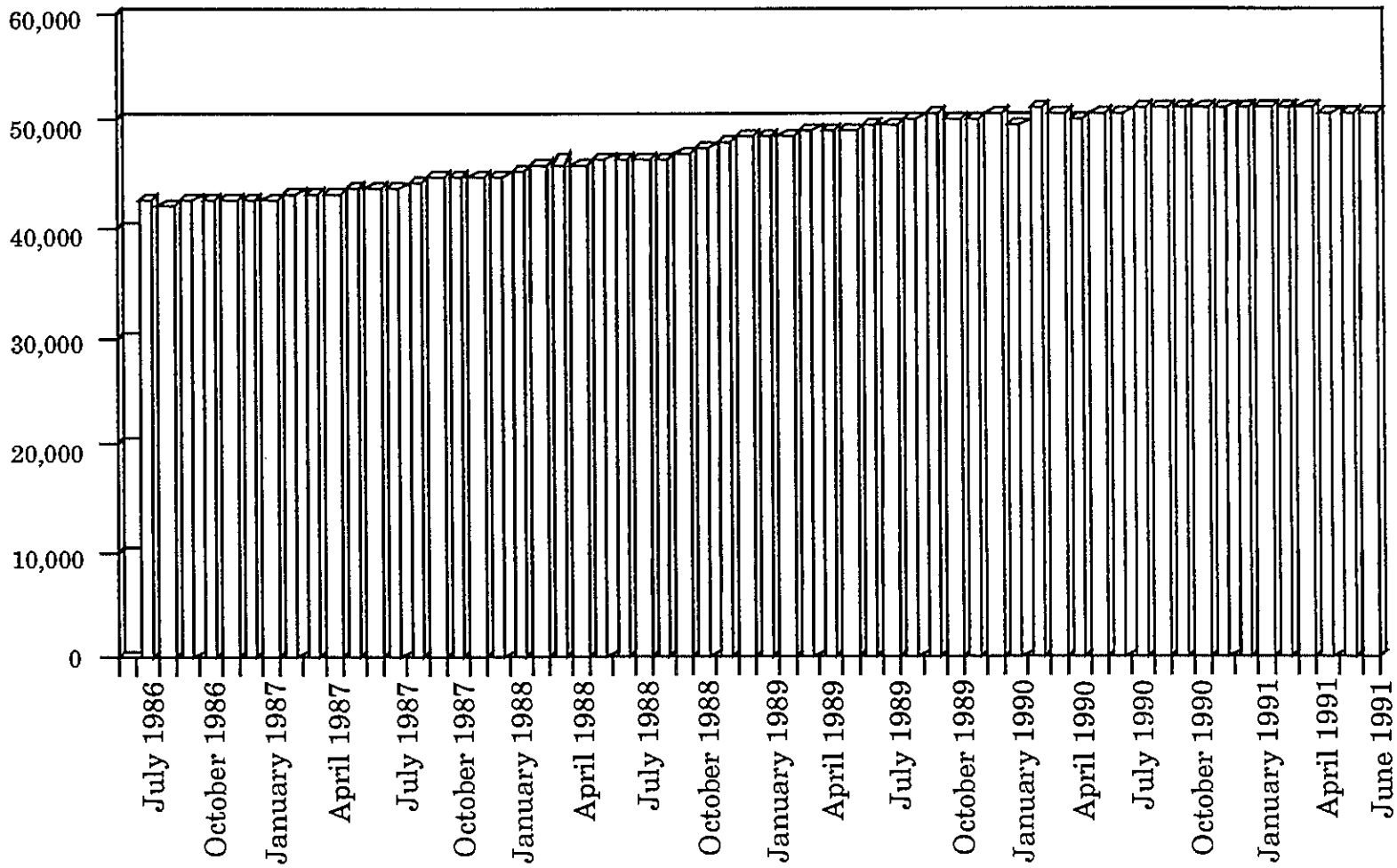
The Plan was originally created to provide major medical insurance coverage of $40,000 per insured member, with the state paying 50% of the employee's premium and the employee paying dependent coverage. Currently the major medical insurance is a maximum of $1,000,000 with the state paying 100% of the employee's coverage. As shown in the chart below, at June 30, 1991, the Plan covered 50,931 employees composed of 5,789 retirees and 45,142 active employees. The 50,931 employees and retirees consisted of 21,813 individuals with salaries less than $15,000 whose Plan deductibles are $150 and 29,118 individuals with salaries of $15,000 or more with Plan deductibles of $200. IHL subscribers totaled 17,032, while non-IHL subscribers numbered 33,899. Total membership in the Plan was 88,073 at June 30, 1991, including an additional 37,142 dependents covered.

Retirees	5,789		
Employees	45,142		
Salaries Less than $15,000		21,813	
Salaries Greater than $15,000		29,118	
IHL Employees			17,032
Non-IHL Employees			33,899
Total Subscribers	50,931	50,931	50,391
Dependents			37,142
Total Members			88,073

As shown in Exhibit 1, page 5, the Plan's enrollment has grown from 42,878 in July 1986 to 50,931 in July 1991, an increase of 18.8%. Total membership in the Plan, including dependents, grew at a slightly higher rate of 20.8% from 72,906 in July 1986 to 88,073 in June 1991. The amount of

EXHIBIT 1

TOTAL MONTHLY STATE HEALTH PLAN ENROLLMENT



Source: Department of Finance and Administration records

claims paid by the fund has grown from $454,682,277 in FY 1987 to $78,810,820 in FY 1991 as shown in Exhibit 2, page 7.

Operation of the Health Plan

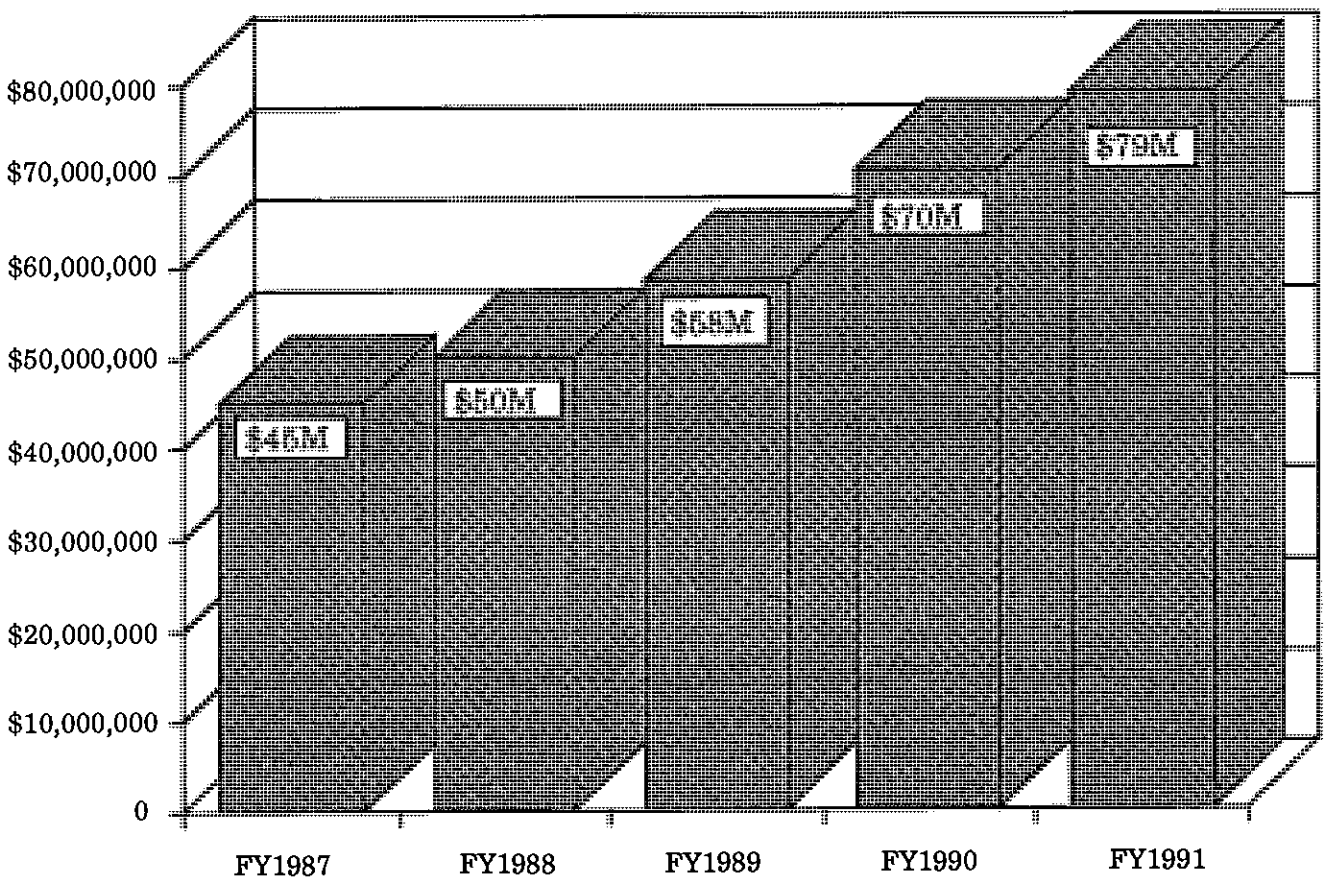
The state employee health plan is financed by premiums collected from Plan members and from the state, which pays one hundred percent of the employee premiums as a fringe benefit. The state does not pay dependent and retiree premiums. During fiscal years 1990 and 1991, the state paid 67% of the total Plan premiums, while state employees and retirees paid the remaining 33%, as shown in Exhibit 3, page 8. During fiscal year 1991, the state paid $46.6 million of the total $69.5 million in premiums received by the Plan; Plan members paid $22.9 million. Effective July 1, 1991, the State of Mississippi began paying the full cost of $102 per month for every active state employee electing individual coverage. If the employee elects dependent coverage, the employee is responsible for paying the additional portion of the premium. State retirees are responsible for paying 100% of their individual and dependent coverage. The rate schedule effective July 1, 1991, is shown in Appendix A, page 47.

The premiums collected under the Plan are used to pay claims for health care costs and to pay the administrative costs of operating the fund. Administrative costs were $3.9 million in 1991. Any income after payment of all expenses is held in the Plan reserve. If the expenses of the fund during a given period are higher than the premium income, the reserve is reduced by the deficit amount. The Plan reserve is important because it serves as a safeguard to cover unexpected losses to the plan. Most importantly the reserve serves as a buffer to cover the amount of claims liabilities that are owed by the plan at any given time. A financially sound insurance fund has a large enough reserve to cover the estimated liabilities owed by the plan.

Measures can be employed to change the levels of premiums, claims and the related reserve fund. Changes in the premium rate directly affect the amount held in the reserve fund. If the premium is increased, the net income of the fund will immediately improve, which favorably impacts the reserve. Changing the benefit levels, such as deductibles and stop loss levels, also affects the reserve in a less dramatic fashion. The deductible is the amount of health costs incurred which must be paid by the Plan member before the Plan benefits begin. If the deductible level increases, then over a period of a year the Plan will pay out less in claims, thus decreasing expenses to the Plan and increasing income to the reserve. If the stop loss level increases (the amount at which claims payments to members increase from 80% to 100%), then the income to the reserve will increase in the same manner.

EXHIBIT 2

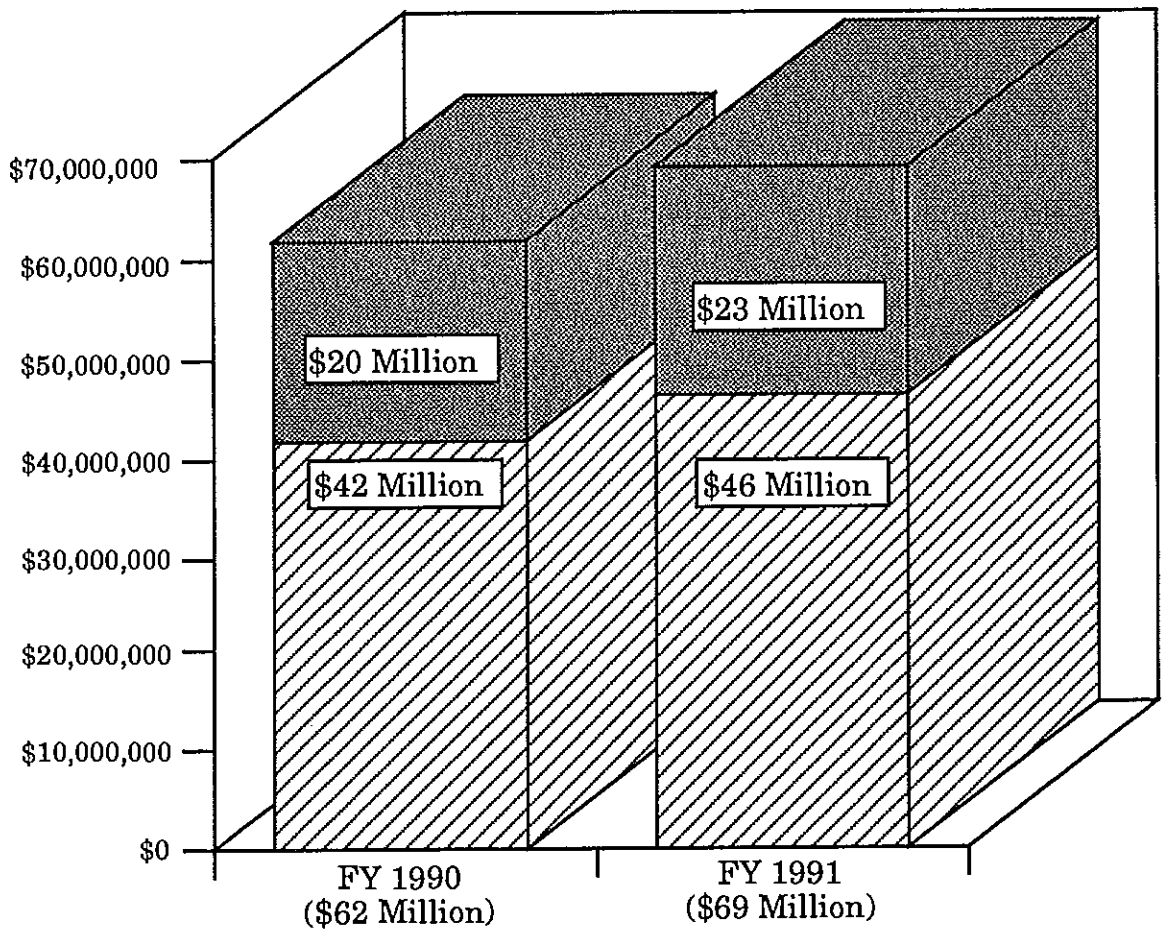
TREND IN TOTAL MEDICAL CLAIMS PAID FROM THE HEALTH PLAN



SOURCE: Department of Finance and Administration records.

EXHIBIT 3

STATE AND MEMBER PORTIONS OF THE HEALTH PLAN PREMIUMS RECEIVED



SOURCE: Department of Finance and Administration records

Administration of the Health Plan

The Plan is administered by the Department of Finance and Administration, a governmental oversight agency, a claims administrator, and a utilization review organization. The state Department of Finance and Administration is responsible for the overall operation of the Health Plan. DFA's duties include monitoring the insurance program; setting premium rates and benefits; maintaining the reserve fund; providing customer service, including handling complaints and appeals of Plan members, corresponding with agencies and retirees, and compiling a newsletter; and selection of a claims administrator. In 1984, DFA selected Blue Cross & Blue Shield (BCBS) as the claims administrator. BCBS reviews claims to determine that benefits are paid as set forth in the contract, reviews claims records to detect duplicate claims, and coordinates with other insurance carriers to assure that the Plan makes no unnecessary or duplicate payments. Blue Cross is also responsible for billing premiums to state agencies and retired employees.

Healthmarc, Inc., is the utilization review organization which is responsible for helping insure that the best possible care is provided to Plan recipients with the least costly combination of services. (PEER reviewed the state's agreement with Healthmarc in *An Analysis of the Department of Finance and Administration's Implementation of a Utilization Review Program as Part of the State of Mississippi's Comprehensive Health Plan*, August 21, 1990). Due to the drastic increases in health costs nationwide, utilization review organizations are becoming increasingly common. Among the state employee health insurance plans, forty-six of fifty utilize hospital inpatient pre-certification and forty-four of fifty use concurrent review of hospital charges, similar to the Healthmarc programs. Twenty-six of the states contract with utilization review firms such as Healthmarc to conduct utilization review activities, while the remaining states use their claims payors (such as Blue Cross) for utilization review.

Additional Healthmarc programs include special attention to large cases costing over $25,000, second surgical opinions, and financial penalties for non-compliance with notification of hospitalization or second opinion requirements.

Administrative Costs

The Department of Finance and Administration incurs costs for operating the health plan, primarily payments to Blue Cross for claims processing and to Healthmarc for utilization review. Total administrative costs increased 205% the last four years, from $1.3 million in FY 1987 to $3.9 million in FY 1991. The components of the $2.6 million increase are:

Type of Increase	Amount	Cause of Increase
Blue Cross	$1,059,394	Inflation and new membership
Healthmarc	1,125,830	Cost containment program started FY 90
Other Utilization Review Firm	(338,880)	Elimination of cost reduction program
FMP Hospital Program	343,619	Cost containment program started FY 90
Other Cost Containment Programs	34,448	Cost containment program started FY90
Key Physician Program	224,703	Benefit to new employees--program started FY 1990
Salaries	132,440	DFA began charging salaries to Health Plan in FY 1990.
Other	58,588	Inflation in other costs or additional overhead
Total	$2,640,142	

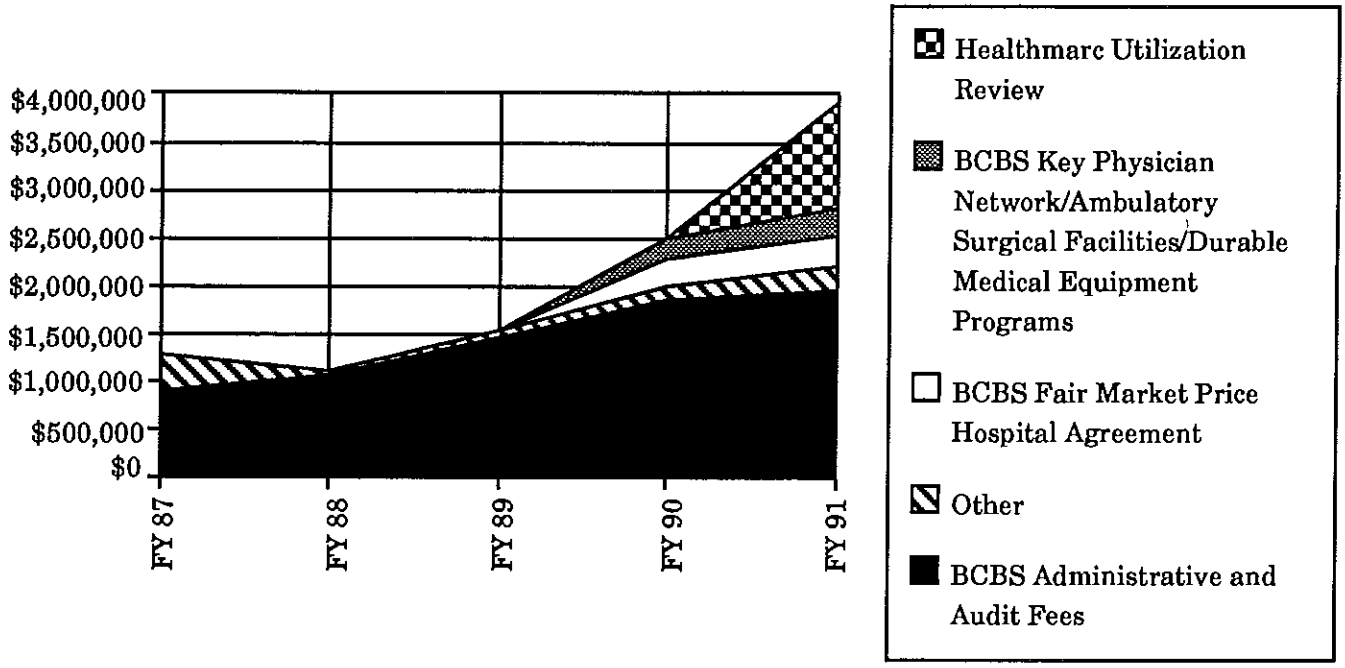
As shown in the top portion of Exhibit 4, page 11, the primary payments were to Blue Cross in the amount of $1,940,447 for claims processing, billing, and auditing of claims. The second largest expenditure was to pay Healthmarc $1.1 million for its utilization review program, which began in July 1990. Although Healthmarc fees accounted for seventy-eight percent of the increase in DFA's administrative costs in FY 1991, the program does appear to have helped reduce claims costs in FY 1991, as described on page 30. As shown in the bottom portion of Exhibit 4, administrative costs have increased as a percent of claims paid. But in fiscal year 1991 the growth in claims paid appears to have slowed due to the investment in cost containment programs.

Payments to Blue Cross for the Key Physician Network totaled $181,716 for nine months in fiscal year 1990 and $224,703 for fiscal year 1991. This program is provided to Plan members as a benefit rather than as a cost reduction tool for the state. Plan members using services of Key Physicians are guaranteed not to incur charges in excess of those reimbursed by Blue Cross.

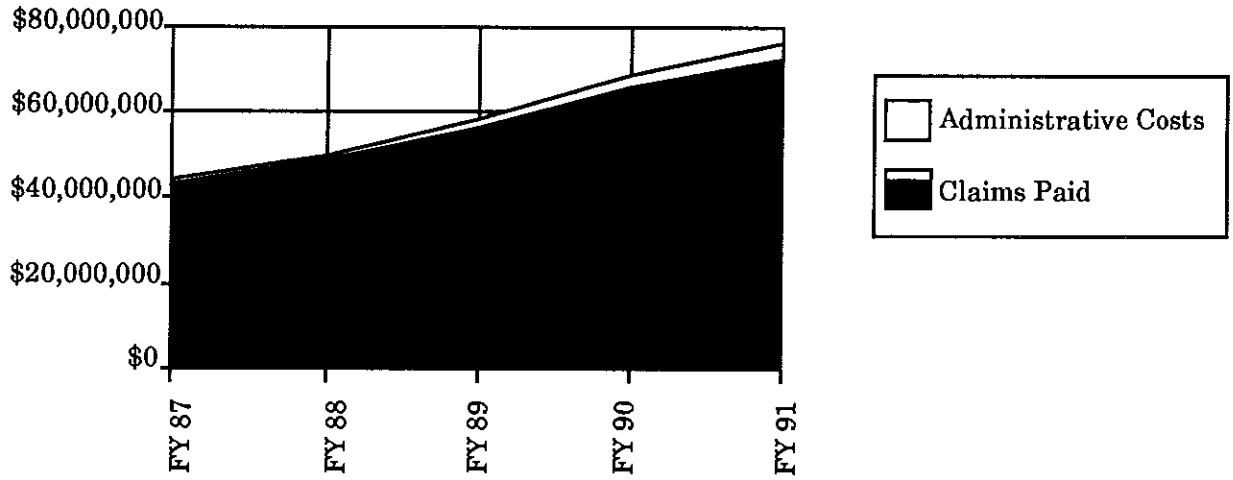
The Ambulatory Surgical Facilities Agreement and the Durable Medical Equipment Program, which cost DFA $27,251 for nine months of FY 1990 and $34,448 in FY 1991, are cost containment programs offered by

EXHIBIT 4

HEALTH PLAN ADMINISTRATIVE COSTS



ADMINISTRATIVE COSTS COMPARED TO CLAIMS PAID



NOTE: Fiscal Year 1990 and 1991 claims paid are net of the $4.2 million in claims discounts obtained as a result of the Fair Market Price Agreement.

SOURCE: Blue Cross and Blue Shield (BCBS) and Department of Finance and Administration records

Blue Cross. DFA has performed no studies to determine whether these two programs have been effective.

The Fair Market Price Hospital Agreement, another cost containment program, is operated by Blue Cross, which contracts directly with hospitals for a competitive price. The Fair Market Price program, further described on page 25, cost the Health Plan $277,090 for nine months in FY 1990 and $343,619 for FY 1991. During those two fiscal years, the Fair Market Price Program reduced claims by $4,185,930, as compared to the total $620,709 in Fair Market Price administrative costs during the same period.

The Plan's other costs, which totaled $256,766 in FY 1991, include salaries ($132,440 in FY 1991), actuarial consulting fees ($37,792 in FY 1991), Department of Audit fees, attorney fees, special reports from Blue Cross, travel and training, supplies, and printing. The other costs in FY 1991 include a non-recurring payment to Blue Cross for $33,535 for programming and computer time in converting its claims processing system to accommodate the Healthmarc program. In FY 1987, the other category included a payment of $338,880 to the Mississippi Medical Foundation Association, another utilization review organization. The contract was reportedly discontinued after one year because of a lack of results in reducing claims costs.

The total FY 1991 Health Plan administrative costs totaled five percent of FY 1991 claims paid, which appears to be a moderate level of overhead. According to Rick Johnson, a managing director of the William M. Mercer health plan consulting firm and Ed Hastings, group manager for Prudential Insurance Company, benefit plan administrative costs have traditionally ranged from four to six percent in the industry.

HAS THE DEPARTMENT OF FINANCE AND ADMINISTRATION PROPERLY MANAGED THE STATE EMPLOYEE HEALTH INSURANCE PLAN?

In reviewing the condition of the State Employee Health Insurance Plan, PEER sought to determine why drastic changes are needed to improve the condition of the Health Plan. PEER found that the Department of Finance and Administration could have managed the Plan better to avoid the depletion of its reserve.

For the past four years, DFA management has postponed making necessary, but politically unpopular, business decisions to manage the State Employee Health Insurance Plan.

During the first four months of fiscal year 1992, Plan expenses exceeded income by over $1,710,086. The Plan is projected to continue to lose money based on the current premium collection and benefit payment levels. Because of the currently low levels of cash held by the Plan and because the Plan will continue to lose money if no changes are made, additional funding is needed. Despite the most recent twenty percent increase in premiums instituted in July 1991, DFA will be forced to revise premiums and perhaps benefits levels again before the end of fiscal year 1992, perhaps as early as January 1992.

Currently the Plan needs basic changes to increase the funding to pay claims, reduce costs so that lower levels of funding will be necessary, and provide for a reserve to protect the financial standing of the plan. Many of the decisions needed to manage the Plan properly could and should have been made over the past four years. If DFA had monitored the plan properly, more closely heeded the advice of actuarial consultants, and been willing to make the hard decisions (such as raising premiums) which are necessary to manage the Plan in a businesslike manner, current financial problems could have been avoided altogether or reduced in magnitude.

State agencies should manage all levels of operations in a fiscally sound manner, and it is especially necessary to manage a health insurance plan properly. Because active employees pay for their dependents to receive health care coverage and because state retirees pay for coverage of both themselves and their dependents, DFA has a fiduciary responsibility to run the Plan in a professional, business-like manner unaffected by political considerations. But instead of properly monitoring premium and benefit levels over the past several years and taking appropriate action, DFA management has instead chosen to postpone making the tough business decisions needed to preserve the financial integrity of the plan. The fact that DFA sought the concurrence of other state officials and disclosed intentions to reduce the reserve and not increase premiums does not lessen DFA's responsibility.

Because DFA has not managed the Plan closely enough, the state and the employees will have to make drastic increases in funding to the plan during one year, rather than over a period of years.

IS THE INSURANCE FUND FINANCIALLY SOUND?

In seeking an answer to whether a problem exists with the current financial standing of the Health Insurance Plan, PEER examined the Plan income and expenses for the past five years and their impact on Plan reserves. PEER also examined insurance industry standards for maintaining reserves, trends in premium collections and claims paid, recommendations by consulting actuaries, and DFA actions affecting the fund. PEER determined that DFA's management over the last four years has led to a financially unsound Plan.

DFA allowed the State Health Plan to become financially unsound with only $3 million in cash reserves at October 31, 1991. The Plan's reserves fall short of $17.9 million, which represents the estimated claims liabilities owed by the Plan.

The health plan reserve equals the cash accumulated from premiums collected which exceed claims paid and administrative expenses during an accounting period. The reserve, or pool of cash, is needed to cover claims liabilities which have occurred but have not yet been reported. PEER reviewed the level of state health plan reserves from January 1986 to the present and found that the current $3 million reserve level, which peaked at $25 million in May 1988, falls far short of the industry standard for estimating unreported claims owed by the Plan. As explained below, the industry standard, or typical amount of claim reserve, is two and one-half times the average claims paid per month.

The reserve needed to protect a health plan is based upon the estimated amount of claims which have been incurred by health plan members but not reported to the plan administrator. If claims paid out each month by the Plan plus administrative expenses are less than premiums received by members during that month, then the net income is added to the reserves. If claims paid and other expenses exceed premiums taken in during that month, then the reserve is depleted by the amount of loss during that month. In general for most health plans, most of the claims incurred but not reported will be collected within two and a half months of any given point. DFA's actuarial consultants in a March 1991 report also found the two and one-half-month benchmark to be an accurate measure of the claims liability specifically for the state health plan. Because the reserve calculation is based on average claims which vary over time, the estimate for the minimum reserve is a moving target which should be periodically recalculated. As of October 31, 1991, PEER estimated a $17.9 million claims liability for the state health plan based upon this industry standard. Therefore the minimum amount of claim reserves which should be kept for the state health plan approximated $17.9 million in October 1991.

Prudent management dictates that the levels of income and expense be monitored over time to insure that the reserve will stay at a financially sound level. Instead of having insured that reserves grow at the appropriate level, DFA has allowed the reserves to steadily erode from $25 million in May 1988 to $3 million in October 1991. As shown in Exhibit 5, page 17, the monthly medical claims paid began regularly exceeding monthly premium receipts in June 1988, which triggered the depletion of the reserve.

The standard industry benchmark for estimating a safe level of health plan reserves is two and one-half times the average claims paid per month, according to health plan consultants at the William M. Mercer and Martin E. Segal consulting firms. This represents the estimated claims liabilities for health plans. The estimated claims liability of the State Health Plan at October 31, 1991, was $17.9 million. However, the actual Plan reserve of $3 million fell far short of the $17.9 million needed. DFA management was well aware that the reserves were being steadily depleted during the last three years. DFA's consultants consistently recommended that premiums be raised in order to boost reserves, but DFA repeatedly downplayed the advice by either not raising premiums or raising them to a lower level than recommended.

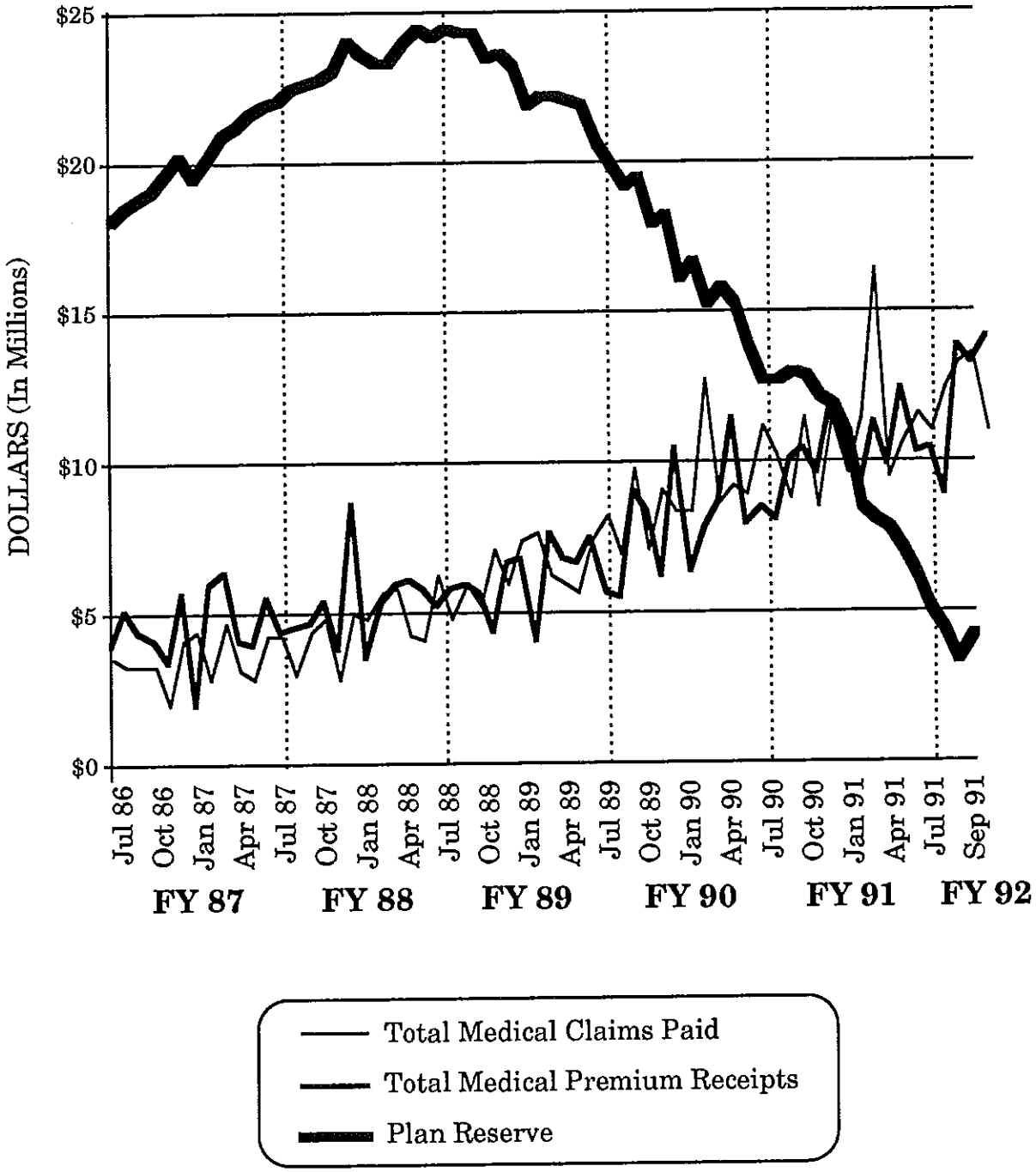
DFA officials contended that the Plan had excess reserves over a period beginning with the high of $25,000,000 in May 1988, and that as a result reserves should have been allowed to deplete. However, DFA actually has had no excess reserves since May 1990 based upon the minimum industry standard for claims reserves described above. Based upon a more stringent commercial insurance carrier standard, DFA has had no excess reserves since January 1989. If the State Health Plan were a commercial insurance plan, DFA would have been required to keep contingency reserves, doubling the required amount of reserves for the Plan to $35,000,000.

The Plan reserves may drop to $2 million or less by the time that DFA implements premium increases, which DFA has stated may be in January 1992. Therefore DFA has mismanaged the plan by allowing reserves to reach a dangerously low level, threatening to jeopardize the regular payment of employees' claims.

The depletion of the health plan reserves was caused by mismanagement by DFA officials, past and present, over the past four years. Although these officials knew the reserve was depleting, they chose the easiest course of action, which was to postpone needed premiums increases. In addition DFA has not created an "Insurance Reserve Fund" in the treasury as required by MISS. CODE ANN. § 25-15-15, enacted in 1983. The present reserves are kept in the State Employees' Insurance Fund, a treasury fund also established by law. The CODE requires establishment of a second treasury fund for holding the reserves separate from operating funds. The provision for a reserve fund in the law shows a clear intent of

EXHIBIT 5

TRENDS IN HEALTH PLAN PREMIUMS RECEIVED, CLAIMS PAID AND RESERVES JULY 1986 - SEPTEMBER 1991



NOTE: The reserve includes accounts from both Life and Health plans.

SOURCE: Department of Finance and Administration records.

the Legislature to establish reserves for the fund. As a result of DFA's mismanagement, the health plan presently is financially unsound.

WHAT CAUSED THE FINANCIAL PROBLEMS?

Based on the finding that the Plan was experiencing serious financial problems, PEER sought to determine what factors caused reserve levels to deplete and why DFA did not rectify the trend in reserve levels over the previous three years of decline. PEER examined DFA's actions, roles, and responsibilities for monitoring the fund and also studied the advice provided to DFA by consulting actuaries during this period. PEER found that DFA did not follow actuarial consultants' advice or develop an adequate system to monitor the position of the reserve fund during a time of rapidly rising health costs. These factors together led to financial problems.

DFA failed to follow the recommendations of its actuarial consultants to raise premiums in order to protect the fund reserve. As a result, the state or state employee Plan members will have to fund large premium increases in one year rather than a number of smaller increases over several years.

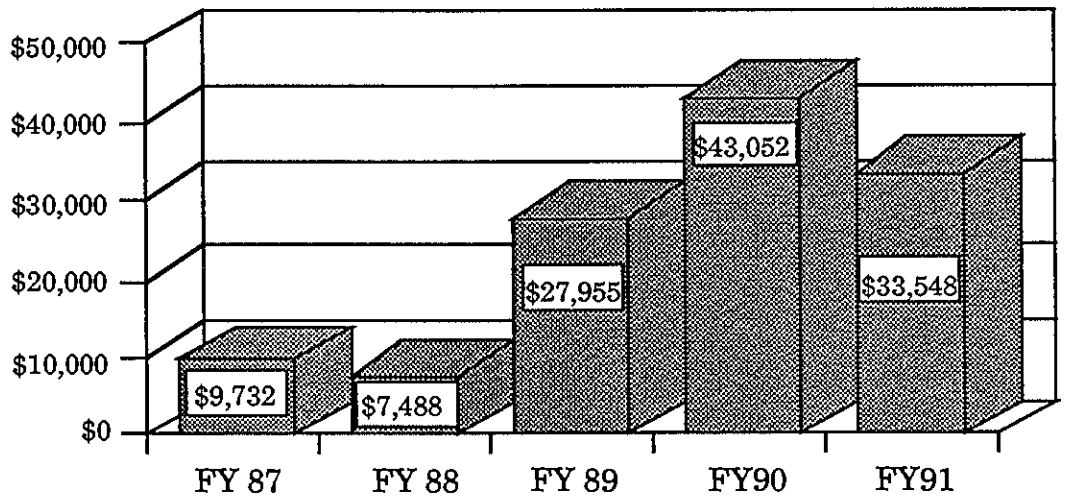
PEER reviewed the actuarial consulting studies conducted for DFA during the last five fiscal years. DFA contracted with William M. Mercer, Incorporated, actuarial consultants, to review the claims experience of the state employee health plan five times from June 1987 to March 1991. DFA paid the consultants a total of $121,775 to aid the state in *"determining appropriate funding levels, identify*[ing] *trends in medical costs and benefits, and estimate*[ing] *future reserve levels."* The expenditures for Mercer's actuarial review are outlined in Exhibit 6, page 20.

Mercer, a national consulting firm, based its recommendations on actual trends in the state health plan data and knowledge of industry practice and actuarial techniques for developing financially sound estimates of proper fund reserves. PEER verified from several industry sources that Mercer's technique of estimating plan reserves is standard industry practice.

As shown in Exhibit 7, page 21, Mercer consistently recommended premium increases over the past four years to maintain the Plan's financial position and bolster the reserve. Instead of following this advice, DFA chose to implement smaller and less frequent premium increases, thus depleting the reserve. DFA implemented a modest rate increase of six percent in July 1989, even though Mercer had recommended increasingly higher rate increases for three consecutive years of ten to twenty-five percent. After DFA chose not to follow Mercer's June 1987 recommendations, Mercer in its August 1988 report reasoned that *"increasing the funding level a small amount now will avoid the adverse publicity and damaged employee morale of a larger rate increase and avoids the risk of draining the reserves."* In a May 1989 report, Mercer suggested that, in addition to a needed premium increase of twenty-five percent, plan changes (such as increasing deductibles and stop loss limits)

EXHIBIT 6

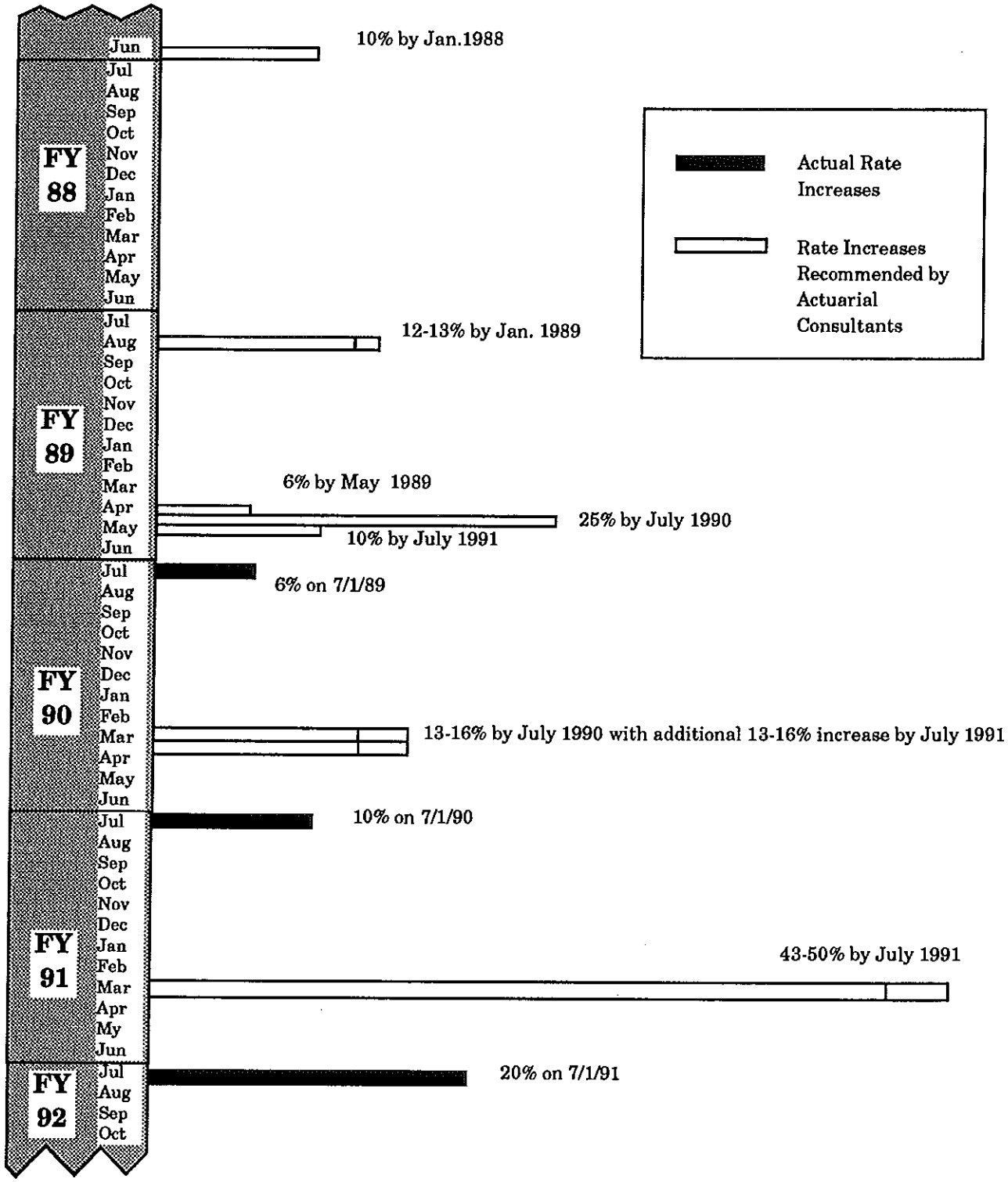
**PAYMENTS MADE TO WILLIAM M. MERCER, INC.,
ACTUARIAL CONSULTANTS
FISCAL YEARS 1987 - 1991**



SOURCE: Department of Finance and Administration records

EXHIBIT 7

TIME LINE COMPARING ACTUAL RATE INCREASES WITH RECOMMENDED INCREASES BY ACTUARIAL CONSULTANTS 1987 - 1991



NOTE: The May 1989 and March 1990 studies recommended graduated rate increases.

SOURCE: William M. Mercer, Inc., Actuarial Consulting Reports dated June 1987 - March 1991

were a way to reduce the cost of the health plan. However, the consultants cautioned that deductible and stop loss benefit changes would not increase the reserve level as effectively as a premium increase would.

Shortly after the six percent funding increase implemented by DFA in July 1989, DFA in January 1990 increased the deductibles from $100 to $150 for employees with salaries of less than $15,000 and to $200 for employees paid $15,000 or more. DFA also increased the stop losses from $1,000 to $1,500 to help solve the funding problems. Increasing deductibles and stop loss levels improves funding problems by decreasing the amount of claims paid out by the Plan. [For instance, based on actuarial tables, PEER has estimated that Plan claims would decrease by close to $1.9 million annually if the deductible was increased by $50. Under the same method, an increase in the stop loss from $1,500 to $2,000 would decrease claims by an estimated $1.2 million annually.]

Despite the January 1990 deductible and stop loss changes, in March 1990 Mercer continued to recommend large rate increases of thirteen to sixteen percent in July 1990 and July 1991 which were needed to maintain a reserve of five to ten million dollars, a very modest amount of reserves according to Mercer. But in July 1990 DFA chose to increase premiums by only ten percent. Again in July 1991 DFA chose to increase premiums by only twenty percent, a small amount in comparison to Mercer's recommendation of forty-three to fifty percent.

DFA officials have stated that one of their biggest concerns was the effects of higher premiums on employees. As a result DFA purposely chose not to raise premiums as much as recommended by Mercer and consequently weakened the reserve. While a concern for the welfare of the employees certainly must be a part of the administration of the health plan, the actual result of DFA's decision to decrease the reserves was ultimately to affect the employees of the state adversely. Had DFA acted in accordance with actuarial recommendations, the dramatic financial impact on both the employees and the state would have been minimized. By postponing politically tough decisions needed to assure financial stability of the Plan, DFA must now drastically raise premiums twice in one fiscal year and in fact may choose to make other plan changes. If premiums had been gradually increased over a period of years, employees and the state would have more easily been able to plan for the future and adjust both personal and agency budgets to handle increased premiums.

According to a recently completed actuarial study by Jackson, Mississippi, actuary Lynn Townsend, premiums must increase 24 percent in January 1992 to pay estimated claims for the calendar year. This is a minimum level of funding needed for the plan and will not increase the reserve, the level of which is presently far below the industry standard for reserves. Assuming a rate increase of 24 percent is implemented on the current premium structure, then the state must increase spending for employee health premiums by approximately $1.1 million monthly, or $13.4

million annually. If the inflation rate continues at the rate of 14% as projected by the actuary, the premiums based on the present flat rate structure will increase to $1.3 million monthly in calendar year 1993. The projected increase in premiums on a fiscal year basis is shown below:

	FY 1992 (January-June)	FY 1993	FY 1994
General funds	$3,250,718	$6,956,536	$7,930,452
Special fund	3,453,175	7,389,796	8,424,367
Total state funds	$6,703,893	$14,346,332	$16,354,819

If the reserve is funded to a proper level then an additional $17.9 million will be needed.

Another result of DFA's failure to follow the advice of its actuarial consultants is that the agency has not made the best use of the funds spent for these services. PEER questions the wisdom of hiring consultants at $184 per hour, or $121,775 over five years, whose advice is not taken more seriously.

DFA has not developed an adequate system to monitor the position of the reserve fund regularly and analyze claims data and usage patterns upon which to base management decisions.

Because of increasing costs of health insurance, the management of health care is becoming increasingly more important. As a result, trends in the claims paid and premiums received and changes in the way the health plan is used by members must be analyzed carefully in order to make the most informed decisions.

In the past DFA has hired actuarial consultants at up to $184 per hour to review trends in claims payable and project future premium and reserve levels. However DFA needs to monitor closely the financial position of the fund and analyze the types of claims paid to help determine why health costs are increasing so drastically and to recommend ways to reduce costs.

Mercer has recommended "*further exploration into the age/sex population mix, patterns of high priced hospitalization use and treatment patterns such as length of stay*" to help explain the rising cost of hospital services covered by the health plan. But DFA has not yet researched this area.

A primary problem is that DFA has no data base of information on state employees such as types and amounts of claims paid, claims usage, and demographics. As a result DFA is dependent upon Blue Cross to

provide pertinent information. Blue Cross provides several regular reports to DFA on claims paid and claims usage, but often these reports include meaningless or contradictory information. For the last four years, Blue Cross provided claims analysis reports which included an indicator for claims utilization which Blue Cross officials now state is not useful. PEER also found that two similar loss ratio reports generated by Blue Cross with the same reporting date contained contradictory information which could not be resolved. The company also does not revise some of its reports to include premiums and claims refunds and adjustments. As a result, regular Blue Cross reports provided to the state do not reconcile to each other. Over the past four years, DFA does not appear to have monitored the Blue Cross reports to ensure that Blue Cross provides the kind of data and reports that will be helpful to the agency in monitoring the plan, including data on the patterns of state employees' utilization of the Plan.

In other instances DFA has not promptly followed up on potential problems brought to its attention. For instance, Mercer, in an October 1990 report, stated that hospital service prices for state employees have risen faster than for other Blue Cross accounts in Mississippi and that state employees have over-utilized hospital services in comparison to other Blue Cross business in Mississippi and national trends. DFA has not pursued this finding to clarify the problem or determine the solution.

DFA has not historically demonstrated the management capability to run a health insurance plan. DFA had no documented agenda or plan of action for the health plan nor did the agency employ an insurance analyst. As a result DFA lacked the objective of placing a priority on analysis of information to enhance decision-making. Therefore DFA did not gather meaningful information to help explain the rising costs of the state health plan specifically, or determine the causes of the high Plan utilization by state employees.

After discussions with DFA's Director of the Office of Insurance, who was employed in September 1991, PEER determined that the new director has begun to develop plans to address some of the problems, such as hiring an analytical staff person, developing an internal data base of information, working with Blue Cross to develop more meaningful reports, and developing goals for the insurance plan.

HAS THE DEPARTMENT OF FINANCE AND ADMINISTRATION AGGRESSIVELY DEVELOPED MEASURES TO MAXIMIZE FUND ASSETS AND CONTAIN PROGRAM COSTS?

While DFA's reluctance to increase rates in a timely manner contributed largely to the depletion of the reserve, several other factors within the control of DFA have accelerated the depletion of reserves. PEER examined several components of fund management which negatively affected the fund balance such as lost interest earnings, lack of cost containment measures for prescription drugs, and agencies' late submissions of premiums without penalty.

DFA has allowed Blue Cross to hold refunds due to the health plan for quarterly periods, rather than remitting the funds to DFA on a daily basis. As a result DFA has lost the opportunity to earn approximately $78,168 in interest for the health plan since October 1989.

DFA has contracted with Blue Cross to enter into Fair Market Price agreements with hospitals in order to reduce the cost of hospital care. Blue Cross contracts directly with hospitals for a competitive price. The subsequent savings from the pricing agreements pass along to the health plan. DFA entered into the Fair Market Price program in October 1989.

According to Blue Cross, the program:

- establishes a standard payment for covered services;
- provides incentives for efficient hospitals; and,
- incorporates a review of hospital services to ensure services are provided in a cost efficient manner.

Blue Cross bases its standard payments to the Fair Market Price hospitals on billed charges to Blue Cross patients in Mississippi hospitals and patterns of length of hospital stays of Blue Cross patients. Hospitals with charging patterns higher than the lowest charge hospital in a service area have a competitive disadvantage. On the other hand, hospitals in some cases may be due a higher payment based on the payment formula. When the Fair Market Price hospital submits a claim, Blue Cross calculates the reimbursement due DFA based on the standard payment method formula described above.

Blue Cross is responsible for refunding the reimbursement obtained from the hospital to DFA. From that amount Blue Cross deducts its administrative fee of approximately $55,000 per month for several cost containment programs. Blue Cross sent DFA the first refund check in August 1990. PEER found that Blue Cross did not refund this first discount

check to DFA until eleven months of discounts had accumulated in the amount of $1,141,471.

Beginning March 1991, DFA officials required Blue Cross to send the discounts on a quarterly basis. According to Blue Cross officials, Blue Cross calculates the amount of the discount at the time that the Fair Market Pricing hospital claims are filed with Blue Cross. When Blue Cross pays the hospitals for health care, the payment is calculated by netting the state savings against the amount that Blue Cross owes the Fair Market Pricing hospitals on its other non-state business. Although the hospitals are, in effect, paid the discounted amount, Blue Cross keeps the discount due to the state and does not refund it to the state until the end of the quarter. As a result, Blue Cross has the use of state funds on which it can earn interest. If DFA had required Blue Cross to refund the discounts as soon as they were received by Blue Cross, then DFA would have had the opportunity to earn approximately $78,168 in interest on the funds since October 1989.

Sound management principles dictate that DFA not allow a commercial vendor to have use of state funds through business practices. The current Fair Market Pricing contract allows Blue Cross & Blue Shield to hold the discount savings realized for up to a full quarter before refunding them to DFA.

Because the premium structure is set at the same level for employees in all risk categories, the state subsidizes certain employee groups within the plan.

In the insurance industry, individual premiums are structured so that at-risk and older individuals will be charged higher premiums for their coverage. As a result, individuals who are more likely to use their insurance plans tend actually to pay more for their coverage. In a group plan, premiums are sometimes structured so that costs are spread more evenly among the plan members. For instance, in the State Plan, retirees under sixty-five and non-retirees must pay the same premium ($102 as of July 1, 1991, for single coverage). (See Appendix A, page 47, for additional rate comparisons.) Because the premium structures of the State Plan are set at the same level for employees in all risk categories, the state subsidizes certain subgroups of state employees.

Recently DFA commissioned Lynn Townsend, a consulting actuary based in Jackson, Mississippi, to study the claims experience of different employee groups within the group plan. Because the employees of the Board of Trustees of Institutions of Higher Learning (IHL) have taken steps to withdraw from the State Health Plan (see finding, page 38), the study included a separate analysis of IHL employee claims experience. The report found that during FY 1990 and FY 1991, premiums paid by the state for individual coverage for IHL active employees subsidized state retirees

(including both IHL and other state retirees) and also subsidized active state employees to a lesser extent.

In FY 1991 the Plan claims paid ($79 million) exceeded premiums paid into the Plan (nearly $70 million). The resulting "loss" totalled $9.5 million. Over $5.3 million of the total loss was attributable to claims paid to retirees, including IHL retirees. Over $4.2 million of the loss was attributable to claims paid to active state employees and their dependents, excluding IHL active employees and dependents. The IHL active employee group had a much better claims experience, with a gain of $61,786.

Exhibit 8, page 28, illustrates the loss on a per-employee basis and outlines the relative contribution to losses by the various subgroups. For instance, for every dollar in premiums paid by the state and non-IHL state employees in FY 1991, the non-IHL active employees received $1.10 in benefits. Active IHL employees received about $1.00 in benefits for every $1.00 paid in premiums by the state and IHL employees. Retirees received $2.06 for every dollar they paid in premiums. Retirees below age sixty-five received $2.43 in benefits for every dollar, while retirees above age sixty-five on Medicare received $1.71 in benefits. Because Blue Cross has not kept data on retirees of the separate IHL and non-IHL groups, PEER cannot determine whether IHL retirees have different loss ratios than non-IHL retirees.

Exhibit 9, page 29, also shows that the state of Mississippi has been subsidizing the premiums for dependent coverage for its employees. For every $1.00 paid by the State of Mississippi for individual coverage for its employees, employees have received $.99 in benefits. Active non-IHL employees have received $1.28 for dependent coverage for the same dollar contribution out of their own pockets, while IHL employees have received $1.21 in dependent coverage benefits for the employee dollar contributed to pay premiums. Appendix B, page 49, contains excerpts from the actuarial report which further describe the subsidies by the state.

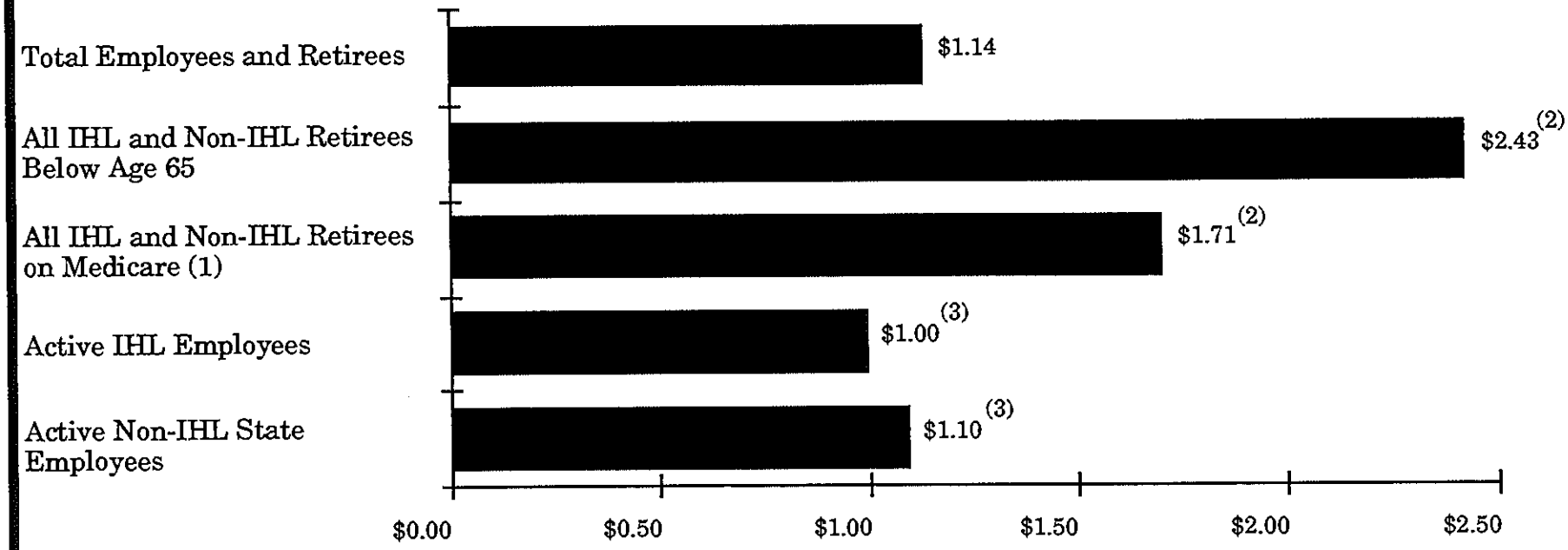
The actuary projected that if the structure of the premiums were not adjusted, all categories of premiums would have to increase 24 percent over present levels in order to pay projected claims for the year. As shown in Appendix C, page 50, he also projected amounts that premiums would increase for the various subgroups if DFA chose to disallow cross-subsidies within the groups. In this scenario, the greatest premium increases fall on retirees and dependent coverage.

DFA should request the actuary to project premiums based on increasing the reserve to proper levels and increases in the deductibles in the $250 to $500 range. DFA can then use this information to determine the proper level of premiums and deductibles.

As shown in Appendix D, page 51, DFA is considering a shift from the present flat-rate premiums to an experience-based system of premiums

EXHIBIT 8

COMPARISON OF BENEFITS RECEIVED FOR EVERY DOLLAR PAID IN PREMIUMS BY EMPLOYEE SUBGROUP FY 1991

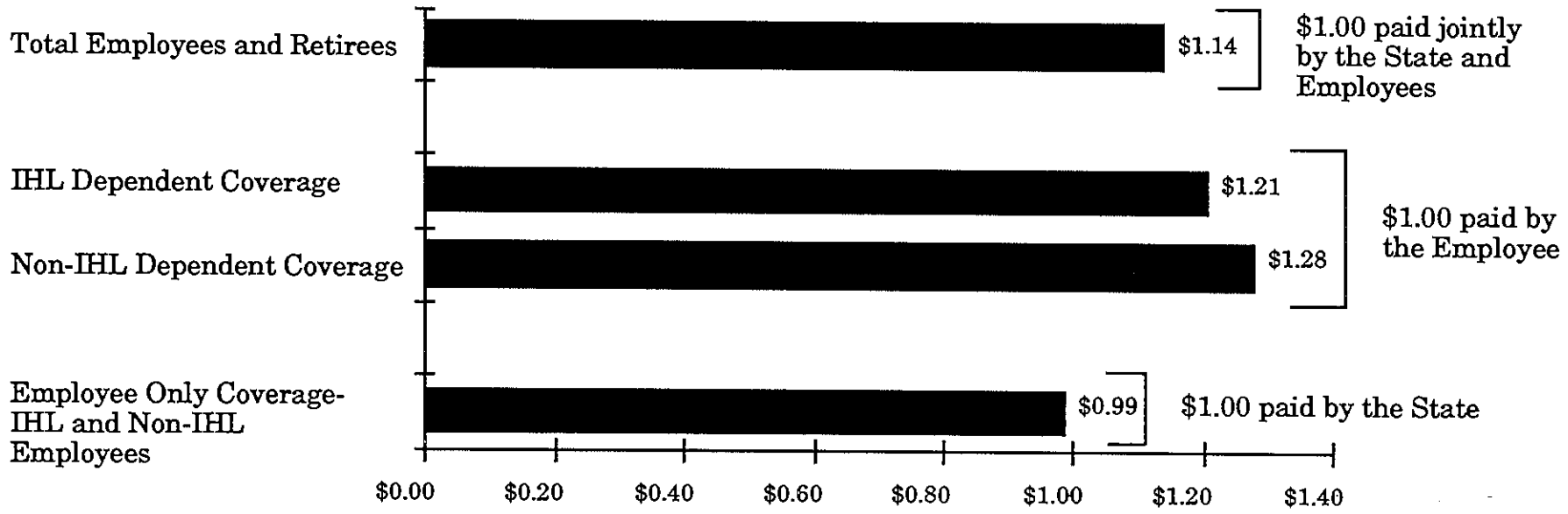


(1) Includes a few non-retiree Medicare-recipient plan members.
(2) Corresponding $1.00 in premiums was paid by the retirees.
(3) Corresponding $1.00 in premiums was paid jointly by the State and its employees.

SOURCE: December 1991 report by Lynn Townsend, FSA, Consulting Actuary, Jackson, Mississippi

EXHIBIT 9

COMPARISON OF BENEFITS RECEIVED FOR EVERY DOLLAR PAID IN PREMIUMS -- EMPLOYEE COVERAGE PAID BY THE STATE VERSUS DEPENDENT COVERAGE PAID BY THE EMPLOYEE FISCAL YEAR 1991



SOURCE: December 1991 report by Lynn Townsend, FSA, Consulting Actuary, Jackson, Mississippi

in which the state pays only for the cost of individual employee claims, the employees pay the full cost of dependent claims, and retirees pay the full cost of their claims. In the event that DFA adjusts the premiums to distribute more equitably the costs for the health plan among the subgroups, PEER suggests a gradual shift from flat-rate to experience-based premiums so that groups such as retirees will not be hit with extraordinarily large increases in one year. The cost-shifting should be less noticeable in the first year of changes, with steadily greater increases toward experience-based premiums. For employees retiring after this point, DFA should consider a more immediate shift to experience-based premiums, with a more gradual phase-in for persons already retired. DFA should explain plan changes thoroughly to retirees and active employees so that they may plan for the future.

Finally, the actuary projected premiums in the event IHL employees are withdrawn into a separate health plan. The actuary's figures show that if the two groups separate, non-IHL employees rates would increase by a larger percentage than those of IHL employees.

Rising health care costs contributed to the increased Plan claims expenditures. State claims expenditure trends show that the January 1990 Plan changes contributed to the lower rate of cost increases in FY 1991. It also appears that DFA's utilization review cost containment efforts may have contributed to the lower rate of cost increases occurring in FY 1991.

In recent years medical costs have risen dramatically, outpacing the general rise in inflation. As shown in the following statistics provided by the U. S. Department of Labor's Bureau of Labor Statistics, the increase in the medical cost component of the Consumer Price Index (CPI) for 1990 was 9.6%, or 57% higher than the overall CPI increase of 6.1%.

	CPI Medical Care Cost Increase	CPI Overall Increase
1990	9.6%	6.1%
1989	8.5%	4.6%

As expected, the State Health Plan has been affected by these nationwide trends in increasing health care costs. State Health Plan claims paid rose 11.7% in FY 1988, 16.5% in FY 1989, and 21.2% in FY 1990. Fortunately, from FY 1990 to FY 1991 the state plan cost increases slowed to an 11.8% rate, from $70 million to $79 million. The Plan changes in January 1990 contributed to the lesser increase in costs. These changes consisted of increasing the deductibles from $100 to $150 for employees with salaries of less than $15,000 and to $200 for employees paid $15,000 or more. DFA also increased the stop losses from $1,000 to $1,500.

As shown in Exhibit 10, page 32, the state Plan's increases, although considerable, were actually more moderate than the average industry-wide trend at 24% projected in a survey by Noble Lowndes (USA), a health care consulting group. The industry health care costs have risen steadily at 23% and 24% in 1989 and 1990, respectively, and a projected 24% in 1991. Exhibit 11, page 33, shows that rising health costs are affected by several factors in addition to the increase in the CPI. Other components of the 24% trend include higher costs due to technological advances, cost shifting from Medicaid and Medicare programs to the private sector, social shifts such as the aging of the workforce, and consumer demand (utilization). As shown in the exhibit, cost increases due to technological advances and utilization are the fastest rising components of the overall inflation rate.

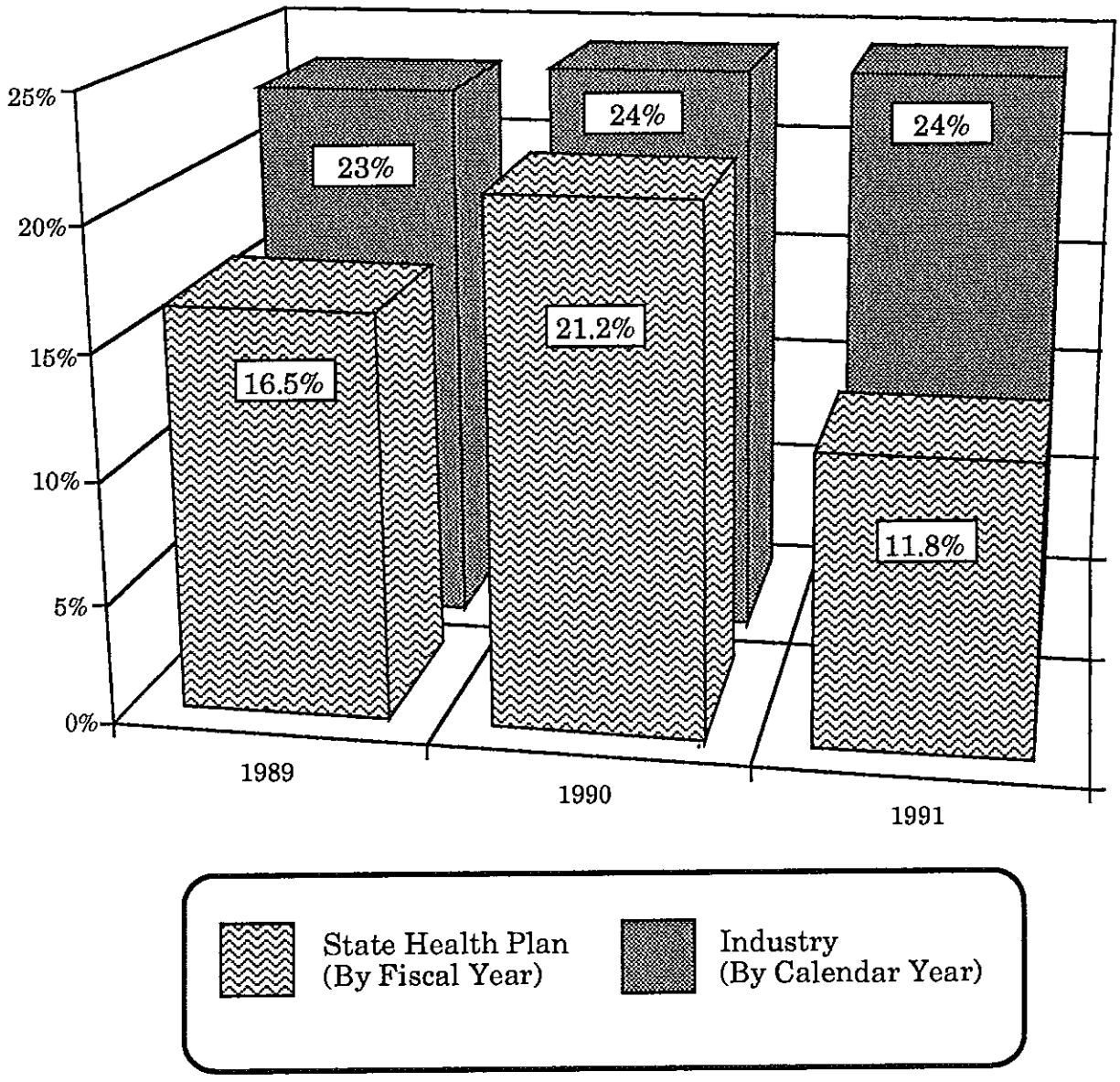
Health care consultants have stated that on average self-insured employers can expect the same levels of cost increases as for insured plans. However, plans with managed care, such as the Healthmarc program, should expect lower cost increase percentages from the high teens to low twenties. In order to determine why State Plan costs specifically have increased, PEER analyzed the State Plan claims paid, the numbers of health care procedures covered by Blue Cross benefits, and the trends in enrollment. In fiscal year 1991, total claims paid by the Plan grew by $9 million to $79 million. As shown in Exhibit 12, page 34, PEER found that 35%, or $3.2 million, was due to an increase in numbers of state employees and dependents. The remaining 65% increase in claims, or $5.8 million, was due to health care inflation, consisting of those factors explained in Exhibit 11.

PEER determined that the utilization, or consumer demand, component of the inflation factor did not increase for the state Plan. PEER was particularly interested in the utilization factor because it can be controlled to a certain extent by managed care companies such as Healthmarc, which work with medical care providers to curb unnecessary medical costs. Although nationwide utilization costs increased in 1990 and are projected to increase by 18% in 1991 and Mississippi's utilization rates remain high in comparison to those of other states, the overall utilization in the state Plan decreased from FY 1990 to FY 1991; this shows that efforts by DFA to reduce costs in the area of utilization review have been effective. PEER examined different components of state medical care costs and found that an increase in utilization in outpatient services has been more than offset by decreased utilization in the most expensive area of medical care, inpatient hospital stays. This occurred because utilization review firms such as Healthmarc consciously work to shift patterns of medical treatment from inpatient services, which are traditionally very expensive, to outpatient services in order to decrease costs.

Although PEER did not review Healthmarc's operations specifically to determine the efficiency of that company's operations, it appears that DFA's use of managed care, such as that provided by Healthmarc, has been beneficial in reducing the state's overall health costs. DFA chose

EXHIBIT 10

COMPARISON OF HEALTH BENEFIT COST INCREASES IN THE STATE PLAN AND THE INDUSTRY

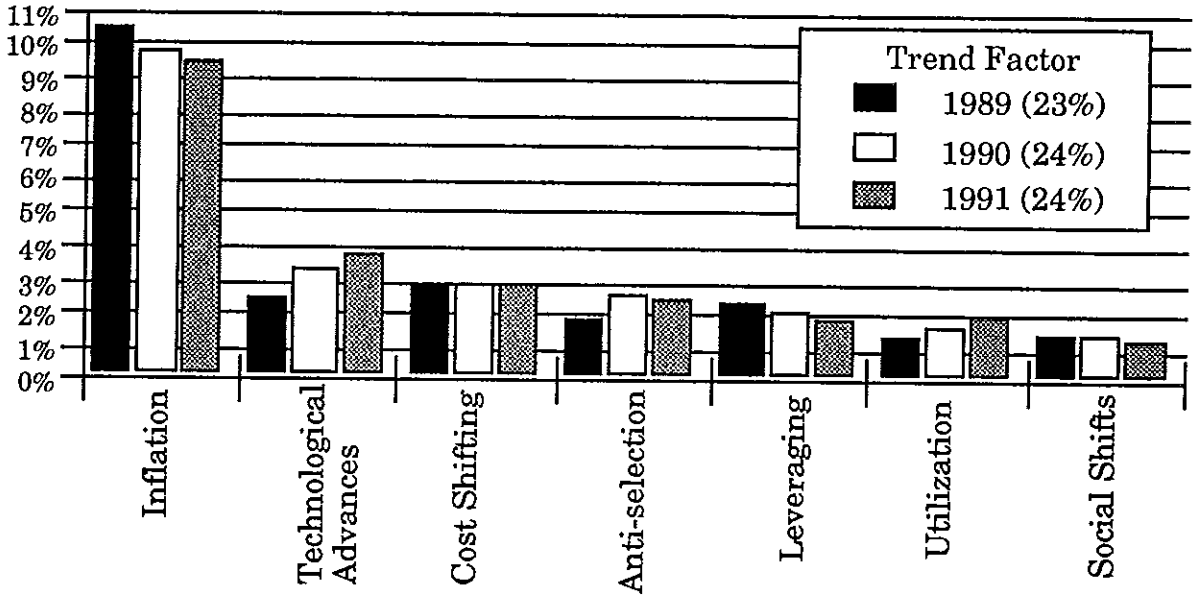


NOTE: Industry costs for 1991 are projected.

SOURCE: Report by Noble Lowndes, health care consultants, and Department of Finance and Administration records.

EXHIBIT 11

FACTORS INFLUENCING INDUSTRY-WIDE HEALTH BENEFIT COSTS



While inflation is moderating slightly, other functions, like technical advances and utilization, continue to push health care cost trend lines above the 20% mark.

Factors Defined:

Inflation - increase in Consumer Price Index

Technological Advances - increased cost of new medical procedures

Cost Shifting - transfer of costs from public to private sectors, i.e., federal government's decreased funding of Medicare

Anti-Selection - process of employees selecting plans which offer greatest benefits, i.e., husband and wife selecting the most flexible plan of those offered by separate employers

Leveraging - the effect of increasing costs arising when deductibles are not increased as fast as the rate of inflation

Utilization - increase in consumer demand for services

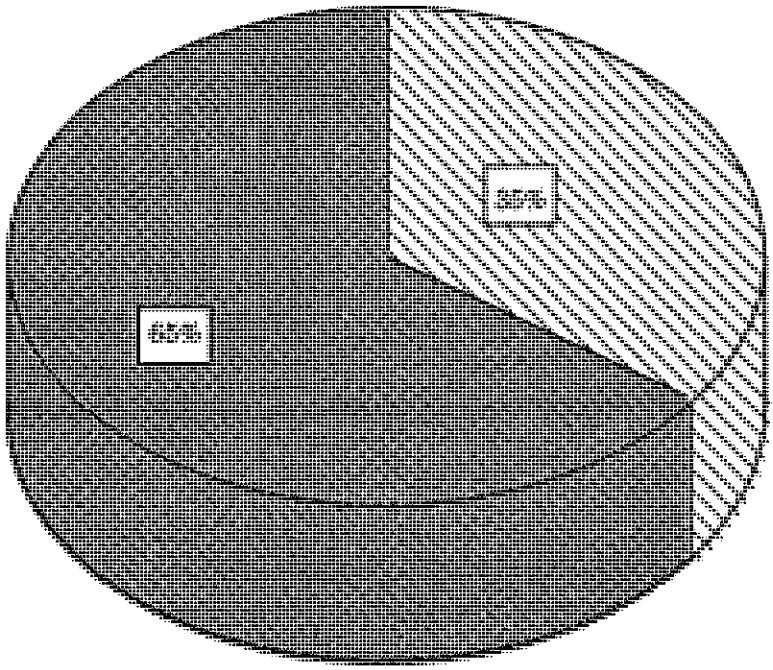
Social Shifts - increase in the aging population, psychiatric care, substance abuse programs, AIDS and mandated benefits

SOURCE: Noble Lowndes, health care consultants

EXHIBIT 12

INCREASE IN TOTAL STATE PLAN CLAIMS PAID FROM FISCAL YEARS 1990 TO 1991

Increase due to cost inflation * ($5,825,431)



Increase due to enrollment growth ($3,154,453)

* Cost inflation includes the factors outlined in Exhibit 11, excluding utilization.

Note: There was no increase in total claims paid due to growth in utilization (consumer demand for medical services).

SOURCE: PEER staff analysis of Blue Cross and Blue Shield records

Healthmarc as its utilization review firm based on a consultant's recommendations. But because DFA pays Healthmarc $1.1 million in annual fees, DFA should closely monitor this utilization review contract in the future to determine whether it is cost beneficial or whether another utilization review firm could provide comparable or better services at a lower price.

DFA has not implemented a cost-reduction drug program which could save the state and its employees an estimated $1,000,000 annually.

Payments for prescription drugs total over ten percent of the benefits paid by the Plan. Consequently it is important that DFA try to keep the costs of drugs under control. One method of keeping drug costs in line is through a mail-order prescription drug program. Seventeen of the fifty states currently use mail-order drug programs as cost containment measures. Savings are generated through mail-order programs when insured parties order routine drug purchases through the mail at discount prices. The process reportedly results in lower costs to the Plan and also financial advantage to the Plan members.

DFA has considered mail-order programs since before October 1989. According to an October 5, 1989, memo from the former Office of Insurance Director to the former DFA Director, a mail-order drug program would result in savings of over $1,000,000 per year. (See Appendix E, page 55.) An alternative to the mail-order program is the Drug Management Program that Blue Cross has offered, which includes a network of pharmacies across the state which have entered agreements to provide discounted prices. Blue Cross has not provided estimates of cost savings for the Drug Management Program.

However, over two years after DFA first began considering the drug programs, DFA still has not taken action to offer programs which should result in savings to the state as well as to employees. Because local pharmacists in other states such as Georgia strongly objected to employees purchasing drugs from out of state, DFA wanted to avoid similar adverse publicity in Mississippi. DFA management has failed to exercise professional judgement by not taking action on implementing a mail-order or other cost-reduction drug program. As a result, the Plan has foregone up to $1,000,000 in annual savings which could have been generated from drug management programs over the last two years.

Delinquent payments of twelve state agencies decreased the Plan's reserve by more than $700,000 at September 30, 1991, money which is badly needed during the present Plan funding shortfall.

Blue Cross bills state agencies to receive premium payments at the first of each month or, in cases of some larger agencies, at the first and

fifteenth of each month. According to a DFA study of delinquent accounts dated October 23, 1991, twelve state agencies were consistently nineteen to thirty-five days delinquent in their payments in the average amount of $1,408,602. The four agencies having the largest amount of delinquent premiums, the Highway Department, the Department of Human Services, the University of Southern Mississippi, and the Department of Public Safety, had average monthly delinquencies of $1,269,302 ranging from twenty-six to thirty-five days late. Details of the delinquencies are shown in Exhibit 13, page 37. PEER determined that if all September 1991 payments due from the twelve agencies had been received by and deposited September 30, then the premium income for September 1991 would have increased by $705,305. Instead of a September 1991 reserve of $3.9 million, the reserves would have increased to $4.6 million at that date.

MISS. CODE ANN. § 25-15-15 allows DFA to "*establish and enforce late charges and interest penalties or other penalties for the purpose of requiring the prompt payment of all premiums for life and health insurance.*" DFA has not established a late penalty to penalize state agencies for late payments. The agencies therefore have less incentive to pay on time. As a result the Plan has not received much needed premium payments in a timely manner and has lost the opportunity to earn interest on the delinquent payments. If DFA had implemented a penalty of one percent per month on the balance of late payments, then DFA could have earned a minimum of $42,000 in penalties over the last six months. The more likely scenario is that with a penalty of one percent, agencies would have not been late on payments, in which case DFA could have earned at least $17,500 in interest on the additional reserve funds generated over the last six months.

DFA has lost approximately $670,195 in interest which could have been earned on a healthy reserve.

As explained earlier in this report, the industry benchmark for a healthy claims reserve is two and a half times the average claims paid out in a month. In May 1990, Plan reserves fell below the industry standard and have continued to decline ever since. PEER determined that if DFA had maintained reserves at the level of the industry standard, $670,195 in interest would have been earned on these reserves from May 1990 to September 1991. This interest would now be a part of the state plan reserves and could reduce the amount by which premiums must be raised in the future.

EXHIBIT 13

REPORT OF DELINQUENT AGENCIES
MARCH 1991 - OCTOBER 1991

		Average Number Of Days Late	Average Monthly Payment	Amount Due in September 1991/ Deposited in October
1.	***Department of Human Services***	35	$399,402	$426,940 *
2.	***Mississippi Highway Department***	31	$463,896	$253,298
3.	***Yellow Creek Watershed Authority***	28	$1,370	$1,634
4.	***Mississippi Department of Public Safety***	26	$127,452	
5.	***Mississippi Crime Lab***	26	$6,524	
6.	***Law Enforcement Training Academy***	26	$3,497	
7.	***Board of Medical Examiners***	26	$527	
8.	***University of Southern Mississippi***	25	$278,553	
9.	***Public Service Commission***	23	$19,194	$23,432
10.	***Boswell Retardation Center***	21	$40,653	
11.	***Industries for the Blind***	19	$34,344	
12.	***Camp Shelby***	19	$33,189	
	TOTAL		$1,408,602	$705,305

SOURCE: Department of Finance and Administration report dated October 23, 1991.

* The September 1st installment of the monthly payment totalled $213,470.09. PEER estimated the September 15th installment to be the same amount.

HOW WOULD THE STATE PLAN BE AFFECTED IF THE BOARD OF TRUSTEES OF INSTITUTIONS OF HIGHER LEARNING WITHDRAWS ITS EMPLOYEES FROM THE PLAN?

At the November 1991 Board meeting of the Institutions of Higher Learning (IHL), the Board gave IHL the permission to withdraw its employees from the state health plan if the standards of MISS. CODE ANN. 25-15-21 were met. The CODE states that IHL may establish a separate health insurance group for institution employees. It also states that the separate group must operate under the same rules as set forth for the total employee group health plan and that *"the total cost [of the separate group] shall not exceed the cost that would have been incurred under the state plan if it had not chosen such action."*

Ray Cleere, the Commissioner of Higher Education, stated that factors involved in IHL's decision to withdraw included:

-- a need to seek solutions to allow IHL's lower-paid employees to pay for dependent coverage;

-- an opportunity to take advantage of University Medical Center programs to lessen the cost for IHL employees; and,

-- a goal of developing a wellness program of preventative medicine for IHL employees.

If IHL employees withdraw from the State Plan, the Plan could be affected in the following manner:

- In the short term, IHL premiums would be lower than State Plan premiums. According to actuarial studies, active IHL employees excluding retirees have had a lower claims experience than other active state employees and therefore lower Plan expenses (see Exhibit 8, page 28). As a result, if IHL employees are separated into a different group, then the premiums for those employees would probably be set at a lower rate and state employee premiums would be set at a higher rate than otherwise.

- Overall administrative costs charged to the state and its employees would be higher after separation of the two groups, although the amount cannot presently be estimated by DFA or IHL officials. A William M. Mercer actuarial consulting report commissioned by IHL and dated November 1991 stated that the overall administrative costs would be slightly higher if the present State Employee Plan were split into two groups, but the actuaries made no estimate of the actual overhead for the two plans.

  In FY 1991, DFA's administrative costs not specifically related to the Blue Cross and Healthmarc administrative contracts totaled

approximately $223,000. These Plan costs would probably not reduce significantly after IHL's withdrawal from the Plan and in addition IHL would also have to incur administrative costs to administer its own self-funded plan, especially if it plans to implement a wellness program. IHL officials also stated that IHL planned to hire Blue Cross to perform utilization review rather than Healthmarc and, as a result, planned to save $87,000 annually on the contract which exceeds $1 million a year for the combined IHL and state plan.

IHL officials claim that additional costs would be negligible considering that claims expenditures for both groups totaled $78 million in FY 1991.

- If the present Plan is split into two group plans, DFA and IHL would split the reserve on hand based on enrollment figures. In either case, the reserve for both groups will be depleted in early 1992 with no plan changes.

At its December meeting, the Board of Trustees of Institutions of Higher Learning reviewed and approved a contract with Blue Cross & Blue Shield establishing a separate group health plan for IHL employees. Subsequent to this approval, Ray Cleere, at the request of Governor-elect Kirk Fordice, contacted board members asking them to rescind their action and allow IHL to remain a part of the state health plan. As of December 18, 1991, the board had not taken formal action on Dr. Cleere's request.

HOW DOES THE STATE PLAN COMPARE TO OTHER STATE HEALTH PLANS AND TO COMMERCIAL HEALTH PLANS?

PEER sought to determine whether the health insurance coverage of the self-insured state plan was similar to the coverage offered by other state health plans. PEER also reviewed the Plan to determine how the premium and benefit levels compared to other commercial insurance coverage, but found it difficult to compare premiums of different plans because benefits vary substantially among plans. In reviewing other plans, PEER found that Blue Cross's reimbursement levels differed from other commercial insurance plans and that the State Plan was administered similarly to most other state employee plans.

Mississippi state employee health coverage is similar to the state employee health plans in the other forty-nine states.

PEER reviewed a state employee health plan survey for the fifty states compiled by the Martin E. Segal Company, health plan consultants. PEER sought to compare the Mississippi state employee health plan with the state employee health plans in the other forty-nine states.

State plans were similar to the Mississippi Plan in the following ways:

- 34 of 50 states have self-insured plans;
- 26 of 50 states have contracted with utilization review companies and another 20 states use their claims payors to conduct utilization review activities such as concurrent review and pre-certification;
- 23 of 50 states use Blue Cross & Blue Shield for their insured and self-insured plans; and,
- 32 of 50 states' executive branches operate or administer their plans.

PEER also found that the practice of subsidizing retiree costs was not unique and that 38 of 50 states subsidize retiree coverage to some extent.

The overall coverage provided to employees in Mississippi and other states is shown in Exhibit 14, page 41.

EXHIBIT 14

COMPARISON OF DEDUCTIBLES AND BENEFITS OF STATE EMPLOYEE HEALTH PLANS

STATE	%Paid by State–Individual Coverage	Deductibles Individual	Deductibles Family	Co-Insurance Hospital	Co-Insurance Med/Surg/Other	Out of Pocket Individual	Out of Pocket Family
Alabama	100	$ 100	$ 300	80	80	$ 400	$ 400
Alaska	100	100	300	90	90	3,950	3,950
Arizona	93	200	400	80	80	1,000	3,000
Arkansas	73	200	600	80	80	1,200	3,600
California	77	200	400	90	90	3,000	6,000
Colorado	74	150	300	80	80	1,000	2,000
Connecticut	100	175	nm	100	80	400	nm
Delaware	100/81	200	500	100	100	nm	nm
Florida	80	200	400	80	80	1,500	3,000
Georgia	82/77	250	750	90	80	1,300	3,300
Hawaii	60	0	0	80	80	1,500	1,500
Idaho	97	110	330	80	80	1,160	2,430
Illinois	100	100	nm	80	80	800	2,000
Indiana	95	100	nm	100	90	1,000	nm
Iowa	100	100	nm	90	90	500	nm
Kansas	99	200	400	70	70	500	1,000
Kentucky	100/92	400	800	80	80	1,500	3,500
Louisiana	50	300	900	80	80	1,300	3,900
Maine	100	100	200	100	80	600	600
Maryland	62	150	450	100	100	150	450
Massachusetts	90	50	100	100	100	500	500
Michigan	95	50	100	100	90	500	500
Minnesota	75	300	800	80	70	3,000	6,000
MISSISSIPPI	100	200	600	80	80	1,500	1,500 *
Missouri	100	300	900	80	80	1,500	3,000
Montana	100	175	525	75	75	625	1,250
Nebraska	100/79	100	200	100	80	4,000	4,000
Nevada	100	200	400	70	80	7,500	nm
New Hampshire	100	100	100	100	100	500	1,500
New Jersey	100	100	200	100	80	400	nm
New Mexico	70	125	375	80	80	1,200	nm
New York	90/92	161	483	100	80	625	625
North Carolina	100	150	450	90	90	300	nm
North Dakota	100	150	450	80	80	1,150	2,450
Ohio	88	100	200	80	80	750	1,500
Oklahoma	100	200	600	80	80	2,000	nm
Oregon	100	100	300/200	80/100	80	700/600	nm/600
Pennsylvania	100	100	300	100	80	480	480
Rhode Island	100	100	200	100	100	nm	nm
South Carolina	90	200	400	85	85	1,500	3,000
South Dakota	100	200	500	75	75	600	600
Tennessee	80	200	500	70	70	3,000	6,000
Texas	100	200	600	80	80	800	nm
Utah	90	0	0	90	70	1,000	2,000
Vermont	80	135	405	100	80	535	1,605
Virginia	100	200	200	100	80	1,160	nm
Washington	100	100	300	80	80	800	2,000
West Virginia	100	100	200	80	80	1,000	nm
Wisconsin	70	25	50	100	100	nm	nm
Wyoming	80	250	500	75	75	2,500	5,000
Mid Range	98	150	400	80	80	1,000	2,000

	%Paid by State–Individual Coverage	Deductibles Individual	Deductibles Family	Co-Insurance Hospital	Co-Insurance Med/Surg/Other	Out of Pocket Individual	Out of Pocket Family
Mid Range	98	150	400	80	80	1,000	2,000
Mississippi	100	150/200	450/600	80	80	1,500	1,500 *

NOTE: nm = no maximum

* $1500 per covered family member

SOURCE: "1991 Survey of State Employee Health Benefit Plans," Martin E. Segal Company

Blue Cross reimburses a lower dollar amount on some health claims than do other commercial insurance companies. DFA could require Blue Cross to reimburse a greater dollar amount for each cost incurred, but that would ultimately increase the cost of state Plan premiums.

Because of numerous complaints about the level of Blue Cross's allowable charges, PEER was requested to review the allowable charges established by Blue Cross and compare them to allowable charges of other insurance plans. Allowable charges, also known as UCR's (usual, customary and reasonable), are the reimbursement amounts allowed by the insurance company for covered services. Companies base UCR's on a profile of actual charges by physicians and hospitals for services in a given area. Depending on the insurance company, the UCR is usually set at the 70th to the 90th percentile of the local customary profile.

Because UCR's of the various insurance companies are confidential, PEER was not able to make a statistical comparison of the more than 10,000 UCR's established for the various medical procedures. However based on interviews with representatives of several major insurance companies, officials of Blue Cross and DFA, and industry brokers who sell for all insurance companies, PEER found a consensus that Blue Cross tends to have lower overall allowable charges and therefore reimburses at lower amounts than other commercial insurance companies. Although there is merit to the complaint that Blue Cross's allowable charges tend to be lower than for other insurance companies, Blue Cross's lower allowable charges keep down the overall cost of the State Health Plan. Therefore requiring Blue Cross to increase its allowable charges would increase the overall premiums of the state health insurance plan. Having lower allowable charges tends to put most of the cost of the insurance plan on the plan members who use the coverage the most.

Most commercial insurance companies base their allowable charges on a profile of actual charges developed by the Health Insurance Association of America (HIAA). In contrast Blue Cross develops its UCR's based upon an internal data base of actual charges which, according to Blue Cross, is larger and therefore more representative than that supplied by HIAA. Regardless of the best UCR profile, PEER determined that Blue Cross updates its UCR's only annually, while HIAA updates its profile quarterly. This contributes to the claims paid by Blue Cross being lower during the year, when Blue Cross is paying claims based on outdated profiles. On the other hand other insurance companies using HIAA data are paying claims based upon updated estimates of actual charges occurring in the marketplace during the year.

In addition Blue Cross uses data for the whole state while HIAA companies break down their charges on a regional basis. According to industry sources, employees in the metropolitan areas such as Jackson and the Coast areas are penalized under Blue Cross's system. Under a state-

wide system, more charges in the metropolitan areas fall outside the usual and customary range.

A former director of the DFA Office of Insurance has stated that in the past DFA management made a conscious decision to let Blue Cross set the UCR's because the health plan was having financial problems. The official stated that if DFA had required Blue Cross to reimburse on higher levels, that the financial position of the Plan would have worsened.

While DFA has allowed Blue Cross to reimburse at the same rate as for the insurance company's other insurance business, it has the ability to require Blue Cross to reimburse at a higher level. Therefore DFA should monitor the levels of allowable charges and determine whether they should be adjusted based on the overall mix of premiums, deductibles, and stop loss limits chosen for the Plan and their effect on the Plan reserve.

WHAT ACTIONS SHOULD THE DEPARTMENT OF FINANCE AND ADMINISTRATION AND THE LEGISLATURE TAKE TO RESTORE THE INTEGRITY OF THE HEALTH PLAN?

1. DFA's Executive Director should take immediate steps to restore financial stability to the state employees' health plan. Items which the DFA Director should consider include:

   - Increases in current premiums. (DFA's insurance actuary recommends an immediate twenty-four percent increase, assuming DFA makes no other changes in the plan.)

   - Increases in current deductible levels. (Insurance experts told PEER that deductible levels for most health plans range from $250 to $500.)

   - Phased-in revision of premiums to experience-based levels to lessen cross-subsidies of various groups contained in the health plan. The cost-shifting should be less noticeable in the first year of changes, with steadily greater shifting towards experience-based premiums. DFA should explain Plan changes thoroughly to retirees and employees so that they may plan for the future. For employees retiring after this point, DFA should consider a more immediate shift to experience-based premiums, with a more gradual phase-in for persons already retired. DFA should explain plan changes thoroughly to retirees and active employees so that they may plan for the future.

   - Evaluation of current services offered by the state health plan

   - Implementation of more aggressive cost-containment programs

2. DFA should establish an "Insurance Reserve Fund" account in the state treasury as provided for in MISS. CODE ANN. § 25-15-15 (1972). Assuming DFA implements a premium increase, the department could utilize any excess cash generated by the higher premiums to fund the reserve account. As a minimum reserve level, DFA should maintain an amount generally equal to two and a half times the monthly claims paid. DFA should attempt to reach the recommended reserve level by December 1994. DFA's reserve account should be maintained separately from the current Employee Insurance Fund treasury fund and be used for emergencies only.

3. In the future, DFA insurance management should more carefully consider the advice of its paid insurance actuary. Following the issuance of actuary reports, DFA's Executive Director should require the Insurance Office Director to compile a written response with recommended action steps. If DFA management deems that the

actuary's advice is no longer needed, the department should terminate the consulting contract, thereby reducing its annual costs by approximately $40,000.

4. Within existing resources, DFA should reorganize its Office of Insurance to designate a staff person who would be responsible for the following analytical duties:

   - forecasting monthly claims payments, premiums receivable and reserve levels of the health plan to lessen dependence on expensive actuarial consultants for decision-making;

   - analyzing claims utilization data to determine what medical procedures are being used more often and to identify the present and potential problems in health care coverage;

   - tracking monthly projections to determine if the fund income and expenditures are in line with expected results;

   - reassessing financial results to determine what decisions should be made to get unfavorable deviations in line with projected results;

   - analyzing Healthmarc, Fair Market Pricing and other programs to determine whether the programs are actually saving the plan money;

   - performing all background work and collection of data and liaison with Blue Cross & Blue Shield to eliminate time spent by actuarial consultants in obtaining needed data and other information;

   - assisting the DFA Office of Insurance Director in evaluating the financial provisions of all Health Plan Contracts, including Blue Cross contracts, to insure that the state plan obtains favorable terms; and,

   - analyzing claims data to provide information for management decision-making.

5. The DFA Office of Insurance should perform a cost/benefit analysis to determine whether it would be cost beneficial to develop an internal data base of information. The data base, which would lessen DFA's reliance on Blue Cross to provide special reports, should include claims amounts by type, utilization indicators, and demographic and other information. The amounts paid to Blue Cross in the past for special reports should be considered in the cost/benefit analysis.

6. DFA should immediately obtain updated cost savings proposals from various mail-order and prescription management programs and select the most advantageous programs for implementation.

7. DFA should revise its contract with the plan administrator, Blue Cross, as soon as possible so that Blue Cross will charge DFA only for the discounted amount of the hospital services under the Fair Market Pricing agreement. The effect will be a remittance of Fair Market Price refunds to DFA on a daily basis.

8. In order to encourage prompt payment of premiums by state agencies and retirees, DFA should adopt an interest penalty of one percent per month on the balance of delinquent premium payments.

9. The Legislature should require the Department of Audit to conduct a separate, full-scope audit of the state employee health plan each year. In addition, the Legislature should require the DFA Executive Director to submit an annual report to the Legislature which fully describes the health plan; presents the plan's financial condition for the calendar year; lists recommendations made by DFA's insurance actuary and actions taken by the department on those recommendations; lists the claims experience for employee subgroups and the corresponding loss ratios of the subgroups; and describes plan revisions made by DFA.

10. DFA should review the current administrative contract with Blue Cross to determine if Blue Cross is providing the best service which can be expected of the State Health Plan claims processor at the best cost obtainable.

11. The Legislature should consider repealing MISS. CODE ANN. Section 25-15-21 (1972), which allows the Board of Trustees of Institutions of Higher Learning to establish a separate group health plan for its employees. Regardless of legislative action on the repeal of this section, the IHL Board should not withdraw from the state plan and establish a separate plan.

APPENDIX A

RATE SCHEDULE FOR STATE OF MISSISSIPPI'S EMPLOYEE HEALTH INSURANCE PLAN JULY 1991

NEW RATES EFFECTIVE JULY 1, 1991

STATE OF MISSISSIPPI
EMPLOYEE GROUP MEDICAL PREMIUM RATES
ACTIVE EMPLOYEES

Medical Fees (Rates) MS01/MS03 ($1,000,000)

COVERAGE	TOTAL	RATES EMPLOYEE PORTION	COBRA	KIND
Employee only (regardless of age).....	$102.00	$ -0-	$104.00	03
Employee and one dependent.....	198.00	96.00	201.50	18
Employee and one dependent on Medicare disability.....	198.00	96.00	201.50	58
Employee and one dependent 65 or over.....	198.00	96.00	201.50	58
Employee and two or more dependents.....	228.00	126.00	232.50	62
Employee and two or more dependents one dependent on Medicare disability.....	228.00	126.00	232.50	64
Employee and two or more dependents with both spouses enrolled as employees..	158.50	56.50	N/A	52

SURVIVING SPOUSES OF EMPLOYEES
WITH LESS THAN 25 YEARS OF SERVICE MS01/MS03 ($1,000,000)

COVERAGE	RATES	COBRA	KIND
Surviving spouse only, under 65 (one year maximum benefit then COBRA)....	$102.00	$104.00	39
Surviving spouse and one dependent (one year maximum benefit then COBRA)....	198.00	201.50	34
Surviving spouse, under 65 with two or more dependents (one year maximum benefit then COBRA)....	228.00	232.50	38
Surviving dependent eligible for COBRA.....	N/A	104.00	32

NEW RATES EFFECTIVE JULY 1, 1991

STATE OF MISSISSIPPI
EMPLOYEE GROUP MEDICAL PREMIUM RATES
RETIRED EMPLOYEES

EARLY RETIREES OR SURVIVING SPOUSES OF EMPLOYEES WITH 25 YEARS OF SERVICE OR MORE — UNDER 65 — MS01/MS03 — ($1,000,000)

COVERAGE	RATES	KIND
Retiree under 65	$102.00	03
Retiree under 65 and one dependent under 65	198.00	18
Retiree under 65 and one dependent 65 or over	150.00	37
Retiree under 65 and two or more dependents	228.00	62
Retiree under 65 and two or more dependents, one with Medicare	180.00	65

REGULAR RETIREES OR SURVIVING SPOUSES OF EMPLOYEES WITH 25 YEARS OF SERVICE OR MORE — 65 OR OVER — MS01/MS03 — ($1,000,000)

COVERAGE	RATES	KIND
Retiree 65 or over	$ 48.00	43
Retiree 65 or over and spouse 65 or over	96.00	88
Retiree 65 or over and one dependent under 65	144.00	48
Retiree 65 or over, spouse 65 or over and one dependent child	126.00	67
Retiree 65 or over and two dependents under 65	174.00	82
Retiree dependent eligible for COBRA	104.00	86

APPENDIX B

PREMIUMS VS. CLAIMS 7-90 TO 6-91

******** 7-90 TO 6-91 ********	AGENCY	PAYOR	PREMIUMS INCURRED	CLAIMS PAID	GAIN (LOSS)	LOSS RATIO
EMPLOYEE COVERAGE	STATE	STATE	30,466,295	31,341,918	(875,622)	1.029
DEP COVERAGE ON ACTIVE EMPLOYEES	STATE	EMPLOYEE	12,147,774	15,550,369	(3,402,595)	1.280
	STATE	SUBTOTAL	42,614,069	46,892,287	(4,278,218)	1.100
EMPLOYEE COVERAGE	IHL	STATE	16,301,385	14,993,369	1,308,016	0.920
DEP COVERAGE ON ACTIVE EMPLOYEES	IHL	EMPLOYEE	5,928,583	7,174,812	(1,246,229)	1.210
	IHL	SUBTOTAL	22,229,968	22,168,181	61,787	0.997
REGULAR COVERAGE ON RET (& RET DEP)	STATE/IHL	RETIREE	2,438,620	5,936,653	(3,498,033)	2.434
MEDICARE SUPP COV ON RET (& RET DEP)	STATE/IHL	RETIREE	2,570,105	4,399,848	(1,829,743)	1.712
	STATE/IHL	SUBTOTAL	5,008,725	10,336,501	(5,327,776)	2.064
	GRAND TOTAL		69,852,762	79,396,969	(9,544,207)	1.137

ACTIVE/ RETIRED	STATE/ IHL	PAYOR	REGULAR/ MEDICARE		PREMIUM INCURRED	CLAIMS PAID	GAIN (LOSS)	LOSS RATIO
ACT	STATE	STATE	REG	EMPLOYEE	30,466,295	31,341,918	(875,622)	1.029
ACT	IHL	STATE	REG	EMPLOYEE	16,301,385	14,993,369	1,308,016	0.920
ACT	STATE	EMPLOYEE	REG	ONE DEPENDENT	3,523,280	4,689,327	(1,166,047)	1.331
ACT	IHL	EMPLOYEE	REG	ONE DEPENDENT	1,572,160	1,906,726	(334,566)	1.213
ACT	STATE	EMPLOYEE	REG	TWO DEPENDENTS	8,614,144	10,792,516	(2,178,372)	1.253
ACT	IHL	EMPLOYEE	REG	TWO DEPENDENTS	4,352,918	5,253,955	(901,037)	1.207
ACT	STATE	EMPLOYEE	MED	DEPENDENT	7,630	23,826	(16,196)	3.123
ACT	IHL	EMPLOYEE	MED	DEPENDENT	2,585	1,844	741	0.713
ACT	STATE	EMPLOYEE	MED	EMPLOYEE	2,720	44,701	(41,981)	16.434
ACT	IHL	EMPLOYEE	MED	EMPLOYEE	920	12,288	(11,368)	13.356
RET	STATE/IHL	RETIREE	REG	EMPLOYEE	1,435,395	4,310,089	(2,874,694)	3.003
RET	STATE/IHL	RETIREE	REG	ONE DEPENDENT	795,100	1,375,699	(580,599)	1.730
RET	STATE/IHL	RETIREE	REG	TWO DEPENDENTS	208,125	250,866	(42,741)	1.205
RET	STATE/IHL	RETIREE	MED	DEPENDENT	548,105	846,606	(298,501)	1.545
RET	STATE/IHL	RETIREE	MED	EMPLOYEE	2,022,000	3,553,242	(1,531,242)	1.757
					69,852,762	79,396,969	(9,544,207)	1.137

RECAP BY PAYOR

	PAYOR				
EMPLOYEE COVERAGE	STATE	46,767,680	46,335,286	432,394	0.991
DEP COVERAGE ON ACTIVE EMPLOYEES	EMPLOYEE	18,076,357	22,725,182	(4,648,825)	1.257
REGULAR COVERAGE ON RETIREES (& RET DEP)	RETIREE	2,438,620	5,936,653	(3,498,033)	2.434
MEDICARE SUPP COVERAGE ON RETIREES (& RET DEP)	RETIREE	2,570,105	4,399,848	(1,829,743)	1.712
		69,852,762	79,396,969	(9,544,207)	1.137

SOURCE: December 1991 report by Lynn Townsend, consulting actuary, Jackson, MS

APPENDIX C

PRELIMINARY 1/1/92 PREMIUM RATES FOR VARIOUS RATING CLASSES
(See Note)

AGENCY	RATING CLASS	CURRENT RATES	PROJECTED RATES (1)	PERCENT INCREASE
	Option 1--No change in Premium structure			
State/IHL	Employee	102.00	126.52	24.0%
	One Dependent	96.00	119.08	24.0%
	Two Dependents	126.00	156.29	24.0%
	Regular Retiree Coverage (2)	102.00	126.52	24.0%
	Medicare Supplement (3)	48.00	59.54	24.0%
	Option 2--Premiums to cover 100% of Claims for each Rating Class--State and IHL Employees Combined			
State/IHL	Employee	102.00	112.48	10.3%
	One Dependent	96.00	129.16	34.5%
	Two Dependents	126.00	168.69	33.9%
	Regular Retiree Coverage (2)	102.00	269.17	163.9%
	Medicare Supplement (3)	48.00	91.78	91.2%
	Option 3--Premiums to cover 100% of Claims for each Rating Class--State and IHL Employees Separated			
State	Employee	102.00	117.87	15.6%
IHL	Employee	102.00	101.65	-0.3%
State	One Dependent	96.00	132.81	38.3%
IHL	One Dependent	96.00	117.59	22.5%
State	Two Dependents	126.00	169.19	34.3%
IHL	Two Dependents	126.00	163.55	29.8%
State/IHL	Regular Retiree Coverage (2)	102.00	269.17	163.9%
StateIHL	Medicare Supplement (3)	48.00	91.78	91.2%

(1) Projected rates assume that benefits remain the same. In addition these rates are projected to cover Calendar Year 1991 costs only and will not add any funding to the reserve.
(2) Does Not Include Dependent Coverage
(3) Primarily Retirees

NOTE: These preliminary rates are subject to change following additional analysis. These rates, if implemented 1-1-92, are projected to cover expected claims and administration costs, by rating class option, for calendar year 1991. These "experience-based" premium rates will be determined after the selection, by DFA, of actual rating classes to be employed, and after addressing the Plan's current accumulated funding deficiency.

SOURCE: Lynn Townsend, FSA, consulting actuary, Jackson, Mississippi.

APPENDIX D

MEMO CONCERNING PROPOSED PLAN RATE INCREASE

M E M O R A N D U M

TO: Dr. Ed Ranck

FROM: Cliff Tucker

RE: Health Insurance Rate Increase

DATE: December 4, 1991

Attached you will find the preliminary actuarial report regarding rates. The current benefits columns are fairly accurate and can be relied on in the decision making process; however, without drugs, without drugs and $500 deductible columns are not based on our plans, just food for thought.

I reviewed this with the actuary in detail and we both agree that a fundamental decision has to be made. Are we going to continue to promulgate rates as has been done in the past or by class of risk? In Exhibit IV, Option I is the way it has been done, Option II is class rates, the way it should have been done to be actuarial sound.

The following are recommendations by myself and the actuary:

1. Place the plan on class rating system. Examples: Option II or Option III, depending on what IHL does. This puts the plan on a sound actuarial basis that can be monitored in the future very securely. Do not exclude drugs. Drug program is presently being reviewed.

2. Place a $500.00 deductible in the plan.

3. Program changes per attached.

In taking these two actions, you will make the plan carry itself and over 12 to 18 months rebuild a reserve of approximately $10 million. The one real problem with this is the under 65 retirees. Their cost will be raised dramatically. They retired with decisions based on less cost of insurance. It is time for a decision. I suggest that Lynn and I meet with the Transition Team to culminate a decision no later than December 15th.

Attachment

I. CHANGES TO ADDRESS IN SHORT TERM

A) Change rate for retirees that agrees with the law example attached. (Ref. Law 25-15-15)

B) Increase employee and dependent coverages by attached actuarial recommendations.

C) Install a $500.00 deductible (one deductible). (Pg. 2 and 9)

D) Establish guidelines to be adhered to on reserves. (Ref. Law 25-15-15)

II. OTHER CHANGES TO BE MADE TO PLAN

A) Maternity (presently pay 100% with certain conditions). Following are proposed changes. (Pg. 28)

1) If not seen by a medical doctor within the first trimester, benefits will pay only 80%.

2) If not seen by a medical doctor within the fifth month of pregnancy, benefits will pay only 50%.

B) Require all claims be filed with BCBS by April 1st of the next year following date of service. (Pg. 14)

C) Substance abuse changed to 50% co-insurance. (Pg. 3)

OTHER CHANGES (Cont'd)

D) Nervous or mental.

1) Inpatient - limit to 30 day period per calendar year. (Pg. 16)

a) $50,000.00 lifetime maximum. (None at present)

b) 50% co-insurance. (Pg. 3)

2) Outpatient - maximum limit $2,000.00 per year, 50% co-insurance.

E) Refunds can only be done for 90 days prior to date of request in writing. (Presently 12 months.)

F) Eliminate Invetro Fertilization benefit.

G) Cap solid organ transplants at $300,000.00. (Pg. 17)

H) Outpatient surgical procedures benefit. (Pg. 27)

1) Surgical procedure listed below when performed in an outpatient department of a hospital or freestanding surgical facility will be paid at 90%, physician's office will be paid at 100% of the allowance charge for

I) Realignment of the way medicare benefits are coordinated with state plan.

J) Change enrollment categories.

1) Example: Employee only, employee and spouse, family.

K) Charge agencies more than 10 days late in premium payment a one percent penalty a month.

OTHER CHANGES (Cont'd)

L) Redefine U/R and penalties. Examples:

1) Take maximum off of days penalized for not reporting. (Pg. 31)

2) Redefine late and not reporting. (Pg. 31)

3) Various clean up of definition and instructions.

M) Bring U/R back to Mississippi base service facility.

1) Easier access.

2) Easier directives enforcement.

3) Higher acceptability by our employees.

Do these effective January 1, 1992, but announce to Personnel Director and agencies by 1st of December if possible, but 15th latest. (Cafeteria plans)

APPENDIX E

DFA MEMO CONCERNING MAIL-ORDER DRUG PROGRAM

To : Cecil C. Brown

From : Tom R. Long

Date : October 5, 1989

Subject: Maintenance Drug Program

As you know we have been approached by a number of providers offering this service. While application differs from firm to firm, the basic idea is that maintenance drugs are ordered through the mail from their dispersion centers and that this process involved substantially lower cost to the plan and financial advantage to the group member. Of the $5,358,000 in prescription drug benefits paid during calendar year 1988 under our program, we are told that approximately 80% of these according to national averages should be of the maintenance variety.

From what we are further told, the usual savings in ordering these drugs at a substantial discount from average wholesale prices should be in the neighborhood of one-third of what is now being paid. The providers all uniformly project something in excess of $1,000,000 in savings even where use of the program is not mandatory and where members can continue to get their prescription filled locally.

The mail order process involves approximately two weeks from the time the orders are mailed until the drugs are delivered which is not a critical time lag since these items can be anticipated ahead of time. Each of the providers also tell you that they will be extremely active in a communication program to educate our members on the appropriate use of their facilities. There are no direct charges to the plan because their revenue will be produced from the sale of the drug itself and also from the prescription fee which is already part of the price that you pay at the local drugstore.

The down side to a program of this sort is the opposition that we may receive from local pharmacists. The states of Georgia and Louisiana recently abandoned efforts to install plans for their employees.

MEMORANDUM
RE: Maintenance Drug Program
DATE: October 5, 1989

The appeal to the member, incidentally, is in the form of a small deductible in lieu of regular deductibles and co-payments. This could be from $5 to $10 for each prescription filled with regular drugs and perhaps with no deductibles for generics.

Please let us know how you want us to proceed.

TRL:dd

cc: Hank Anderson
Beverly Hutchison
Cathy Brister

AGENCY RESPONSE

STATE OF MISSISSIPPI

DEPARTMENT OF FINANCE AND ADMINISTRATION
RAY MABUS
GOVERNOR

December 17, 1991

Mr. John W. Turcotte, Executive Director
PEER Committee
Professional Building
P.O. Box 1204
Jackson, MS 39215-1204

Dear Mr. Turcotte:

The Department of Finance and Administration acknowledges the State Health Plan faces many challenges now and in the future. When I became Director of DFA in March, 1991, I felt that a change in the office director was warranted. In September DFA hired a new office director with the directive to evaluate the plan and its needs. DFA, through the Office of Insurance, is aware of the concerns portrayed in the PEER report. We have already taken steps to rectify many of these concerns as follows:

1. We are working with the actuary to promulgate the correct rate increase necessary to maintain the plan through 1992 as well as fund the reserves.

2. We have made a study of alternate deductible choices of $350.00, $500.00 and $650.00.

3. We have requested and received a preliminary actuarial report addressing experience-based rating of separate groups contained in the health plan.

4. Evaluation of current services offered by the state plan is in process with some recommendations already made.

5. Evaluation of more aggressive cost containment programs is in process.

6. DFA is aware of the Insurance Fund Reserve Account requirement and is presently working on a formula to handle this in the future.

7. The Director of the Office of Insurance has already written a preliminary report addressing the plan, taking into account the preliminary actuarial report.

8. The Director of the Office of Insurance has been studying a way to include a Financial Analyst as a staff employee.

9. In October, 1991 we met with a firm to discuss the construction of a data base. We are looking at outside vendors as well as capabilities of creating an internal data base.

10. The Office of Insurance is studying some traditional cost saving methods on drugs as well as some innovative ones.

11. DFA has been discussing with Blue Cross and Blue Shield changes in the Fair Market Pricing Agreement.

12. The Office of Insurance has studied ways of encouraging prompt payment of premiums from interest penalties to suspension of claim payments.

13. The Department of Audit audited the state plan for the last two years. It has been a goal of DFA to provide the legislature with all the information they need.

14. The Office of Insurance deals daily with the BCBS contract and is aware of its shortcomings.

It is necessary to point out that DFA advised everyone that the July, 1991 premium increase was only to sustain the plan 6 months so we could make a more comprehensive study of the health plan and its problems. I feel we have made significant progress with much more work to be done. One of the major steps in facilitating this study is to create a data base to allow a more in-depth study.

In selecting the Utilization Review vendor, Healthmarc, DFA used the services of Mercer Meidinger Hanson Medical Audit Firm to evaluate interested vendors. I wish to point out we took their recommendation. Enclosed you will find the latest financial information as of November, 1991.

Thank you for allowing us the opportunity to respond to your report.

Sincerely,

Edward L. Ranck
Executive Director

ELR:CAT:emc

Enclosure

STATE OF MISSISSIPPI HEALTH/LIFE INSURANCE PLAN
STATEMENT OF RECEIPTS, DISBURSEMENTS, AND BALANCE
MONTH ENDED NOVEMBER 30, 1991
ESTIMATED

	CURRENT MONTH	CALENDAR YEAR TO DATE	FISCAL YEAR TO DATE
RECEIPTS:			
PREMIUMS RECEIVED:			
MEDICAL	$ 6,971,211.45	68,667,084.83	33,587,623.04
LIFE	310,148.62	3,197,968.83	1,525,574.33
INTEREST EARNED:	19,068.72	428,418.07	130,583.08
REFUNDS & RETURNED CHECKS:	41,904.58	562,760.08	324,871.65
HOSPITAL SAVINGS:	0.00	3,016,963.87 (1)	1,571,246.25
OTHER RECEIPTS & DEPOSITS:	0.00	7,747.60	4,825.48
TOTAL RECEIPTS:	7,342,333.37	75,880,943.28	37,144,723.83
FUNDS DISBURSED:			
CLAIMS PAID MEDICAL	$ 6,682,232.22	77,560,166.07	36,022,755.40
CLAIMS PAID LIFE	254,965.40	2,723,166.27	1,276,718.00
PREMIUM REFUNDS:	11,669.72	168,600.97	91,392.45
ADMINISTRATIVE COSTS:			
BLUE CROSS/BLUE SHIELD	163,635.79	1,766,321.36	817,428.46
LAMAR LIFE ADMINISTRATIO	9,683.80	107,405.26	49,146.00
BCBS BILL AUDIT	1,981.35	34,155.00	13,875.42
HEALTHMARC	0.00	887,096.57	351,264.67
UTILIZATION REVIEW COSTS	0.00	18,571.40	10,842.40
FUND 3141/PATIENT AUDIT	40,380.36	201,074.53	43,302.40
OTHER	0.00	420.00	0.00
OTHER DISBURSEMENTS:	57.41	1,841.32	357.41
TOTAL DISBURSEMENTS:	7,164,606.05	83,468,818.75	38,677,082.61
NET INCREASE (DECREASE):	177,727.32	(7,587,875.47)	(1,532,358.78)
LOANS TO GENERAL FUND:			
REPAYMENT OF LOANS:			
BEGINNING FUND BALANCE:	2,968,268.12		
ENDING FUND BALANCE:	3,145,995.44		

(1) For period December, 1990 - October 10, 1991

PEER Staff

Director

John W. Turcotte
Janet Moore, Administrative Assistant

Administrative Division

Steve Miller, General Counsel and Controller

Betty Heggy
Ann Hutcherson
Debbie Woods

Planning and Support Division

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