



**Johnson County Auditor**  
Johnson County, Kansas  
**PERFORMANCE AUDIT**

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**May 10, 2007**

**Self-Insured Health Care Plan Review**

*"Health Care Fund reserve exceeds policy target amount."*



## Johnson County Audit Services

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May 10, 2007

To: The Johnson County Board of County Commissioners  
Mike Press, County Manager  
Tom Franzen, Office of Financial Management

In accordance with the approved audit plan, we performed an audit of the County's Self-Insured Health Care Fund. The audit objective was to determine if the Health Care Fund was fiscally sound and managed in accordance with County policy.

We concluded the Health Care Fund reserve balance needs to be reduced, health care invoice management needs to be improved, and the review by the health care administrator can be improved.

We conducted this performance audit in accordance with Generally Accepted Government Auditing Standards, except that Peer Review has not been performed. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence that provides a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

I appreciate the cooperation received from County staff during this audit.

William D. Miller, CIA, CGFM  
County Auditor

The following auditors contributed to this report:

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**SELF-INSURED HEALTH CARE PLAN REVIEW**

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## **RESULTS AND RECOMMENDATIONS**

### **1. Health Care Fund Reserve Exceeds Policy Target Amount**

The reserve in the County's Self-Insured Health Care Fund (HCF) has exceeded the "secure funding level"<sup>1</sup> authorized by the Board of County Commissioners (BOCC) by over \$14,000,000 as of December 31, 2006. The BOCC adopted a HCF reserve policy which directed the County Manager to maintain a reserve that is "not less than high minimal funding level" and have "secure funding level" as a goal in each year. The policy does not establish a maximum reserve. The current reserve balance is the result of a number of factors including lower than expected claims costs over the past several years and improved data collection and reporting systems in the health care industry which has led to reduced risk for the County. Continued funding should proceed in such a way that the ending balances do not increase any further until such time the targeted reserve calculation dictates. This would lessen the impact on the County and employees and allow the opportunity for the BOCC to allocate future funds to areas of need.

### **Recommendations**

We recommend the County Manager:

- 1.1 Begin the process of reducing the HCF Fund Balance to more closely match the "secure funding level" goal in the current policy. This reduction should be planned to reach "secure funding level" within 5 years by using the HCF fund balance to offset general fund and employee contributions as needed.
  
- 1.2 In conjunction with the reduction in 1.1, develop an amended Health Care Fund Reserve policy for Board discussion which:
  - Establishes an upper limit on the HCF Fund Balance in addition to the lower limit in the current policy,
    - This upper limit should be approximately 20% to 50% above the calculated Secure Funding Level.
    - This upper limit should be a trigger for BOCC notification and discussion rather than an absolute prohibition on funding above that limit.
  - Requires notification to the BOCC that the limit has been exceeded as part of the next available budget setting process,
  - Requires the use of prior year excess funding to reduce the calculated funding required for the next available budget based on the upper limits established, and
  - Requires reporting to the BOCC, as part of the budget process, the most recent year's results including the difference between projected and actual collections, expenditures, and change in fund balance.

Completion of recommendation 1.2 may modify or eliminate the reductions required in recommendation 1.1.

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<sup>1</sup> "Secure funding level" and "high minimal funding level" will be discussed below.

## **Management Comments**

*Staff agrees with Recommendations 1.1 and 1.2.*

### **Discussion**

Johnson County provides health care coverage to its employees through a self-insured plan.<sup>2</sup> The County and the employees make contributions to the HCF. Blue Cross Blue Shield of Kansas City (BCBS) provides administrative services and some insurance services to the County by handling claims, paying service providers, and providing two levels of insurance (stop loss provisions).

#### **Handling claims and paying service providers**

BCBS maintains a network of service providers (doctors, hospitals, etc.) and Johnson County employees use that network for health care services. The provider bills BCBS. BCBS pays the provider and bills Johnson County for reimbursement. BCBS manages the paperwork related to these transactions and Johnson County pays BCBS an administrative fee for this work in addition to the cost reimbursement mentioned above.

#### **Stop-loss insurance limits HCF liability**

The stop-loss provisions of the County agreement with BCBS protect the HCF from extraordinary losses. There is an overall stop-loss coverage (aggregate stop-loss) which limits the HCF liability on an annual basis. The coverage amount varies based on the number of participants in the health care plan. In 2005, the aggregate stop-loss was approximately \$19 million. The aggregate stop-loss level has never been reached. There is also an individual stop-loss which in 2005 was \$175,000 per participant. The individual limit was reached in eight instances between 2002 and 2004 but in those years the stop-loss level was lower. During that time, there were only three instances where the current \$175,000 stop-loss would have been reached.

#### **The HCF has accumulated a large reserve account**

The HCF has a fund balance (reserve account) which holds the difference between the contributions collected from the County and employees and the combined claims, administrative fees, and insurance costs. Since 2001, the amounts contributed have consistently exceeded the related costs. As of December 31, 2005, the balance in the reserve was 104.25 percent of the projected costs for 2006.

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<sup>2</sup> The County's plan is a "cost plus" arrangement with BCBS. This arrangement qualifies as a fully insured plan under Kansas Department of Insurance regulations but the claims are paid by County tax funds, employee contributions, and some "stop loss" insurance.

## **Past experience with low reserves prompted action to stabilize the reserve account**

In 1991, Johnson County instituted a self-insured health care plan. By 1998, the reserve balance for health care costs grew to such an extent that a premium holiday was declared for 1 month. There immediately followed several years where claims exceeded expected amounts and budget cuts reduced the contributions to the HCF. As a result, the HCF reserve fell to the point that the BOCC had to allocate extra general fund revenue to the HCF.

As a consequence, the BOCC adopted Johnson County Financial Policy 110.4 which states, in part:

It is the policy of the BOCC to establish and maintain a reserve, including funding for plan run-out, within the County's Health Care Fund. The amount of the reserve shall be determined annually by the BOCC based upon funding recommendations prepared by the County Manager. The reserve amount for any given year shall not be less than that amount which is determined to provide a reserve level of high minimal funding and the reserve goal for each year shall be that amount which is determined to provide a reserve level of "secure funding."

The terms "high minimal funding" and "secure funding" were based on a document prepared by a contractor which calculated these amounts based, to a large extent, on Incurred But Not Reported<sup>3</sup> (IBNR) costs.

In 2001, when this process was initiated, the County staff used a time lag between providing the services and recording the claim of 90 days, which was commonly used. This time lag remained constant and was not adjusted for Johnson County experience until the budget was prepared for 2006. Once the expected costs were determined, the contribution rate for the County and employees was established at a high enough level to cover expected costs and build the HCF reserve to the "secure funding" level.

Over the next few years, the County experienced claims cost which were less than anticipated, and by 2004 the estimated "secure funding" reserve level, based on the 90 day lag, had been reached.

Johnson County staff worked with Johnson County's benefit consultant to revise the definition and calculation of "secure funding" to reduce the reliance on IBNR. This calculation is now based on other factors. The "secure funding" level for 2007, as well as a revised estimate for 2006, shown below, were based on this new method. In the 2007 budget overview the "secure funding" level was shown as \$8,553,002 for 2006 and \$9,977,923 for 2007. The actual fund balance as of December 31, 2006, was \$23,119,022 and the projected fund balance for 2007 is \$25,776,543.

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<sup>3</sup> Incurred But Not Reported cost is the estimated amount of claims cost for services that have been provided to insured individuals but not yet claimed by the service providers.

**Table 1.2: “Secure Funding” Compared to Reserve Level**

	<b>Secure Funding Level</b>	<b>Fund Balance</b>	<b>Excess of Reserve over Secure Funding</b>	<b>Reserve as a percentage of Secure Funding</b>
2006	\$ 8,553,002	\$ 23,119,022	\$ 14,566,020	270.30%
2007	\$ 9,977,923	\$ 25,776,543	\$ 15,798,620	258.34%

Source: 2006 Fund Balance – Johnson County General Ledger : The final corrected year end 2006 Fund Balance was \$24,468,874

Secure Funding Level , 2006 and 2007, and the projected 2007 Fund Balance – 2007 Budget Overview, June 1, 2006

### **Reserve now exceeds secure funding level**

Because of the favorable claims experience over the past few years and the change in the Secure Funding calculation, the reserve in the Health Care Fund now exceeds the amounts contemplated in the County’s reserving policy. The reserve in the Health Care Fund is restricted and cannot be used for purposes other than health care. In order to provide more flexibility to the County Manager and the BOCC in future budgets the reserve balance in this fund needs to be reduced.

### **Risk and volatility in health care costs**

In discussing the issues with Johnson County staff, we understand the Health Care costs are increasing at rates much greater than general inflation rates. The ability to adequately budget for these increases is made more complex by the need to prepare budgets 18 to 20 months in advance of the actual expenditures. The budget staff has prepared 5-year estimates which are based on worst case assumptions and indicate there could be the need to fund health care costs at much higher levels than the County has experienced.

Contributions to the Health Care Fund are currently based on expected claims. This has resulted in increases to the reserve over the past few years because claims have been lower than expected. It is likely that in some years claims will exceed the expected amounts and the reserve will be reduced. We believe this natural reduction in the reserve would be a very slow process.

### **Reserve management**

The contribution calculations need to be based on expected claims, as determined by the County’s actuaries, and then modified by the experience of the most recent year. That is, the contributions need to be adjusted up or down to maintain the reserve within clearly established limits. This will result in minimizing the amount of general fund reserve which is restricted to this one use and result in minimizing the contributions of current employees.

Changes are needed in calculations

Managing the reserve on a budget by budget basis and using actual experience to regulate the stability of the reserve balance provides the best use of the taxes and employee contributions. We also realize a series of catastrophic events could reduce the reserve to levels below the secure funding level and require contribution increases in subsequent years. The County’s actuarial calculations do not indicate this is likely. We believe the policy adopted by the Commission

directs that the reserve be moved toward the goal each year without regard to whether the movement needs to be an addition to or reduction of the balance.

## **2. Management of Health Care Invoices Needs Improvement**

The monthly invoices from BCBS, which average in excess of \$1.5 million per month, are not verified for accuracy and completeness and the data needed to make that reconciliation is not currently gathered by OFM staff. Good internal control procedures require that all invoices paid be verified as accurate and complete and approved by appropriate staff. OFM has a procedure to reconcile the BCBS invoices but it reconciles the invoice to other summary reports prepared by the vendor. This OFM procedure is not currently being followed. Approving these invoices for payment without verification creates the risk of errors and overpayments.

### **Recommendations**

- 2.1 Obtain the supporting data for the invoice from the vendor in electronic format so the amounts of the invoices can be verified as correct.
- 2.2 Establish a program of continual audit of the health care expenditures and, to the extent possible, continual monitoring of contract compliance.

### **Management Comments**

*Staff agrees with recommendation 2.1 and most of recommendation 2.2.*

*The discussion section of item 2 of the report alleges that invoices are paid without verification of accuracy. Staff disagrees with this claim. Staff has developed an alternative procedure to review financial accuracy. BCBSKC provides OFM staff with monthly internal audit reports which are used to verify BCBSKC's financial accuracy. These are closely monitored by staff to confirm that the administrator maintains a high percentage of financial accuracy and claim processing timeliness. We understand that using a BCBSKC-generated report is not as good as an independent audit and analysis. However, the findings are used as an additional barometer to confirm that the self-reported accuracy is within acceptable parameters and to identify the need and timing of additional claim compliance audits. Therefore, staff believes financial accuracy is monitored to a certain degree.*

*We agree that a continual audit program is appropriate to evaluate and verify the financial or numerical accuracy of the claim billings and will assist with the determination of a random sample. Regarding the corresponding recommendation to purchase audit software, OFM is reviewing the software that is available and the corresponding costs. Given the significant price ranges of audit software, the expenditure of funds for the audit software needs to be carefully analyzed and the software capabilities determined and listed to make sure it will provide the detailed analysis needed and desired.*

*Staff does not believe there is sufficient information in the electronic billing generated and received from BCBSKC (e.g. description of service, CPT-9 or HCPCS code) to actually determine contract compliance (therefore, bullet numbers 2, 4 and 5 on page 7 could not be analyzed through audit software). Only a detailed on-site claims compliance audit will definitively determine that the County's administrator is properly adjudicating claims in*

*accordance with the County's group health plan contracts. We interpret contract compliance to mean the determination of whether a service or item is a covered expense under the County's medical plan.*

**Auditor's Response:** Each monthly invoice from BCBSKC is now over \$2,000,000 and consists of over 10,000 transactions lines. We believe this is the largest and most complex monthly vendor invoice currently received by the County. The volume of data does not lend itself to timely manual review. We do not believe that comparing several different reports from the same contractor assures the accuracy of the invoice.

The County Auditor maintains that obtaining sufficient electronic data from BCBSKC to verify the numerical accuracy of the invoice and also verify the appropriateness of the transactions invoiced in relation to the contract is essential. This may include requesting additional supporting information from BCBSKC.

*To determine administrator contract compliance, the prevalent practice in the health insurance industry for large employers is to either hire an external audit firm or use internal staff to perform periodic on-site claims compliance audits of the medical plan administrator/carrier. OFM has always placed a high priority on the verification of accuracy of billed items contained in invoices and claim payment accuracy. This is evidenced by the development of procedures in 2005 to perform periodic on-site claims compliance audits. In addition, when the current Health Insurance Program Manager was hired, the Finance Director stressed that claims compliance audits were an important aspect of his job duties and function.*

*In addition, it should be noted that the Health Insurance Program Manager ("Manager") does perform a monthly high level review of the administrator's performance by reviewing cost containment reports specifically requested by and generated for the Manager. By reviewing these reports and asking questions of BCBSKC, staff verifies that BCBSKC is aggressively managing claims and controlling claims costs through disease and case management programs.*

*For example, the Manager receives a high dollar report that lists all claims on plan participants that have at least \$50,000 in claims during a calendar year. Review of the claim activity on this report is used to monitor the ongoing nature of these claimants' condition(s). This review allows two important analyses: 1) the Manager determines the most economical and financially advantageous specific retention level at renewal and decides whether to increase or decrease retention amount for the next year; and 2) the Manager closely reviews each claimant to look for anomalies or issues to be raised as part of a continual auditing process. This review allowed the Manager to identify the existence of premature twins and, as the result of questions asked of BCBSKC, enabled the discovery of other group insurance coverage through the employee's spouse that saved the County over \$250,000.*

**Auditor's Response:** None of the measures discussed deal with the accuracy of the monthly invoice from BCBSKC. The "high level" and "high dollar" reviews are targeted reviews and do not cover the broad scope of the services in the invoices from BCBSKC. The County should not rely on BCBSKC reports to verify the accuracy of the BCBSKC invoice or to verify BCBSKC's compliance with contract provisions. The County Auditor continues to recommend that OFM

independently verify the accuracy of the monthly BCBSKC invoice and independently verify the contractor's compliance with the provisions of the BCBSKC contract.

### **Discussion**

The County receives an invoice and some reports from BCBS monthly. The invoice consists of a summary sheet and approximately 400 pages of detailed charges which identify the individual using the service, the cost of the service, discounts applied and the amount to be paid to BCBS. These invoices range from \$1.5 million to over \$2 million per month and the average amount is increasing as health care costs increase.

#### **County pays invoices without verification for accuracy**

OFM has a procedure to verify that the amount of the invoice agrees with other reports prepared by the vendor. In June of 2005, County staff recognized this process did not provide any substantive value and ceased to follow the reconciliation procedure. No alternative procedure has been developed. Accordingly, these invoices are approved and paid without verification of their appropriateness.

In our opinion, the invoice information currently received by the County is insufficient to verify the accuracy and completeness of the invoice. Even a simple footing of the charges is impractical because the invoice is a printed document of over 400 pages.

Detailed data supporting the invoice is available in electronic format and is currently received from BCBS by the County's benefit consultant. This data could be used to reconcile the monthly invoice and provide substantial additional improvements in overall contract management.

More data is  
needed from  
BCBS

Additional data could be requested from BCBS to allow the use of software techniques, currently available commercially, to allow the County to:

- Verify that all claims are paid for eligible individuals,
- Verify that all medical procedures and medications are allowable under the County's medical plans,
- Verify that the invoice is accurate and complete,
- Provide timely information for questioning costs and monitoring services,
- Verify vendor compliance with contract provisions including timeliness of service,
- Provide monthly reports for management purposes allowing management by exception, and
- Provide a simplified, and more targeted, approach to the periodic audit of the vendor. (See Recommendation 3.1 below.)

### **3. A Better Audit Design Is Needed for Audits of the County's Third Party Administrator**

The Office of Financial Management's (OFM) initial audit of the BCBSKC, the County's third party administrator for health care claims, selected claims based on a risk profile rather than on statistical methods. This method provides audit coverage only for the areas determined to be high risk on a national basis but does not allow the results to be used in reaching conclusions about the overall administration of the health care claims process. While using a targeted transaction approach to audit allows for identification of high risk transactions, it does not capture the magnitude of identified problems that would be found with a statistically valid sample of transactions. OFM staff has subsequently adopted a procedure requiring the use of statistical methods. The audit recovered \$199<sup>4</sup> for claim amounts that should not have been paid. Using statistical methods to analyze the administration process would allow the results to be used, not only in collecting improper payments, but in improving the overall contract management process and providing a basis for settlement of inappropriately paid claims.

#### **Recommendations**

- 3.1 Use statistical methods to review the claims administrator's performance while continuing to use the targeted case review.

#### **Management Comments**

*We agree with Recommendation 3.1.*

*The need for a random sampling statistical methodology for future claim audits was specifically stated in the report from the July, 2005 claim compliance audit. This statistical methodology is also stated in the Claims Audit Policy and Procedures written in 2005.*

**Auditor's Response:** While statistical methodology is required by the Claims Audit Policy and Procedures, it was not used in the audit performed by OFM in 2005. Based on their stated intent to follow this procedure in future audits, we are satisfied that such audits should be more representative.

#### **Discussion**

During 2005, Johnson County's Office of Financial Management (OFM) audited BCBS' performance of the administrative functions. They completed an internal audit report and presented it to the Finance Director and BCBSKC representatives. They concluded BCBS needs to improve in the following services to contain costs:

- Accident injury claims such as automobile accidents and possible work related injuries should be investigated for third party liability prior to payment of claims.
- Notes for medical necessity should be kept with cosmetic procedures claims and investigated prior to payment of claims.

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<sup>4</sup> Another \$24,000 in potential recovery is still under review by BCBS.

- Only “complicated” pregnancies of dependent daughters’ should be covered under participant’s eligibility, however BCBSKC needs to ensure “complicated” pregnancies are confirmed before covering costs for dependent daughters’ pregnancies.
- Member services needs to exercise greater detail in processing terminations to make sure all terminated employees provided by the OFM Benefits staff are processed.
- Increased referrals to case management of claimants with serious medical conditions are needed to enable the determination by HCM if intervention is pertinent and warranted.

As part of the process, the County received refunds from BCBS of \$199.

We reviewed the work papers and methodology employed in OFM’s audit of BCBS. Statistical methods were not used to develop the sample used for testing. Consequently, the results could not be projected to the claims universe, nor could conclusions be reached about compliance with specific contract provisions.

OFM staff stated this was an initial audit. They used a contractor to develop a selection which included areas of high risk as developed by the health care industry. OFM staff said they planned to use statistical methods along with targeted testing in subsequent audits.

Although the audit was conducted in July 2005, a formal report was not issued until October 2006. Timely reporting is essential to good management practice and decision making. In addition, the length of the audit process and the subsequent settlement of the issues may lead to long intervals between audits. Regular audits of BCBS with carefully designed procedures and goals will provide the County with the best possible use of this resource. Timely, formal reporting of those results to the Health Care Management Team will assist in the decision making required of that group and document the due diligence required of the County.

## **OBJECTIVES, SCOPE AND METHODOLOGY**

### **Objectives**

The audit objective was to determine if the Johnson County Self Insured Health Care Fund was being managed effectively and efficiently and in accordance to county policy. The audit included these objectives:

- Review the contract with the third party administrator, Blue Cross Blue Shield (BCBS), and establish that the County has sufficient access to records and agreements to adequately review the payments made to BCBS and the payments made on behalf of the County by BCBS.
- Review the rate structure for health coverage for employees.
- Review the financial transactions in the Health Care Fund (HCF) in 2004 and 2005.
- Review the adequacy of the HCF Reserve at the present time.
- Review the amount, adequacy, and cost of the Aggregate Stop Loss insurance during 2004 and 2005.
- Review the calculation of interest allocated to the HCF.
- Follow-up on the findings from the 2001 Johnson County Health Care Fund internal audit.

### **Scope and Methodology**

To accomplish the audit objectives the auditors:

- Reviewed county policy and procedures related to the Health Care Fund
- Reviewed revenues, expenditures, and the reserve fund from 2001 to 2006.
- Benchmarked peer counties expenditures and year end reserves for 2005.
- Reviewed the 2005 BCBSKC Claim Compliance Audit performed by OFM and related work papers and methodology.
- Verified the credited interest methods.
- Examined the reserve funding methodology for 2004, 2005, and 2006.
- Examined the contribution calculations for 2004, 2005, and 2006.

We interviewed management and staff members to obtain an understanding of management and internal controls. We had staff members explain how they performed tasks relating to the HCF.

We also consulted with OFM staff; the County's benefit consultants, County counsel, and the Department of Budget and Financial Planning to obtain an understanding of the use and functionality of the HCF and its reserve.