Report To

The Mississippi Legislature

An Investigation of the Administration of the State and Public School Employees' Health Insurance Plans

January 23, 1995

The State Department of Finance and Administration (DFA) contracted with CENTRA Benefit Services to administer the state and public school employees' health insurance plans effective July 1, 1994. Since then, the nature of complaints from Plan participants and health care providers regarding claims processing and reimbursements raised questions about DFA's and CENTRA's ability to administer the plans.

DFA, CENTRA, and Blue Cross (the former administrator) share responsibility for the problems that have plagued administration.

- The Department of Finance and Administration, which controls the Plan, did not properly plan and coordinate the transition. Its reactive posture allowed avoidable situations to escalate.
- CENTRA, as DFA's new third-party administrator, apparently underestimated the magnitude and complexities of transition and implementation.
- Blue Cross, as former third-party administrator, made indemnification and internal repricing demands that aggravated problems beyond those expected during a transition.

PEER proposes creation of a legislative oversight committee to effect resolution of the claims processing delays within thirty days, and legislation to improve future selection and transition of third-party administrators.

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.

Mississippi's constitution gives the Legislature broad power to conduct examinations and investigations. PEER is authorized by law to review any public entity, including contractors supported in whole or in part by public funds, and to address any issues which may require legislative action. PEER has statutory access to all state and local records and has subpoena power to compel testimony or the production of documents.

PEER provides a variety of services to the Legislature, including program evaluations, economy and efficiency reviews, financial audits, limited scope evaluations, fiscal notes, special investigations, briefings to individual legislators, testimony, and other governmental research and assistance. The Committee identifies inefficiency or ineffectiveness or a failure to accomplish legislative objectives, and makes recommendations for redefinition, redirection, redistribution and/or restructuring of Mississippi government. As directed by and subject to the prior approval of the PEER Committee, the Committee's professional staff executes audit and evaluation projects obtaining information and developing options for consideration by the Committee. The PEER Committee releases reports to the Legislature, Governor, Lieutenant Governor, and the agency examined.

The Committee assigns top priority to written requests from individual legislators and legislative committees. The Committee also considers PEER staff proposals and written requests from state officials and others.

An Investigation of the Administration of the State and Public School Employees' Health Insurance Plans

January 23, 1995

The PEER Committee

Mississippi Legislature

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Joint Committee on Performance Evaluation and Expenditure Review

PEER Committee

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January 23, 1995

Honorable Kirk Fordice, Governor
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At its meeting of January 23, 1995, the PEER Committee authorized release of the report entitled **An Investigation of the Administration of the State and Public School Employees' Health Insurance Plans.**

Alyce Clarke

Representative Alyce Clarke, Chairman

This report does not recommend increased funding or additional staff.

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An Investigation of the Administration of the State and Public School Employees' Health Insurance Plans

January 23, 1995

Executive Summary

Introduction

One benefit currently provided to Mississippi's state and public school employees is major medical health insurance fully paid by the state, with dependent coverage available at reasonable premiums. Such a benefit provides much-needed insurance coverage to employees and reduces the burden on the employees' personal financial resources to cope with rising health care costs. However, the value of the insurance benefit is diminished if employees' medical claims are not adjudicated properly or if their medical expenses are not reimbursed in a timely manner.

Background

The Legislature, in 1971 and 1991, respectively, established the State Employees' Life and Health Insurance Plan and Public School Employees' Health Insurance Plan. The Plans constitute a state-funded insurance program which provides major medical insurance coverage to state and public school employees. As of December 1, 1994, the Plans provided insurance coverage to 171,680 covered lives (enrolled employees and their dependents).

State law authorizes the Department of Finance and Administration (DFA) to administer the Plans. State law also establishes advisory councils to advise the department in the formulation of the Plans. Currently, DFA, through its Office of Insurance, manages the Plans in a similar manner, while technically maintaining each as a separate plan with separate fund reserves. On a day-to-day basis, the Plans are administered by DFA, a claims administrator, a utilization review organization, and a network contractor. DFA currently contracts with CENTRA Benefit Services, Inc., to serve as the claims administrator for the Plans. Prior to July 1, 1994, BlueCross BlueShield of Mississippi (hereafter referred to as "Blue Cross") served DFA for ten years as its claims administrator and was the actual insurer of the School Plan.

Recent Complaints Relative to the Administration of the Plans

CENTRA began serving as the third-party administrator for the State and Public School Employees' Health Plans effective July 1, 1994. Plan participants and health care providers initially noticed few changes as Blue Cross relinquished its role as administrator and CENTRA assumed that role and began processing claims.

During the latter part of July and early August of 1994, Plan participants and health care providers began experiencing difficulties, primarily with claims processing and receipt of reimbursement checks. Participants' and health care providers' complaints regarding CENTRA and administration of the Plans escalated during late summer and early fall. CENTRA and DFA were inundated with telephone calls from participants and health care providers seeking information relative to their claims and/or Plan status. In addition, the Department of Insurance and legislators have received complaints from participants and health care providers regarding untimely processing of health claims.

Overview

Inarguably, there have been delays, disruptions, and difficulties as Blue Cross relinquished its role as DFA's third-party administrator and CENTRA assumed that role and began processing claims. With the advent of complaints from participants and health care providers regarding claims processing delays, all of the parties involved—DFA, CENTRA, and Blue Cross—have attempted to focus the blame for the problems on each other. The reality is that all three parties must bear responsibility for causing and also for resolving the problems which have plagued administration of the Plans.

DFA, with its statutory responsibility for administration of the Plans, failed to plan and coordinate properly the transition and implementation process to ensure that its current and former third-party administrators effected a smooth transition. DFA's passive and reactive role

in the transition process allowed many avoidable and correctable situations to escalate beyond reasonable resolution and prevented literally hundreds of participants and health care providers from receiving timely processing of claims.

CENTRA, as DFA's new third-party administrator, apparently underestimated the magnitude and complexities of the transition and implementation process. The new third-party administrator should have drawn on its past experiences and quickly assessed the transition situation to realize that implementation of DFA's account, CENTRA's largest, required extraordinary efforts steeped in precision and analytical rigor.

Blue Cross, as DFA's former third-party administrator, should have realized that its demands upon the new claims administrator, such as indemnification and internal repricing, would create problems well beyond those expected during a transition of short duration.

Findings

Due to the number of employees covered by the State and Public School Employees' Health Insurance Plans, legislators and others have a keen interest in knowing whether certain aspects of the Plans have been administered properly. This report contains answers to two specific questions which can be used to make such a determination.

Was the selection process used by DFA in compliance with state law and adequate to ensure that the selected third-party administrator was capable of administering the Plans?

- DFA solicited competitive bids for a third-party administrator for the Plans in compliance with state law (page 12).

- DFA's process for selecting a third-party administrator was not adequate to ensure that the selected third-party administrator was capable of administering the Plans. The process did not effectively utilize the time available, did not produce a request for proposals containing sufficient information for proposers to compile informed responses, and did not require DFA's consultant, Coopers & Lybrand, to evaluate uniformly the three finalist proposers and document such evaluation (page 13).

What problems have contributed to recently experienced delays in CENTRA's processing of state and public school employees' health insurance claims?

- Neither DFA nor CENTRA developed a comprehensive plan to manage the transition/implementation process and coordinate efforts of all parties involved (page 24).

- During the transition period, CENTRA did not perform in accordance with its response to DFA's request for proposals document because it did not assign a dedicated transition team for the duration of the implementation process and establish and adequately staff a Jackson office to perform all services on DFA's account (page 26).

- Certain aspects of the transition process did not progress in a timely manner because CENTRA and Blue Cross could not come to agreement over an indemnification from errors issue and the use of computerized data integrity edits (page 29).

- CENTRA's agreement to process run-out claims (hard-copy claims for services rendered prior to the end of a contract but processed after expiration of the contract) created an immediate backlog of approximately 10,000 health claims and contributed directly to future claims processing delays. The agreement also resulted in the Plans bearing an additional expense of approximately $66,000 which, in effect, was a double payment and could have been avoided (page 32).

- CENTRA did not develop a master data conversion plan to guide its transition process. As a result, CENTRA and Blue Cross did not resolve major data transmission and claims processing problems prior to July 1, the effective date of DFA's contract with CENTRA, and are continuing to attempt to resolve such problems (page 34).

- CENTRA's and DFA's lack of communication regarding plan benefits/coverage and DFA's failure to address public school employees' carryover deductible credit properly have slowed claims processing and created confusion among plan participants (page 36).

- DFA's decision to have CENTRA handle telephone calls regarding provider networks (and CENTRA's agreement to handle such calls) congested the third-party administrator's telephone system and detracted from claims processing during a critical transition period (page 39).

Recommendations

The complete text of these recommendations begins on page 42 of the report. Appendix B, page 46, contains proposed legislation to accomplish these recommendations.

1. The Legislature should adopt a joint resolution creating a legislative oversight committee to meet with the Governor, DFA Executive Director, and relevant parties to effect resolution of the claims processing delays within thirty days. The resolution should require the joint committee to determine whether the Legislature should enact an assignment clause for assignments of benefits to a health-care provider which would be binding on the insurer; whether state law should exempt Blue Cross Blue Shield from Mississippi's laws regulating the insurance industry; and whether the state has a reasonable alternative to using the Blue Cross network for repricing.

   Specifically, the Joint Committee should determine if Blue Cross should sign an agreement with CENTRA to provide CENTRA with proprietary repricing information which CENTRA would agree to keep confidential.

   The Joint Committee should further determine whether CENTRA is aggressively pursuing resolution and payment of pending insurance claims and whether the Department of Finance and Administration should continue its contract with CENTRA as State Plan Administrator.

   (See Appendix C, page 59 of the report, for a proposed joint resolution for a legislative oversight committee to seek resolution of claims processing delays.)

2. The Legislature should require the Department of Finance and Administration to contract with a third-party administrator on a calendar-year basis (January 1-December 31) notwithstanding terminations which may be necessary during the calendar year.

3. The Legislature should require the Department of Finance and Administration to disclose proposed health plan changes fully and to educate state and public school employees on the changes.

4. The Legislature should require DFA to prepare for a minimum of six months' transition time between third-party administrator contracts. The transition period should be defined as the period beginning at the date of the award and ending at the effective date of the new contract.

5. The Legislature should require DFA to develop a comprehensive transition plan when preparing for transition to a new third-party administrator.

6. The Legislature should require DFA's Office of Insurance to follow a specific process for contracting out third-party administrator services and other professional services. In the event of a documented emergency, the Legislature should allow DFA to retain the services of a third-party administrator without using a competitive bid process.

7. The Legislature should require the PEER Committee to hire, from funds specifically appropriated by the Legislature for this purpose, an independent contractor to audit and review on an annual basis the third-party administrator's compliance with performance standards contained in the contract.

8. The Legislature should require the Department of Finance and Administration to develop a strategic plan for the State and Public School Employees' Health Plans.

9. The Legislature should require DFA to include performance standards regarding pended claims in its third-party administrator contracts.

10. The Legislature should review the provisions common to the two health insurance plans and consolidate the two plans in law by January 1, 1997.

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An Investigation of the Administration of the State and Public School Employees' Health Insurance Plans

Introduction

One benefit currently provided to Mississippi's state and public school employees is major medical health insurance fully paid by the state, with dependent coverage available at reasonable premiums. Such a benefit provides much-needed insurance coverage to employees and reduces the burden on the employees' personal financial resources to cope with rising health care costs. However, the value of the insurance benefit is diminished if employees' medical claims are not adjudicated properly or if their medical expenses are not reimbursed in a timely manner.

Authority

The PEER Committee reviewed the Department of Finance and Administration's selection of a third-party administrator for the state employees' and public school employees' health plans and claims processing delays experienced by the administrator. The Committee conducted the review pursuant to MISS. CODE ANN. § 5-3-57 (1972).

Scope and Purpose

PEER conducted this investigation primarily to respond to complaints from legislators, state employees, public school employees, and health care providers regarding the untimely processing of the state's self-funded health insurance claims. Specifically, PEER sought answers to the following questions:

- Was the selection process used by DFA in compliance with state law and adequate to ensure that the selected third-party administrator was capable of administering the Plans?

- What problems have contributed to recently experienced delays in CENTRA's processing of state and public school employees' health insurance claims?

Because PEER did not receive complaints relative to the state's life insurance coverage, the Committee did not include the life component of the state's self-funded insurance program in this investigation. Therefore, all references concerning the insurance program in the report refer to the health component of the program only.

Method

In conducting this investigation, PEER:

- reviewed state statutes and administrative contracts entered into by DFA;
- interviewed personnel of the Department of Finance and Administration; Coopers & Lybrand (Human Resource Advisory unit); CENTRA Benefit Services, Inc.; BlueCross BlueShield of Mississippi, Inc.; and the Department of Insurance;
- reviewed financial, administrative, and operational information provided by the Department of Finance and Administration; Coopers & Lybrand; CENTRA Benefit Services, Inc.; BlueCross BlueShield of Mississippi, Inc.; and the Department of Insurance;
- interviewed selected members of the Health Advisory Council for the State Employees' Health Insurance Plan; and,
- interviewed Plan participants and health care providers and analyzed documentation provided by such.

Overview

Inarguably, there have been delays, disruptions, and difficulties as Blue Cross relinquished its role as DFA's third-party administrator and CENTRA assumed that role and began processing claims. With the advent of complaints from participants and health care providers regarding claims processing delays, all of the parties involved--DFA, CENTRA, and Blue Cross--have attempted to focus the blame for the problems on each other. The reality is that all three parties must bear responsibility for causing and also for resolving the problems which have plagued administration of the Plans.

DFA, with its statutory responsibility for administration of the Plans, failed to plan and coordinate properly the transition and implementation process to ensure that its current and former third-party administrators effected a smooth transition. DFA's passive and reactive role in the transition process allowed many avoidable and correctable situations to escalate beyond reasonable resolution and prevented literally hundreds of participants and health care providers from receiving timely processing of claims.

CENTRA, as DFA's new third-party administrator, apparently underestimated the magnitude and complexities of the transition and implementation process. The new third-party administrator should have

drawn on its past experiences and quickly assessed the transition situation to realize that implementation of DFA's account, CENTRA's largest, required extraordinary efforts steeped in precision and analytical rigor.

Blue Cross, as DFA's former third-party administrator, should have realized that its demands upon the new claims administrator, such as indemnification and internal repricing, would create problems well beyond those expected during a transition of short duration.

Background

State Employees' Life and Health Insurance Plan

The Legislature created the State Employees' Life and Health Insurance Plan (the "Plan") effective July 1, 1972, through Chapter 523, *Laws of 1971.* Benefits of the Plan are currently codified in MISS. CODE ANN. § 25-15-9 (1972) and are provided to any "person who works full time for the State of Mississippi and receives his compensation in a direct payment from a department, agency or institution of the state government."

The health component of the Plan originally provided 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 Plan provides a lifetime maximum of $1,000,000 of major medical insurance coverage with the state paying 100% of the employee's monthly premium. State employee retirees and dependents of state employees may participate in the Plan by paying monthly premiums.

Public School Employees' Health Insurance Plan

The Legislature created the Public School Employees' Health Insurance Plan (the "School Plan") effective April 12, 1991, with the enactment of Chapter 558, *Laws of 1991.* The School Plan was created to provide health insurance coverage to full-time employees of public school and community/junior college districts. Benefits of the School Plan are currently codified in MISS. CODE ANN. § 25-15-255 (1972). Chapter 558 states that it was the intent of the Legislature that coverage under the School Plan "shall, to the extent practicable, be the same coverage provided state employees" under the State Employees' Health Insurance Plan.

Chapter 558, *Laws of 1991,* allows the Department of Finance (DFA) to contract with a corporation or association licensed in Mississippi to transact accident and health insurance business to provide the benefits of the School Plan. DFA, through a competitive bid process, selected BlueCross BlueShield of Mississippi to serve as the underwriter for the School Plan. Chapter 558 provided that the cost of the School Plan for certificated employees be borne by an annual state appropriation of not less than $5 million, a contribution of at least $75 of non-minimum program funds for each participating certificated employee, and that each participating certificated employee pay premiums. Chapter 558 allowed non-certificated employees and retirees to participate in the School Plan with such employees and retirees paying 100% of the monthly premiums.

Chapter 615, *Laws of 1994*, expanded the scope of participation in the School Plan to include all school and community/junior college district employees who work at least twenty hours during each week and regular

non-student public school bus drivers. Chapter 615 provides that the State Board of Education allot to each school district appropriated funds to pay 100% of the costs of the School Plan and states that the Legislature shall annually appropriate to the community/junior college districts funds to pay 100% of the costs of the School Plan for their employees. Chapter 615 also states that the Legislature's intent was that coverage of the School Plan may be self-insured by the State of Mississippi and that the coverage of the School Plan be the same as that provided state employees under the State Employees' Health Insurance Plan.

Participants in the State and Public School Employees' Health Plans

As illustrated in the table below, the Plans provided insurance coverage to 171,680 covered lives (enrolled employees and their dependents) as of December 1, 1994.

	Employees	Dependents	Total
State Employees' Plan	52,704	29,888	82,592
Public School Employees' Plan	61,964	27,124	89,088
Total	114,668	57,012	171,680

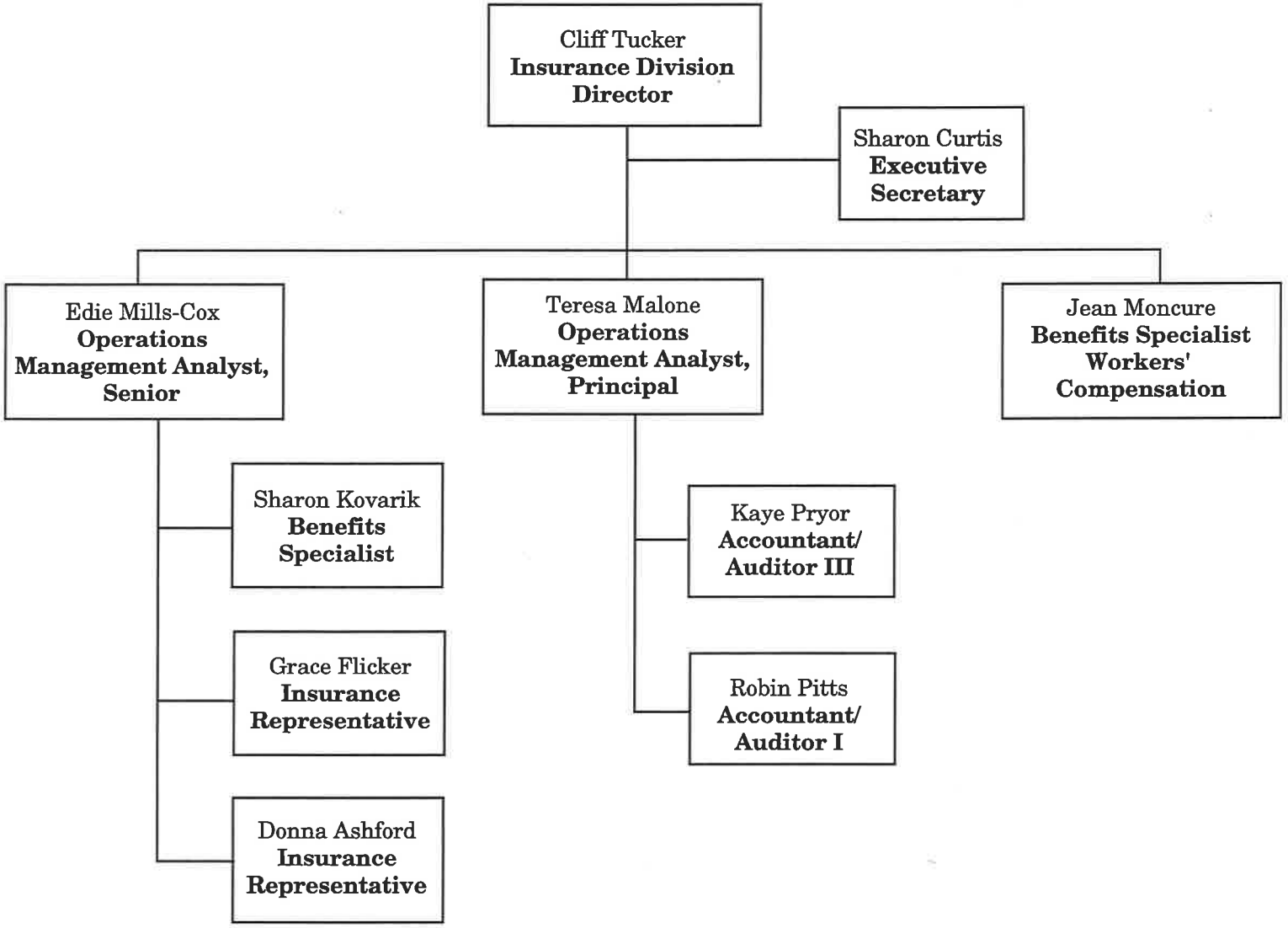
Administration of the State and Public School Employees' Health Plans

MISS. CODE ANN. § 25-15-5 and § 25-15-253 (1972) authorize the Department of Finance and Administration (DFA) to administer the State Employees' Health Insurance Plan and the Public School Employees Health Insurance Plans (hereafter referred to as the "Plan" or the "Plans") and to promulgate necessary rules and regulations for their administration. MISS. CODE ANN. § 25-15-9 and § 25-15-255 (1972) establish advisory councils to advise the department in the formulation of the Plans. Currently, DFA, through its Office of Insurance, manages the Plans in a similar manner, while technically maintaining each as a separate plan with separate fund reserves. (Exhibit 1, page 6, presents an organization chart of DFA's Office of Insurance.) MISS. CODE ANN. § 25-15-11 and § 25-15-255 (1972) authorize DFA to contract the administration and service of the self-insured Plans to a third-party administrator.

On a day-to-day basis, the Plans are administered by DFA, a claims administrator, a utilization review organization, and a network contractor. DFA's duties include monitoring the overall insurance program for state and public school employees; establishing premium rates and benefits; maintaining reserve funds; providing customer service, including handling complaints and appeals of members of the Plans; and selecting a claims administrator.

Exhibit 1

Department of Finance and Administration Office of Insurance Organization Chart (FY 1994)



NOTE: The Office of Insurance Fiscal Year 1995 staffing profile consisted of nine additional positions, including two vacancies.

SOURCE: Department of Finance and Administration Office of Insurance organization chart for Fiscal Year 1994.

DFA currently contracts with CENTRA Benefit Services to serve as the claims administrator for the Plans. CENTRA processes claims; maintains eligibility files based upon information provided by the agencies, schools, and Public Employees' Retirement System; and bills agencies, schools, and retirees for premiums. Exhibit 2, page 8, illustrates the steps used by CENTRA to process health claims. [Prior to July 1, 1994, BlueCross BlueShield of Mississippi (hereafter referred to as "Blue Cross") served DFA for ten years as its claims administrator and was the actual insurer of the School Plan.]

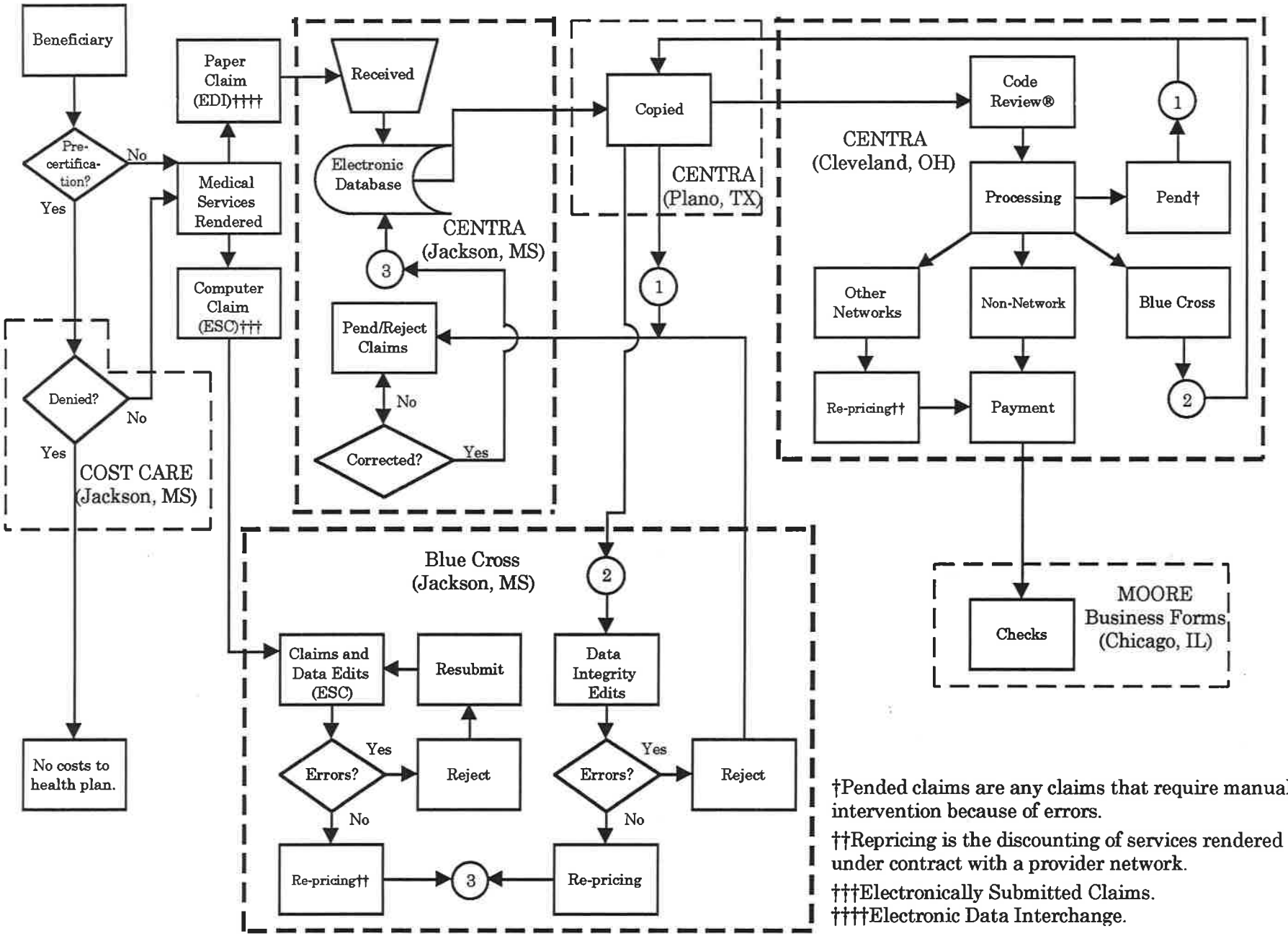
DFA contracts with Cost Care, Inc. as a utilization review organization responsible for helping ensure that the best possible care is provided to participants of the Plans with the least costly combination of services. Cost Care is responsible for pre-certification of inpatient hospital stays, review of continued inpatient stays, second surgical opinions, large case management, and operation of a patient assistance line.

DFA has two arrangements with Blue Cross for network services: the Key Provider Network and the Community Pharmacy network. Blue Cross has contracted with specific hospitals, physicians, and pharmacies to provide discounts to the state Plans without residual billing to Plan participants. Participants' use of such networks results in reduced billed charges to plan participants for medical services.

Recent Complaints Relative to the Administration of the State and Public School Employees' Health Plans

CENTRA began serving as the third-party administrator for the State and Public School Employees' Health Plans effective July 1, 1994. Plan participants initially noticed few changes as Blue Cross relinquished its role as administrator and CENTRA assumed that role and began processing claims. During the latter part of July and early August of 1994, Plan participants began experiencing difficulties, primarily with claims processing and receipt of reimbursement checks. Participants' complaints regarding CENTRA and administration of the Plans escalated during late summer and early fall. CENTRA was inundated with telephone calls from participants seeking information relative to their claims and/or Plan status. DFA also received a large volume of telephone and mail inquiries from participants. As illustrated in Appendix A, page 45, DFA has handled more than 1,800 inquiries relative to CENTRA's administration of the Plans for the period September through December, 1994. In general, complaints to DFA have involved delayed claims payment, refiling of claims lost by CENTRA, lack of coordination of benefits, and inability to reach a CENTRA employee successfully and quickly by telephone. (Please refer to Appendix A, page 45, for additional details regarding the types of complaints DFA has received regarding CENTRA.)

Exhibit 2
CENTRA Benefit Services Flow of Claims Processing



†Pended claims are any claims that require manual intervention because of errors.

††Repricing is the discounting of services rendered under contract with a provider network.

†††Electronically Submitted Claims.

††††Electronic Data Interchange.

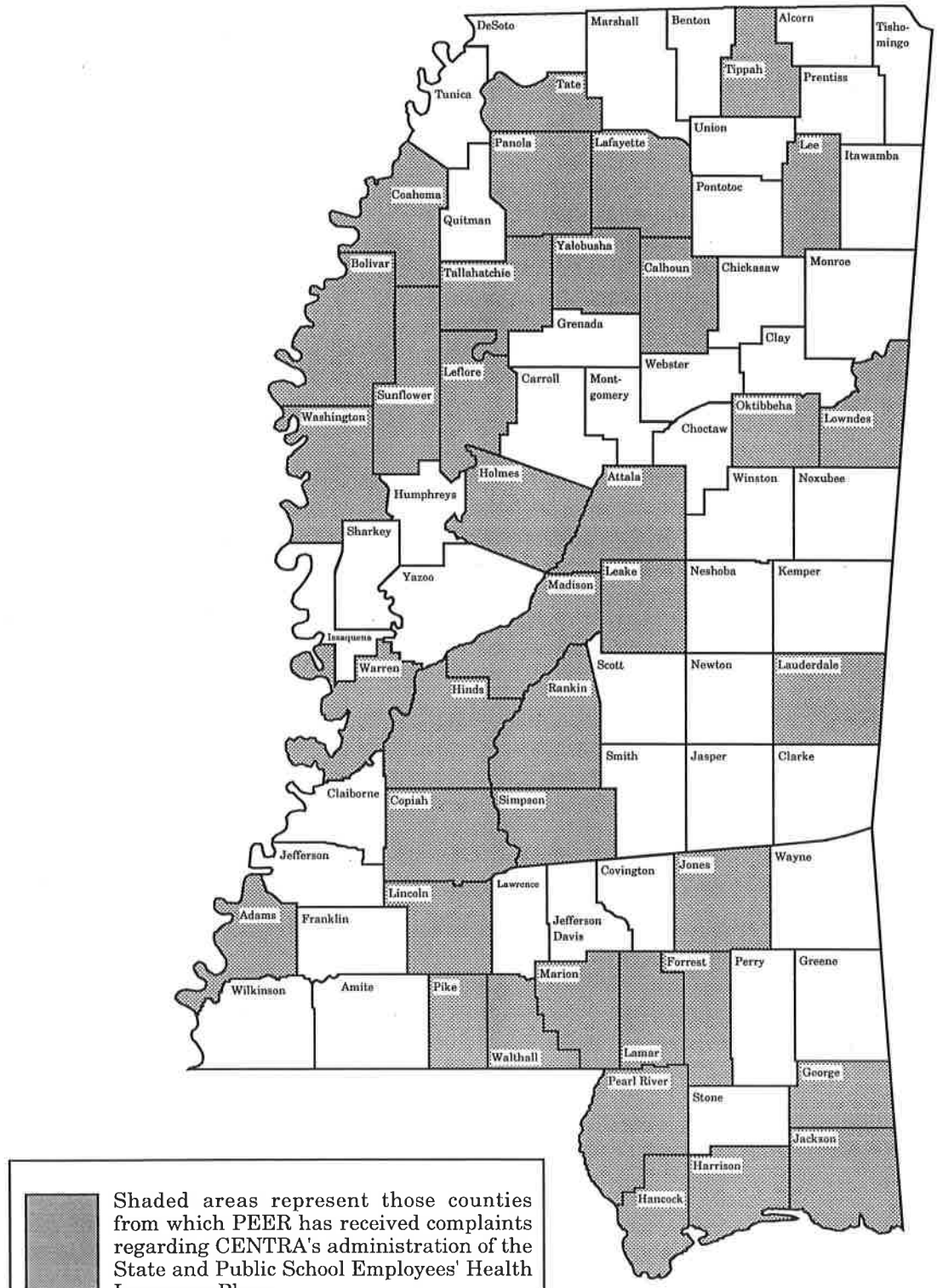
SOURCE: PEER analysis of CENTRA and Blue Cross Interviews.

DFA has not been the only recipient of participant complaints regarding CENTRA. The Department of Insurance has handled several hundred telephone calls regarding CENTRA. Department of Insurance staff initially attempted to assist participants who called, although the department has no regulatory authority over DFA's administration of the Plans. According to Department of Insurance staff, the volume of complaint telephone calls became so great that they began referring calls directly to DFA's Office of Insurance.

Legislators have also received complaints from state and public school employee constituents covered by the Plans and health care providers. Also, after several newspapers throughout the state published an article stating that the PEER Committee would investigate DFA's contract with CENTRA, PEER began receiving written and telephone complaints from Plan participants and health care providers. Exhibit 3, page 10, depicts the counties of residence of Plan participants lodging complaints with PEER. Exhibit 4, page 11, presents a sample of complaints received by PEER.

Exhibit 3

Origin of Complaints Regarding Third-Party Administrator Forwarded to PEER



Shaded areas represent those counties from which PEER has received complaints regarding CENTRA's administration of the State and Public School Employees' Health Insurance Plans.

SOURCE: PEER analysis.

Exhibit 4

Sample Complaints Regarding CENTRA's Administration of the State Employees' and Public School Employees' Plans

- A retired teacher in Pascagoula, MS, received an explanation of benefits regarding pharmacy claims that he had filed with CENTRA, only to discover six weeks later that his reimbursement check had been sent to another Plan member in Sumrall, MS.

- One Plan member claims that over $1,200 worth of medical claims filed over several months have not been paid. She has retained an attorney who threatens legal action against the Plan.

- One COBRA participant complained of not being billed for premiums and forwarded complaints to her personnel officer, who on several occasions received confirmation from CENTRA employees that the problem had been corrected. To date, the participant has not been billed. In addition, the participant complained that the current administrator would not accept claims for medical services that were covered and paid by the prior administrator and that she has consequently incurred over $3,000 in out-of-pocket medical expenses.

- Several employees have stated concerns regarding the timely payment of claims and the coordination of benefits applicable to primary and secondary coverage. In most cases, the coordination of benefits has been limited to retirees with Medicare but has also applied to Plan members with CHAMPUS.

- A retired chancery judge attempted to return a duplicate payment of $427.52 to CENTRA. After several unanswered letters and attempted phone calls to CENTRA, the retiree contacted DFA to return the overpayment.

- Regarding timeliness of CENTRA's claims payment, one teacher notes an outstanding balance of $9,000 with her pharmaceutical provider covering several months. This balance reflects charges for three drugs the employee must take to maintain her transplanted kidney.

- A state employee noted problems with his eligibility file when he received notice that his mother was listed as his wife on an explanation of benefits.

- One state employee complained of multiple checks for a single visit to one health care provider. The employee submitted one claim with eleven itemized charges. To date, she has received four checks for nine of the eleven charges with no explanation of the remaining two. In addition, she has received an explanation of benefits from CENTRA for services rendered by a provider that she nor her dependents have ever visited.

- Another state employee claims that CENTRA has refused to pay medical claims because the employee has other insurance which is her primary carrier; however, she states that she has no other insurance.

- Several employees have noted different payment ratios. For example, some Key Providers have been reimbursed at eighty percent rather than eighty-five percent of covered costs. Moreover, some generic pharmaceuticals have been reimbursed at eighty percent rather than one hundred percent.

SOURCE: Unaudited and unverified participant complaints provided to PEER.

Findings

Due to the number of employees covered by the State and Public School Employees' Health Insurance Plans, legislators and others have a keen interest in knowing whether certain aspects of the Plans are administered properly. This report contains answers to two specific questions which can be used to make such a determination. The first question deals with whether DFA complied with state law in selecting a third-party administrator and whether the department selected a claims administrator which could administer the program. The second question addresses problems which have contributed to claims processing problems experienced by DFA's new third-party administrator. Each question is followed by a series of findings and sub-findings which provide detailed answers to the questions.

Was the selection process used by DFA in compliance with state law and adequate to ensure that the selected third-party administrator was capable of administering the Plans?

DFA complied with state law by competitively soliciting proposals to select a new third-party administrator for the Plans. However, DFA's process was not adequate to ensure that the selected third-party administrator was capable of administering the plans.

- *DFA solicited competitive bids for a third-party administrator for the Plans in compliance with state law.*

State law allows the Department of Finance and Administration to contract with a third-party administrator for the administration and service of the State Employees' and Public School Health Plans. With the December 31, 1993, expiration of DFA's contract with Blue Cross as administrator for the State Employees' Plan and the School Plan becoming self-funded on July 1, 1994, DFA determined that it should solicit bids to locate a third-party administrator.

Generally, state law does not address the process to be used by state agencies to obtain professional services, such as third-party administrator services. The law contains no specific provisions regarding the process to be used by DFA to contract with a third-party administrator for administration and service of the State Employees' Plan. MISS. CODE ANN. § 25-15-11 (1972) simply states that DFA may contract the administration and service of the State Employees' Plan to a third party. CODE § 25-15-255 (1972) states that DFA may "contract the administration and service of the self-insured program [School Plan] to a third-party" and specifically requires that DFA "actively solicit bids for the administration and service" of the School Plan. The section also states that DFA may contract for

consulting services to assist the department in preparation of specifications for the School Plan and in the process of advertising for bids for the School Plan.

Thus, although the law specifically required DFA to seek bids only for a third-party administrator for the School Plan, DFA took bids for a third-party administrator to administer both Plans. (Exhibit 5, page 14, presents a timeline of the process DFA used to select CENTRA Benefit Services as the third-party administrator for the State Employees' and Public Schools Health Plans.) On August 10, 1993, DFA entered into a contract with Coopers & Lybrand (C&L), a nationally recognized accounting firm, to assist DFA in preparing and evaluating an RFP for bidding the claims administration contract, utilization review contract, and other necessary contracts. DFA selected C&L on a competitive basis by receiving and evaluating seven proposals from interested companies.

C&L representatives, in conjunction with DFA staff, compiled a request for proposals document, which was advertised in a newspaper with statewide circulation on three occasions and distributed to thirty-one interested companies in late December 1993 and early January 1994. DFA received eight responses to the RFP, which C&L representatives analyzed and evaluated prior to selecting CENTRA Benefit Services to recommend to DFA. Exhibit 6, page 16, lists companies which responded to the RFP. DFA awarded the contract to CENTRA on April 4, 1994, to serve as the third-party administrator for the Plans.

- *DFA's process for selecting a third-party administrator was not adequate to ensure that the selected third-party administrator was capable of administering the Plans.*

While DFA complied with state law relative to soliciting bids for a third-party administrator, the process did not ensure that the department selected an administrator capable of administering and servicing the Plans. The process did not:

- effectively utilize the time available to select and contract with a third-party administrator because DFA used four months to select competitively a new consultant to assist with the process, had concerns that the Legislature may alter the Plans during the 1994 session, and, focused on other administrative concerns rather than focusing primarily on contracting with a third-party administrator;

- produce an RFP with sufficient information upon which proposers could base an informed response; or,

- require its consultant to uniformly evaluate proposers and document its final analysis upon which its recommendation was based.

Exhibit 5

Chronology of DFA's Process of Selecting a Third-Party Administrator

1993

04/08/93	The Legislature amends MISS. CODE ANN. §25-15-255 requiring that the public school employees' insurance plan be self-insured by the State of Mississippi. The amended law also requires DFA to bid out any third-party administrator contract which includes the public school employees' plan.
06/23/93	At a State Employees' Insurance Advisory Council meeting, DFA presents a Request for Proposals for health consulting assistance in selecting contractors for claims administration and other services.
07/27/93	At a State Employees' Insurance Advisory Council meeting, members vote to accept DFA's recommendation of Coopers & Lybrand as consultant.
08/10/93	DFA and Coopers & Lybrand sign a consulting agreement for assistance in preparing and evaluating proposals for claims administration and other necessary contracts.
11/29/93	Coopers & Lybrand sends DFA a draft vendor questionnaire to be included in the Request for Proposals.
12/14/93	Coopers & Lybrand sends DFA the first draft of the Request for Proposals.
12/23/93	DFA places the first of four advertisements for the Request for Proposals in the *Clarion-Ledger*.
12/30/93	Coopers & Lybrand sends letters to vendors announcing that a Request for Proposals will be issued on January 7, 1994.

1994

01/07/94	Coopers & Lybrand mails a Request for Proposals to each vendor on the bid list.
01/14/94	Coopers & Lybrand sends DFA a revised Request for Proposals schedule and emphasizes the importance of selecting an administrator by April 4, 1994, to allow the chosen administrator the minimum ninety days necessary for implementation of claims services by July 1, 1994.
01/28/94	Coopers & Lybrand mails to all vendors the answers to vendor questions regarding the Request for Proposals.
02/14/94	Eight vendors provide proposals to Coopers & Lybrand by the deadline.
02/16/94	Coopers & Lybrand sends DFA the proposed review criteria for selection of the administrator, levels one through four.

Exhibit 5 (continued)

03/09/94	Coopers & Lybrand conducts an on-site visit to CENTRA offices and completes four reference checks on CENTRA.
03/11/94	Coopers & Lybrand conducts an on-site visit to ACMG, Inc., a third-party administrator bidder.
03/14/94	Coopers & Lybrand selects the third-party administrator finalists based on a five-level review process.
03/21/94	ACMG, Inc., a third-party administrator finalist, presents its proposal to the state and public school employees' insurance advisory councils.
03/22/94	Blue Cross and CENTRA, third-party administrator finalists, present proposals to the state and public school employees' insurance advisory councils.
03/30/94	DFA representatives visit CENTRA's claims office for the State of Washington to observe operations and ask questions.
04/04/94	Coopers & Lybrand recommends to the advisory councils that CENTRA be awarded the contract.
	DFA's Executive Director sends a letter to CENTRA confirming its appointment as the state's claims administrator.
04/06/94	DFA, CENTRA, and Blue Cross meet to begin the transfer of the administration of claims processing from Blue Cross to CENTRA.
05/06/94	CENTRA mails DFA a first draft of the CENTRA/DFA contract.
07/01/94	CENTRA begins claims processing for the State of Mississippi.
07/15/94	CENTRA and DFA execute a contract for administration of state and public school employee claims.

SOURCE: PEER analysis of DFA records.

Exhibit 6

State of Mississippi's Third-Party Administrator Selection Process
Vendor-Proposed Three-Year Contract Prices

Vendor		State	Administrative Fees (year 1)	Administrative Fees (year 2)	Administrative Fees (year 3)	Total Three Year Contract*
ACMG, Inc.	**(1)**	Ohio	$3.99	$4.19	$4.40	$17,310,281
BlueCross BlueShield of Mississippi	**(1)**	Mississippi	$5.00	$4.76	$4.76	$19,979,752
CENTRA Benefit Services	**(1)**	Texas	$3.49	$4.15	$4.15	$16,223,229
Consolidated Benefit Services	**(2)**	Georgia	$6.50	$5.75	$6.00	$25,112,292
Fortis Healthcare	**(2)**	Minnesota	$8.15	$8.15	$8.15	$33,643,591
Mississippi Administration Service, Inc.	**(2)**	Mississippi	$6.25	$6.25	$6.25	$25,800,300
Mutual of Omaha	**(3)**	Nebraska	$8.38	$10.92	$11.47	$42,340,012
Philadelphia American Life	**(3)**	Texas	$5.20	$6.48	$6.77	$25,387,495

(1) Chosen as a finalist by Coopers & Lybrand
(2) Eliminated at Coopers & Lybrand's Second Level of Review, mandatory vendor terms
(3) Eliminated at Coopers & Lybrand's Fourth Level of Review, the financial offers

* Based on total enrollment as of December 1994 at 114,668.
Note: Administrative Fees based on number of enrolled employees per month.
Note: Additional charges were included in each vendor's RFP proposals, such as COBRA & interface fees, that are not included in the above computations.

SOURCE: PEER analysis of Coopers & Lybrand's documentation.

The following sections discuss each of these process problems in detail.

-- *DFA's process did not effectively utilize the time available to select and contract with a third-party administrator.*

As early as April, 8, 1993 (the date of the Governor's signature of House Bill 822--now Chapter 533, *Laws of 1993)*, DFA knew that its existing third-party administrator contract for the State Employees' Plan would expire on December 31, 1993, and that the School Plan would become self-funded on July 1, 1994, requiring a third-party administrator. Such knowledge gave DFA staff approximately fifteen months within which to prepare an RFP, distribute the RFP, receive and evaluate responses, and award a contract.

Given the inherent complexities associated with DFA transforming the privately underwritten School Plan into a self-insured plan and selecting an administrator which could process claims for well over 100,000 enrolled employees, DFA needed to utilize available time effectively. As illustrated in Exhibit 5, page 14, DFA's process did not effectively utilize the fifteen months available to select and contract with a third-party administrator. DFA did not release its RFP for the Plans' third-party contract until January 7, 1994 (approximately six months prior to the date a new administrator was to begin processing claims), and did not award the third-party administrator contract until April 4, 1994 (approximately three months prior to the date a new administrator was to begin processing claims).

DFA's failure to utilize effectively the fifteen months available to select and contract with a third-party administrator has three primary causes.

Selection of a consultant--During the spring of 1993, DFA staff decided to seek competitive proposals to retain a consultant to assist the department in preparing and evaluating an RFP for bidding the claims administration contract, utilization review contract, and other necessary contracts. Prior to this decision, DFA had used its former consulting actuary, William M. Mercer Meidinger Hansen, Inc., to provide assistance relative to the Plans.

The department's consultant solicitation and selection process took approximately three months. As a result, DFA did not enter into a contract with its new consultant, Coopers & Lybrand, until August 10, 1993, approximately four months after DFA knew that a third-party administrator would be necessary for both the State Employees' and Public School Employees' Plans.

Possible changes in the Plans--DFA had concerns that the Legislature might amend legislation affecting the Plans during the 1994

session, such as expanding the number and types of employees who would be covered by the Plans. This argument, although theoretically valid, becomes flawed when considered in light of the timing of the RFP process. The 1994 legislative session began on January 4, three days before DFA issued the RFP for the third-party administrator. If DFA was indeed concerned about possible changes in the law during the 1994 session, the RFP would not have been issued three days after the session began. Furthermore, DFA awarded the contract to CENTRA on April 4, 1994, four days before the changes in the statutes were signed into law by the Governor. Again, if DFA had been worried about changes in the law affecting the Plans, the department would not have awarded the contract before any changes in the law were approved by the Governor.

Competing priorities--During the latter part of 1993 and early part of 1994, DFA proceeded with its decision to award a pharmacy network contract and a new third-party administrator contract; to establish health care networks for the Plans; and, to enroll and/or re-enroll employees in the Plans and health care networks. All of these changes had to be negotiated, executed and implemented within a relatively short period, as illustrated below. However, the only statutory deadline was the requirement to have a third-party administrator contracted by July 1, 1994 for the School Plan. The remaining implementation dates were developed by DFA and could have been amended.

	Contract Award	Implementation Date
Pharmacy Network	November 5, 1993	January 1, 1994
Third-Party Administrator	April 4, 1994	July 1, 1994
Health Care Networks	May 2, 1994	July 1, 1994*
Re-Enrollment-Public Schools	-N/A-	July 1, 1994
Re-Enrollment-State Employees	-N/A-	November 1, 1994

* Upon the recommendation of the Health Advisory Committee, DFA postponed the implementation date of the health care networks to January 1, 1995.

Due to the number of participants and dependents involved in the Plans (171,680 as of December 1, 1994) and the fact that implementation of most of the changes was scheduled to occur in the middle of a plan year, any one of the items listed above would have been a major undertaking for DFA. However, DFA undertook all of these changes almost simultaneously without developing a strategic plan which addressed their overall importance to the Plans and their timely implementation.

DFA's decision to proceed with implementation of networks and re-enrollment contributed directly to CENTRA's claims processing problems, as discussed on page 39. Implementation of the health care networks has also suffered due to this decision to implement several changes within a brief period. During the summer and fall of 1994, DFA required Plan participants to choose one of six health care networks in which to participate. As of January 18, 1995, DFA had formally signed a contract

with only one (the University of Mississippi Medical Center) of the six networks offered to Plan participants. As of January 1, 1995, approximately 12,000 of the 171,680 of the Plans' participants had not made a choice, although the networks became effective on January 1.

DFA embarked on an ambitious plan of action for 1993 and 1994 with limited comprehensive planning (see page 18) to ensure the effective coordination and implementation of the changes. Due to the complexities of each change, DFA could not focus its time and attention on any one change to ensure its total success. As a result, DFA did not ensure that the third-party administrator transition from Blue Cross to CENTRA occurred smoothly and did not implement the networks effectively.

-- *The RFP used by DFA to select a third-party administrator lacked sufficient information to allow potential proposers to assess the claims administration and processing needs of the health plans.*

In most competitive procurements, a request for proposals (RFP) is used to inform potential proposers of the specifications and/or requirements associated with the procurement. As stated on page 13, DFA contracted with Coopers & Lybrand (C&L) to assist with the preparation of an RFP to solicit proposals from interested third-party administrators. C&L staff had primary responsibility for preparing the document based on information and data provided by DFA, with DFA staff reviewing, revising, and approving components of C&L's proposed RFP on a periodic basis. According to C&L staff, they developed DFA's request for proposals document in accordance with procedures and information routinely used by C&L to develop such a document for other clients.

C&L produced an RFP consisting of seven major sections: Introduction; RFP Questionnaire; Financial Quotations; Current Plan Designs and Plan Designs Under Consideration; Accounting Requirements; Contract Conditions; and, Statement of Compliance. The RFP also included five appendices which primarily provided proposers with programmatic, statistical, and legal information.

Given the transition and claims processing delays experienced by CENTRA, it is apparent that the RFP utilized by DFA to locate a third-party administrator did not contain sufficient information to allow potential proposers to assess the claims administration and processing needs of the Plans. Specifically, the RFP contained only limited data on public school employees and insufficient explanation of relationships between the third-party administrator and other entities involved with the Plans.

Limited data for public school employees--At C&L's request, DFA provided for inclusion in the RFP historical information from Blue Cross's standard monthly reports on the number of state employees enrolled in the

Plan and the number and dollar volume of claims paid for employees and health care providers. The RFP contained only an estimate of public school employees eligible for enrollment in the plan and the dollar volume of claims paid for public school employees and health care providers when the employees were insured by Blue Cross. The RFP did not include the number of claims paid for public school employees. Such information would have been helpful in responding to the RFP, considering that public school employees now represent more than fifty percent of the participants included in the Plans.

C&L also did not summarize claims and other statistical information in the RFP. C&L contends that proposers prefer to analyze raw data on their own and apply their own assumptions to develop a response. A summarization of data would have theoretically ensured that all proposers correctly interpreted the data on which their proposals were based. During the three finalists' oral presentations, C&L determined that at least two of the three finalists had differing conclusions regarding the annual number of claims each enrolled employee would generate, although both finalists theoretically used the RFP information to develop their estimates.

Insufficient explanation of relationships--The RFP did not fully disclose the relationship which would exist between the third-party administrator and other entities involved with the Plans, especially Blue Cross, as shown in the examples below:

* *The RFP did not disclose that DFA might require the future third-party administrator to accept "repriced" claims from Blue Cross.* (As explained on page 35, this arrangement requires an additional step in claims processing which varies from industry practice. Due to proprietary reasons, Blue Cross insists, as it has historically insisted, on electronically processing every claim generated by its Key Provider Network in order to apply its confidential negotiated medical service discounts.) The RFP also did not ask respondents whether they had the capability to interface with a network which electronically priced its own claims.

  After being awarded the third-party administrator contract, CENTRA learned of Blue Cross's repricing procedures. CENTRA reportedly needed sixty additional days beyond the ninety-day transition period to allow for sufficient time to interface with Blue Cross's repricing mechanisms.

* *The RFP did not include the data transfer requirements for computer interface with Blue Cross's pharmacy network, which was contracted for prior to release of the RFP.* In contrast, the RFP included the data transfer requirements for interface with DFA's utilization review (Cost Care, Inc.) and claims reporting (MEDSTAT) contractors.

Just as the RFP lacked sufficient information to assist proposers in compiling their responses, the RFP did not require proposers to submit information which would have assisted C&L in reviewing the responses, such as:

- resumés of the proposer's project team which would be responsible for implementing the contract, if received;
- an organization chart for the proposed claims office;
- resumés of supervisory claims processing personnel to be assigned to the claims office; and,
- an audited financial statement.

-- *DFA's consultant, Coopers & Lybrand, did not uniformly evaluate the three finalist proposers and did not document the final analysis on which its recommendation of CENTRA was based.*

Upon receipt of the responses from the eight proposers, Coopers & Lybrand (C&L) evaluated the responses by subjecting them to a multi-level review process, as illustrated below.

First Level	Review of general completeness of each response
Second Level	Review of each proposer's answers to "must have" items in the RFP
Third Level	Analysis of each proposer's answers to selected questions
Fourth Level	Review of each proposer's financial offer
Fifth Level ("Tie Breaker")	Review of each proposer's willingness to open a Jackson office

Upon completing its five-level review process, C&L declared three proposers to be finalists--CENTRA Benefit Services, Inc.; ACMG, Inc.; and BlueCross BlueShield of Mississippi, Inc. The three finalists had successfully completed each level of review and represented the three lowest financial offers, with CENTRA being the lowest of the three.

Once C&L determined which proposers would be finalists, it checked references on each finalist. In addition to other references, C&L contacted Cost Care and MEDSTAT, two of DFA's other health contractors, to

determine the experiences of both companies in dealing with each finalist. Following the reference checks, C&L performed on-site inspections at ACMG and CENTRA "to evaluate the exact processes and procedures each followed in processing claims, and to better assess the automated edits and reporting capabilities of their systems." Subsequent to the reference checks and two on-site inspections, C&L recommended to DFA that all three finalists be invited to make presentations to DFA and the advisory councils. C&L concluded that the proposals of the three finalists were of "high enough quality and so evenly and competitively priced that they all were deserving of an opportunity to make a final presentation."

On March 21 and 22, 1994, the three finalists made formal presentations to DFA and the advisory councils and responded to questions. Subsequent to the presentations, C&L concluded the following:

> Although there were clear advantages to each finalist, going into the presentations, ACMG was a long shot. In BCBS's [Blue Cross's] favor was the fact that they were the incumbent, they were familiar with the plan and with State operations, and they currently were operating a claims office in Mississippi. Areas of concern related to BCBS were their inexperience as a processor for other networks, their past reluctance to provide raw data and/or timeliness in providing reports to the DFA, and the degree of manual edits. In CENTRA's favor was their experience with network interfaces, the degree of automated edits provided, and their reporting capabilities. The chief disadvantages to CENTRA were that they did not have a claims office in Mississippi at that time, and that selecting them would require a transition.
>
> At the end of the presentations, ACMG still was a long shot, and BCBS had neither helped nor hurt its position. However, it became apparent that those present had been impressed by CENTRA's presentation, their staff, and by their experience in transferring the account for the State of Washington from BCBS to CENTRA.

C&L recommended that DFA conduct its own on-site inspection of CENTRA, preferably at CENTRA's Washington State claims center. DFA conducted an inspection and found no issues to disqualify CENTRA. Therefore, C&L recommended that CENTRA be awarded the contract "based on their automated claims system, their experience with processing claims for other networks, their track record with the State of Washington transition and ongoing account, and their financial bid."

While the five-level process used by C&L to review the eight proposals demonstrated some degree of objectivity, the final phase of the evaluation process was flawed. C&L did not uniformly evaluate the three finalist proposers and did not document the analysis upon which its final recommendation was based.

Lack of an on-site inspection at Blue Cross--C&L acknowledged to PEER that C&L did not perform an on-site inspection at Blue Cross as it had at ACMG and CENTRA. C&L stated that "since BCBS was the incumbent,

and their performance in the payment of claims had been acceptable, C&L felt, and the DFA concurred, that it was unnecessary for the State to incur the time and travel costs for C&L to conduct an on-site visit at BCBS."

While C&L's explanation of its failure to conduct an on-site at Blue Cross may sound reasonable on its face, the explanation is unacceptable from an evaluation standpoint. C&L staff acknowledged to PEER that their only knowledge of Blue Cross's operations came from DFA staff and Blue Cross's written response to the RFP and formal presentation. Therefore, C&L staff had no primary knowledge, as they had from ACMG and CENTRA, on which to evaluate Blue Cross. C&L had no documented proof that Blue Cross could not provide some, if not all, of the services for which CENTRA was recommended by C&L--i.e., automated claims processing and network interfacing.

Lack of documentation regarding the final recommendation--In a response to PEER, C&L stated that it had "identified an advantage to CENTRA in the areas of automation, management reporting capabilities, and network interface experience." Despite this contention, C&L staff have yet to produce analytical work papers which illustrate how they concluded that CENTRA's operational capabilities exceeded those of Blue Cross and ACMG. While most competitive procurements are decided according to the "lowest and best" rule, C&L cannot prove to an independent reviewer that the lowest proposer, CENTRA, was necessarily the best proposer.

What problems have contributed to recently experienced delays in CENTRA's processing of state and public school employees' health insurance claims?

Since its selection as DFA's third-party administrator, CENTRA has experienced difficulties which have caused the processing of health insurance claims to be disrupted and/or delayed. The disruptions and delays occurred due to:

- DFA's and CENTRA's failure to develop a comprehensive transition/implementation plan;
- CENTRA's failure to adhere strictly to its response to DFA's request for proposals;
- an inability by CENTRA and Blue Cross to communicate effectively and resolve major transition issues;
- CENTRA's agreement to become responsible for run-out claims before the effective date of their contract with DFA;

- CENTRA's and DFA's lack of communication regarding plan benefits/coverage and DFA's failure to address at least one major transition issue relative to public school employees;

- DFA's decision to have CENTRA handle telephone calls regarding DFA's new provider networks during a critical transition period.

With the advent of the claims processing delays and disruptions, the parties involved, DFA, CENTRA, and Blue Cross, have attempted to focus blame for the problems on each other. The reality of the matter is that all three parties must bear responsibility for causing and also for resolving the problems which have plagued administration of the Plans.

- *Neither DFA nor CENTRA developed a comprehensive plan to manage the transition/implementation process and coordinate efforts of all parties involved.*

When a company assumes claims administration of a large health plan requiring the transfer of complex hard-copy and computerized data from one entity to another, a detailed and complete management plan is necessary for a smooth transition. DFA's request for proposals addressed the transition/implementation issue by requesting proposers to respond to the following question:

> Assuming notification of your selection as the claims administrator on or by April 4, 1994, how do you propose to organize the transition and implementation schedule for a contract effective date of July 1, 1994? Provide a "PERT" chart outlining the specific tasks required, actions involved, and the responsibilities of all parties during each phase.

According to DFA's consultant, Coopers & Lybrand, the client generally plays a strong role in the transition phase. C&L also states that industry practices make the new vendor (third-party administrator) responsible for establishing a transition plan in accordance with its operating structure and system, and coordinating with the incumbent. Following the April 4, 1994, award of the third-party administrator contract, neither DFA nor CENTRA developed a comprehensive transition/implementation plan to guide the transition process and ensure a smooth and timely implementation.

DFA's lack of a transition plan--MISS. CODE ANN. § 25-15-5 and 25-15-253 authorize the Department of Finance and Administration to administer the State Employees' Health Insurance Plan and the Public School Employees Health Insurance Plan. DFA has chosen to administer the Plans by contracting with a third-party administrator. Due to DFA's statutory responsibility for the Plans, the department has a vested interest in ensuring that an efficient transition occurs when changing third-party administrators.

Although DFA staff served as a resource to CENTRA and met routinely with CENTRA staff as the new third-party administrator attempted to effect a transition, DFA did not develop or adhere to a comprehensive plan to guide the transition process and measure CENTRA's accomplishments during the process. DFA relied almost exclusively on the current and former third-party administrators to resolve transition issues, with only limited intervention from the department. Without a comprehensive transition plan, DFA had no first-hand knowledge and/or definite assurances that CENTRA was progressing through the transition process in a timely and efficient manner in order to begin processing claims on July 1, 1994.

DFA's lack of a comprehensive transition plan cannot be attributed to limited knowledge of the issues involved or the technology required to effect a transition. Coopers & Lybrand stated that "DFA is as knowledgeable, if not more so, than most of our clients, and should have been capable of managing the transition."

CENTRA's lack of a transition plan--DFA's request for proposals asked proposers to provide in their responses a transition implementation schedule along with a PERT chart containing requested information. CENTRA provided the following response:

> Please find, enclosed, a basic installation timetable regarding CENTRA's installation of claims administration for the State of Mississippi. A detailed installation document and timetable would be prepared upon selection of CENTRA as claims administrator. Given the fact that CENTRA's expertise is in large case implementation and administration, the exact proprietary document will be shared at the appropriate time. [Emphasis added.]

CENTRA's "basic installation timetable" was not responsive to DFA's request for proposals because it was generic in nature, was not specific to DFA's particular transition needs, contained no dates, and did not include a PERT chart outlining the specific tasks required, actions involved, and the responsibilities of all parties during each phase.

In response to a request for its detailed transition/implementation plan, CENTRA provided PEER with a document entitled "Project Task List" which was dated June 10, 1994. Although the Project Task List is more detailed and date-oriented than the basic installation timetable, the document also is not responsive to DFA's request for proposals. A significant portion of the Project Task List is dedicated to hiring/staffing and the logistics of establishing an office in location in Jackson. Given the complaints which have arisen subsequent to CENTRA's processing of claims, the portion which should have been the most important part of CENTRA's transition plan--systems and data transfer issues--was ill-defined and cryptic in CENTRA's Project Task List. There is no evidence that DFA and/or Blue Cross were involved in, made a party to, or received a copy of CENTRA's task list. It would be unreasonable for CENTRA and/or

DFA to contend that the Project Task List is the transition and implementation scheduled envisioned by the RFP. Without a comprehensive transition plan, CENTRA had no organized process with which to effect a transition.

- *During the transition period, CENTRA did not perform in accordance with its response to DFA's request for proposals document because it did not assign a dedicated transition team for the duration of the implementation process and establish and adequately staff a Jackson office to perform all services on DFA's account.*

CENTRA, as well as the other seven proposers, provided responses designed to address the questions and requirements contained in DFA's request for proposals document. C&L and DFA used the responses to evaluate each proposer's strengths and weaknesses and capabilities to serve as DFA's third-party administrator. A successful proposer's failure to perform in accordance with its response could constitute a misrepresentation which unfairly disadvantaged other proposers.

CENTRA's lack of adherence to its response in the following three areas has contributed to transition difficulties and claims processing delays: lack of a "dedicated transition team," Mississippi office to perform all services, and lack of adequate staffing.

Lack of a "dedicated transition team"--In its February 17, 1994, response to DFA's request for proposal, CENTRA stated that it "has a dedicated new customer installation team whose sole function is to effectively install clients and properly maintain their benefit programs within our system." The response further states that "we have assembled a team of top quality personnel to manage our organization and we believe the combination of talent and knowledge that we have put together is unsurpassed in the benefits industry." The response then includes the resumés of ten individuals identified as CENTRA's management staff. CENTRA states that Robert L. Franus, Assistant to the President, Special Projects, would be the account manager and service representative for DFA's account. The response noted that Mr. Franus "has a high level of negotiating authority."

While CENTRA has assigned various employees on a full- and part-time basis to the project during the implementation of DFA's account, the employees assigned did not constitute a "dedicated new customer installation team whose sole function is to effectively install clients." CENTRA has primarily developed and staffed its implementation team on an as-needed basis, depending on the particular needs of the transition.

After award of the contract on April 4, 1994, CENTRA's President and Chief Executive Officer and seven other staff members met on April 5,

1994, with DFA and Blue Cross representatives to discuss the transition process. Following this initial meeting, five of the seven CENTRA staff members were given responsibility for various portions of the transition, such as customer service and claims processing; hiring and training; office site selection; plan specifications; and systems operations. Of the seven implementation team members who attended the April 5 meeting, CENTRA assigned only three to work full-time for the duration of the implementation on DFA's account, and only one of those assigned to work full-time, a business analyst, temporarily relocated to Mississippi to resolve transition issues.

During the course of the transition and implementation, CENTRA assigned at least forty staff members to work on DFA's account with their lengths of involvement ranging from seven days to nine months. After the first several weeks on transition, CENTRA began experiencing transition difficulties in receiving data from Blue Cross. On May 2, 1994, CENTRA assigned Don Rainville, Vice President of Finance and Administration in CENTRA's Plano, Texas office, to direct the implementation team and the Jackson operations. Rainville temporarily relocated to Mississippi for approximately five months. After Rainville's arrival in Jackson, CENTRA decided the employee responsible for the customer service and claims processing aspect of the implementation was no longer needed as a team leader. In addition to Rainville and the business analyst previously mentioned, eleven trainers, a systems support employee, and a vice-president temporarily relocated to Mississippi for periods ranging from one to five months. Despite the number of CENTRA employees who worked on the implementation and transition and the limited number of employees who temporarily relocated to Mississippi, CENTRA handled, and continues to handle, a portion of the implementation and transition through teleconferences with CENTRA staff located off-site, usually in Plano, Texas, and DFA and Blue Cross staff located in Jackson.

Documentation provided by DFA and CENTRA and interviews of DFA and CENTRA staff show that two lower-level business analysts have primarily served as CENTRA's day-to-day interface among CENTRA, DFA, and Blue Cross to effect the transition and implementation of systems and data from Blue Cross to CENTRA. While each of the employees reportedly has ten years' work experience in claims processing and operations, the business analyst who handled the major portion of the interface duties had been employed by CENTRA for only one year at the time CENTRA assigned her to perform a major role in the implementation and transition of DFA's contract. The business analyst with one year of CENTRA experience told PEER that she had been fully "empowered" by CENTRA managers to make necessary decisions regarding the implementation and transition.

Contrary to CENTRA's response to DFA's request for proposals, CENTRA never assigned Robert Franus, Assistant to the President, Special Projects, as account manager to DFA's account with the responsibility of making management-level decisions to effect the implementation and

transition. (Mr. Franus reportedly resigned from CENTRA after submission of the RFP response.)

Setting up a Mississippi office to perform all services--DFA's request for proposals document states that DFA "would prefer to contract with a firm who has offices in Mississippi." The RFP also asked proposers whether they would be willing to establish an office in the State of Mississippi. The RFP also questioned proposers as to what services would be provided in its Mississippi office.

At the time of responding to DFA's request for proposals, CENTRA did not have an office location and/or operation in the State of Mississippi. In its response to the RFP, CENTRA stated that it would establish an office in Jackson. On May 25, 1994, CENTRA leased space from The Home Insurance Company for offices located at 1080 River Oaks Drive, Jackson, Mississippi. CENTRA then had approximately one month to finalize logistics of equipping, supplying, and staffing its office prior to the July 1, 1994, effective date of its contract with DFA.

CENTRA also stated in its response to DFA's request for proposals that "all services would be performed" in its Jackson office. While CENTRA did not define the term "all" in its response, the company has since only located its claims adjudication function for the Plans in its Jackson office. Other services, such as computer systems/programming, medical review, and explanation of benefits processing/mailing, are handled at out-of-state locations. Exhibit 2, page 8, illustrates how CENTRA's Jackson office is but one of five locations in four different states through which a claim must flow during processing. CENTRA contends that DFA and Coopers & Lybrand had full knowledge of CENTRA's operational structure. However, a member of the Health Advisory Council or any other independent reader of CENTRA's response to the RFP could easily have concluded that CENTRA implied that its Jackson office would serve as the primary location for the processing of the Plans' claims.

Lack of adequate staffing--DFA's request for proposals document requested proposers to provide the total staff level of their proposed Mississippi claims offices. CENTRA stated that its Mississippi office would have a staff level of approximately 100 to 150 employees. CENTRA further stated that actual staffing required would be a function of the total number of enrolled employees and the overall claim submission rate. CENTRA's response also stated that a typical group of 80,000 enrolled employees required a staff of approximately 142 employees, with eighty of those being claims examiners and thirty being customer service representatives.

CENTRA became responsible for the Plans' 114,668 enrolled employees on July 1, 1994, and began its Jackson operations with seventy-five employees, twenty-five to seventy-five employees fewer than the proposed staffing profile contained in its response to DFA's request for proposals. CENTRA contends that it had no plans to have a fully staffed

office on July 1, but planned to be fully staffed by November 1994. As of November 30, 1994, CENTRA had 115 employees physically located in its Jackson office, with an additional forty employees in its Plano, Texas, and Lynwood, Washington, processing centers temporarily assigned to assist in processing Mississippi's claims. CENTRA contends that it has "staffed well beyond its expected requirements" and "...will be able to operate with less than the current staff level of 155 [115 Jackson employees and 40 employees located elsewhere]" once initial transition problems have been resolved.

Based on CENTRA's staffing profile in its response to the RFP, PEER computed that CENTRA should have at least 198 employees in its Jackson office to process claims for 114,668 enrolled employees. Again, using CENTRA's staffing profile, CENTRA should have at least 114 claims examiners located in its Jackson office. As of November 30, CENTRA had only thirty-six claims examiners physically located in its Jackson office, with an additional forty claims examiners located in Plano and Lynwood. Considering the seventy-six claims examiners CENTRA has located in all three locations processing DFA's claims, CENTRA still has thirty-eight fewer claims examiners than needed based on its own staffing profile.

CENTRA stated in its response to DFA's request for proposals that the claims submission rate would become a factor in staffing a proposed Jackson office. At the time of responding to the RFP, CENTRA assumed that each enrolled employee would file 7.1 health claims annually. After July 1, CENTRA determined that the average number of claims filed annually by each enrolled employee is approximately 14. Considering that the Plans' 114,668 enrolled employees constitute CENTRA's largest single group and that CENTRA is processing more claims per employee than expected, it is unreasonable for CENTRA managers to contend that they have overstaffed its Jackson office and could in fact eventually operate with fewer staff.

- *Certain aspects of the transition process did not progress in a timely manner because CENTRA and Blue Cross could not come to agreement over an indemnification from errors issue and the use of computerized data integrity edits.*

Claims administrators such as Blue Cross and CENTRA maintain enrollment and claims history data on plan participants in vast computer files. When a company or agency changes claims administrators, the previous claims administrator must transfer detailed computer files to the new contractor. Because of the complexity of the computer data, problems in the transfer of the data routinely occur. As a result, planning and the provision of sufficient time for transition is important. Cooperation of all parties involved, including the plan administrator and the previous and current claims administrators, can speed the transition process. Lack of

cooperation in an already complex procedure can greatly hinder the smooth transition of claims administration.

During the transfer of Mississippi's state employee and public school employee data, Blue Cross and CENTRA could not agree in a timely manner on several issues. The failure to agree on two important issues delayed information transfer between Blue Cross and CENTRA. These information transfer problems delayed processing of claims during the latter half of 1994.

Hold harmless agreements--Because the School Plan was a fully insured plan of Blue Cross prior to July 1, 1994, Blue Cross maintained the history files for the public school employees' claims and enrollment. On April 25, 1994, CENTRA requested copies of Blue Cross's computerized enrollment and claims information for participants in the Public School Plan. CENTRA requested the computerized information in an effort to avoid having to enter such information into its own computer system manually.

On April 28, a Blue Cross manager wrote CENTRA and requested a "hold harmless" agreement in return for release of the Public Schools enrollment and claims information to CENTRA. Because Blue Cross had underwritten the School Plan and the data records were not owned by the state (unlike data records for the State Employees' Plan, which the state owned), Blue Cross wanted to limit its liability in providing information which CENTRA would use in processing claims. Blue Cross wanted CENTRA to indemnify, or protect from loss and damage, and hold harmless Blue Cross for any damages and lawsuits filed against Blue Cross as a result of gross negligence on the part of CENTRA in using the confidential information. Blue Cross included the following language in the first draft of the hold harmless agreement:

> CENTRA will also accept full responsibility for any inaccurate information contained in the membership records of BCBSMS and will hold BCBSMS harmless and indemnify BCBSMS for any damages, lawsuits, judgments, expenses and attorney's fees incurred by BCBSMS as a result of CENTRA's use of the aforementioned membership records.

On May 2, 1994, CENTRA sent Blue Cross a revised agreement deleting the section quoted above. After continuing negotiations during May, Blue Cross finally agreed to delete the language cited above from the agreement. In return, CENTRA agreed to indemnify Blue Cross for lawsuits resulting from any type of negligence by CENTRA employees (not just gross negligence) and for lawsuits resulting from CENTRA's reliance on the information. The parties signed the final agreement on May 27, 1994.

After signing the hold harmless agreement and receiving the School Plan information from Blue Cross, CENTRA determined that the eligibility

files received from Blue Cross did not include information on three school districts. CENTRA requested additional computer files from Blue Cross on the school districts. Blue Cross required CENTRA to sign a second hold harmless agreement before releasing the information on the three schools to CENTRA.

Both CENTRA and Blue Cross perceived the need to negotiate a hold harmless agreement which would protect their legal positions. Because of the parties' inability or unwillingness to agree on appropriate language limiting liability to Blue Cross, the transition of data to CENTRA was delayed by at least a month. This delay reduced the time available to CENTRA for transition and therefore significantly affected CENTRA's ability to pay claims, primarily public schools claims, in a timely manner subsequent to July 1, 1994.

Release of Blue Cross's data edits--Blue Cross routinely receives data directly on-line from health care providers through a statewide computer network. Such data is processed through a series of edits to ensure that the data is accurate and properly coded to be handled by the appropriate computer application. As stated on page 7, Blue Cross operates a "Key Provider" network for the Plans. The processing of such claims requires CENTRA to code and transmit Key Provider claims electronically to Blue Cross for pricing before final processing by CENTRA. Blue Cross, as part of its routine processing procedures, subjected Key Provider claims coded and transmitted by CENTRA to its data integrity edits.

Prior to and after July 1, 1994, CENTRA concluded that Blue Cross's data integrity edits were not necessary for claims processing by CENTRA because they duplicated CENTRA's own edits and were causing some claims to be placed in a suspense status due to coding differences between CENTRA and Blue Cross. In early June, CENTRA asked Blue Cross to remove its data integrity edits from claims electronically transmitted by CENTRA. Following the initial request, CENTRA made several telephone requests asking Blue Cross to remove all data integrity edits from claims electronically transmitted by CENTRA, except those necessary for Blue Cross's pricing process. On July 11, 1994, DFA requested Blue Cross to remove its data integrity edits except those necessary for repricing. Despite CENTRA's and DFA's requests, Blue Cross continued to subject CENTRA's claims transmissions to data integrity edits. On August 3, 1994, a CENTRA vice-president requested in writing that Blue Cross remove its data integrity edits from CENTRA's claims transmissions. On August 11, one month after DFA's written request, Blue Cross requested DFA to agree in writing that Blue Cross would not be responsible for inaccurate claims payments occurring due to release of data integrity edits. On August 11, 1994, DFA wrote Blue Cross stating that DFA would not agree to absolve Blue Cross of "all responsibility for any inaccurate data" resulting from the removal of data integrity edits. Blue Cross removed the data integrity edits from CENTRA claims transmission on August 23. Due to CENTRA's and Blue Cross's inability to resolve the data integrity edits issue, claims were placed

in a suspense status and not processed for reimbursement due to data edit problems.

- *CENTRA's agreement to process run-out claims created an immediate backlog of approximately 10,000 health claims and contributed directly to future claims processing delays. The agreement also resulted in the Plans bearing an additional expense of approximately $66,000 which could have been avoided.*

DFA's request for proposals stated that all proposers should assume that Blue Cross would process "run-out" claims associated with both the State Employees' and Public School Employees' Plans. (In this case, "run-out" claims were hard-copy claims for services rendered prior to the end of Blue Cross's contract period, June 30, but processed after the expiration of that contract by either the previous or new third-party administrator.) Because the Public School Employees' Plan was an underwritten plan, Blue Cross would have already been responsible for processing such claims for that plan.

Subsequent to March 22, 1994, formal presentations for C&L, DFA, and Health Advisory Council members, C&L requested each of the three finalist proposers to commit to processing run-out claims if requested by DFA and to disclose the fees each would charge for processing such claims, although the RFP had stated that proposers should assume that Blue Cross would handle these claims as the former third-party administrator. Regarding processing of run-out claims for the State Employees' Plan, Blue Cross stated:

> *The SCHP* [State Comprehensive Health Plan] *and state employees are valued customers. Even if we were not successful in continuing our relationship, we would not want state employees to be disadvantaged by a poor transition. We pointed out in our oral presentation the potential for significant transition problems for employees in changing claims administrators (and probably benefits) in the middle of a benefit year. If another proposer is selected as claims administrator, we would want to ensure that a workable arrangement could exist to provide a smooth transition before committing to process run-out claims incurred prior to July 1, 1994.*

After awarding the third-party administrator contract to CENTRA, DFA requested CENTRA to administer the run-out claims. As evidenced by the final contract, CENTRA agree to process run-out claims for a fee of $7.05 each. Although the reasons for this request to CENTRA are not documented, DFA stated that the initial purpose of requesting prospective third-party administrators to process run-out claims had been to resolve bidding differences between the incumbent third-party administrator and other proposers. (Run-out claims and resulting costs would not have occurred if the incumbent third-party administrator had received the contract award.) DFA also contends that its decision was "for the

convenience of state employees" and to create an easier transfer of data between Blue Cross and CENTRA. DFA and C&L believed that a new third-party administrator would place more emphasis on and provide better service for the run-out claims than the incumbent third-party administrator, although Blue Cross had notified C&L and DFA that any mid-year transition and resulting run-out claims would create the "potential for significant transition problems."

CENTRA notified Blue Cross on May 17, 1994, to cease processing paper claims received after June 18, as CENTRA would process such claims. DFA's contract with CENTRA stipulated that CENTRA would process all claims received by Blue Cross on or after June 18, 1994, that had an incurred date of service prior to July 1, 1994, at $7.05 each.

On or about June 17, 1994, Blue Cross stated that there were approximately 500 run-out claims for the State Employees' Plan which were to be transferred to CENTRA. In reporting the estimate to DFA and CENTRA, Blue Cross only included claims it had already processed and held in a pended status. Blue Cross did not include or project the number of hard-copy claims received after June 17, 1994, that were to be transferred to CENTRA without further Blue Cross intervention. This miscommunication occurred due to the parties' differing interpretations of what constituted a run-out claim. Thus, after July 1, Blue Cross actually transmitted approximately 10,000 state employee hard-copy claims to CENTRA for processing. According to CENTRA, Blue Cross also transferred in error an additional 10,000 public schools run-out claims, which Blue Cross was still liable to process, creating additional claims processing problems for CENTRA.

CENTRA's agreement to process run-out claims created an immediate backlog and contributed directly to claims processing delays. During a critical phase of the transition, CENTRA immediately had to handle approximately 20,000 paper run-out claims. Of this 20,000 claims, CENTRA had to process 10,000 state employee claims which had accumulated and then were brought to CENTRA for processing. CENTRA also had to identify another 10,000 claims as being those of public school employees and return them to Blue Cross.

DFA's arrangement for paying CENTRA to process run-out claims cost the state at least an additional $66,000. DFA had paid Blue Cross to process claims for enrolled employees for the full month of June 1994, but then asked Blue Cross to stop processing claims on June 17. When CENTRA began charging fees for processing on June 18, even though Blue Cross already had a contractual obligation to process all claims through June 30, this in effect created a double payment situation. As of November 28, 1994, CENTRA had processed 78,800 run-out claims, at an approximate total cost to the state of $555,540, which includes the $66,000 "double payment" amount.

Given the routine difficulties associated with any transition of this magnitude, DFA's decision to allow Blue Cross to cease processing hard-copy claims prior to the end of its contract and to allow such claims to accumulate for processing by the new third-party administrator must be questioned.

- *CENTRA did not develop a master data conversion plan to guide its transition process. As a result, CENTRA and Blue Cross did not resolve major data transmission and claims processing problems prior to July 1, the effective date of DFA's contract with CENTRA, and are continuing to attempt to resolve such problems.*

After being awarded the third-party administrator contract, CENTRA's major task was effecting the transfer of a mass of historical computerized data from Blue Cross's computer system to CENTRA's. Given the number of enrolled employees covered by the Plans (over 114,000), the data transfer issue was one which should not have been underestimated or poorly planned.

CENTRA began the data transfer process by meeting with DFA staff and Blue Cross representatives on April 6, 1994, to discuss data needs. The process continued over ensuing weeks through personal meetings and teleconferences. Through these contacts, CENTRA requested from Blue Cross copies of computerized data and its supporting documentation.

CENTRA and Blue Cross have had difficulty resolving numerous data transfer and claims processing problems during the transition period. As a result, CENTRA has not been able to process all claims in an accurate and timely manner since the effective date of its contract, July 1. CENTRA, Blue Cross, and DFA continue to attempt to resolve data transfer and claims processing problems on a weekly basis, primarily through teleconferences. Theoretically, the types of problems being addressed by the three entities (problems with data transfer, repricing, pended claims) should not be occurring in work for a contract which has been operational for more than six months.

Data transfer--CENTRA has encountered difficulty in interpreting or obtaining computer information from Blue Cross.

- CENTRA had to reformat employee eligibility files received from Blue Cross for its computer system.

- The original computer tapes Blue Cross provided to CENTRA did not include complete hospital and physician data. As a result, CENTRA paid some claims directly to participants rather than Key Provider hospitals and pharmacies, in conflict with Key Provider contracts.

- Due to a failure to interpret employee status information contained on Blue Cross's computer files properly, CENTRA did not issue pharmacy identification cards to all enrolled employees.

Repricing--Blue Cross, in order to protect the proprietary nature of its data, will not allow CENTRA to apply directly Blue Cross's negotiated "Key Physician" network discounts (i.e., to reprice) to claims. Although other networks in the state health plan reportedly intend to allow CENTRA to "reprice" for them, Blue Cross has insisted, as it has historically insisted, on applying the confidential discounts in its own computer network before transferring the claims to CENTRA's computer system for payment. However, CENTRA's and Blue Cross's computer systems have yet to interface properly, as illustrated in the following examples:

- Due to an undefined incompatibility problem, CENTRA's computer system could not periodically transfer claims containing all of the data codes necessary for Blue Cross's computer system to reprice the claims and transmit them back to CENTRA.

- Data integrity edits in Blue Cross's computer system rejected claims submitted from CENTRA. Although DFA and CENTRA requested Blue Cross to remove the edits, since CENTRA's system already performed similar edits, Blue Cross continued to do so from July 1 to August 23, 1994. (See page 31 for additional discussion of this issue.)

- CENTRA incorrectly loaded hospital and physician identification numbers provided by Blue Cross into its computer system. As a result, CENTRA paid some claims directly to participants rather than Key Provider hospitals and pharmacies, in conflict with Key Provider contracts.

- Various problems, such as Blue Cross's inability to use certain revenue codes and disagreement on proper data submission forms, continue to impair Blue Cross's ability to reprice certain claims transmitted by CENTRA, contributing to nearly $6.9 million in unpaid claims held in suspense as of January 10, 1995.

Pended claims--Blue Cross's computer system has rejected and placed in a suspense ("pended") status many claims submitted from CENTRA for various reasons. Rather than studying and resolving such problems with individual claims and/or manually adjudicating such claims, CENTRA has repeatedly resubmitted the claims electronically to Blue Cross, contributing to the significant number of claims which have not being adjudicated at all, even though participants are waiting to receive reimbursement checks for the claims.

In November 1994, four months after the contract became operational and after CENTRA had experienced many processing difficulties, DFA

requested C&L to review a portion of the original computer data sent to CENTRA by Blue Cross. In its report on the transition data issue, C&L made the following conclusion:

> It is the opinion of Coopers & Lybrand L.L.P. that there were problems in the data provided by BCBS of Mississippi [Blue Cross] to CENTRA during the transition implementation. While none of these problems in and of itself were insurmountable, the problems related to the data, including data format, along with the timeliness in which the data tapes were provided (as noted in our prior report), contributed directly to the claims payment problems experienced by CENTRA.

The work performed by C&L on DFA's behalf focused only on a very limited portion of data received by CENTRA from Blue Cross--three of twenty-five computer tapes. C&L's report does not state that the consultants specifically reviewed CENTRA's general receipt and handling of computerized data from Blue Cross. Therefore, C&L's report should not be viewed as an exhaustive commentary on the data transition issues involving DFA's current and former third-party administrators.

Data transmission problems inarguably occurred. However, at this point in the contract, assigning blame for those problems is difficult due to a lack of objective documentation maintained by the parties involved. The major cause of the data transmission problems experienced by CENTRA is that DFA did not require CENTRA to develop or adhere to a master data conversion plan throughout the data transfer process. Such a plan should have been developed and agreed upon by all parties involved before CENTRA began any transition work, considering the number of participants involved and the fact that a majority of those were converting from the insured public school plan. A data conversion plan would have logically organized the type of data available, the type of data needed, and the time frame in which the data was needed. The plan could have also required a commitment on the part of DFA and Blue Cross to provide such data in an unfettered and timely manner.

- *CENTRA's and DFA's lack of communication regarding plan benefits/coverage and DFA's failure to address public school employees' carryover deductible credit properly have slowed claims processing and created confusion among plan participants.*

Because decisions relating to the adjudication of every possible type of health claim cannot be included in a claims booklet or in a contract, those decisions must be made in the daily process of adjudicating a claim. The plan administrator (e.g., DFA) either accepts responsibility for and instructs its claims administrator on those detailed decisions or assigns those decisions to the third-party administrator. Blue Cross, a not-for-profit corporation which provides fully insured services, made those decisions when it was DFA's claims administrator. When DFA awarded the contract to CENTRA, which is a third-party administrator and not an

insurance company, DFA accepted the responsibility of relaying to CENTRA its decisions on detailed benefit coverage. As evidenced by the multitude of complaints received by CENTRA, DFA, and others, confusion has arisen over the understanding and application of plan benefits and coverage. This confusion resulted primarily from a lack of communication regarding plan benefits/coverage and DFA's failure to address public school employees' carryover deductible credit properly.

CENTRA's and DFA's lack of communication regarding plan benefits/coverage--After receiving the third-party administrator contract on April 4, 1994, CENTRA staff met on April 5 and 6 with DFA staff to complete a very lengthy installation document. The installation document is a generic, "fill in the blank" document designed to record the various characteristics and benefits of a client's health plan. In addition to the installation document, CENTRA referred to DFA's plan benefits booklet (which is provided to plan participants) and DFA's previous contract with Blue Cross. DFA intended to provide the same benefits during the FY 1995 plan year that Blue Cross had provided prior to the transition. Subsequent to the early April meetings, DFA staff routinely communicated in person and by telephone with CENTRA staff to clarify coverage issues and discuss Blue Cross's previous payment of benefits.

As of November 22, 1994, CENTRA had implemented and/or re-programmed its computers to accommodate at least twenty-seven changes affecting claims processing. The reasons for the changes vary, but most were necessary for the following reasons.

- DFA did not fully understand how Blue Cross had previously administered and paid certain benefits of the plan. For several changes, DFA staff consulted with former Blue Cross employees currently employed by CENTRA to determine how Blue Cross had paid such benefits so they could instruct CENTRA on how to pay those benefits.

- CENTRA did not fully understand how DFA intended certain benefits to be paid and could not program its computers accordingly.

- DFA administratively changed how certain benefits would be paid after initially instructing CENTRA how to pay those benefits.

- CENTRA did not fully and accurately analyze the benefits booklet and previous Blue Cross contract provided by DFA and program its computers accordingly.

Most of the needed changes occurred after DFA and/or CENTRA received complaints that claims were not adjudicated the same manner that they had been under Blue Cross. All of the changes caused, to some degree, delays which prevented CENTRA from processing claims in a timely manner.

Had DFA provided CENTRA with a comprehensive master benefit plan document (which did not exist in early January 1995) prior to the transition process beginning in April 1994 and had CENTRA provided DFA with a complete and formal document illustrating CENTRA's understanding and application of all plan benefits, most plan changes could have been avoided and participants could have been spared processing problems and delays.

DFA's failure to address public school employees' carryover deductible credit properly--As stated throughout this report, the Public School Employees' Plan was a fully underwritten plan of Blue Cross through a contract with DFA. Legislative intent was that benefits of the public school plan would be the same as those of the state employees' plan. CENTRA's transition difficulties proved that the benefits of the two plans were not the same.

After loading all of Blue Cross's claims history in its computer system and receiving complaints from School Plan participants, CENTRA discovered that public schools employees' previous fully underwritten plan insured by Blue Cross allowed a deductible carryover from the end of the prior calendar year. A deductible carryover is defined as any covered services incurred during the calendar months of October, November and December which were applied toward the deductible amount of that benefit period, but did not satisfy the deductible amount, which may be applied to the deductible amount for the next succeeding calendar year.

In mid- to late July of 1994, CENTRA and DFA began receiving complaints from public school employees that CENTRA was not honoring carryover deductibles accumulated by such employees when they had been previously insured by Blue Cross. CENTRA's claims processing procedures required all plan participants to begin accumulation of their deductibles as of January 1, 1994. The Benefits Director of DFA's Office of Insurance researched the issue and compiled an August 2, 1994, memorandum which concluded the following regarding carryover deductibles for the School Plan.

> Although I do not recall any specific conversation regarding deductible roll-over credit, our goal in original contract negotiations with Blue Cross/Blue Shield was to mirror the State Employees' Health Insurance Plan (SEHIP) to the extent possible. Deductible roll-over credit is not allowed in the SEHIP.
>
> I have carefully reviewed both the PSEHIP [School Plan] contract between BCBS [Blue Cross] and DFA and the Employee Membership Certificate and find no clause stipulating a benefit of deductible credit roll-over in either document. [Emphasis added.]

DFA instructed CENTRA to not take any carryover deductibles on claims received in the future. DFA's and CENTRA's resolution of the carryover

deductible issue resulted in "many angry people questioning why CENTRA's EOBs [explanation of benefits] did not reflect the same numbers that BCBS [Blue Cross] did."

During this investigation, PEER reviewed DFA's previous School Plan contract with Blue Cross and determined that the contract described the carryover deductible as a benefit, as follows:

> Any Covered Services incurred during the calendar months of October, November and December which were applied toward the Deductible Amount, for that Benefit Period, but did not satisfy the Deductible Amount, may be applied to the Deductible Amount for the next succeeding calendar year.

Benefit brochures distributed to public school employees at the time the plan began also described the carryover deductible as a benefit of the plan. DFA staff acknowledged to PEER that they had 'overlooked' the carryover deductible provision in the contract. DFA's incorrect understanding of the carryover deductible issue directly contributed to countless telephone calls received from CENTRA by disgruntled public school employees.

Despite the fact that the benefits of the insured public schools plan did not mirror the benefits of the self-funded state employees' plan as intended by the Legislature, DFA was not fully aware of the benefits of the public school plan. As a result, DFA did not properly plan for and handle at least one important transition issue, the carryover deductible matter, when changing third-party administrators. At the very least, DFA should have been knowledgeable of the carryover deductible matter and notified public school employees that the benefit would not be applicable after July 1, 1994. Such a notification probably would have spared CENTRA a significant number of telephone calls from irate public school employees.

- *DFA's decision to have CENTRA handle telephone calls regarding provider networks (and CENTRA's agreement to handle such calls) congested the third-party administrator's telephone system and detracted from claims processing during a critical transition period.*

As stated in this report, DFA decided to develop and offer to Plan participants health care networks designed to decrease claims costs to the Plans. Networks promote savings not only to the Plans but also to participants through lower deductibles ($250 rather than $500) and higher benefits ratio (85%/15% rather than 80%/20%).

In late August, DFA sought to re-enroll Plan participants in the new health care networks. In an effort to educate Plan participants, DFA made several formal presentations throughout the state and provided a summary information booklet entitled *New Health Benefit Options* to each participant. Participants were to use the information available to determine the network

which best suited their health care needs. In *New Health Benefit Options*, DFA informs the reader:

> *If you have further questions after reading this brochure and the network materials, please call 1-800-948-6008* [the toll-free number for CENTRA Benefit Services].

Although there is no mention of network customer service responsibility in DFA's third-party administrator RFP or contract, DFA informed CENTRA (after it received the third-party administrator contract) that it should be the focal point for communications regarding the provider network options. In order to assist CENTRA's customer staff in answering inquiries regarding networks, DFA conducted two ninety-minute training presentations, which did not involve representatives of network providers. DFA instructed CENTRA staff to provide explanatory information only regarding the networks and avoid assisting callers in selecting a particular network option.

Because the toll-free telephone number listed in DFA's *New Health Benefit Options* belongs to CENTRA, the third-party administrator began receiving numerous telephone calls as soon as DFA's re-enrollment efforts began. According to CENTRA staff, approximately sixty percent of all telephone calls received during September and October 1994 were related to networks. The sudden influx of network-related telephone calls impeded CENTRA's ability to handle other telephone calls relating to claims processing. At one point, CENTRA's telephone system was literally incapacitated.

During the request for proposals process, DFA handled the third-party administrator and health care networks contracts as separate endeavors. Once the contracts for each had been awarded, DFA combined the endeavors, to a degree, by requiring its new third-party administrator to function as a clearinghouse for network option inquiries. DFA had at least two other methods available for handling network telephone calls instead of requesting CENTRA to handle such calls. DFA could have made its Office of Insurance the focal point for participants who needed assistance in understanding network options. Theoretically, Office of Insurance staff had more first-hand knowledge of networks since they had worked directly with health care providers in developing such networks. DFA also could have instructed participants to direct network option questions to the networks themselves. In the *New Health Benefit Options*, DFA provides the telephone numbers to the respective networks, yet refers readers to CENTRA's toll-free number. According to DFA staff, they had feared undue influence of networks on a participant's choice of networks if networks had handled inquiries. DFA informed state employees that networks individually would forward applicable information to employees necessary for selecting a network. However, if DFA had provided complete and thorough information to employees in one packet of information,

employees would have had fewer questions and fewer reasons to telephone CENTRA.

In summary, DFA's decision to have CENTRA handle telephone calls regarding networks (and CENTRA's agreement to handle such calls) congested the third-party administrator's telephone system and detracted from claims processing during a critical transition period. DFA's decision to have CENTRA handle network inquiries created an untenable situation which could have been avoided with better foresight and planning.

Recommendations

Appendix B, page 46, contains proposed legislation to accomplish the following legislative recommendations:

1. The Legislature should adopt a joint resolution creating a legislative oversight committee to meet with the Governor, DFA Executive Director, and relevant parties to effect resolution of the claims processing delays within thirty days. The resolution should require the joint committee to determine whether the Legislature should enact an assignment clause for assignments of benefits to a health-care provider which would be binding on the insurer; whether state law should exempt Blue Cross Blue Shield from Mississippi's laws regulating the insurance industry; and whether the state has a reasonable alternative to using the Blue Cross network for repricing.

   Specifically, the joint committee should determine if Blue Cross should sign an agreement with CENTRA to provide CENTRA with proprietary repricing information which CENTRA would agree to keep confidential.

   The joint committee should further determine whether CENTRA is aggressively pursuing resolution and payment of pending insurance claims and whether the Department of Finance and Administration should continue its contract with CENTRA as State Plan Administrator.

   See Appendix C, page 59, for a proposed joint resolution for a legislative oversight committee to seek resolution of claims processing delays in the state insurance plans.

2. The Legislature should require the Department of Finance and Administration to contract with a third-party administrator on a calendar-year basis (January 1-December 31) notwithstanding terminations which may be necessary during the calendar year.

3. The Legislature should require the Department of Finance and Administration to disclose proposed health plan changes fully and to educate state and public school employees on the changes. DFA should publicize the changes in both summary and detail form to all employees in a timely manner to permit informed decision-making. For instance, DFA should provide detailed and complete information packets to each employee four to six weeks in advance of a deadline for choosing a network. DFA should publicize major changes through the use of public service announcements in print, radio, television, and through state-owned media.

4. The Legislature should require DFA to prepare for a minimum of six months' transition time between third-party administrator contracts. The transition period should be defined as the period beginning at the date of the award and ending at the effective date of the new contract.

5. The Legislature should require DFA to develop a comprehensive transition plan when preparing for transition to a new third-party administrator. Upon contracting with a new third-party administrator, DFA should be required to update and implement the transition plan to ensure the orderly transition of responsibility and records from the current third-party administrator to the new third-party administrator. The transition plan should include detailed responsibilities and tasks of DFA, the current administrator, and the new administrator, to include deadlines for each task. The department also should include transition requirements within the terms of the third-party administrator request for proposal and contract.

6. The Legislature should require the DFA's Office of Insurance to follow a specific process for contracting out third-party administrator services and other professional services.

   This process should consist of:

   a. Specific request for proposal requirements and criteria upon which bidders will be evaluated. (Such criteria shall not include questions and answers. While questions may be utilized to elicit information, specific criteria should be stated in order to prevent misinformation);

   b. Internal review by DFA personnel with respect to bids received;

   c. Written contracts with all contractors; and,

   d. Agency review of contractors.

   In the event of a documented emergency, the Legislature should allow DFA to retain the services of a third-party administrator without using a competitive bid process.

7. The Legislature should require the PEER Committee to hire, from funds specifically appropriated by the Legislature for this purpose, an independent contractor to audit and review on an annual basis the third-party administrator's compliance with performance standards contained in the contract.

8. The Legislature should require the Department of Finance and Administration to develop a strategic plan for the state and public

school employees' health plans. This plan should detail major directions and foreseeable problems with the plan, including dates for required actions (i.e., rebidding of contracts). All areas within reason should be addressed prior to issuance of a request for proposal. This should be a continuous process performed by the DFA. As a part of the strategic plan, DFA should:

- *utilize market research methods (such as focus groups, questionnaires, attitudinal surveys, and Likert scales) to determine group member needs and preferences prior to implementation of proposed plan changes.* After determining the needs and preferences of the plans' beneficiaries, DFA should incorporate the research results into the administration of the plans. In performing the market research, DFA should determine if plan members prefer a simplified health plan without options or a more complex plan with multiple options which may result in savings to plan participants. For example, if less than 5% of beneficiaries desire a network option, DFA should consider not utilizing this option.

- *develop a comprehensive plan benefits document listing all benefits eligible for coverage under the state and public school employees' health insurance plans.* DFA should be required to maintain an updated version of the benefits document in typewritten form at DFA offices available for public inspection and ensure that the third-party administrator maintains an identical version at its offices.

The Legislature should also require DFA to report to each house on an annual basis regarding the state and public school employees' health plans.

9. The Legislature should require DFA to include performance standards regarding pended claims in its third-party administrator contracts.

10. The Legislature should review the provisions common to the two health insurance plans and consolidate the two plans in law by January 1, 1997.

Appendix A

DFA's Office of Insurance Customer Service Calls Summary
(September through December 1994)

CENTRA Inquiry Category	Inquiries	
	Number	**Percentage**
Deductible/Claims/Enrollment History Not Transferred Correctly	142	7.67%
Initial Contact Problems	149	8.05%
Delay Claim Payment	364	19.67%
Blue Cross Re-pricing Causing Delay	87	4.70%
Claim Not On File/Excessive Refiling	86	4.65%
Incorrect Address	58	3.13%
Never Received ID Cards	64	3.46%
Coordination of Benefits/Medicare Secondary	76	4.11%
Deducting Incorrect Amount from Retirement Check	96	5.19%
Diagnosis or not Recognizing Secondary Diagnosis	26	1.40%
Health Care Excellence (Medical Utilization Review)	52	2.81%
Code Review	50	2.70%
Program Errors/Denying Eligible Claims	42	2.27%
Duplicate Payment on Pharmacy	10	0.54%
Direction of Pay (Provider vs. Employee)	20	1.08%
General Complaints	286	15.45%
Delay in Receiving COBRA Notices	50	2.70%
Incorrect Effective Date/Checking Pre-Existing	31	1.67%
Medicare Review Pend/Untimely Response	21	1.13%
Explain CENTRA EOB	6	0.32%
Agency Invoice Incorrect	43	2.32%
Accident Related/Posted by CY Deductible	13	0.70%
Claim Paid Incorrectly	51	2.76%
Claim Paid/Payment Not Received	15	0.81%
Membership/Enrollment Incorrect	10	0.54%
Duplicate Hospital/Physician Claim Paid	3	0.16%
Totals	**1851**	**100.00%**

Inquiries shown represent those received by DFA regarding CENTRA only.

SOURCE: PEER analysis of information from DFA's Office of Insurance.

Appendix B

Proposed Legislation to Improve Administrative Processes for Selection of and Transition to a Third-Party Administrator

Mississippi Legislature Regular Session, 1995

BY:

BILL

AN ACT TO ESTABLISH A PROCESS FOR THE SELECTION OF THIRD-PARTY ADMINISTRATORS FOR STATE EMPLOYEES' AND PUBLIC SCHOOL EMPLOYEES' HEALTH INSURANCE PLANS BY THE DEPARTMENT OF FINANCE AND ADMINISTRATION; TO REQUIRE THE PEER COMMITTEE TO CONDUCT COMPLIANCE AUDITS OF THE ADMINISTRATORS' COMPLIANCE WITH CONTRACT PERFORMANCE STANDARDS WHEN THE LEGISLATURE SPECIFICALLY APPROPRIATES FUNDS FOR SUCH; TO AMEND SECTION 25-15-5, MISSISSIPPI CODE OF 1972, TO REQUIRE THE DEPARTMENT TO FOLLOW CERTAIN PLANNING PROCEDURES WITH RESPECT TO CHANGES IN THE INSURANCE PLANS; TO AMEND SECTIONS 25-15-9, 25-15-11, AND 25-15-255 IN CONFORMITY THERETO; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

Section 1. (1) Whenever the Department of Finance and Administration chooses to contract with an administrator for the insurance plans established by Sections 25-15-3 et. seq, and 25-15-251 et. seq, it shall comply with the procedures set forth in this section:

(a) In the event that the department determines that it should contract out the administration of the plans to an administrator, it shall cause to be prepared a request for proposals. This request for proposals shall be prepared for distribution to any interested party. Notice of the department's intention to seek proposals should be published in a newspaper of general circulation at least one time per week for three weeks prior to closing the period for interested parties to respond. Additional forms of notice may also be used. The newspaper notice shall inform the interested parties of the service to be contracted, existence of a request for proposals, how it can be obtained, when a proposal must be submitted, and to whom the proposal must be submitted. All requests for proposals should clearly describe what service is to be contracted, and shall fully explain the criteria that an evaluation of proposals will be based upon. The criteria to be used for evaluations shall, at minimum, include:

(i) The insurer's proven ability to handle large group accident and health insurance plans,
(ii) the efficiency of the insurer's claims-paying procedures,
(iii) an estimate of the total charges for administering the plans.

(b) All proposals submitted by interested parties shall be evaluated by an internal review committee which shall apply the same criteria to all proposals when conducting an evaluation. The committee shall consist of at least three members of the department staff. The results and recommendations of the evaluation shall be presented to the Executive Director of the department for review. All evaluations presented to the department shall be retained by the department for at least three years. The department may accept or reject any recommendation of the review committee, or it may conduct further inquiry into the proposals. Any further inquiry should be clearly documented and all methods and recommendations shall be retained by the department.

(c) (i)The department shall be responsible for preparing a contract which shall be in accordance with all provisions of this act and all other provisions of law. The contract shall also include a requirement that the contractor shall consent to an evaluation of his performance. Such evaluation shall occur after the first six months of the contract, and shall be followed up upon at times the department shall determine to be necessary. The contract shall clearly describe the standards upon which the contractor shall be evaluated. Evaluations shall include, but not be limited to, efficiency in claims processing, including the processing of pended claims.

(ii) The PEER Committee shall, from funds specifically appropriated annually for this purpose, contract with an accounting firm or with other professionals to conduct a compliance audit of any administrator responsible for administering either or both insurance plans established by Sections 25-15-3 et. seq, and 25-15-251 et. seq. Such audit shall review the administrator's compliance with the performance standards required for inclusion in the administrator's contract. Such audit shall be performed annually, and delivered to the Legislature no later than January 1 of each calendar year.

(2) Contracts for the administration of the insurance plans established in Sections 25-15-3 et. seq, and 25-15-251 et. seq, shall commence at the beginning of the calendar year and shall end on the last day of a calendar year. This shall not apply to contracts provided for in sub-section 3 of this section.

(3) In the event that the Department determines that it is necessary to not renew the contract of an administrator, or finds it necessary to terminate a contract with or without cause as provided for in the contract of the administrator, the department is hereby authorized to select an administrator without complying with the bid requirements in subsections 1 and 2 of this section. Such contracts shall be for the balance of the calendar year in which the non-renewal or termination occurred, and may be for an additional calendar year if the department determines that the best interests of the plan members are served by such.

(4) Except for contracts executed under the authority of sub-section 3 of this section, the department shall select administrators at least six months prior to the expiration of the current administrator's contract. The period between the selection of the new administrator and the effective date of the new contract shall be known as the transition period. Whenever the newly selected administrator is an entity different from the entity performing the administrator's function, it shall be the duty of the department to prepare a detailed transition plan which shall insure the orderly transfer of responsibilities between administrators. This plan shall be effective during the transition period, and shall include, but not be limited to, provisions regarding the transfer of records, files, and tapes. Further, the plan shall detail the steps necessary to transfer records and responsibilities and set deadlines for when such steps should be completed. The department shall include in all requests for proposals, contracts with administrators, and all other contracts provisions requiring the cooperation of administrators and contractors in any future transition of responsibilities, and their cooperation with the department and other contractors with respect to ongoing coordination and delivery of health plan services. The department shall keep the Legislature, Governor, and Advisory Committee informed of all transition plans and progress.

Section 2. Section 25-15-5, Mississippi Code of 1972, is amended as follows:

§ 25–15–5. ~~Powers of~~ board.

Department

(1) ~~The board~~ is hereby empowered and authorized to administer the plan for the employees of the State of Mississippi and to adopt and promulgate rules and regulations for its administration, subject to the terms and limitations contained in this article. ~~The board~~ shall employ, subject to the rules and regulations of the State Personnel Board, such personnel as may be needed to carry out the provisions of this article.

Department

(2) It shall be the further duty of the ~~board~~ to survey and make an inventory of all existing contracts and the cost of premiums for fire insurance, automobile insurance, casualty insurance, workmen's compensation insurance and liability insurance covering the property and/or employees of all state agencies, institutions, political subdivisions and local governing authorities in the State of Mississippi. The ~~board~~ shall consider the fiscal effect of the removal of the requirement that all public insurance contracts be subject to competitive bidding procedures and shall make a recommendation thereon to the Legislature during the 1986 Regular Session. The ~~board~~ shall also consider the fiscal effect of the removal of the doctrine of sovereign immunity as it relates to insurance requirements of the various governmental entities of the state. The ~~board~~ shall consider the feasibility and cost-effectiveness of the State of Mississippi becoming a self-insurer for all types of insurance on state properties and employees, and shall make a recommendation thereon to the Legislature during the 1986 Regular Session.

~~SOURCES: Codes, 1942, § 8834-133; Laws, 1971, ch. 523, § 3; 1984, ch. 488, § 144; 1985, ch. 525, § 33, eff from and after July 1, 1985 (See Editor's Note below).~~

(3) The department shall develop a strategic plan for the insurance plans established by Sections 25-15-3 et. seq, and 25-15-251 et. seq. The strategic plan should address, but not be limited to:

(a) changing trends in the health care industry, and how they effect delivery of services to members of the plans,
(b) alternative service delivery systems,
(c) any foreseeable problems with the present system of delivering and administering health care benefits in Mississippi,
(d) the development of options and recommendations for changes in the plan.

(4) To carry out the requirements of subsection (3) of this section, the department shall:

(a) Conduct formal research including questionnaires and attitudinal surveys of members' needs and preferences with respect to service delivery,
(b) Determine whether members of the plans would prefer a simplified plan without options or a more complex plan with multiple options for services.

(5) After the Department has complied with all provisions of Sections 25-15-9 and 25-15-255 regarding the establishment of the plans, it shall be responsible for fully disclosing to plan members the provisions of the plan. Such disclosure shall consist of the dissemination of educational material on the plan and any proposed changes thereto. The department shall provide members with complete educational materials at least thirty (30) days prior to the date upon which the plans' members must select a plan option for health care services. The department should further use the resources of the Mississippi Authority for Educational Television to provide information on proposed changes. The department may also use other state-owned media, as well as public service announcements on private media, to disseminate information regarding proposed changes in the plan.

(6) The department shall develop and make available for public review at its offices a comprehensive plan document which documents all benefits for which members of the plans created by Section 25-15-3 et. seq, and 25-15-251 et. seq are eligible. This document shall be typed and maintained also at the offices of any administrator contracted with in accordance with Section 1 of this act.

(7) (a) The department is further authorized to enter into contracts with accountants, actuaries, and other persons whose skills are necessary to carry out the purposes of this act.

(b) Prior to entering into any contract for services mentioned in paragraph (a) of this sub-section, the department shall first conduct a needs assessment. This needs assessment shall consist of a review of the department's requirements for services, and the relative experience and background of department staff, and other personnel of state agencies who might be competent to render the same services to the department. If the department determines that the services are required, and that staff and other personnel of agencies are not sufficiently experienced to provide the services, the department may enter into contracts with qualified persons to render the service.

(c) In the event that the service is to be rendered for a period of in excess of six months, the department shall seek and obtain bids for the service in a manner identical to that provided for in Section 1, sub-section 1 (a) and (b) of this act, except for those provisions which specifically state criteria which are applicable only to third-party administrators contracted with in accordance with this act.

(d) The department is also authorized to procure legal services if it deems these services to be necessary to carry out its responsibilities under this act.

Section 3. Section 25-15-9, Mississippi Code of 1972, is amended as follows:

§ 25-15-9. ~~Formulation of state employees health insurance plan; benefits.~~

(1)(a) The department shall design a plan of health insurance for state employees which provides benefits for semi-private rooms in addition to other incidental coverages which the department deems necessary. The amount of the coverages shall be in such reasonable amount as may be determined by the department to be adequate, after due consideration of current health costs in Mississippi. The plan shall also include major medical benefits in such amounts as the department shall determine. The department is also authorized to accept bids for such alternate coverage and optional benefits as the department shall deem proper. The department may employ or contract for such consulting or actuarial services as may be necessary to formulate the State Employees Health Insurance Plan, and to assist the department in the preparation of specifications and in the process of advertising for the bids for the plan. The department is authorized to promulgate rules and regulations to implement the provisions of this subsection.

The department shall develop plans for the insurance plan authorized by this section in accordance with the provisions of Section 2 of this act.

(b) There is hereby created an advisory council which shall serve in a purely advisory capacity to advise the department in the formulation of the State Employees Health Insurance Plan. The council shall be composed of the State Insurance Commissioner or his designee, an employee-representative of the institutions of higher learning appointed by the board of trustees thereof, an employee-representative of the Department of Transportation appointed by the director thereof, an employee-representative of the State Tax Commission appointed by the Commissioner of Revenue, an employee-representative of the Mississippi Department of Health appointed by the State Health Officer, an employee-representative of the Mississippi Department of Corrections appointed by the Commissioner of Corrections, and an employee-representative of the Department of Human Services appointed by the Executive Director of Human Services.

The Lieutenant Governor may designate the Secretary of the Senate, the Chairman of the Senate Appropriations Committee and the Chairman of the Senate Insurance Committee, and the Speaker of the House of Representatives may designate the Clerk of the House, the Chairman of the House Appropriations Committee and the Chairman of the House Insurance Committee, to attend any meeting of the State Employees Insurance Advisory Council. The appointing authorities may designate an alternate member from their respective houses to serve when the regular designee is unable to attend such meetings of the council. Such designees shall have no jurisdiction or vote on any matter within the jurisdiction of the council. For attending meetings of the council, such legislators shall receive per diem and expenses which shall be paid from the contingent expense funds of their respective houses in the same amounts as provided for committee meetings when the Legislature is not in session; however, no per diem and expenses for attending meetings of the council will be paid while the Legislature is in session. No per diem and expenses will be paid except for attending meetings of the council without prior approval of the proper committee in their respective houses.

(c) Medical benefits for retired employees and dependents under age sixty-five (65) years. The same health insurance coverage as for all other active employees and their dependents shall be available to retired employees and all dependents under age sixty-five (65) years, the level of benefits to be the same level as for all other active participants. This section will apply to those employees who retire due to one hundred percent (100%) medical disability as well as those employees electing early retirement.

(d) Medical benefits for retired employees over age sixty-five (65) years; the health insurance coverage available to retired employees over age sixty-five (65) years, and all dependents over age sixty-five (65) years, shall be the major medical coverage with the lifetime maximum of One Million Dollars ($1,000,000.00). Benefits shall be reduced by Medicare benefits as though such Medicare benefits were the base plan.

All covered individuals shall be assumed to have full Medicare coverage, Parts A and B; and any Medicare payments under both Parts A and B shall be computed to reduce benefits payable under this plan.

(2) Nonduplication of benefits–reduction of benefits by Title XIX benefits: When benefits would be payable under more than one (1) group plan, benefits under those plans will be coordinated to the extent that the total benefits under all plans will not exceed the total expenses incurred.

Benefits for hospital or surgical or medical benefits shall be reduced by any similar benefits payable in accordance with Title XIX of the Social Security Act or under any amendments thereto, or any implementing legislation.

Benefits for hospital or surgical or medical benefits shall be reduced by any similar benefits payable by workers' compensation.

(3) Schedule of life insurance benefits–group term: The amount of term life insurance for each active employee shall not be in excess of Forty Thousand Dollars ($40,000.00), or the amount of the employee's annual wage to the next highest One Thousand Dollars ($1,000.00), whichever may be less, but in no case less than Fifteen Thousand Dollars ($15,000.00), with a like amount for accidental death and dismemberment on a twenty-four-hour basis. Life insurance amounts shall be adjusted upon the policy anniversary next following the earning adjustment. The plan will further contain a premium waiver provision if a covered employee becomes totally and permanently disabled prior to age sixty-five (65) years. Retired employees shall be eligible to continue life insurance coverage in an amount of Two Thousand Dollars ($2,000.00), Four Thousand Dollars ($4,000.00) or Ten Thousand Dollars ($10,000.00) into retirement.

(4) Any eligible employee who on March 1, 1971, was participating in a group life insurance program which has provisions different from those included herein and for which the State of Mississippi was paying a part of the premium may, at his discretion, continue to participate in such plan. Such employee shall pay in full all additional costs, if any, above the minimum program established by this article. Under no circumstances shall any individual who begins employment with the state after March 1, 1971, be eligible for the provisions of this paragraph.

(5) Any participant of the State Employees Health Insurance Plan who otherwise would lose coverage and who would be eligible as a dependent under an existing Public School Employees Health Insurance Plan contract may transfer to the Public School Employees Health Insurance Plan as a dependent under the existing contract. Any participant of the Public School Employees Health Insurance Plan who otherwise would lose coverage and who would be eligible as a dependent under an existing State Employees Health Insurance Plan contract may transfer to the State Employees Health Insurance Plan as a dependent under the existing contract. A transfer pursuant to this subsection must occur within thirty-one (31) days of losing coverage. Credit shall be given for any deductible amount satisfied, out-of-pocket expenses and timeserved toward the twelve-month pre-existing waiting period.

(6) If both spouses are eligible employees who participate in the plan, the benefits shall apply individually to each spouse by virtue of his or her participation in the plan. If those spouses also have one or more eligible dependents participating in the plan, the cost of their dependents shall be calculated at a special family plan rate. The cost for participation by the dependents shall be paid by the spouse who elects to carry such dependents under his or her coverage. The special family plan rate shall also apply if the state employee's spouse is a covered eligible employee under the Public School Employees Health Insurance Plan.

SOURCES: Laws, 1992, ch. 568 § 1; 1994, ch. 615, § 5, eff from and after July 1, 1994.

Section 4. Section 25-15-11, Mississippi Code of 1972, is amended as follows:

§ 25–15–11. Contracts of insurance; self insurance.

The department is hereby authorized to execute a contract or contracts to provide the benefits under the plan. Such contract or contracts may be executed with one or more corporations or associations licensed to transact life and accident and health insurance business in this state; however, no such contract shall be executed with any corporation, association or company domiciled in any other state except that such corporation, association or company shall meet the conditions and terms for a like contract established by the state of the domicile of such corporation, association or company for a Mississippi corporation, association or company. No corporation, association or company with less than five (5) years' experience in the life and health field may bid. All of the benefits to be provided under the plan may be included in one or more similar contracts, or the benefits may be classified into different types with each type included under one or more similar contracts issued by the same or different companies.

The department shall supply the statistical information upon which a quotation is to be calculated, upon request, to all carriers licensed in the state. Bids may be accepted at the discretion of the department, and the department shall have the right to adjust rates on an annual basis if the department shall deem such adjustment necessary. The plan for active employees shall be on retention accounting basis, and a separate retention accounting basis shall be used for retired employees. Any additional written information the carrier wishes to submit, supporting the proposed benefits and premium rate, may accompany the proposal. Within thirty (30) days after receiving the proposals, the department shall determine whether to contract with the carrier which has been determined to have submitted the lowest and best bid, or to reject all such bids and receive new proposals.

The department shall authorize any corporation licensed to transact accident and health insurance business in this state issuing any such contract to reinsure portions of such contract with any other such corporation which elected to be a reinsurer and is legally competent to enter into a reinsurance agreement. The department may designate one or more of such corporations as the administering corporation or corporations. Each employee who is covered under any such contract or contracts shall receive a certificate setting forth the benefits to which the employee is entitled thereunder, to whom such benefits shall be payable, to whom claims should be submitted, and summarizing the provisions of the contract principally affecting the employee. Such certificate shall be in lieu of the certificate which the corporation or corporations issuing such contract or contracts would otherwise issue.

The department may, as of the end of any contract year, discontinue any contract or contracts it has executed with any corporation or corporations and replace it or them with a contract or contracts in any other corporation or corporations meeting the requirements of this section.

The department, in its discretion, may reject any and all bids and contracts under this section and may elect for the state to become a self-insurer; however, administration and service of any such self-insured program may be contracted to a third party by the department.

Any contract with a third party to administer the plan shall be bid and entered into entered into in accordance with the procedures provided in Section 1 of this act.

The Department of Finance and Administration shall annually report to the Joint Legislative Budget Committee the condition of the State Employees Life and Health Insurance Plan. Such report shall contain, but not be limited to, a report of the plan's financial condition at the close of the most recent complete calendar year. The report shall also include all recommendations made to the department by consultants regarding the plan and its administration, including a complete departmental response to each recommendation. The department shall also list the history of yearly claims paid and premiums received for each employee subgroup, including, but not limited to, active employees, dependents and retirees, and shall also publish the loss ratios for these subgroups. For purposes of this section, the term "loss ratios" shall mean claims paid by the plan for each subgroup divided by premiums received by the plan for insurance coverage of the members in that subgroup. Any plan revisions made during the previous year shall also be listed in the report and fully described in the report.

Annually, the Department of Finance and Administration shall request, and the Department of Audit shall conduct, a comprehensive audit of the State Employees Life and Health Insurance Plan. For purposes of this section, the audit required herein shall be separate and distinct from any audit prepared in conjunction with the development of the Comprehensive Annual Financial Report (CAFR).

SOURCES: Laws, 1992, ch. 568 § 3; 1994, ch. 615, § 6, eff from and after July 1, 1994.

Section 5. Section 25-15-255, Mississippi Code of 1972, is amended as follows:

§ 25–15–255. Advisory council; benefits and coverages generally; collection of premiums and contributions; application of premium differentials, etc.

(1)(a) The Department of Finance and Administration shall design a plan of health insurance for employees which provides benefits for semiprivate rooms in addition to other incidental coverages which the department deems necessary. The amount of the coverages shall be in such reasonable amount as may be determined by the department to be adequate, after due consideration of current health costs in Mississippi. The plan shall also include major medical benefits in such amounts as the department shall determine. The department is also authorized to accept bids for such alternate coverage and optional benefits as the department shall deem proper. Any contract for alternative coverage and optional benefits shall be awarded by the department after it has carefully studied and evaluated the bids and selected the best and most cost-effective bid. The department may reject all such bids; however, the department shall notify all bidders of the rejection and shall actively solicit new bids if all bids are rejected.

It is the intent of the Legislature that coverage under this plan may be self-insured by the State of Mississippi and the same as coverage provided state employees under the Public Employees Health Insurance Plan created in Section 25-15-3 et seq. The department may contract the administration and service of the self-insured program to a third party; however, before executing any contract, the department shall actively solicit bids for the administration and service of the program. ~~Any such contract shall be awarded by the department after it has carefully studied and evaluated the bids and selected the best and most cost effective bid. The department may reject all such bids; however, the department shall notify all bidders of the rejection and shall actively solicit new bids if all bids are rejected.~~

The Department shall conduct the solicitation and contracting process in strict accordance with Section 1 of this act.

Beginning on January 1, 1996, any contract entered into between the department for the administration and/or service of the self-insured plan and a third party shall be for the calendar year that begins on the first day of January and expires on the following thirty-first day of December.

The department may employ or contract for such consulting or actuarial services as may be necessary to formulate the Public School Employees Health Insurance Plan, and to assist the department in the preparation of specifications and in the process of advertising for the bids for the plan.

Such contracts shall be solicited and entered into in accordance with Section 2 of this act.

The department shall keep a record of all persons, agents and corporations who contract with or assist the department in preparing and developing the plan. The department, in a timely manner, shall provide copies of this record to the members of the advisory council created in paragraph (b) of this subsection and those legislators, or their designees, who may attend meetings of the advisory council. The department shall provide copies of this record in the solicitation of bids for the administration and servicing of the self-insured program. Each person, agent or corporation which, during the previous fiscal year, has assisted in the development of the plan or employed or compensated any person who assisted in the development of the plan, and which bids on the administration or servicing of the plan, shall submit to the department a statement accompanying the bid explaining in detail its participation with the development of the plan. This statement shall include the amount of compensation paid by the bidder to any such employee during the previous fiscal year. The department shall make all such information available to the members of the advisory council and those legislators, or their designees, who may attend meetings of the advisory council before any action is taken by the department on the bids submitted. The failure of any bidder to fully and accurately comply with this paragraph shall result in the rejection of any bid submitted by that bidder or the cancellation of any contract executed when the failure is discovered after the acceptance of that bid.

The department is authorized to promulgate rules and regulations to implement the provisions of this subsection. After expiration or termination of the contract between the state and the administering corporation existing immediately before the date on which the plan becomes self-insured by the State of Mississippi, the remainder of funds in the Premium Stabilization Fund shall revert to the Public School Employees Insurance Fund and shall be used exclusively for payment of future premiums.

Any corporation, association, company or individual that contracts with the department for the third-party claims administration of the self-insured plan shall prepare and keep on file an explanation of benefits for each claim processed. The explanation of benefits shall contain such information relative to each processed claim which the department deems necessary, and at a minimum, each explanation shall provide the claimant's name, claim number, provider number, provider name, service dates, type of services, amount of charges, amount allowed to the claimant and reason codes.

The information contained in the explanation of benefits shall be available for inspection upon request by the department. The department shall have access to all claims information utilized in the issuance of payments to employees and providers. Any corporation, association, company or individual that contracts with the department for the administration and/or service of the self-insured plan shall remit one hundred percent (100%) of all savings or discounts resulting from any contract to the department and/or participant. Any corporation, association, company or individual that contracts with the department for the administration and/or service of the self-insured plan shall allow, upon notice by the department, the department or its designee to audit records of the corporation, association, company or individual relative to the corporation, association, company or individual's performance under any contract with the department. The information maintained by any corporation, association, company or individual, relating to such contracts, shall be available for inspection upon request by the department and such information shall be compiled in a manner that will provide a clear audit trail.

~~Before January 1, 1996, and at least once during each subsequent three-year period,~~ the Performance Evaluation and Expenditure Review (PEER) Committee ~~shall thoroughly investigate and report~~ to the Legislature concerning the administration of ~~the~~ self-insured plan. The PEER Committee report shall contain ~~sufficient~~ information to establish whether or not the plan provides ~~the~~ best possible coverage at the lowest possible price to the state ~~and~~ the individuals participating in ~~the~~ plan and whether or not ~~the~~ plan is being administered and serviced in ~~the~~ most ~~cost-effective~~ ~~manner.~~

(b) There is hereby created an advisory council to the department to serve in a purely advisory capacity to advise the department in the formulation of the Public School Employees Health Insurance Plan. The advisory council and those legislators, or their designees, authorized to attend meetings of the advisory council pursuant to this subsection shall be informed in a timely manner concerning each aspect of the formulation and development of the plan.

The council shall be composed of the State Insurance Commissioner or his designee, two (2) certificated public school administrators appointed by the State Board of Education, two (2) certificated classroom teachers appointed by the State Board of Education, a noncertificated school employee appointed by the State Board of Education, and a community/junior college employee appointed by the State Board for Community and Junior Colleges. Members of the council shall serve at the will and pleasure of the appointing authorities; however, no member shall serve for a period of less than one (1) year. The members of the council shall serve without compensation, per diem or expense reimbursement.

The Chairman of the Senate Insurance Committee, the Chairman of the Senate Education Committee, the Chairman of the House of Representatives Insurance Committee and the Chairman of the House of Representatives Education Committee, and/or their designees from their respective houses, may attend any meeting of the advisory council. The legislators, or their designees, shall have no jurisdiction or vote on any matter within the jurisdiction of the council. For attending meetings of the council, the legislators shall receive per diem and expenses which shall be paid from the contingent expense funds of their respective houses in the same amounts as provided for committee meetings when the Legislature is not in session; however, no per diem and expenses for attending meetings of the council will be paid while the Legislature is in session. No per diem and expenses will be paid except for attending meetings of the council without prior approval of the proper committee in their respective houses.

(c) **Medical benefits for retired employees and dependents under age sixty-five (65) years.** The same health insurance coverage as for all other active employees and their dependents shall be available to retired employees and all dependents under age sixty-five (65) years, the level of benefits to be the same level as for all other active participants. This section will apply to those employees who retire due to one hundred percent (100%) medical disability as well as those employees electing early retirement.

(d) **Medical benefits for retired employees over age sixty-five (65).** The health insurance coverage available to retired employees over age sixty-five (65) years, and all dependents over age sixty-five (65) years, shall be the major medical coverage with the lifetime maximum of One Million Dollars ($1,000,000.00). Benefits shall be reduced by Medicare benefits as though such Medicare benefits were the base plan.

All covered individuals shall be assumed to have full Medicare coverage, Parts A and B; and any Medicare payments under both Parts A and B shall be computed to reduce benefits payable under this plan.

(2) **Nonduplication of benefits–reduction of benefits by Title XIX benefits.** When benefits would be payable under more than one group plan, benefits under those plans will be coordinated to the extent that the total benefits under all plans will not exceed the total expenses incurred.

Benefits for hospital or surgical or medical benefits shall be reduced by any similar benefits payable in accordance with Title XIX of the Social Security Act or under any amendments thereto, or any implementing legislation.

Benefits for hospital or surgical or medical benefits shall be reduced by any similar benefits payable by workers' compensation.

(3) The department is hereby authorized to determine the manner in which premiums and contributions by the state and local school districts shall be collected to provide the self-insured health insurance program for school employees and community/junior college employees as provided under this article.

(4) Any premium differentials, differences in coverages, discounts determined by risk or by any other factors shall be uniformly applied to all active employees participating in the insurance plan. It is the intent of the Legislature that premium rates and coverage under the plan shall be exactly the same throughout the state.

(5) Any participant of the State Employees Health Insurance Plan who otherwise would lose coverage and who would be eligible as a dependent under an existing Public School Employees Health Insurance Plan contract may transfer to the Public School Employees Health Insurance Plan as a dependent under the existing contract. Any participant of the Public School Employees Health Insurance Plan who otherwise would lose coverage and who would be eligible as a dependent under an existing State Employees Health Insurance Plan contract may transfer to the State Employees Health Insurance Plan as a dependent under the existing contract. A transfer pursuant to this subsection must occur within thirty-one (31) days of losing coverage. Credit shall be given for any deductible amount satisfied, out-of-pocket expenses and time served toward the twelve-month pre-existing waiting period.

SOURCES: Laws, 1993, ch. 533, § 2; 1994, ch. 615, § 2, eff from and after July 1, 1994.

Section 6. The Department of Finance and Administration shall study the provisions of the Mississippi Code of 1972 pertinent to the insurance plans and prepare a report to the Legislature by January 1, 1996, regarding the legal consolidation of the two plans. Such consolidation shall include recommendations on the amendment and repeal of present law.

Section 7. This act shall take effect and be in force from and after its passage.

Appendix C

Proposed Joint Resolution for a Legislative Oversight Committee to Seek Resolution of Claims Processing Delays in the State Insurance Plans

MISSISSIPPI LEGISLATURE — REGULAR SESSION, 1995

BY: — TO:

SENATE CONCURRENT RESOLUTION NO. ____

A SENATE CONCURRENT RESOLUTION TO ESTABLISH A JOINT LEGISLATIVE COMMITTEE TO CONSULT WITH THE GOVERNOR AND THE DEPARTMENT OF FINANCE AND ADMINISTRATION TO SEEK RESOLUTION OF CLAIMS PROCESSING DELAYS IN THE STATE INSURANCE PLAN.

WHEREAS, the Department of Finance and Administration entered into a contract with CENTRA Benefit Services effective July 1, 1994, for administrative services with respect to the insurance plans created by Sections 25-15-3 et seq., and 25-15-251, et seq., Mississippi Code of 1972;

WHEREAS, the administrator CENTRA has had continuous and systematic difficulties respecting the administration of benefits;

WHEREAS, the members of the plans have experienced frustration and hardship because their benefits have not been paid on a timely basis and in some cases have not been paid in the correct amounts;

WHEREAS, the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER Committee) is charged by law with overseeing all

public funds and entities which handle public funds, and reporting its findings to the Legislature; and

WHEREAS, the PEER Committee has released its report, "An Investigation of the Administration of the State and Public School Employees' Health Insurance Plans," which contains much useful information for the Legislature:

NOW, THEREFORE, BE IT RESOLVED BY THE MISSISSIPPI STATE SENATE, THE HOUSE OF REPRESENTATIVES CONCURRING THEREIN, That we do hereby create a Joint Legislative Committee for Oversight of State Insurance Plans, which shall be comprised of three (3) Senators appointed by the Lieutenant Governor and three (3) members of the House of Representatives appointed by the Speaker of the House.

The members of the Joint Committee shall be appointed immediately upon passage of this resolution. The Joint Committee shall immediately organize itself with a Chair and a Vice-Chair. The Joint Committee shall cease to exist on February 28, 1995.

The Joint Committee shall attempt to determine and facilitate a resolution of the matters referred to in the PEER Committee's report. The Committee shall meet with the Governor, the executive director and other officials of the State Department of Finance and Administration, and other parties which it determines may assist in its purpose.

The Joint Committee shall determine whether the State Legislature should enact an assignment clause for assignments of benefits to a health-care provider which would be binding on the insurer; whether state law should exempt BlueCross BlueShield from Mississippi's laws regulating the insurance industry; and whether the state has a reasonable alternative to using the Blue Cross network for repricing. Specifically, the Joint Committee shall determine if Blue

Cross should sign an agreement with CENTRA to provide CENTRA with proprietary repricing information which CENTRA would agree to keep secret.

The Joint Committee shall further determine whether CENTRA is aggressively pursuing resolution and payment of pending insurance claims and whether the Department of Finance and Administration should continue its contract with CENTRA as State Plan Administrator.

BE IT FURTHER RESOLVED, that a copy of this resolution be furnished to the Governor, the Department of Finance and Administration, CENTRA Benefit Services, and Blue Cross.

STATE OF MISSISSIPPI

DEPARTMENT OF FINANCE AND ADMINISTRATION

EDWARD L. RANCK
EXECUTIVE DIRECTOR

January 25, 1995

John W. Turcotte
Director
Joint Committee on Performance Evaluation and Expenditure Review
222 North President Street
Jackson, MS 39201

Dear Mr. Turcotte:

Thank you for the opportunity to respond to your report entitled *An Investigation of the Administration of the State and Public School Employees' Health Insurance Plans.* While we agree, for the most part, with the recommendations in the report, we must disagree with several of the findings.

You note that DFA followed the law in soliciting competitive bids for a third-party administrator (TPA) for the Plans, but you add that the process, and specifically the Request for Proposals (RFP), was not adequate to ensure that the selected third-party administrator was capable of administering the Plans. We take issue with this finding.

Through a competitive bidding process, we contracted with Coopers & Lybrand, one of the "Big Six" accounting firms which offers a full range of management consulting services and benefits and compensation consulting services through its 700 offices worldwide. Having chosen third-party administrators for several hundred clients, they are experts at preparing RFP's and evaluating proposals for third-party administrators, and use the same process with their other clients as used in Mississippi.

The three finalists, ACMG, BlueCross BlueShield, and CENTRA, all clearly demonstrated their ability to perform the tasks of the third party administrator. However, CENTRA's bid was almost $6 million lower than BlueCross BlueShield, the high bidder, and almost $1.5 million lower than the second low bidder, ACMG. (The bids for 3 years of claims administration were BlueCross BlueShield - $21,326,550; ACMG - $16,842,953; and Centra - $15,338,500.) CENTRA was the low bidder and there was and <u>still</u> is no evidence that at the time of contract award CENTRA was not capable of functioning as third-party administrator for the Plans. After Coopers & Lybrand made their recommendation to hire CENTRA, DFA staff was sent to visit CENTRA's Washington state office and contacted other CENTRA clients for verification. With Coopers & Lybrand's recommendation and our staff follow-up, to ignore the low bid, would have

rightly angered Mississippi taxpayers, invited lawsuits, and undoubtedly triggered a PEER investigation.

We take great exception to the assertion that DFA played a passive role in the transition process. DFA was aggressively involved from the beginning in developing the RFP, selecting the TPA, and meeting with BlueCross and CENTRA on an almost daily basis during the transition process. Of the nine staff members in the Office of Insurance at that time, three put in more than 400 hours of overtime on this project alone from January to August. We do not believe this indicates a "passive and reactive role" by DFA, not does it demonstrate "limited intervention."

DFA staff were constantly involved in resolving the myriad transition problems noted in your report, as documented by the more than 600 pages of meeting notes provided to your staff. We used every resource available during the transition process. The suggestion that DFA's Office of Insurance should have handled the thousands of telephone calls regarding provider networks is impractical. DFA is not staffed nor equipped to deal with routine customer service calls. Routine customer service is within the purview of the third party claims administrator.

As you stated in your report, the general practice is for the new third-party administrator to outline the transition plan and data requirements. We agree. Micromanagement of a contract would logically lead to higher costs and poorer performance.

Many of the transition issues center on data transfer between the former TPA and the new TPA. Unfortunately, DFA had no means by which to force BlueCross to transfer data in a specified format. The five and a half year old contract under which BlueCross operated as third-party claims administrator included no data transfer requirement. Even though DFA facilitated nearly daily meetings between the programmers for each company, we still experienced the type of data problems noted in the Coopers & Lybrand Transition Data Review.

No amount of planning and oversight could have avoided some of the transition problems that occurred. Even when there were requests outlining with specificity the type of data needed and the time in which it was needed, there were problems:

> While none of these problems in and of itself were insurmountable, the problems related to the data, including data format, along with timeliness in which the data tapes were provided ..., contributed directly to the claims payment problems experienced by CENTRA. (Coopers & Lybrand, Transition Data Review, dated November, 1994.)

Never having anticipated the lack of cooperation that we found in the subject transition process, we have, nevertheless, corrected this situation for future transitions by including a provision in the contract requiring transfer of data in a format to be determined by DFA.

We note and agree with your recommendation that the TPA contract be on a calendar year basis. You should be aware that the TPA contract which began on July 1, 1994, extends for a three and a half year period ending December 31, 1997.

In the preceding paragraphs, we have pointed out areas in which we disagree with your findings, and we have brought to your attention facts that you may have overlooked, which in our opinion would alter your conclusions. While we would have preferred some immediate guidance, we feel that your recommendations are sound and will substantially assist us in solving the problem which we face.

Sincerely,

Edward L. Ranck
Executive Director

CENTRA

BENEFIT SERVICES

January 25, 1995

VIA HAND DELIVERY

Mr. John W. Turcotte
Joint Committee on Performance Evaluation
and Expenditure Review
Post Office Box 1204
Jackson, Mississippi 39215-1204

Re: CENTRA Benefit Services, Inc.

Dear Mr. Tucotte:

Enclosed please find CENTRA Benefit Services, Inc.'s Response to the Executive Summary of Report on Administration of the State and Public School Employees Health Insurance Plans.

If you have any questions or if we can provide additional information, please do not hesitate to call.

Sincerely,

CENTRA BENEFIT SERVICES, INC.

Jon Lineweaver

Jon Lineweaver

Enclosure

c: Mr. Jim Warren
Mr. Robert R. Weinstine

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CENTRA'S RESPONSE TO PEER COMMITTEE EXECUTIVE SUMMARY OF REPORT ON ADMINISTRATION OF THE STATE AND PUBLIC SCHOOL EMPLOYEES HEALTH INSURANCE PLANS

CENTRA appreciates the opportunity, however limited, to respond to the Executive Summary in advance of the official publication of the PEER Committee Report. Nevertheless, the brief time period allowed does not give CENTRA a sufficient opportunity to respond in any detailed way. The limited focus of the investigation necessarily fails to address the true cause of the claims administration problems encountered since July 1, 1994. Moreover, the PEER Committee has not had the benefit of the additional evidence and information which has been uncovered regarding Blue Cross' misconduct after the PEER Committee began its work. The expedited timeframe and narrow focus of the PEER Report makes it clear that the appropriate forum for CENTRA to present its case is a judicial one where it will have the benefit of full access to information and the right of cross-examination. Accordingly, CENTRA respectfully but emphatically takes issue with the adequacy of the investigation and objects to the many incorrect perceptions and mistaken judgments which have obviously been formed on the basis of incomplete or inaccurate information.

CENTRA respectfully directs the Committee's attention to the fact that its Findings ignore the fundamental cause which has created delays in or complaints about the processing of claims. Blue Cross is guilty of delay, misdirection, nonperformance, refusal to cooperate and other improper conduct. Before any claims were examined, before any delays in processing were encountered and before any complaints were raised, there was the inaccuracy of, delays in, or the nonproduction of critical information by Blue Cross. CENTRA has still not been able to fully overcome the myriad of challenges and complications created by the Blue Cross subterfusion. While CENTRA will not further elaborate here, it has previously

provided considerable documentation and evidence to the Committee which supports this view; moreover, additional information has been uncovered. No amount of paperwork or scheduling could have insured that Blue Cross would, in fact, cooperate in the transition process and honor deadlines or information requests. As further evidence of this point, CENTRA notes that new legislation has been recently introduced that would require the inclusion of a specific contractual provision in future DFA agreements mandating that the outgoing TPA must cooperate with the incoming TPA in any transition of responsibilities. Regrettably, no such provision was included in the DFA contract with Blue Cross.

There is a suggestion that CENTRA "apparently underestimated the magnitude and complexities of the transition and implementation process." This is wrong. The only thing CENTRA failed to appreciate was the lack of cooperation and the undermining tactics employed by Blue Cross. No amount of "steeped precision" or "analytical rigor" could have either revealed in advance or counteracted the wrongful conduct of Blue Cross.

Subject to the time limitations imposed on this Response, CENTRA further notes its objections to the following inaccuracies or misperceptions, among others, included in the PEER Committee's Findings:

1. Contrary to the Committee's understanding, CENTRA did prepare an installation timetable and comprehensive plan based on its past experience. In any reasonable transition environment, this plan would have been more than adequate. CENTRA strongly believes the Committee's understanding of normal industry practices and expectations in this area is lacking.

2. Contrary to the Committee's findings, CENTRA assigned a capable, dedicated transition team to the Plans. The 14 employees that were 100% dedicated to the transition and implementation of the Plans were assisted by another 25 CENTRA employees, who for significant periods of time, were also 100% dedicated to the process. With respect to the latter group, it was not essential that they be 100% dedicated to the transition for the entire period. After their assignments were completed, their full-time presence was no longer required.

3. Contrary to the Committee's apparent misunderstanding of the RFP process and its conclusion that CENTRA did not adequately provide services from its office in Jackson, CENTRA followed a staffing/services plan that was discussed with, understood by and implemented with the approval of the DFA and Coopers & Lybrand prior to contract award.

4. Blue Cross' insistence on holding critical information hostage evidenced more than a concern about confidential information pertaining to state employees and teachers. CENTRA intends to demonstrate in the litigation that Blue Cross' requirement of a non-standard, highly unusual indemnification provision was part of its orchestrated delay, obstruction, and subterfuge as well as an attempt to secure absolution in advance from an unwitting victim.

5. The Report comments upon the perceived "lack of communication regarding plan benefits/coverage" between CENTRA and the DFA. CENTRA and DFA held regular, detailed, and documented meetings relative to plan benefits/coverage. Once received, CENTRA implemented all communicated information and requirements in a timely manner.

There was no lack of communication; there was only a lack of accurate information available to CENTRA.

6. A major omission in the Report is the lack of recognition that the number of claims submitted per employee is running 50% higher than the claims submittal experience provided CENTRA during the RFP process. At the time of contract, CENTRA set its resource and staffing plans based upon the historical volume of claims reported in information the DFA received from Blue Cross. The extraordinary rate of claims submission has caused CENTRA to dramatically adjust its initial staffing and resource plans beyond what the RFP indicated.

7. CENTRA was not told of Blue Cross' uncustomary insistence that it control information necessary to timely process claims, vis-a-vis its re-pricing role in Key Provider Network claims, until two weeks after contract award. CENTRA was required to do extensive re-programming to accommodate this re-pricing, and this process continues to be a major contributor to the high volume of pended claims and processing delays.

BlueCross BlueShield
of Mississippi

P.O. Box 1043
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Richard J. Hale
President and
Chief Executive Officer

January 25, 1995

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

Hand Delivered and
Delivered by Fax

Re: PEER Committee Report Review Response
"An Investigation of the Administration of the State and Public School Employees' Health Insurance Plans"

Dear Mr. Turcotte:

Blue Cross & Blue Shield of Mississippi appreciates the opportunity to review and respond to the Draft Executive Summary and the over 30 page PEER Committee Report on "An Investigation of the Administration of the State and Public School Employees' Health Insurance Plans". We commend the PEER Committee on a very thorough and comprehensive analysis of the issues involved.

The complete PEER report clearly details that the ultimate accountability for the State Health Plan and the vast majority of the problems that have resulted due to the mid-year administrator change cannot be attributed to Blue Cross & Blue Shield of Mississippi. We agree with the PEER report that the accountability for the State Health Plan rests with the Department of Finance & Administration and that the transition responsibility rests with the new claims administrator, Centra Benefit Services.

The following will address issues in the complete PEER Report specific to Blue Cross & Blue Shield of Mississippi.

Transition

Blue Cross & Blue Shield of Mississippi was aware of and did express in writing and verbally during the claims administrator and network administrator RFP process our concerns as to the demands and potential problems that could arise with a mid-year, short time frame transition of the State Health Plan.

We quote from our RFP response that was submitted to Coopers & Lybrand on February 18, 1994.

> "DFA is considering multiple changes in its program simultaneously -- benefit changes, multiple network vendors, and a possible change in claims administrator. The claims administrator stands at the "hub" of the service configuration. There are risks involved in managing a large amount of infrastructure change affecting this many employees.
>
> As pointed out by Coopers & Lybrand recently in a joint meeting of the two Advisory Committees, the multiple vendor strategy is likely to increase administrative costs. Multiple service vendors increase costs of claims administration due to complex network benefit roles required to adjudicate the claims, or due to cost of interfaces to receive and transmit claims data from multiple vendors.
>
> In summary, it is critical that the claims administrator be flexible, demonstrate a proven track record and have the capability and expertise to manage the conversion to multiple vendors. Without a proven integration approach, the viability of the multiple vendor strategy could be in jeopardy.
>
> Good service cannot be taken for granted. To achieve provider network savings, the State must be sure it brings proven levels to the table."

Indemnification Agreement

The indemnification that was requested by Blue Cross and agreed to by Centra was done to protect the confidentiality of the Public School Employees' records. The Public School Employees' Plan was insured by Blue Cross & Blue Shield of Mississippi and was not, until 7-1-94, part of the State Employee Plan self-funded program. Anyone in Centra's position should have known that an indemnification would be necessary in transferring data to them because the Public School Employees are entitled to have the confidentiality of their records protected. Further Blue Cross needed to be protected in the event the information given to Centra was not used accurately or kept confidential by Centra. The time spent in the negotiations between the two parties should not have prevented Centra from processing claims timely.

Network Pricing

As to network pricing of claims, it was understood by all parties during the RFP process and prior to the implementation of the health plan changes that Blue Cross & Blue Shield of Mississippi would not release its network pricing information to another party. Blue Cross and Blue Shield considers this proprietary competitor information. DFA selected Blue Cross & Blue Shield of Mississippi as network administrator with full knowledge that the pricing information would not be released.

It was also understood and stated in the claims administrator RFP that whoever was chosen as claims administrator must be able to interface with networks. The State of Mississippi Request for Proposal for Claims Administration specifically asked a question related to pricing network claims.

> RFP Question
>
> "The State of Mississippi is considering the use of managed care networks, both hospital and physician, to be offered on either a point-of-service basis or as an option under the medical plan. How will your organization coordinate the payment of medical claims for network providers with the network(s) offered by the State?"
>
> Centra Response
>
> "Interface with any managed care networks can be by paper, tape, or electronic transmission. The system can be designed to load any fee arrangements or the claims can be re-priced prior to receipt of the managed care networks..."

In its Network RFP response on March 14, 1994, Blue Cross & Blue Shield of Mississippi made the option available to DFA where all network claims would be received by Blue Cross, priced and sent directly to Centra for processing.

> RFP Question
>
> "Are you willing to provide your network data (provider demographics and contracted fee arrangements) to the State's selected claims administrator for claims repricing purposes?"

BCBS Response

"Unless we are chosen as the claims administrator we would prefer not to provide network data to the claims administrator."

RFP Question

If yes, how do you propose to transmit that data to the claims administrator?

BCBS Response

"Our systems are capable of pricing/repricing the claims efficiently and then routing them to the claims administrator for further processing."

RFP Question

"If you are not willing to provide network data, how will repricing be accomplished?"

BCBS Response

"While we are able to receive the original claim for pricing in hardcopy, State participants will receive better service if we use the efficiency of our statewide electronic network and the BCBSMS EDI Facility. By receiving a high percentage of the claims electronically, pricing them properly, and then routing them to the claims administrator for further processing, the overall cost of claims processing relating to our networks will be held to a minimum. Any other scenario where the claims administrator received the claim first, then routed the claim to a network administrator for pricing would involve an unnecessary extra step in the cycle. This would not only affect the timeliness of claims processing but could result in lost claims."

It is our understanding that the decision was made by DFA and agreed to by Centra that Centra would input hard copy claims and send to Blue Cross for pricing. This decision resulted in a major system issue for Centra and pended claims.

Since the Claims Administrator contract was awarded to Centra, Blue Cross has worked diligently to provide assistance solving pricing issues. These included, until Centra chose to file a lawsuit against Blue Cross, weekly meetings with DFA and Centra to discuss and address issues. We have given DFA and Centra specific information that should have allowed them to resolve claims pended due to pricing issues. Centra has chosen, as is noted in the PEER report, not to resolve these claims but continue to submit them to Blue Cross.

We have provided our networks to the State for over 5 years resulting in millions of dollars in savings to the State Health Plan. Removal of the Blue Cross networks would result in the loss of valuable savings to State and Public School Employees; and as identified in the PEER Report would not solve the service problems currently being experienced by the State Health Plan.

The State and Public School Employees are the most important party in the PEER Committee Report. Blue Cross & Blue Shield of Mississippi has always been and continues to be committed to ensuring State Health Plan Employees receive the service they became accustomed to and deserve.

Sincerely,

Richard J. Hale

Coopers & Lybrand

Coopers & Lybrand L.L.P.
a professional services firm

Human Resource Advisory

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January 25, 1995

Mr. John W. Turcotte
Director
Joint Committee on Performance Evaluation
and Expenditure Review
222 North President Street
Jackson, Mississippi 39201

Dear Mr. Turcotte:

Thank you for allowing us the opportunity to respond to your findings as listed in the Executive Summary of your report entitled An Investigation of the Administration of the State and Public School Employees' Health Insurance Plans. Since we were not furnished the entire report, our comments are directed only to the points raised in the Executive Summary.

Although we respect the effort expended by your staff in reviewing the activities concerning the selection of a Third Party Administrator, we must take strong exception to some of your findings. Listed below is our response to the findings we believe to be inaccurate.

Information Contained in the RFP

In your findings you state the DFA's process "...did not produce a request for proposals containing sufficient information for proposers to compile informed responses,...". Since we have not reviewed the entire report, we do not know the basis of this conclusion.

The request for proposals (RFP) did in fact contain the data necessary for any experienced administrator to compile and submit an informed bid. Among the consultants involved in the development of the RFP was a consultant whose previous job was that of a Group Representative for a major insurance company with responsibility for responding to RFPs, and who therefore had a detailed understanding of the information required by the bidders. At no time did any of the organizations who received an RFP state that they did not have adequate information to prepare a bid.

The RFP contained the following information for use by proposers in submitting their bid:

- A description of the current benefit plan designs.
- A description of the benefit plan design changes under consideration.

- Five (5) pages of specific State accounting requirements.

- Fifteen (15) Specific State contract conditions.

- A copy of the State Employees' Comprehensive Health Plan Document which provided information on COBRA, conversion rights, subrogation, benefits limitation, enrollment, eligibility, and other benefits information.

- Historical plan changes since 1991 so that the bidders could determine trends in plan operations and determine volatility of the plan.

- A description of the Public School Plan and the benefits options currently in place.

- A section on plan data which explained funding, employee participation rates, the number of eligible employees, the number of disabled employees and other information pertaining to both plans.

- A section on plan experience which included two (2) years of enrollment data by coverage type (single, family, etc.) and two (2) years of claims experience including the number of claims, total charges, and benefits paid sorted by active, retiree and COBRA for the State Plan. This data was supplied to us by DFA from routine reports supplied to them from Blue Cross.

- Two (2) years of claims data on the Public School Plan sorted by regular and retired participants. This data was requested from DFA and it is our understanding that DFA requested and received this data from Blue Cross.

- A listing for both plans of the monthly premiums and the employee contribution to that premium.

- At a later date, additional information concerning the Public School Plan was supplied to each potential bidder. This information included a listing of current and projected enrolled employees in the Public School Plan sorted by male vs female and employee classification (certified, non-certified, etc.), along with two (2) years of claims activity by cause of illness (accident, maternity, etc.) This data was requested from DFA, who requested the data from Blue Cross.

Each bidder was provided the opportunity to ask questions and request additional information. The telephone numbers and fax number of the Coopers & Lybrand consultants involved were listed in the RFP, and the consultants were readily available to answer any questions a bidder may have had. On January 28, 1994, Coopers & Lybrand distributed a letter to all bidders summarizing the questions received and our response to the questions.

The letter contained specific responses to sixteen (16) questions and included a clarification of the definition of a claim, provided a map of employee locations throughout the state, supplied additional information on the claims experience of the Public School Plan, and discussed the increase in the number of eligible employees in both plans. Data concerning the employee locations and claims data on the Public School Plan was received from Blue Cross through DFA.

In summary, the information in the RFP, the responses to questions and requests for additional information responded to by Coopers & Lybrand, and the ability of any potential bidder to contact the consultants working on the TPA selection process, provided more than sufficient information for bidders to prepare informed responses.

Selection Process

The Executive Summary states that "DFA's process for selecting a third-party administrator was not adequate to ensure that the selected third-party administrator was capable of administering the Plans." Since we have not reviewed the entire report, we do not know the basis of this conclusion.

The process followed by DFA and Coopers & Lybrand conformed to the standard process followed by the major benefits consulting firms for selecting a claims administrator. We followed a detailed nine-step process, which was reviewed with and approved by DFA and the Governor's Office. As stated by the PEER Committee staff in our meeting of January 17, the RFP, which is the centerpiece of a selection process, was similar to the RFP distributed by the State's prior benefits consultant in a previous bid process. The process for selecting a third-party administrator was the same process followed in selecting the pharmacy network and the current managed care network providers.

C&L and DFA worked together closely to assure that the Plan administration requirements of the State were described completely and explicitly, and to assure that all bidders could be evaluated not just with regard to their general claims processing capability, but with regard to the specific needs of the State's Plans. We are not aware of any aspect of this process that could be termed inadequate.

Uniform Evaluation

In your findings, you state that the process "...did not require DFA's consultant, Coopers & Lybrand, to evaluate uniformly the three finalist proposers and document such evaluation." Since we have not reviewed the entire report, we do not know the basis of this conclusion.

The three finalists were evaluated uniformly. All were required to respond to the exact same RFP, and all made formal presentations in Jackson to Coopers & Lybrand, DFA staff, and Advisory Council members who chose to attend. The only difference in the process was that an on-site visit to evaluate actual claims processing was not conducted at BCBSMS, as both DFA and C&L were aware that BCBSMS was capable of processing the State's claims, since as the incumbent they were performing that function.

In our presentation to DFA and the Advisory Councils recommending CENTRA, we presented documentation of our evaluation of the finalists, listing the strengths and weaknesses of each finalists, and a summary of the financial proposals. The consultants at C&L worked together closely with each other and with DFA in meetings and in conference calls to assure that the requirements of the State were met in selecting a third party administrator. As a result of this detailed, collaborative process, CENTRA Benefit Services was selected to be the third party administrator.

Thank you again for allowing us to respond to your Executive Summary. We look forward to reviewing your full report.

Sincerely,

Coopers + Lybrand L.L.P.

Coopers & Lybrand L.L.P.

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Linda Triplett
Larry Whiting