PERFORMANCE AUDIT

REVIEW OF MISSOURI CONSOLIDATED HEALTH CARE PLAN MANAGEMENT

From The Office Of State Auditor
Claire McCaskill

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Office of
Missouri State Auditor
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YELLOW SHEET

Missouri law requires Missouri Consolidated Health Care Plan (MCHCP) to provide healthcare benefits for eligible state and public entity employees and their dependents. During calendar year 2003, MCHCP provided group healthcare and prescription drug benefits for approximately 104,000 state members and 5,000 public entity members. Our audit showed MCHCP has taken steps to contain costs in the face of rising healthcare costs, but an examination into further cost cutting measures appears warranted.

More feedback from members could show if services are affordable, good quality

Our survey of active and retired state participants in plans offered by MCHCP shows while 63 percent of respondents rated MCHCP's management of the rising cost of healthcare as adequate, good, or excellent, 66 percent are also less or much less satisfied with MCHCP than they were five years ago. Common reasons for dissatisfaction were a lack of plan choices in some areas and increasing health care costs with no corresponding increase in pay or level of benefits. MCHCP's cost containment efforts in the past several years are similar to those used by other entities, and have helped hold down premium cost increases and produced premiums similar to other states and entities reviewed, without a substantial decrease in benefits covered. (See page 10)

MCHCP does not routinely obtain formal or measurable feedback from its members. Instead, it relies on informal feedback from members through calls to the customer service center and comments or questions heard at open enrollment meetings, etc. Lack of a formal process makes it difficult to quantify the input for use by management, and may help explain why dissatisfaction remains high even when MCHCP appears to be doing a good job at cost containment. (See page 12)

MCHCP should review its structure for potential cost savings

MCHCP services significantly fewer members per employee than other states reviewed. For example, the Kansas state employee health system services 4,392 members per employee and appears to perform services similar to what MCHCP employees handle. MCHCP services only 1,375 members per employee, a difference of more than 3,000 members per employee. (See page 15)

One explanation for the large staff is that MCHCP offers healthcare programs to public entities. At one time, MCHCP serviced 59,000 public entity members. Increasing healthcare costs for that segment resulted in a decrease in members to approximately 3,900 in 2004. While the number of MCHCP employees rose when public entity enrollment increased, those increased staffing levels did not significantly change after public entity enrollment declined. (See page 18)

(over)

Considering staffing levels at other states, costs savings could possibly be achieved by reducing staffing levels as appropriate and/or discontinuing offering healthcare to Missouri public entities. MCHCP could save approximately $47,500 for every employee it reduces. MCHCP is required by statute to offer healthcare options to public entity members, so a legislative change would be needed to discontinue public entity offerings. (See page 21)

State funds are used for services to public entity members

Auditors found state funds are possibly being used to provide services to public entity members. Administrative fees paid by public entities served by MCHCP are supposed to cover the service costs of public entity members. When public enrollment was high, it appeared the administrative fees covered the costs of providing these services. However, the state has always paid the fringe benefits paid to MCHCP employees servicing public sector members, rather than having these costs reimbursed. These employee benefit costs equal approximately 28 percent of the base salary of each employee. MCHCP only estimates how much time employees spend on public entity business versus state member business and the accuracy is not documented. (See page 19)

Few other states have healthcare system run outside a state agency

In a review of 24 mid-continent states, we found only two other states had health care programs run outside a state agency. While MCHCP officials explain their organizational structure was modeled after the Missouri State Employees' Retirement System, placing MCHCP outside a state agency results in performing functions duplicated within state agencies, such as information systems, human resources, and receiving services. This arrangement might have been beneficial when MCHCP serviced a large number of public entity members, but a re-evaluation in light of the current small number of public entity members is warranted. (See page 16)

Eligibility for services should be monitored more closely

MCHCP has no process to ensure all members participating in the health care plans are actually eligible for coverage under the plans. Instead, MCHCP relies on personnel clerks within each state agency to monitor the eligibility of members. Documentation is only required in limited circumstances such as a disabled dependent over 23 years of age or covering a dependent through a court ordered divorce decree. Other states' eligibility reviews indicate more thorough checking, such as requiring marriage, birth and death certificates, may result in the discovery of ineligible members receiving services. (See page 25)

Written procedures needed to ensure contractors adhere to performance standards

MCHCP has no written procedures for monitoring contractor adherence to performance standards, which could cost the state if penalties are not paid. Contractors self-measure some standards and report to MCHCP, with MCHCP relying on the contractors to report non-compliance and apply the appropriate penalties. MCHCP does not periodically require or review documentation to support this self-measurement process. For performance standards monitored by MCHCP, the procedures used to measure performance are not documented. (See page 25)

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ABBREVIATIONS

MCHCP	Missouri Consolidated Health Care Plan
HMO	Health Maintenance Organization
HEHPIP	Highway Employees and Highway Patrol Insurance Plan
MOSERS	Missouri State Employee's Retirement System
POS	Point-of-Service Plan
PPO	Preferred Provider Organization
SAO	State Auditor's Office

CLAIRE C. McCASKILL
Missouri State Auditor

Honorable Bob Holden, Governor
and
Members of the General Assembly
and
Members of the Missouri Consolidated Health Care Plan Board
and
Ron Meyer, Executive Director
Missouri Consolidated Health Care Plan

Healthcare costs have risen considerably nationwide since the late 1990's. Healthcare premium costs paid by the state, Missouri Consolidated Health Care Plan (Missouri Consolidated) members, and public entities increased significantly between 2000 and 2001, after an initial 5-year healthcare contract period ended. Missouri Consolidated has seen double digit increases nearly every year since. This increase in premiums has become a growing concern for the state and Missouri Consolidated members. This concern is especially great given the state's current budget situation and lack of cost of living raises for many state employees for the past 3 years. Because this matter is of utmost importance to Missouri and its employees, we performed an audit of Missouri Consolidated pursuant to our authority under Chapter 29, RSMo. Our objectives were to determine if 1) competitive rates are being obtained for state employees, 2) administrative costs appear reasonable, and 3) the state's health insurance plans are effectively managed.

Missouri Consolidated's rates appear to be reasonable based on two national surveys of state governments' employee health plans and in relation to a comparison study group of 5 surrounding states, 3 other Missouri governmental plans with statewide coverage, and 1 major metropolitan governmental plan. In addition, cost containment efforts are similar to steps taken by other entities to control rising healthcare costs. However, members we surveyed expressed frustration with rising premiums and co-payments and a lack of plan options in some regions. Missouri Consolidated does not routinely solicit formal or measurable feedback from members regarding potential plan design or benefit changes.

Missouri Consolidated has not performed a review of its staff size or structure. While public entity membership has decreased significantly in recent years, the number of employees has remained relatively unchanged and Missouri Consolidated services fewer members per employee than the other surrounding states in the comparison study group. Also, Missouri Consolidated's structure as a separate benefits entity is uncommon among 23 other mid-continent states. In addition, Missouri Consolidated does not ensure enrollees are eligible for healthcare coverage

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and does not adequately monitor the contract performance standards of its self-funded healthcare plans by obtaining supporting documentation or documenting reviews performed.

We have included recommendations to improve the management, oversight, and operation of the Missouri Consolidated Health Care Plan.

We conducted our work in accordance with applicable standards contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and included such tests of the procedures and records as were considered appropriate under the circumstances.

Claire C. McCaskill
State Auditor

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INTRODUCTION

Background

Chapter 103, RSMo, requires Missouri Consolidated to provide healthcare benefits for eligible state and public entity employees and their dependents (including active employees, retirees, Consolidated Omnibus Reconciliation Act (COBRA) participants, disabled members, survivors, and vested members). A Board of Trustees, consisting of thirteen members, is responsible for the general administration and proper operation of Missouri Consolidated. The Board and its staff, along with a consulting actuary, design the benefit levels and structure of the group health care benefits program, which includes medical, prescription drug, dental, vision, and employee assistance components. The Board periodically issues Requests for Proposals to provide such benefits and, with its consultant, negotiates costs with the bidders. Missouri Consolidated also provides services to its membership such as answering general benefit and eligibility questions, serving as an intermediary between members and the contracted healthcare plans, and enrolling members.

During calendar year 2003, Missouri Consolidated provided group healthcare and prescription drug benefits for approximately 104,000 state members and 5,000 public entity members. State employee membership levels have fluctuated slightly over the years; however, public entity membership levels have decreased from a high of approximately 59,000 members in 2000.

For the purposes of obtaining group medical and prescription drug premium rates, Missouri Consolidated has segregated state members and public entity members into two pools, each with its own rates. In establishing rates, the claims experience and other characteristics of each pool as a whole is analyzed to predict expected costs rather than analyzing each member's individual data. The two pools are separated to prohibit state monies from subsidizing public entity members' healthcare expenses. Healthcare plans who bid for fully insured Health Maintenance Organization (HMO) healthcare contracts with Missouri Consolidated are required to submit bids for both public entity employees and state employees. Missouri Consolidated separates the state into eight regions for bidding purposes, and rates may vary for each region. Healthcare plans generally determine which regions to bid based on where their networks of providers are strongest.

Missouri Consolidated offers four different levels of coverage to active members. Each level of coverage for both active and retired state employees is partly subsidized by state funds, with the employee paying the remaining percentage of cost. For active and retired employees, the percentages subsidized by the state are generally based on the low cost plan in each region. For example, if there is more than one plan option in a region and an employee chooses employee-only coverage, the state will subsidize 94.5 percent of the premium cost of the low cost plan. If the low cost plan premium is $100 per month, the state will then subsidize $94.50 per month for all plans available in that region. An employee would then pay the remaining $5.50 per month to enroll in the low cost plan, but would pay more per month to enroll in any other plan. Each level of coverage, the corresponding active employee state subsidy, average active employee state subsidies, and the average retiree/dependent state subsidy is shown in Table 1.

Table 1: 2003 State Subsidy Percentages of Healthcare Premiums

Level of Coverage	State Subsidy Percentage
Active employee-only	94.5
Active employee/spouse	73.5
Active employee/child(ren)	94.5
Active employee/family	78.5
Average active employee state subsidy	83
Average retiree state subsidy[1]	49

[1] The state contribution strategy for retirees is based on several factors, including length of service and date retired.
Source: Missouri Consolidated

Missouri Consolidated utilizes a combination of self-funded and fully insured plans to provide benefits. During calendar year 2003, Missouri Consolidated offered two self-funded medical plans and a self-funded prescription drug plan to state members. Under these plans, Missouri Consolidated contracted with third parties to administer the plans and process the claims; however, the state assumed the risk that the cost of paying claims incurred by members might have exceeded the amount of premiums collected. In addition, six fully insured HMOs were offered. With fully insured plans, the contracted healthcare plans assumed the related risk of paying claims incurred by members in exchange for the premiums collected. The eight medical plans provided several different healthcare options for most state members. The Co-pay Plan option is statutorily required to be offered to state employees located in counties in which HMO coverage is not available and must have benefits coverage substantially identical to HMO benefits coverage. This plan's premium costs to those individuals cannot exceed the average cost to employees for HMO coverage in counties where HMO coverage is available. There are also seven HMO plans, each offering a premium or a standard option. Members choosing the premium option pay higher monthly premium rates in exchange for lower co-payments on services used, while the standard option provides lower monthly premiums but higher service co-payments.

The most populated healthcare plan for state members during calendar year 2003 was Mercy Health Plans HMO - standard option (this plan operates under the name Premier Health Plans HMO in the southwest region of the state). This plan covered healthcare for 35 percent of total state members. It was also the least expensive plan in the regions where offered. The Co-pay Plan was the second most populated, with 17 percent of total state members. This plan was offered statewide and was the only available option to members in the northeast, southeast, and south central regions.[1]

Methodology

To determine if Missouri Consolidated obtained competitive rates for state employees and whether administrative costs were reasonable, we interviewed officials responsible for developing bid specifications and obtaining healthcare contract bids and reviewed Missouri Consolidated's bidding procedures. We also performed analytical reviews of Missouri

[1] The types of healthcare plans offered to state members during calendar year 2003, the number of state members and dependents covered by each plan, and the general availability of plans across the state are described in Appendix I.

Consolidated's revenues and expenses for fiscal years 1996 through 2003. We obtained this data from Missouri Consolidated's annual reports. In addition, we acquired information from five surrounding states regarding their pooling and bidding requirements, administrative structures, services provided to members, and eligibility requirements, as well as other healthcare related information. We used this information in comparison with Missouri to analyze whether various aspects of Missouri Consolidated's duties and functions, procedures, and structure were adequate and necessary.

To establish how Missouri's 2003 medical and prescription drug monthly premiums compared to other entities and states, we obtained health insurance cost information from a comparison group consisting of five surrounding states, three other state entities or agencies within Missouri, as well as the city of Kansas City, Missouri. We acquired average monthly premium information, as well as co-payment, deductible, coinsurance percentage, and out-of-pocket maximum figures for each entity's most populated HMO and conventional healthcare plan (plans other than HMOs). We did not compare the specific benefits covered under each plan (e.g., in-patient and out-patient services, type of office visits covered, percent coverage of preventive care, etc.). We assumed certain basic services were covered to some extent by all plans. In addition, we reviewed other available healthcare literature and studies available. Due to the relatively small number of public entity members currently enrolled in Missouri Consolidated, our analysis of health insurance premiums focused on rates relative to state members only.

To determine if the state's health insurance plans were effectively managed, we reviewed the contracts related to Missouri Consolidated's self-funded and fully insured medical and prescription drug plans. We also reviewed the performance standards outlined by Missouri Consolidated in each of the self-funded contracts, as well as the basis for measurement and penalties assessed for noncompliance. We also interviewed Missouri Consolidated officials and staff responsible for managing the plans. In addition, we interviewed Missouri Consolidated officials regarding the policies and procedures put in place to monitor eligibility of both new and existing members.

To gain an understanding of state members' use of and satisfaction with Missouri Consolidated and their current healthcare plan options, we randomly selected 200 of the 45,000 active state employees and 50 of the 11,000 retired state employees enrolled through Missouri Consolidated in 2003 to survey. We received responses from 152 employees, with 147 of the employees (113 active and 34 retired) choosing to answer part or all of our survey questions. The survey form and summary responses are described in Appendix IV.

We obtained comments on a draft of this report during a meeting with the Missouri Consolidated’s executive director and other officials on May 19, 2004, and in a letter dated June 1, 2004. We incorporated their comments as appropriate. We conducted our work from March 2003 to February 2004.

RESULTS AND RECOMMENDATIONS

1. Continuing to Explore Additional Cost Containment and Healthcare Plan Options Would Be Beneficial and Could Help Improve Member Satisfaction

The weighted average monthly premium cost of healthcare[2] for Missouri Consolidated's state members increased 159 percent between 1996 and 2003, from $191 to $495 per month. This increase occurred because of healthcare market trends and the end of a 5-year healthcare contract period in 2000.[3] However, recent increases seen by Missouri Consolidated were not unusual or significantly different from increases seen nationwide. In addition, Missouri Consolidated's 2003 premiums were reasonable compared to many of its surrounding states, other Missouri governmental plans with statewide coverage, and a Missouri metropolitan government plan. While Missouri Consolidated has taken several steps to contain healthcare premiums, these efforts have been instituted without routinely soliciting formal or measurable feedback from Missouri Consolidated members. Although Missouri Consolidated's healthcare cost increases were not unusual from national increases for the last two years, many Missouri Consolidated members have expressed frustration in their rising premiums, lack of cost of living raises, and limited healthcare plan options.

Missouri Consolidated's 2003 premiums and recent cost containment efforts were comparable to national healthcare averages and trends

The weighted average monthly premium cost between 1996 and 2003 increased primarily as a result of Missouri Consolidated's increased medical related expenses, which rose from $122 million to $344 million during the same time frame.[4] Missouri Consolidated's weighted average monthly premium cost increased 46 percent between 2000 and 2001, while the national average monthly healthcare cost for active and retired employees increased only 13 percent.[5] As noted earlier, this occurred at the end of the 5-year contract period. Since 2001, Missouri Consolidated's weighted average monthly premium cost increases have been more in line with the national average, with a 19 percent increase in 2002 compared to a 14 percent national increase, and a 7 percent increase in 2003 compared to a 16 percent national increase.

The active employee-only monthly premium rate of Missouri Consolidated's most populated plan in 2003 averaged $289, which is $19 less than the active employee national average of state governments of $308.[6] Missouri subsidized 94.5 percent of this monthly premium cost, which

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[2] The term "premium cost of healthcare" is defined here as active and retired state employee medical and prescription costs only, and does not include optional costs such as dental or vision. These average monthly premiums include both the state and employee shares. Average premiums for 1996 through 2003 are presented in Appendix II, Table II.1.

[3] Under the 5-year contracts, healthcare contractors' yearly premium increases were capped at a rate less than the general trend for the healthcare market. In 2001, contracted healthcare plans revised premiums to catch up to market trends, and accordingly, Missouri Consolidated's healthcare premiums have seen double digit increases nearly every year since.

[4] Missouri Consolidated's fiscal years 1996 through 2003 revenues, expenses, and changes in net assets are presented in Appendix II, Table II.2.

[5] National average monthly healthcare cost information issued in Towers Perrin, 2004 Health Care Cost Survey.

[6] National averages obtained from 2003 Segal State Health Benefits Survey: Medical Benefits for Employees and Retirees.

was higher than the national average of state governments of 90 percent. The active employee/family monthly premium rate of Missouri Consolidated's most populated plan in 2003 averaged $868, which is $100 more than the active employee/family national average of state governments of $768. However, the state subsidized 78.5 percent of this monthly premium cost, which was essentially the same as the national average of state governments' subsidy of 78 percent. In addition, another 2003 national survey of state government employee benefits ranked Missouri Consolidated's total monthly premium for employee-only coverage in the most populated plan as 21st out of 42 responding states.[7] This survey also ranked Missouri Consolidated 35th lowest out of 40 responding states in total monthly premium cost for family coverage in the same plan. That survey also found the percentages subsidized by the state for those two coverage levels approximated the averages of the states responding.

Based on interviews with healthcare contractors' officials and reviews of healthcare literature and studies, we determined various factors affected the rising costs of healthcare. For example, drug and medical advances, rising provider expenses and reimbursement rates, government mandates and regulations, increased demand due to an aging population, increased consumer awareness of the newest drugs and treatment options, and poor lifestyle habits. Efforts by Missouri Consolidated to contain rising costs included:

- increasing self-funding of various aspects of healthcare,
- joining a multi-state prescription drug purchasing initiative and contracting with a Pharmacy Benefits Manager,
- modifying the benefit design for pharmaceuticals to provide differing co-payments for generic, formulary, and non-formulary drugs,
- increasing co-payments and modifying the co-payment structure for medical benefits to offer standard and premium HMO plans, and
- implementing utilization and case management through contracts with HMOs.

Based on interviews with healthcare contractors' officials and other state government healthcare plans and reviewing various on-line literature, Missouri Consolidated's cost containment efforts were similar to efforts put in place by others to control rising healthcare costs. While modifying the pharmacy design benefits and the co-payment structure for medical benefits has passed additional costs to members when prescriptions were filled or services were utilized, the result has been slower growth in monthly premiums for the members. In addition, passing these additional costs to members at the time of service had been intended to encourage members to become better healthcare consumers and make more informed healthcare decisions. According to discussion in Missouri Consolidated board meeting minutes, without these modifications and the resulting shifts in member enrollment to lower premium plans, state members would likely have faced higher premium increases in recent years.

[7] National averages obtained from Workplace Economics, Inc,. 2003 State Employee Benefits Survey. Rankings based on SAO calculations.

Missouri's 2003 healthcare premiums were comparable for HMO plans, but were the highest for conventional plans in comparison group

Our analysis shows Missouri Consolidated's average 2003 HMO premium in the middle of the range of premium rates for the most populated HMO plan in our comparison group.[8] Missouri Consolidated's most populated HMO, also the most populated plan of any type, covered 35 percent of total state members (subscribers and dependents) and 42 percent of the total HMO population. Overall, 83 percent of total state members were enrolled in one of the seven available HMO plans. As shown in Figure 1, Missouri Consolidated's average employee-only monthly premium (one entity did not offer an HMO option) equaled the group's average. Other than the highest and lowest rate, the HMO rates of the comparison group appeared to be very similar.

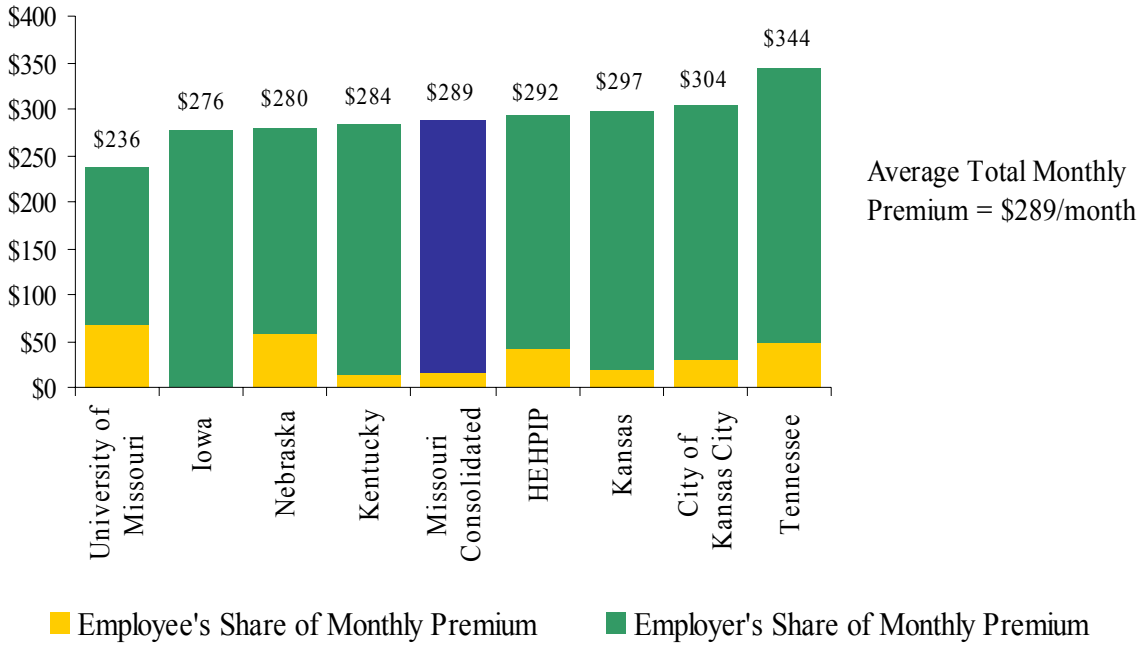
While Missouri Consolidated's 2003 HMO premium was comparable, our analysis shows the average 2003 premium for its conventional plan as the highest of all 10 entities in the comparison group. As shown in Figure 2, the employee-only monthly premium for Missouri Consolidated's only conventional plan, the second most populated plan of any type and covering 17 percent of total state members (subscribers and dependents), was significantly higher than the comparison group's average. However, Section 103.081, RSMo Cumulative Supplement 2003, requires this plan's benefits to be substantially identical to HMO benefits coverage. Therefore, Missouri Consolidated's conventional plan does not require deductibles or co-insurance for most services utilized, as most of the comparison group's conventional plans require. This difference results in less potential out-of-pocket costs to Missouri Consolidated members enrolled in its conventional plan than most of the comparison group's members.

The comparisons are presented in Figures 1 and 2.

- The figures show total monthly premiums for each state's or entity's most populated HMO and conventional plan We did not adjust them for possible benefit design differences or the possible risk factors of the various enrolled populations.
- The figures also show both the employee's share and the employer's share of applicable monthly premiums.
- All entities in the comparison group have multiple levels of coverage (i.e., employee-only, employee/spouse, employee/child(ren), employee/family). Since all entities at least had employee-only coverage we used that rate category for analysis. In addition, 51 percent of Missouri Consolidated's active state members were enrolled in employee-only coverage. As shown in Appendix III, the rankings of family coverage premiums were substantially the same as employee-only. In addition, where premiums vary due to salary levels or region, we determined a weighted average for the most populated plans.

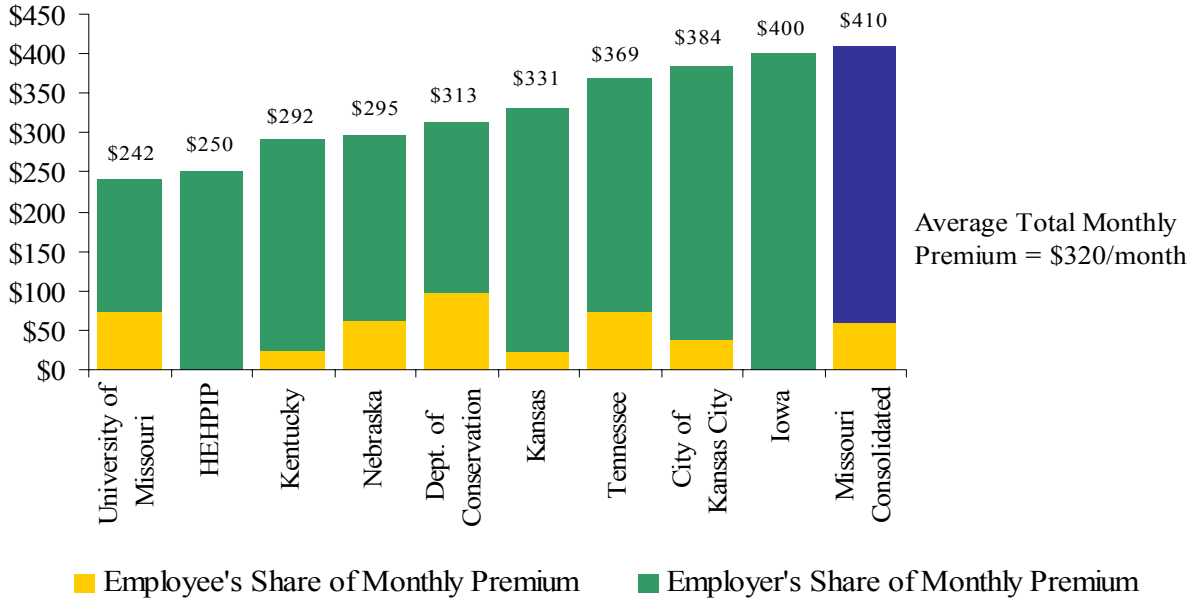
[8] To analyze healthcare costs of Missouri Consolidated and its comparison group, we focused on the most populated HMO plan and conventional plan in each state or entity for the 2003 healthcare year. The comparison group consists of the states of Kansas, Kentucky, Iowa, Nebraska, and Tennessee, as well as the Missouri Highway Employee's and Highway Patrol Insurance Program (HEHPIP), the Missouri Department of Conservation, the University of Missouri, and the city of Kansas City.

Figure 1: 2003 Monthly Premiums in HMO Plans for Employee-Only Coverage



Averages Exclude Missouri Consolidated
Source: Based on SAO analysis of information obtained from comparison group

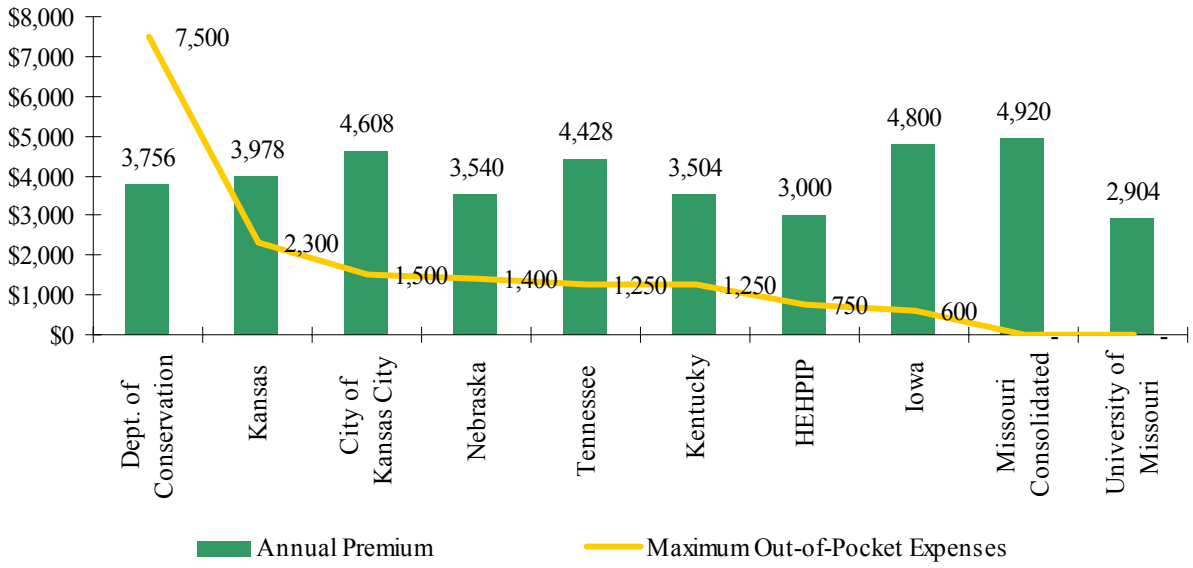
Figure 2: 2003 Monthly Premiums in Conventional Plans for Employee-Only Coverage



Averages Exclude Missouri Consolidated
Source: Based on SAO analysis of information obtained from comparison group

Our analysis indicates plans which pass on more financial responsibility and risk to members generally have lower premiums, which is consistent with most types of insurance. In other words, the more a member will potentially pay out-of-pocket (e.g., deductibles, coinsurance, co-payments, etc.) the lower the premiums. Our comparison of total annual premiums and maximum out-of-pocket costs indicates, as presented in Figure 3, while Missouri Consolidated's annual premiums were higher, most of the other entities and states passed on more of the financial responsibility to their members through various out-of-pocket costs. The amounts of potential out-of-pocket costs ranged widely among the plans reviewed. Through a combination of statutory requirements and policy choices, Missouri Consolidated determined not to offer a plan requiring more member out-of-pocket costs for the 2003 health plan year.

Figure 3: Comparing 2003 Annual Premiums To Maximum Out-Of-Pocket Costs In Conventional Plans for Employee-Only Coverage



Source: Based on SAO analysis of information obtained from comparison group

Appendix III contains additional analysis of conventional plans regarding out-of-pocket and maximum medical expenses.

State member healthcare survey results indicate dissatisfaction in rising premium costs and availability of plans throughout the state

Most active state employees and retirees responding to our survey rated Missouri Consolidated's performance adequate (44 percent), good (24 percent) or excellent (9 percent) in offering options to fit their needs, and most rated Missouri Consolidated's management of the rising cost of healthcare adequate (46 percent), good (15 percent) or excellent (2 percent). However, 66 percent still indicated less or much less satisfaction than 5 years ago. Common reasons cited for dissatisfaction included a lack of plan choices in many parts of the state and increasing costs for

employees through rising premiums and higher co-payments even though employees received little or no pay raises or no increase in benefits.

Responses regarding plan choices were not surprising since members in five of the eight regions of the state have limited choices in healthcare plan offerings. For members in the northeast, southeast, and south central regions only one plan (Co-pay Plan) is available, while members in the northwest and southwest regions have only two healthcare plan choices (Co-pay Plan and one HMO). Fewer choices in plans can mean fewer choices of providers or hospitals, according to a Missouri Consolidated official.

Missouri Consolidated does not restrict the number of fully insured HMO plans that can contract for healthcare services each year. As long as HMOs bidding for fully insured healthcare contracts comply with the specifications of the Request for Proposal, Missouri Consolidated has generally offered the plan as an option to members. To foster competition, Missouri Consolidated has separated the state into eight regions for bidding purposes. According to Missouri Consolidated officials and their current healthcare contractors, a regional strategy is necessary because few plans have large enough networks to allow for statewide bids. The healthcare plans bid for membership in particular regions based on the strength of their networks. This bidding strategy has resulted in more healthcare plans available to members in the central, east, and west regions of the state, where the majority of healthcare plans were strongest. However, fewer options exist in other rural parts of the state where most plans have small or no networks. We found Missouri Consolidated has no control over healthcare contractors' ability to establish networks in these areas.

Missouri Consolidated's offerings have been primarily HMO plans. The one conventional plan (Co-pay Plan) offered statewide also mimics the structure of an HMO as required by statute. A Missouri Consolidated official told us bids for a fully insured Preferred Provider Organization (PPO) plan have not been requested since 1999. The official further stated no fully insured bids were received at that time and due to this lack of response, Missouri Consolidated has not solicited bids for this type of plan since. While Missouri Consolidated has received bids for self-funded PPO plans since that time, their limited ability to fund actuarially required claims reserves of these plans and the network duplication with the Co-pay Plan has limited the offering of such plans.

Over 50 percent of survey respondents included written comments expressing concern with the rising cost of healthcare premiums, with many citing the issues of little or no employee raises or no corresponding increase in the level of benefits offered. As noted earlier, in the face of rising healthcare costs, the cost containment efforts instituted by Missouri Consolidated were similar to those used by many other entities and has helped hold premium cost increases to levels comparable to other states while causing no substantial decrease in benefits covered. The state has continued to subsidize approximately the same percentage of healthcare premiums for all state members each year.

State employees and retirees responding to our survey also indicated a reluctance to accept future changes to either plan design or benefits offered, while at the same time they believed Missouri Consolidated should focus on reducing monthly premiums and co-pay amounts. Unfortunately,

given the national trends of rising healthcare costs, it appears balancing these expectations will be very difficult. The entire state member healthcare survey and responses received are shown in Appendix IV.[9]

Missouri Consolidated has not routinely solicited formalized and measurable feedback from members regarding possible and implemented plan design or benefit changes

Missouri Consolidated's stated mission is to provide access to quality and affordable health insurance for state and local government employees; however, Missouri Consolidated does not routinely obtain formal or measurable feedback from its members to determine what the members consider "quality and affordable health insurance."

Based on information obtained through our research, discussion with healthcare insurance industry practitioners, and the comparison group, many variables can affect insurance premium rates. For example, the types of plan options offered (HMO or conventional plans), the specific medical services covered by the plan, and the amount of financial responsibility placed on the member through co-payments, deductibles, and coinsurance. In recent years, Missouri Consolidated has begun requiring or increasing co-payments for specific medical services and pharmaceuticals in its various plan offerings; however, it has not made significant changes to the specific benefits offered to members.

Missouri Consolidated hired a consultant to conduct focus groups in 2001 to determine members' perception of Missouri Consolidated, the usefulness of benefits, and members' opinion of the open enrollment process. However, members were not asked about possible changes to decrease or contain costs. Since that time, Missouri Consolidated has made some efforts to gain information from members. These efforts have come in the form of surveys included in the periodic newsletters mailed to members. The newsletters include Missouri Consolidated health information directly relayed to members. During our review of the 2003 newsletters, the only survey included regarded the confidentiality of medical information and communication materials sent to members from Missouri Consolidated.

Missouri Consolidated officials indicated they also obtain informal feedback from members through calls received at the customer service call center and through comments or questions heard at open enrollment meetings, etc. While such methods may provide useful information, the informal, unstructured nature of these communications makes it difficult to quantify the input for use by management and the board in its decision-making processes or for reporting results back to members.

Conclusions

Missouri Consolidated has taken several steps to contain the rising cost of healthcare and has managed to maintain costs relative to national averages. Eighty-three percent of Missouri Consolidated's state members were enrolled in an HMO product, with the most populated HMO plan covering 42 percent of the total HMO population. This plan's 2003 monthly premium

[9] Questions regarding acceptance of future changes and Missouri Consolidated's focus are located in section C, questions 1 and 2.

approximated the average HMO monthly premium of Missouri Consolidated's comparison group. Seventeen percent of Missouri Consolidated's state members were enrolled in the single conventional plan offered. The 2003 monthly premium of Missouri Consolidated's conventional plan was the highest in its comparison group; however, Missouri Consolidated passes little to no additional financial responsibility to it members in the form of deductibles or co-insurance compared to most of the other entities in its comparison group.

Members are frustrated with rising healthcare premiums and lack of cost of living raises, as well as limited plan options. Missouri Consolidated has instituted various healthcare cost control measures and not restricted healthcare plans from bidding. Missouri Consolidated cannot control whether state employees receive cost of living raises to help compensate for rising costs or require healthcare plans to bid where their networks are not adequate. However, Missouri Consolidated needs to continue to develop new cost containment efforts and explore alternatives to provide more options to members in all regions of the state.

Missouri Consolidated is not routinely soliciting formal or measurable feedback from members regarding what cost containment measures members would prefer or consider in order to reduce healthcare premiums or out-of-pocket costs. In order for Missouri Consolidated to achieve its stated mission of providing access to quality and affordable health insurance, it should solicit input from its members regarding important plan design and benefit change considerations.

Recommendations

We recommend the Missouri Consolidated Health Care Plan:

1.1 Continue to develop new efforts to contain rising healthcare premiums and explore alternatives to offer additional healthcare plan options to members.

1.2 Routinely solicit and measure input from its membership regarding important plan design and benefit change considerations.

Agency Comments

The Board of Trustees and the Executive Director of the Missouri Consolidated Health Care Plan provided the following comments in a letter dated June 1, 2004:

1.1 As it has in the past, MCHCP will continue to research all available options to control healthcare costs and to determine when/if further health plan options become available. This will be accomplished by continuing to meet and discuss alternatives with other public and private employers, researching pertinent literature and reports, obtaining information from various vendors, analyzing MCHCP specific data and obtaining feedback from our members. MCHCP also continues to review options for further self funded plans (specifically in the current RFP).

1.2 MCHCP has solicited and/or received feedback from its members from earlier surveys, during open enrollment meetings, personnel/payroll meetings, pre-retirement seminars,

through the customer call center and through e-mail. In addition, focus groups have been held with state employees and just recently a survey regarding benefits and rates was completed with the public entities. These efforts have frequently resulted in responses similar to those contained in the survey conducted by the State Auditor's Office.

However, MCHCP will review its policies and procedures in regard to implementing a more formalized and documented process for receiving feedback from members. This could take the form of more routine survey responses and/or meetings with a group representing state employees. Our Customer Support department would take the lead on this project.

2. Missouri Consolidated's Administrative Structure and Costs Could Be Reduced

Missouri Consolidated's administrative costs[10] have risen 51 percent in the past 7 years, from approximately $4.8 million in 1996 to approximately $7.2 million in 2003. Missouri Consolidated's payroll and related benefits expenses accounted for almost $1.5 million, or 60 percent, of the increase in administrative costs between these years. The main increase in payroll and related benefits expenses occurred between 1996 and 2000, when Missouri Consolidated increased its number of employees from 71 to 80 to correspond with growing public entity enrollment. However, since that time, public entity enrollment has decreased significantly, while the number of employees has remained relatively the same. Missouri Consolidated serviced fewer members per employee than states in a comparison group and its organizational structure as a separate health benefits agency is uncommon in comparison to 23 area states. Missouri Consolidated has not performed a review of its organizational or administrative structures to determine if the organization and number of employees is necessary or most appropriate given its current state and public entity membership levels. As a result, cost savings could possibly be achieved by a combination of (1) reducing staffing levels, (2) combining Missouri Consolidated with a current state agency, and/or (3) discontinuing offering healthcare to Missouri public entities.

Missouri Consolidated could streamline its administrative structure

Missouri Consolidated services fewer members per employee than any state in our comparison group.[11] Missouri Consolidated has not performed a review of its administrative structure to determine if the current number of employees on staff is necessary. In addition, Missouri Consolidated operates an organizational structure as a separate benefits entity, which is fairly uncommon when compared to many other area states' healthcare programs. According to a Missouri Consolidated official, the legislature established Missouri Consolidated as a separate benefits organization to model the Missouri State Employees' Retirement System (MOSERS), which had managed healthcare benefits for state members prior to 1994. However, no review of this organizational structure has been performed to determine whether it is the most efficient and cost-effective method of administering the state's healthcare program.

As shown in Table 2.1, Missouri Consolidated's number of members serviced per employee in 2003 was the lowest of all five states in our comparison group.[12]

[10] Administrative costs generally include payroll and benefits, professional services, and general state and public entity operating expenses.

[11] For comparative purposes, we requested information from Iowa, Kansas, Kentucky, Nebraska and Tennessee.

[12] Tennessee's number of members and employees is based on 2002 data because 2003 data was unavailable. Iowa declined to provide such data.

Table 2.1: Comparison of 2003 Members Serviced Per Employee

State	Number of Members	Number of Employees[1]	Ratio of Members Per Employee
Missouri Consolidated	108,610	79	1,375
Kansas	87,843	20	4,392
Kentucky	225,742	40	5,644
Nebraska	31,100	5	6,220
Tennessee	292,082	39	7,489

[1] The number of employees may not include functions that may be shared or contracted with state agencies, insurance companies or other intermediaries by Missouri Consolidated or the other states.
Source: Based on SAO analysis of information obtained from comparison group

Officials of Kansas' and Tennessee's state healthcare programs - the comparison states with the lowest and highest ratios of members per employee, excluding Missouri - told us their programs provide many of the same types of services to members as Missouri Consolidated. These services include determining the level of benefits, bidding and contracting with healthcare companies, and coordinating enrollment of members. Other services include the issuance of communication materials to members, accounting services, and various customer service functions. While not included in the employee numbers in the table above, Missouri Consolidated, Kansas, and Tennessee all utilize payroll and personnel staff of other agencies to varying degrees. Missouri Consolidated and Kansas utilize payroll staff of other agencies to prepare enrollment applications for new employees and verify eligibility for changes made by existing members throughout the year. Missouri Consolidated and Kansas staff then process these enrollments and changes, as well as performing all enrollment activities during the annual open enrollment period. Tennessee utilizes payroll staff of other agencies to perform all processing functions related to enrollment and eligibility. Officials from Kansas and Tennessee stated both programs are administered by a division within a state agency and governed by a board or commission. Human resource and information systems/technology services for the Kansas state healthcare program are provided/shared at the division level. Likewise, human resource services for the Tennessee state healthcare program are provided at the division level.

Missouri Consolidated's organization as a separate entity for healthcare is uncommon among area states

Given the few public entity members now served by Missouri Consolidated, the need to be a separate entity appears to be diminished. The current structure as a separate benefits entity may have been appropriate when Missouri Consolidated was serving a significant number of public entity members, since the agency was required to have a much broader focus and its goal was to keep state monies from subsidizing public entity related costs.

Missouri Consolidated was statutorily created "for the purpose of covering medical expenses of the officers, employees and retirees, the eligible dependents of officers, employees and retirees and the surviving spouses and children of deceased officers, employees and retirees of the state and participating member agencies of the state." A Missouri Consolidated official told us the reasoning behind establishing Missouri Consolidated as a separate entity which answers to an independent board was to model the organizational structure of MOSERS, due to the specialization of healthcare.

In order to determine how Missouri Consolidated's structure compares to other states, we surveyed the healthcare programs of the comparison group regarding eligible members, where each plan is located, and how each plan is governed. Table 2.2 shows the results of our survey.

Table 2.2: Comparison of the Structure of Health Benefits Programs

	Who's eligible to participate?		Where is it located?		How is it governed?	
States	State Employees	Public Entities	State Agency	Separate State Entity	Agency Head	Board or Commission
Iowa	X		X		X	
Kansas	X	X	X			X
Kentucky	X	X	X			X
Missouri Consolidated	X	X		X		X
Nebraska	X		X		X	
Tennessee	X	X	X			X

Source: Based on SAO analysis of information obtained from comparison group

Four of the six states' healthcare programs offer healthcare to public entities, and each of the four are governed by a board or commission. The two state programs that do not offer healthcare to public entities are governed by an agency head. Of the four state programs offering healthcare to public entities, Missouri Consolidated is the only program located within a separate benefits state entity.

We also found that 16 of 18 other mid-continent states' healthcare programs are located within a state agency. These states include: Arkansas, Colorado, Georgia, Illinois, Indiana, Louisiana, Minnesota, Mississippi, New Mexico, North Carolina, Ohio, South Dakota, Virginia, West Virginia, Wisconsin, and Wyoming.[13] The other two states, Oklahoma and Alabama, are set-up as a separate benefits entity.

In a 2001 report, the Kansas Legislative Division of Post Audit reviewed the staffing and structure of the Kansas State Health Benefits Program.[14] An issue reviewed during that audit was whether the structure of the Kansas State Health Benefits Program was appropriate given its responsibilities and how the structure compared to those of similar programs in other states. The Kansas audit found that although the Kansas State Health Benefits Program served both state and public entity members, the location within an existing state agency was appropriate given the high ratio of state to public entity members. The Kansas audit found states that served only or predominately state employees tended to be located within a state agency, while states such as Missouri, which served the highest percentage of public entity employees in Kansas' comparison group at the time, were located in a separate benefits agency. At the time of Kansas' audit in 2001, Missouri serviced almost 16,000 public entity members, or 13 percent of the total population of state and public entity members, whereas Kansas serviced only approximately 2,000 members, or 2 percent of its total state and public entity members.

[13] In addition to surveying the comparison states, we searched the websites or contacted 18 other area states' healthcare programs (these states either surround Missouri or border the surrounding states) to determine whether they were located within a state agency or set up as a separate benefits entity.

[14] Legislative Division of Post Audit, State of Kansas, performance audit report titled, The State Health Benefits Program, Part 2: Reviewing the Staffing and Structure of the Current Program, July 2001.

Since the time Kansas completed its audit, Missouri Consolidated's public entity membership levels have declined to approximately 3,900 members in 2004, or only 4 percent of the total population of state and public entity members. In addition, of the four states noted in Table 2.2 offering healthcare to public entities, Missouri Consolidated provided healthcare for the least number of public entity members in 2003. The Kansas audit also noted that being within an existing state agency that dealt with all state employee benefits allowed for coordinated management of all human resource programs, the sharing of staff and other resources, and provided a single point-of-contact for benefits for state employees.

A Missouri Consolidated official told us that due to the specialization of health care, being a separate entity provides the ability to better react to industry and market conditions and to achieve additional bidding opportunities. The official stated that even though following the same purchasing rules as the Office of Administration, being separate allows for quicker reaction, faster and easier negotiations, added internal expertise, and that moving to a department setting would result in lost independence and reaction to the market place. However, we believe there are potential benefits and cost savings related to such a move, particularly in light of the declining public entity membership.

Discontinuing healthcare offerings to Missouri public entities could further reduce administrative costs

Considering the decreased public entity membership levels, Missouri Consolidated has not yet assessed whether offering healthcare services to public entities is useful or cost-effective. Missouri Consolidated had more employees compared to members than comparison group states. This unfavorable comparison was due in part to failing to reduce the number of employees servicing public entities as the number of public entity members shrank. When public entity membership rose significantly between 1996 and 2000, Missouri Consolidated increased its number of employees to assume the additional administrative burden, growing from 71 to 80 employees. However, even though public entity membership levels declined significantly the past 4 years, Missouri Consolidated still employs 79 individuals, with at least 16 employees currently dedicated to public entity business. Missouri Consolidated officials stated these employees have been retained in hopes of regaining or expanding public entity business and to help implement any potential changes to be identified to make the public entity program more competitive. However, Missouri Consolidated officials provided no evidence that the steady downward trend in public entity membership will soon be reversed. Missouri Consolidated officials have not analyzed current employment levels to determine the number of employees necessary to provide services to its current membership.

Missouri Consolidated is statutorily required to offer healthcare to eligible public entities throughout Missouri, and began doing so in calendar year 1995. In order for a public entity to be eligible to participate, the healthcare plans offered through Missouri Consolidated must be made available to all eligible employees and their dependents, as well as all retirees of the public entity, if applicable. In addition, a public entity must meet other requirements regarding level of employee participation and minimum employer contribution amounts. The state does not pay any portion of the medical premium for public entity members.

Inability to provide competitive public entity premium rates resulted in a significant decline in membership levels

By 2000, Missouri Consolidated was providing services to approximately 108,000 state members and 59,000 public entity members, according to its annual reports and other enrollment data. However, by 2003, Missouri Consolidated was serving only approximately 5,000 public entity members. Public entity enrollment figures for 2004 were down further to approximately 3,900, while state enrollment figures dropped slightly to approximately 103,000.

Missouri Consolidated officials told us initial goals related to public entity membership included actively recruiting new members to quickly create a large membership pool to try to achieve better premium rates. Because of the declining public entity enrollment, the focus has shifted to both recruiting and trying to retain members. However, premium costs continue to rise for public entity members and a Missouri Consolidated official said the substantial loss of members is a primary result of those rising costs. Based on discussions with a Missouri Consolidated official and various healthcare plans that currently contract with Missouri Consolidated, these members are considered higher risk than state members due to increased health issues and lack of membership stability caused by the public entities' ability to shop for healthcare insurance through other carriers and opt into Missouri Consolidated if a better plan or price cannot be found. The officials and contractors we interviewed told us claims data shows members remaining with Missouri Consolidated tend to have more serious health issues and in many cases Missouri Consolidated is the only insurer available.

In addition, the majority of the various healthcare plans we contacted believed that mandating coverage for all public entity groups or, at the least, requiring the entities to stay with Missouri Consolidated for 3 or more years would reduce premium costs for these entities as it would provide a more stable and risk-diverse pool. Neither of these options have been adopted by Missouri Consolidated. However, in 2000, the legislature passed a statutory requirement that entities terminating coverage cannot be eligible for participation under any circumstance for 2 years after the termination date. According to a Missouri Consolidated official, this requirement was added in an effort to stabilize the public entity population, but has had limited effectiveness in controlling premium costs. While Missouri Consolidated does not require public entities electing to participate in its plans to stay beyond one year, Kansas' Health Benefits Program requires all participating entities to enroll for at least 3-year periods.

Allocations of administrative costs associated with offering healthcare to public entities have not been complete or adequately supported

While Missouri Consolidated's records show public entity administrative fee revenues adequately covered public entity related expenses most fiscal years, these amounts are skewed since applicable employee benefits are not included and other allocated salaries and general operating expenses are allocated based on a revenue income ratio or undocumented time allotment rather than actual work effort related to public entities. In addition, a running balance of public entity administrative fee revenues earned and public entity expenses paid had not been maintained, but was generated upon our request. State and state member monies were being expended to cover costs of all employee benefits, regardless of time spent on public entity related

matters. The state and state members could also be subsidizing additional salary costs for the majority of Missouri Consolidated employees whose time actually spent on public entity related matters is unknown.

Missouri Consolidated officials told us the state's expenses associated with offering healthcare to public entities have been reimbursed by administrative fees paid for by entities that receive services. Missouri Consolidated charged each public entity a monthly administrative fee per employee in addition to the monthly premium. Both the administrative fees and the premiums were paid directly to Missouri Consolidated. The premiums were passed on to the appropriate healthcare contractors, while the administrative fee was retained to pay for public entity related expenses. Administrative fee revenues and related public entity expenses reimbursed for the past 7 fiscal years are shown in Table 2.3.

Table 2.3: Public Entity Administrative Fee Revenues and Expenses

	FY 2003	FY 2002	FY 2001	FY 2000	FY 1999	FY 1998	FY 1997
Revenues	$ 1,103,382	1,198,977	2,405,698	3,242,948	2,540,276	1,799,421	732,036
Expenses	(1,480,645)	(1,314,061)	(2,060,892)	(2,728,062)	(1,820,113)	(1,469,029)	(897,886)
Revenues over/under expenses	(377,263)	(115,084)	344,806	514,886	720,163	330,392	(165,850)
Surplus	$ 1,252,050	1,629,313	1,744,397	1,399,591	884,705	164,542	(165,850)

[1]Missouri Consolidated provided us with administrative fee revenues received for fiscal years 1995 and 1996 of $41,191 and $256,627, respectively. In addition, while they provided expenses for fiscal years 1995 and 1996 of $197,739 and $789,755, respectively, they were unable to attest to the accuracy of expenses paid during those two fiscal years.
Source: Missouri Consolidated Health Care Plan calculations

According to accounting records provided by officials, direct expenses paid from public entity administrative fees included broker commissions, staff travel and room charges for meetings held with local governments, advertising and publication costs, postage and supplies, and the salaries of 11 Missouri Consolidated employees within the Marketing and Membership Services Departments who devote their time to public entity matters. Fifty percent of the salaries of an additional 10 Customer Support communications employees were paid from public entity administrative fees. These employees conduct open enrollment, orientation, pre-retirement and payroll clerk meetings and workshops. They also function as account representatives and liaisons to the individual state agencies, participating public entities, members, and the contracted insurance providers for Missouri Consolidated. In addition, an allocated portion of the salaries of all remaining employees and other general operating expenses, such as lease and utilities, were paid from the public entity administrative fee revenues. While salary costs were included in the reimbursement, related employee benefits costs (which can be approximately 28 percent of salary) were not reimbursed.

Missouri Consolidated does not periodically monitor time spent by each employee on public entity versus state issues. Because the Customer Support communications employees provide essentially the same services to both state and public entity members, Missouri Consolidated arbitrarily allocates 50 percent of the cost of salaries for those 10 employees. However, Missouri Consolidated has no documentation to support the accuracy of this allocation method. In addition, a Missouri Consolidated official stated the allocated portion of salaries for all remaining employees was based on the assumption that the amount of time spent on public entity

related matters by these employees would ultimately average out, with some employees spending less time and some spending more time. Again, this assumption is not substantiated because Missouri Consolidated does not monitor actual time spent on state versus public entity related matters by these employees. A Missouri Consolidated official told us they based the allocation of salaries of these remaining employees and general operating expenses upon the percentage of public entity revenues into total revenues received by Missouri Consolidated during the prior year. Public entity revenues were 25 percent, 11 percent, and 7 percent of total revenues in fiscal years 2001, 2002, and 2003, respectively. State appropriations and state member revenues paid the remaining salaries of employees who were not paid 100 percent by public entity administrative fee revenues, in addition to benefits of all Missouri Consolidated employees.

Cost savings could be achieved

Missouri Consolidated could achieve cost savings by reducing its number of employees and/or relocating into a state agency setting. Our analysis shows Missouri Consolidated has, to some extent, employee functions currently provided for itself which could be shared with another department. These include functions such as data management (information systems/technology), human resources, and receiving services. While our review did not encompass a job analysis, it did note that Kansas, Tennessee, and Missouri Consolidated all provide many of the same categories of service to members. In addition, some cost savings could be achieved by discontinuing healthcare offerings to Missouri public entities.

While a service level comparable to either Kansas or Tennessee may or may not be realistic for Missouri Consolidated, based on $3.75 million in payroll and benefit costs for 2003, our analysis shows Missouri Consolidated could save approximately $47,500 for every employee it reduces.[15] These reductions could include both individuals directly and indirectly paid by public entity related administrative fees and individuals paid with state member related funds. Such changes could also possibly reduce other administrative costs and overhead. If some of the cost savings are generated by moving to another state agency, the potential savings would likely be reduced by costs for some shared functions that would be allocated back to Missouri Consolidated.

Conclusions

Missouri Consolidated could reduce costs by streamlining its administrative structure through one, or a combination of factors. Missouri Consolidated has not performed a review of its structure to determine if the organization and number of employees is necessary or most appropriate given its current state and public entity membership levels. In addition, Missouri Consolidated's organization as a separate benefits agency is uncommon compared to most other area states reviewed. Reducing staffing levels and/or sharing some functions by relocating Missouri Consolidated into an existing state agency could reduce payroll and benefits costs. Missouri Consolidated has not analyzed whether offering healthcare to public entities is useful or cost-effective to the state. By discontinuing offering healthcare services to public entities, Missouri Consolidated could further reduce costs.

[15] This cost per employee could be slightly lower based on actual number of employees throughout the year. For example, in March 2003, Missouri Consolidated employed 80 individuals, whereas, in June 2003, Missouri Consolidated employed 79 individuals. This calculation assumed 79 individuals the entire 2003 fiscal year.

Not all costs associated with providing service to public entity members were covered by public entity administrative fees and the bases used to allocate some of the costs were not related to the actual effort expended to provide the service. The result is that the state and state members may be subsidizing some of the costs of offering healthcare to public entity members.

Recommendations

We recommend the Missouri Consolidated Health Care Plan:

2.1 Perform an analysis of current staffing and structure based on current membership levels to determine the actual number of employees necessary to provide services to its members.

2.2 Ensure all costs associated with providing healthcare coverage to public entities is borne by those entities. In addition, periodically monitor the actual time spent by employees to provide public entity services and allocate indirect salaries and costs on that basis.

We recommend the General Assembly:

2.3 Determine whether to maintain the administration of the Missouri Consolidated Health Care Plan as a separate independent organization rather than as a benefits division within an existing state agency.

2.4 Determine whether to continue offering healthcare options to Missouri's public entities through Missouri Consolidated Health Care Plan.

Agency Comments and Our Evaluation

The Board of Trustees and the Executive Director of the Missouri Consolidated Health Care Plan provided the following comments in a letter dated June 1, 2004:

2.1 MCHCP is concerned about the comparability of the services performed by the other states listed in Table 2.1 when compared to those provided by MCHCP. As reported in the footnote, staff utilized from other departments and/or the costs of outsourcing are not included in the data. For example:

State	*Services*
Kansas	*> outsources COBRA administration and all direct billing* *> other agency personnel representatives are direct contacts for members*
Kentucky	*> 600 state Health Insurance Coordinators (HICs) handle eligibility issues, enrollment and act as direct contacts for members* *> benefit and claims information provided by health plans*

Nebraska > *other agency personnel handle eligibility, enrollment, customer service, budget functions, information systems and management*
> *claims issues directed to the health plans*

Tennessee > *over 200 Insurance Preparers are responsible for enrollment, eligibility and other coverage issues (not all are full time); health plans are next contact point*
> *open enrollment meetings not generally held*

Auditor's Comment: The number of employees in Table 2.1 did not include shared functions such as the use of payroll and personnel staff of other agencies, which Missouri Consolidated, Kansas and Tennessee all utilize to varying degrees. While Missouri Consolidated does provide direct customer service, its member handbook directs members to first contact their agency payroll/personnel clerks with eligibility/enrollment questions and to first contact their medical plan to obtain ID cards and provider directories, or with claim, referral, or service questions or complaints. As evidence of this, our survey of state members and retirees indicated only 27 percent would contact Missouri Consolidated first if they experienced a problem with a claim. Given the large decrease in public entity members, the need for the current level of staffing is not clear.

MCHCP will review its staffing levels (currently each opening is reviewed and some staff reductions have taken place through attrition) in regard to its current membership and any future potential membership changes. The review would include an analysis of the staff required to efficiently provide all the necessary services in connection with meeting the mission and vision statements of MCHCP. The Human Resources department would take the lead on this project.

2.2 *Public entity costs have been included in the premiums borne by those entities. As in the past, this will be done when the public entity rates are developed in July. The Fiscal department will have responsibility for this task. It should be noted that although it has been the practice to make the public entities self-sustaining (benefit costs will now be included), there is no statutory provision to this effect. Under 103.016 <u>all</u> MCHCP staff are state employees.*

Also, it has been our experience that traditional "time sheets" are not very accurate in regard to actual time allocation. In developing the current methodology for determining indirect costs, our independent auditor reviewed our cost methodology and felt it to be a reasonable approach to cost allocation for our organization. However, we will research whether or not some periodic time studies might be implemented and could be used to validate the current methodology or determine if another approach may be more accurate. The Human Resources department, with assistance from the Fiscal department, would take the lead on this item.

2.3 *It is difficult to respond to this recommendation due to the unknown nature of any future organizational structure. However, being a separate entity has worked well. The enabling legislation established the plan in this fashion because of the special expertise*

required and the complicated nature of administering healthcare benefits. It has allowed MCHCP the flexibility to respond quickly to a marketplace that is very dynamic. Under the current Board structure, it also allows an atmosphere for independent decision making. Finally, since MCHCP is a covered entity under HIPAA, the current structure allows MCHCP direct control over maintaining the privacy and security of protected health information. MCHCP's legal structure also reduces the state's liability and the exposure of other state agencies.

2.4 *While the number of public entity members has decreased significantly, there are approximately 3,900 members with coverage through MCHCP. It is likely that many of them could not get coverage if it was not available through MCHCP and they could end up on Medicaid, in the high risk pool or uninsured. Rather than abandoning the program, MCHCP is trying to modify how it operates in an effort to make it more attractive and affordable for public entities. These efforts have begun with the current request for proposal (RFP). It makes several significant modifications that should help moderate the premium increases. Among other changes, this will be accomplished by eliminating most of the unknown risk assumed by the bidders and requiring the public entities to remain in the plan for a specified period, thus helping to stabilize the pool.*

3. Procedures and Controls Are Not Adequate to Ensure Effective Management of Resources

Improvements are needed in the management and oversight of member eligibility and contractors' performance standards. Missouri Consolidated does not ensure enrollees are eligible for healthcare coverage and does not adequately monitor the contract performance standards of its self-funded healthcare plans. Implementing more effective management controls and oversight could result in possible cost savings to the state and increased contractor compliance.

Procedures are needed to ensure eligibility of members

Missouri Consolidated has not established procedures ensuring ongoing eligibility of all members already enrolled or studied the feasibility of performing such an eligibility review. In addition, it does not require documentation for some qualifying events for new enrollment of spouses or dependents. Documentation is only required in special situations, such as covering a disabled dependent over age 23 or a dependent through a court ordered divorce decree. However, adding individuals to coverage for events such as marriage or birth of a child does not require documentation. Missouri Consolidated relies on personnel clerks within each state agency to monitor eligibility of members. Personnel clerks were made aware of eligibility requirements, but not how to verify eligibility. Of the comparison group, Nebraska, Kansas, and the University of Missouri require documentation for all new spouse and dependent enrollees.

Like Missouri Consolidated, Tennessee's Group Insurance Program (Tennessee) has no procedures in place to verify eligibility of all new spouse or dependent enrollees. Instead, in 2001, Tennessee performed an eligibility review comparing member information to available state databases of wage, marriage, divorce, and birth records. As reported in Tennessee's 2001 annual report, this eligibility review resulted in the termination of coverage for 500 ineligible married dependents and 100 ineligible divorced spouses. Tennessee plans to begin including a match against death records and performing eligibility reviews quarterly during 2004 to ensure ongoing eligibility of enrolled members.

Because Missouri Consolidated is not requiring supporting documentation for all qualifying events or performing periodic reviews of eligibility, the extent of possible ineligible members enrolled and the costs associated with that coverage is unknown. Eligibility review programs like Tennessee's are becoming more common, particularly among private employers and appear effective in ensuring the employer is only subsidizing valid costs.

Adequate procedures and controls are needed to monitor self-funded plans' contractors

Missouri Consolidated had not established written procedures for monitoring contractor adherence to performance standards of its self-funded plans. Missouri Consolidated also had not (1) maintained documentation of work performed to measure and reconcile some performance standards, (2) received or reviewed documentation of contractors' reported compliance, and (3) applied penalties to all unmet performance standards.

Missouri Consolidated contracted with several companies to administer its self-funded plans. The contracts included various performance standards which the contractors had to follow. Examples of performance standards included timely distribution of identification cards and provider directories to members, financial and claims payment accuracy, timeliness of claims processing, and resolution of member queries. The contracts specified the guarantee level for each standard, such as the percentage or timeframe of compliance; a basis or means for measurement of each standard, such as contractor internal claims samples, internal contractor reports, or Missouri Consolidated reports; and penalties to be assessed for noncompliance with each standard, such as $100 per incident. Some of the performance standards were to be measured by Missouri Consolidated, while others were to be measured and reported by the contractors.

While several Missouri Consolidated staff monitored some standards, procedures had not been documented. In addition, no procedures existed to measure the standard relating to the contractors' resolution of inquiries made by Missouri Consolidated staff and members. To address staff and member questions, Missouri Consolidated staff would call and e-mail contractors' account representatives. While Missouri Consolidated officials told us they tracked the status of each contact with the account representatives to ensure they were resolved, they did not track the length of response time to measure whether the performance standard of 16 business hours had been met and whether a penalty should have been assessed.

Missouri Consolidated had not retained documentation of the procedures performed for several standards measured through logs of calls made by members to its customer service department. A Missouri Consolidated staff member said customer service call logs were scanned for calls related to several standards. If a possible non-compliance issue had been noted requiring follow-up with the healthcare contractor, the staff member highlighted the member's name on the call log and contacted the contractor representative to resolve the issue. The staff member told us the highlighted call logs or any supporting documentation related to resolving the issue had not been retained. A Missouri Consolidated official indicated documentation existed of such penalties being assessed in 1995 through 1997. However, no penalties related to these particular performance standards have been assessed since 1998. Because no documentation had been retained in recent years, we were unable to determine whether these performance standards had been adequately measured and penalties had been applied when necessary.

For most performance standards measured and self-reported by the contractors, Missouri Consolidated did not require documentation supporting the reported compliance levels. Instead, Missouri Consolidated relied on the contractors to report non-compliance and apply penalties. Several performance standards had been measured by each contractor through internal reports or internal audits and communicated to Missouri Consolidated through reports or by simply informing Missouri Consolidated of compliance or non-compliance with the standard. While one contractor had self-reported and paid penalties on two occasions, without periodically requiring and reviewing supporting documentation, Missouri Consolidated could not ensure each contractor's reported compliance figures were correct and whether a penalty should have been assessed.

Missouri Consolidated had not established penalties in contracts for two performance standards. Based on discussions with Missouri Consolidated officials and a review of the contracts, exclusion of one penalty relating to a reporting requirement had been an oversight due to language regarding the requirement occurring in two different places in the contract. For the other penalty relating to established percentages of written inquiries responded to within certain time frames, a Missouri Consolidated official said that no penalty had been established due to a belief that the contractor's system had not allowed the necessary information to be captured and reported. However, the contractor later reported the compliance information. Our review showed the standard had been reported as not being met for six months during 2003. Because no contract penalty had been established for this standard, no penalty had been assessed or collected for the non-compliance.

Conclusions

The state could be subsidizing healthcare costs for spouses and dependents of state employees that are actually ineligible for coverage through Missouri Consolidated. Requiring documentation supporting all qualifying events of spouse or dependent coverage, as well as performing a periodic eligibility review, could lower this risk.

Missouri Consolidated has little assurance that the self funded plan contractors complied with the performance standards outlined in the contracts. Creating written procedures to properly monitor contractor adherence to all performance standards, maintaining documentation of work performed to measure and reconcile each performance standard, reviewing documentation of self-reported compliance figures, and applying penalties to all performance standards are necessary to ensure proper compliance with contract requirements.

Recommendations

We recommend the Missouri Consolidated Health Care Plan:

3.1 Develop procedures to verify new spouse and dependent enrollees are eligible for coverage.

3.2 Perform a cost analysis to determine if performing a periodic eligibility review would be beneficial.

3.3 Develop written procedures to monitor contractors' adherence to performance standards. Procedures should include reviewing supporting documentation to contractors' self-reported figures to verify compliance.

3.4 Maintain supporting documentation to performance standard related issues that justified follow-up with the contractor.

3.5 Review current performance standard penalties to determine if penalties should be added or modified.

Agency Comments

The Board of Trustees and the Executive Director of the Missouri Consolidated Health Care Plan provided the following comments in a letter dated June 1, 2004:

3.1 Currently, there are some instances that require documentation. These include court ordered coverage, adoption and continued coverage as a result of a disability. However, much of the eligibility verification is through the employee's payroll officer. We will review this policy to determine if there is a more effective and feasible procedure that could be implemented to verify dependent eligibility (marriage license, birth certificate, etc.). The Membership department will take the lead on this project.

3.2 MCHCP will research options that compare the cost versus any potential savings to the state. This would include the frequency of any such eligibility review. The lead department for this project would be Information Systems.

3.3 MCHCP currently monitors the performance standards and reviews the results with the contractors. However, no formal written procedure is in place that describes the policy. MCHCP will develop a documented policy as to how the reviews will be completed, including analysis of the supporting documentation and how any necessary follow-up will be conducted with the contractor. The Research division will take the lead with this project.

3.4 This will be part of the policy developed in reference to item 3.3.

3.5 Performance standards are reviewed each time an RFP is released. MCHCP will continue this analysis to ensure that the necessary standards are included for the type of service(s) being solicited and that the associated criteria and penalties are appropriate. This will be the responsibility of the RFP team which is under the direction of the Assistant Executive Director.

HEALTHCARE PLAN AVAILABILITY AND ENROLLMENT FIGURES

The purpose of this appendix is to illustrate the healthcare plans available to state members in 2003, the corresponding number of state members in each plan, and additional information regarding the 2004 state member plan availability and membership levels.

Table I.1: Healthcare Plans Available to State Members in 2003

Healthcare Plan	Available Counties (in Missouri)	No. of State Members (and percentage of total)[1]
First Health Co-pay Plan	115	17,931 (17)
Mercy Health Plans HMO	38	28,762 (28) – Standard 1,638 (2) – Premium
Group Health Plan HMO	16	6,743 (7) – Standard 13,679 (13) – Premium
HealthLink HMO	32	9,537 (9) – Standard 1,697 (2) – Premium
Coventry HMO	9	656 (.6) – Standard 1,432 (1) – Premium
Community Health Plan HMO	15	1,318 (1) – Standard 5,729 (6) – Premium
Humana HMO	10	1,428 (1) – Standard 5,269 (5) – Premium
Premier HMO	19	7,598 (7) – Standard 405 (.4) – Premium

[1] The number of state member participants as of May 2003
Source: Missouri Consolidated member handbook and enrollment statistics

In 2003, First Health Co-pay Plan and HealthLink HMO were offered on a self-funded basis. In calendar year 2004, the same plans are offered as in 2003 with Coventry HMO and Humana HMO changing to a self-funded basis. In addition, enrollment figures and percentages as of January 2004 are similar to the enrollment figures and percentages of calendar year 2003.

MISSOURI CONSOLIDATED PREMIUM AND FISCAL INFORMATION

The purpose of this appendix is to illustrate the weighted average monthly state employee healthcare premiums and Missouri Consolidated's revenues, expenses, and changes in net assets for fiscal years 1996 to 2003.

Table II.1: Weighted Average Monthly State Employee Healthcare Premiums[1]

	2003	2002	2001	2000	1999	1998	1997	1996
Weighted average monthly premiums	$ 495	$ 462	$ 388	$ 266	$ 211	$ 204	$ 194	$ 191
Percentage change from prior year	7	19	46	26	3	5	1.6	n/a

[1] Averages include both employee and state share of active and retired state employees total monthly premiums.
Source: Missouri Consolidated analysis

Table II.2: Revenues, Expenses, and Changes in Net Assets [1]

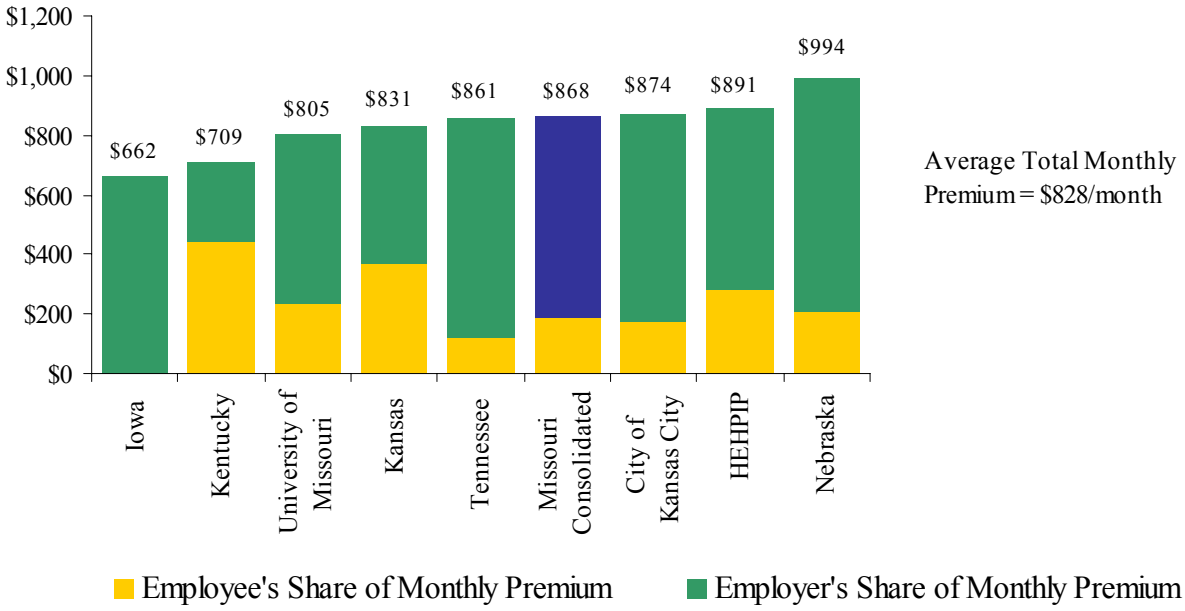
	Year Ended June 30,							
	2003	**2002**	**2001**	**2000**	**1999**	**1998**	**1997**	**1996**
REVENUES:								
State/employer contributions	$ 264,052,867	222,987,803	169,804,969	108,821,820	95,312,925	85,949,062	87,344,715	87,317,364
Member contributions	84,372,737	75,701,524	62,083,511	48,561,768	41,993,101	37,805,702	34,371,511	31,166,898
Public entity income	26,378,699	37,630,463	76,430,017	94,336,655	72,710,319	53,123,454	25,127,413	9,397,618
Investment income	668,168	968,329	2,157,472	2,125,779	2,124,487	2,805,315	2,918,054	2,890,665
Total revenues	375,472,471	337,288,119	310,475,969	253,846,022	212,140,832	179,683,533	149,761,693	130,772,545
EXPENSES:								
Medical claims, claims administration services, and capitation expense	344,043,387	334,208,591	306,651,524	258,313,998	212,036,418	182,673,726	143,518,142	122,430,722
Administrative expenses:								
Payroll and related benefits	3,753,395	3,697,765	3,590,842	3,398,416	3,144,763	2,766,029	2,412,237	2,283,319
Employee assistance program	912,175	889,080	917,299	1,013,368	796,806	729,388	707,105	347,676
Administration	1,866,567	1,616,841	1,962,420	2,094,726	2,220,348	1,713,762	1,565,321	1,421,031
Professional services	417,463	626,456	850,023	1,372,514	962,413	633,947	158,675	224,742
Depreciation	281,314	280,172	228,666	222,917	274,921	293,803	357,756	479,321
Miscellaneous	7,460	1,722	5,101	745	9,018	335	6,175	0
Total administrative expenses	7,238,374	7,112,036	7,554,351	8,102,686	7,408,269	6,137,264	5,207,269	4,756,089
Total expenses	351,281,761	341,320,627	314,205,875	266,416,684	219,444,687	188,810,990	148,725,411	127,186,811
REVENUES OVER (UNDER EXPENSES)	24,190,710	(4,032,508)	(3,729,906)	(12,570,662)	(7,303,855)	(9,127,457)	1,036,282	3,585,734
NET ASSETS (DEFICIT), BEGINNING	(811,379)	3,221,129	6,951,035	19,521,697	26,825,552	35,953,009	34,916,727	31,330,993
NET ASSETS (DEFICIT), END	$ 23,379,331	(811,379)	3,221,129	6,951,035	19,521,697	26,825,552	35,953,009	34,916,727

[1] Revenues and expenses are presented using the accrual basis of accounting.
Source: Missouri Consolidated Health Care Plan Annual Reports

2003 FAMILY COVERAGE AND OUT-OF-POCKET MEDICAL EXPENSES

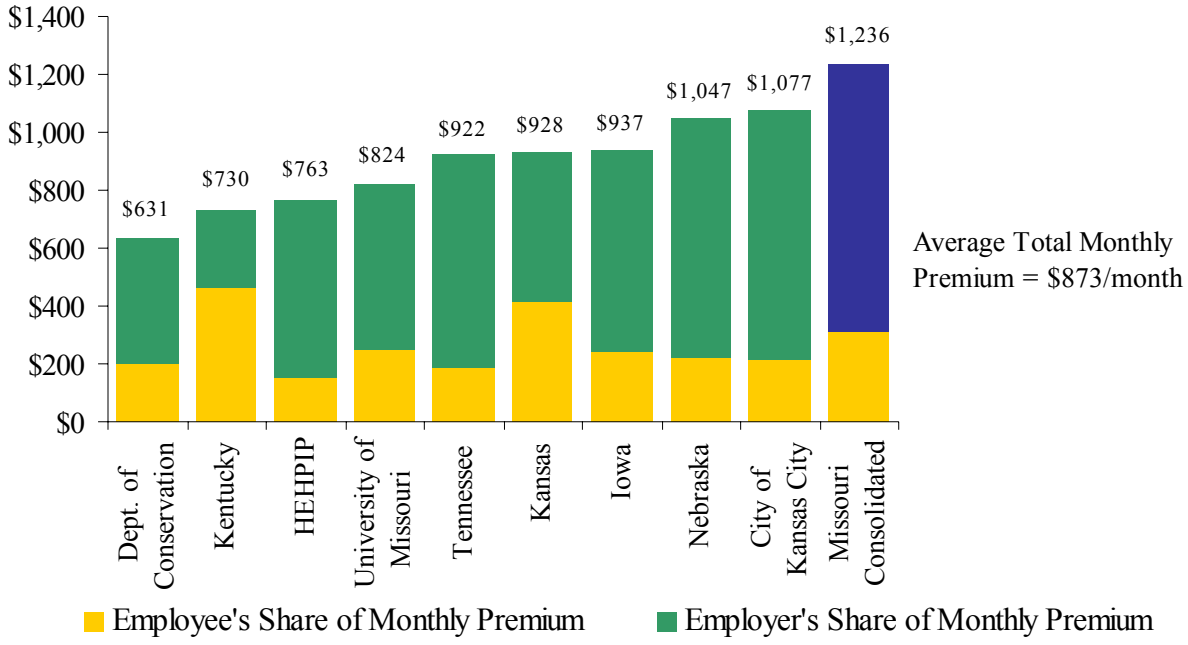
The purpose of this appendix is to illustrate the comparison group's calendar year 2003 monthly medical premiums in HMO and conventional plans for family coverage, as well as the relation of annual medical premiums to out-of-pocket medical costs for family coverage in the comparison group's most populated conventional plans. In addition, the comparison group's out-of-pocket costs of the most populated conventional plans are further analyzed below.

Figure III.1: 2003 Monthly Premiums in HMO Plans for Family Coverage



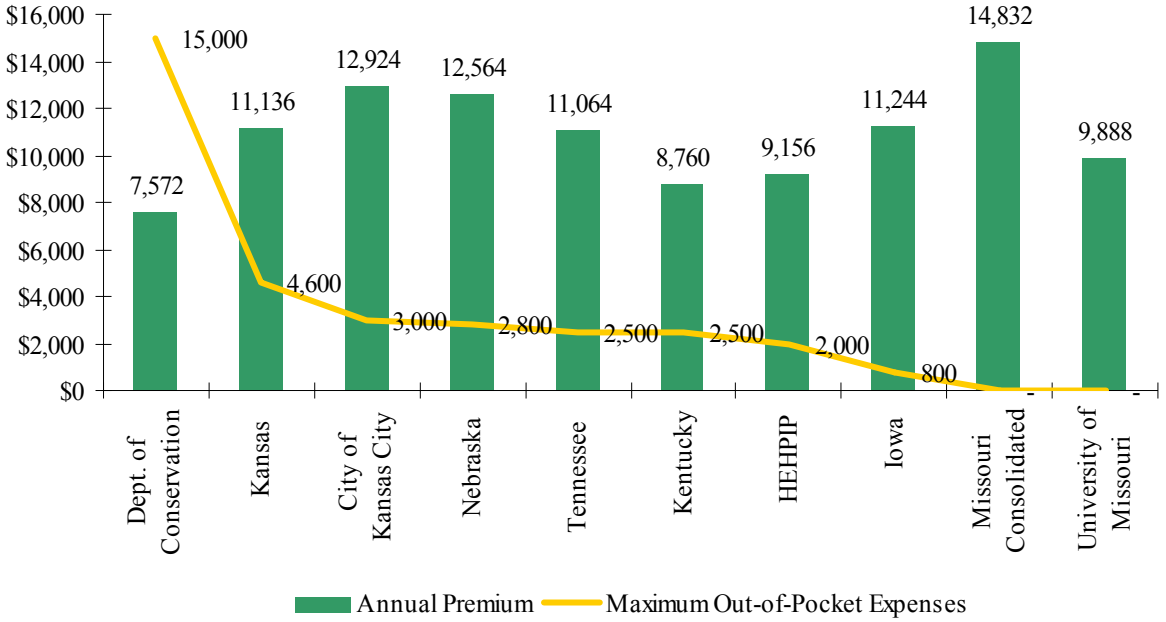
Averages Exclude Missouri Consolidated
Source: Based on SAO analysis of information obtained from comparison group

Figure III.2: 2003 Monthly Premiums in Conventional Plans for Family Coverage



Averages Exclude Missouri Consolidated
Source: Based on SAO analysis of information obtained from comparison group

Figure III.3: Comparing 2003 Annual Premiums To Maximum Out-Of-Pocket Costs In Conventional Plans for Family Coverage



Source: Based on SAO analysis of information obtained from comparison group

Table III.1 shows that Missouri Consolidated is one of two entities that do not require deductibles for members in the conventional plan, regardless of level of coverage.

Table III.1: 2003 Out-of-Pocket Medical Expenses for Conventional Plans (In-network)

	Deductible[1]			Maximum Amount Payable	
	Employee Only	Family	Co-insurance Percentage	Employee Only	Family
Conservation (PPO)	$ 600	1,200	20%	7,500	15,000
Kansas (Indemnity)	300	600	20%	2,300	4,600
City of Kansas City (PPO)	300	600	20%	1,500	3,000
Nebraska (PPO)	400	800	20%	1,400	2,800
Tennessee (PPO)	250	625	10%	1,250	2,500
Kentucky (PPO)	250	500	20%	1,250	2,500
HEHPIP (PPO)	300	900	10%	750	2,000
Iowa (Indemnity)	300	400	20%	600	800
Missouri Consolidated (POS)[2]	0	0	0%	0	0
University of Missouri (POS)	$ 0	0	0%	0	0

[1] The deductible amount does not include prescription deductibles or mental health/substance abuse deductibles if considered a separate deductible than medical. In addition, all amounts and percentages presented are for in-network services.

[2] Co-insurance of 20 percent is only paid in this plan for non-routine network services such as durable medical equipment, medically necessary supplies, hearing aids, orthotics, oxygen, and prosthetics repair or replacement. Infertility services are covered at 50 percent co-insurance; however, the coinsurance amount paid does not apply to the maximum amount payable. Since the majority of state employees or their dependents would not utilize these services, and all other covered services require a co-payment, we did not include a co-insurance percentage for Missouri. The other entities and states in our comparison group applied co-insurance percentages to routine services such as doctor's visits and in-patient hospital services.

Source: Based on SAO analysis of information obtained from comparison group

Table III.2 shows in further detail how much members would pay in out-of-pocket medical expenses given varying levels of medical costs incurred. Assuming its members did not utilize less common services, Missouri Consolidated is one of two entities in which its members would incur no out-of-pocket costs, other than required co-payments, no matter what medical costs were incurred each year. Since it is impossible to estimate how often specific services might be utilized, co-payments were excluded from this analysis.[1]

[1] Generally co-payments do not apply towards an out-of-pocket limit and would be difficult to estimate since they are based on how often the services are used. Therefore, we only took into consideration deductibles and coinsurance when analyzing the out-of-pocket maximums for Missouri Consolidated and the comparison group for 2003.

Table III.2: Amount Employees Will Pay in 2003 At Various Levels of Medical Costs

		Medical Costs Incurred in 1 Year			
		$500	**$1,000**	**$5,000**	**$100,000**
Employee Only Coverage	Conservation	500	680	1,480	7,500
	Kansas	340	440	1,240	2,300
	City of Kansas City	340	440	1,240	1,500
	Nebraska	420	520	1,320	1,400
	Kentucky	300	400	1,200	1,250
	Tennessee	275	325	725	1,250
	HEHPIP	320	370	750	750
	Iowa	340	440	600	600
	Missouri Consolidated	0	0	0	0
	University of Missouri	0	0	0	0
Family Coverage	Conservation	500	1,000	1,960	15,000
	Kansas	500	680	1,480	4,600
	City of Kansas City	500	680	1,480	3,000
	Nebraska	500	840	1,640	2,800
	Kentucky	500	600	1,400	2,500
	Tennessee	500	663	1,063	2,500
	HEHPIP	500	910	1,310	2,000
	Iowa	420	520	800	800
	Missouri Consolidated	0	0	0	0
	University of Missouri	0	0	0	0

Source: Based on SAO analysis of information obtained from comparison group

Tables III.3 and III.4 present the maximum amounts that members could potentially spend on healthcare in a conventional plan in 2003, based on information provided by members of the comparison group. This maximum amount includes the employee's share of annual premiums, the deductible that must be met, and the maximum rate of coinsurance that could be applied. Missouri Consolidated's maximum annual employee expenses were among the lowest of our comparison group for both employee-only and family coverage.

Table III.3: 2003 Employee-Only Coverage - Comparing Maximum Health Care Expenses For State Employees

	Employee Share of Annual Premium	Deductible	Maximum Rate of Co-Insurance	Maximum Annual Employee Expenses
Conservation	1,170	600	6,900	8,670
Kansas	274	300	2,000	2,574
Nebraska	743	400	1,000	2,143
Tennessee	886	250	1,000	2,136
City of Kansas City	461	300	1,200	1,961
Kentucky	271	250	1,000	1,521
University of Missouri	868	0	0	868
HEHPIP	0	300	450	750
Missouri Consolidated	719	0	0	719
Iowa	0	300	300	600

Source: Based on SAO analysis of information obtained from comparison group

Table III.4: 2003 Family Coverage - Comparing Maximum Health Care Expenses For State Employees

	Employee Share of Annual Premiums	Deductible	Maximum Rate of Co-Insurance	Maximum Annual Employee Expenses
Conservation	2,400	1,200	13,800	17,400
Kansas	4,980	600	4,000	9,580
Kentucky	5,527	500	2,000	8,027
City of Kansas City	2,584	600	2,400	5,584
Nebraska	2,639	800	2,000	5,439
Tennessee	2,212	625	1,875	4,712
HEHPIP	1,812	900	1,100	3,812
Iowa	2,915	400	400	3,715
Missouri Consolidated	3,695	0	0	3,695
University of Missouri	3,012	0	0	3,012

Source: Based on SAO analysis of information obtained from comparison group

STATE MEMBER HEALTH CARE SURVEY RESULTS

SAO

Missouri State Auditor's Office

State Health Care Survey

Introduction

The Missouri State Auditor's Office (SAO) is conducting a review of the Missouri Consolidated Health Care Plan (Missouri Consolidated).

You have been randomly selected to complete this questionnaire due to your enrollment in Missouri Consolidated. Your response to this questionnaire will help us gain an understanding of the effectiveness of the plan and Missouri Consolidated members' ideas and opinions. We cannot develop meaningful information without your frank and honest answers to the questions.

The SAO will safeguard the privacy of your responses to this questionnaire. They will be combined with those of other respondents and will be reported only in summary form. The control number at the top is included only to aid us in our follow-up efforts.

This questionnaire should take about 10 to 15 minutes to complete.

If you have any questions concerning any part of this survey, please call Robyn Lamb or Andrea Paul of our Jefferson City Office at (573) 751-4213, or e-mail at SAOHealth@auditor.state.mo.us.

Please return the completed questionnaire in the enclosed pre-addressed envelope within 2 weeks from the time you receive it. In the event the envelope is misplaced, the return address is:

Missouri State Auditor's Office
ATTN: Robyn Lamb
P.O. Box 869
Jefferson City, MO 65102

Thank you for your assistance.

A. Background Information

To help us gain an understanding of the population of Missouri Consolidated members who receive this survey, please provide the following member background information.

1. In what health care plan are you currently enrolled? N[1]=139

16%	First Health Co-pay Plan
4%	Community Health Plan
3%	Coventry Health Care of Kansas
19%	Group Health Plan
13%	HealthLink
9%	Humana
28%	Mercy Health Plan
8%	Premier Health Plan

2. If enrolled in an HMO, is it the standard or premium health care plan? N=116

67%	Standard
33%	Premium

3. In what region are you enrolled? N=146

41%	Central
27%	East
11%	West
1%	Northeast
4%	Northwest
6%	Southeast
1%	South Central
8%	Southwest
1%	Out-of-State

4. What level of coverage do you have (i.e., employee only, employee/spouse, employee/family, employee/child(ren))? N=146

54%	Employee/Only
14%	Employee/Spouse
23%	Employee/Child(ren)
9%	Employee/Family

5. If your level of coverage is employee/spouse, employee/family, or employee/child(ren), please indicate the number of individuals covered. N=67

54%	2
46%	3+

6. Are you considered an active employee or retiree? N=146

76%	Active
23%	Retiree
1%	Disabled

7. How many years have you been/were you employed with the state? N=145

28%	1-5 years
19%	6-10 years
25%	11-20 years
28%	Over 20 years

[1] N is the number of respondents for each question.

B. Level of Satisfaction with Health Plans

This section will allow us to gain an understanding of what factors affect members' choices in plan type and level of coverage. In addition, this section will allow us to gauge members' use of and satisfaction with Missouri Consolidated and their current health care plan options.

1. **Rank the following factors in order** of most important factor (1) to least important factor (7) when choosing **your current** health care plan. (*Enter a number in each box.*)

1[2]	2	3	
34%	**13%**	**19%**	a. Specific doctor or hospital. N=120
8%	**10%**	**18%**	b. Wide variety of health care providers. N=120
35%	**29%**	**18%**	c. Lowest cost in a monthly premium. N=119
4%	**9%**	**19%**	d. Lack of administrative restrictions (Copay Plan, Preferred Provider Organization, etc.) versus use of gatekeepers and referrals (Health Maintenance Organization). N=120
2%	**3%**	**5%**	e. Relationship established with selected health care plan. N=119
15%	**35%**	**21%**	f. Lowest out-of-pocket costs such as co-payments, deductibles, and coinsurance. N=120
7%	**0%**	**0%**	g. Other. N=45

2. If your ranking in question 1 is different from how you have historically chosen your health care plan, please indicate **your prior ranking of these factors in order** of most important factor (1) to least important factor (7). If there has been no change in order of importance, please check "no change". (*Enter a number in each box.*)

1[2]	2	3	
53%	**5%**	**11%**	a. Specific doctor or hospital. N=19
0%	**16%**	**16%**	b. Wide variety of health care providers. N=19
32%	**26%**	**26%**	c. Lowest cost in a monthly premium. N=19
0%	**16%**	**11%**	d. Lack of administrative restrictions (Copay Plan, Preferred Provider Organization, etc.) versus use of gatekeepers and referrals (Health Maintenance Organization). N=19
0%	**11%**	**5%**	e. Relationship established with selected health care plan. N=19
5%	**21%**	**37%**	f. Lowest out-of-pocket costs such as co-payments, deductibles, and coinsurance. N=19
33%	**0%**	**0%**	g. Other. N=6

3. Is your entire family covered by a health plan offered by Missouri Consolidated? N=143

   37% Yes
   63% No → If not, which of the following best describes why you chose not to enroll your spouse or children in Missouri Consolidated? (*Check all reasons that apply.*) N=88

   16% Cost of monthly premiums.
   31% Spouse/child(ren) covered under other health care plan.
   42% Not applicable. No family.
   7% Cost of monthly premium and other healthcare plan
   4% Other

4. Taking everything into consideration, (i.e., co-pays, deductibles, monthly premiums, health benefits covered, types of plan offered, etc.), how satisfied or dissatisfied are you with your current health care options? N=146

   8% Very satisfied
   34% Satisfied
   24% Neither satisfied nor dissatisfied
   27% Dissatisfied
   7% Very dissatisfied

5. In your opinion, how do you feel Missouri Consolidated performs in offering options that fit your needs (selecting number and type of plans, benefits covered, etc.)? N=145

   9% Excellent
   24% Good
   44% Adequate
   19% Poorly
   4% Very poorly

[2] In order to impart which factors members feel are most important, we have presented only rankings of 1, 2, or 3.

6. In your opinion, how do you feel Missouri Consolidated manages the rising cost in health care premiums? N=144

2% Excellent
15% Good
46% Adequate
33% Poorly
4% Very poorly

7. To what extent, if at all, has your satisfaction or dissatisfaction with Missouri Consolidated increased or decreased over the last five years? N=134 applicable to this question.

4% I am more satisfied now than I was 5 years ago.
21% I am as satisfied now as I was 5 years ago.
42% I am less satisfied now than I was 5 years ago.
24% I am much less satisfied now than I was 5 years ago.
9% No opinion.

.....
N=16 not applicable to this question due to no prior history with Missouri Consolidated.

8. To what extent, if at all, have the following Missouri Consolidated services been useful to you?

	Missouri Consolidated Service	Not aware of the service (1)	Aware of service but have not used (2)	Very useful (3)	Moderately useful (4)	Of some use (5)	Of little use (6)	Not useful at all (7)
a.	General benefit questions. N=140	**3%**	**37%**	**25%**	**22%**	**12%**	**0%**	**1%**
b.	Eligibility questions. N=139	**4%**	**38%**	**23%**	**20%**	**12%**	**2%**	**1%**
c.	Intermediary between member and health care plans (e.g., claims dispute). N=136	**24%**	**48%**	**6%**	**7%**	**9%**	**6%**	**0%**
d.	Open enrollment meetings/ facilitating enrollment. N=136	**6%**	**26%**	**31%**	**18%**	**12%**	**6%**	**1%**
e.	New employee orientation. N=132	**15%**	**38%**	**14%**	**13%**	**11%**	**6%**	**3%**
f.	Active employee and pre-retirement seminars. N=131	**10%**	**43%**	**26%**	**11%**	**8%**	**1%**	**1%**
g.	Issue communication materials to members (e.g., quarterly newsletters). N=134	**5%**	**16%**	**22%**	**33%**	**16%**	**7%**	**1%**
h.	MCHCP's Internet site. N=135	**13%**	**37%**	**16%**	**18%**	**11%**	**2%**	**3%**
i.	Member handbook. N=135	**2%**	**7%**	**41%**	**34%**	**15%**	**1%**	**0%**

9. How often have you contacted Missouri Consolidated in the last year? N=144

1% Once a month
14% Once a quarter
33% Once a year
45% None
7% Other

10. Did Missouri Consolidated resolve your issue(s) in a timely manner? N=73 applicable to this question

82% Yes
18% No

.....
71 not applicable to this question because have not contacted Missouri Consolidated in the last year.

11. How well did Missouri Consolidated resolve your issue(s)? N=73 applicable to this question
79% Satisfactorily
18% Neither satisfactorily nor unsatisfactorily
3% Unsatisfactorily

.....
71 not applicable to this question because have not contacted Missouri Consolidated in the last year.

12. If you experience a problem with a claim, whom would/do you contact first? N=136

    27% Missouri Consolidated
    33% Health Care Provider
    40% Health Care Plan

C. Health Care Premiums

As the cost of health care continues to increase, the State is left with the responsibility of developing ways to contain costs. The following are some potential cost containment measures, incentives, or alternatives identified or used by other organizations. These measures are **not** necessarily planned changes to the State's health care plan which Missouri Consolidated is currently considering. Discussion of these issues is solely for the purposes of the State Auditor's Office in planning and performing our review of Missouri Consolidated.

1. To what extent, if at all, would you consider the following possible alternatives in exchange for a potential reduction in your monthly premium **or** out-of-pocket costs (e.g., co-pays, deductibles, coinsurance, etc.). (Check one *box in each row.*)

	Possible Alternatives	To a great extent (1)	To a moderate extent (2)	To some extent (3)	To a little extent (4)	To no extent (5)	**Description of Possible Alternatives**
a.	Reduced level of benefits. N=143	**7%**	**7%**	**23%**	**17%**	**46%**	This would include benefits such as well visits requiring a co-payment instead of covering them at 100%, reduction of optional benefits, such as chiropractic visits.
b.	Limited number of health care providers and hospitals. N=140	**8%**	**8%**	**18%**	**23%**	**43%**	Offer only one HMO option and one Co-pay plan, which limit the number of providers and hospitals.
c.	Consumer driven healthcare plan. N=136	**7%**	**13%**	**15%**	**17%**	**48%**	Employee receives an annual allotment (e.g. - $1,000 for single coverage, $2,000 for family). The employee may spend this on any medical expenses he/she chooses with any doctor (no gatekeepers), but expenses are paid at full cost. If there's money left over, the employee can roll over the remainder into the next year. Should expenses rise above the allotted amount, the employee must pay the remainder of his/her medical plan's deductible (e.g. - if deductible is $1,600 for single coverage, employee would pay an additional $600; if deductible is $3,200 for family coverage, employee would pay an additional $1,200); however, preventative services are generally covered by the plan at 100%. Once the deductible has been met, company coverage takes over, often a Preferred Provider Organization plan, which allows members the freedom to utilize any provider in a network of preferred providers. If a network provider is utilized, the employer could pay the expenses up to 90%, whereas there is usually a split (e.g., 70/30) for out of network provider use.
d.	Major medical plan. N=133	**3%**	**6%**	**9%**	**12%**	**70%**	Covers catastrophic illness only and large deductible applies. Other routine costs are paid entirely by the member.
e.	Other. N=7	**29%**	**0%**	**0%**	**0%**	**71%**	Please provide a description below.

2. Considering the rising costs in healthcare benefits, please **rank in order** from most important factor (1) to least important factor (5) which health care services or cost containment efforts Missouri Consolidated should focus on.

1[3]	2	3	
31%	**36%**	**25%**	Lowering monthly premiums. N=121
22%	**40%**	**26%**	Lowering co-pay or out-of-pocket expenses. N=121
37%	**15%**	**24%**	Maintaining current benefits. N=121
8%	**6%**	**26%**	Increasing benefits. N=120
10%	**10%**	**0%**	Other. N=30

[3] In order to impart which factors members feel are most important, we have presented only rankings of 1, 2, or 3.

GLOSSARY

The purpose of this appendix is to provide definitions for various technical healthcare related terms.

Co-insurance: the shared portion of payment between the medical plan and the member where each pays a percentage of covered charges (e.g., 70 percent/30 percent).

Co-payment: a set dollar amount that the covered individual must pay for specific services.

Co-pay Plan: an open access plan that provides set co-payments for network services as well as non-network benefits, similar to a Point Of Service plan.

Conventional Plan: any type of healthcare plan other than a Health Maintenance Organization, such as Point of Service Plan or Preferred Provider Organization.

Deductible: the amount of expense the member must pay before the medical plan begins to pay for covered services and supplies. This amount is not reimbursable by the medical plan.

Fully insured plan: the employer hires a medical plan contractor to assume the risk of paying claims from premium monies. All premiums are paid to the medical plan contractor and the contractor assumes the risk that medical claims for a given time period might exceed the premiums that have been collected.

Health Maintenance Organization (HMO): a healthcare system that provides a wide range of healthcare services for a specified group at a fixed periodic prepayment.

Lifetime maximum: the maximum amount payable by a medical plan during a covered member's life.

Member: any person eligible as either a subscriber or a dependent in accordance with an employee benefit plan.

Out-of-pocket maximum: the maximum amount the member must pay before the medical plan will begin to pay 100% of covered charges for the remainder of the calendar year.

Network: the group of physicians, hospitals, pharmacies, etc., contracted with a medical plan to which the plan's members have access.

Pharmacy Benefit Manager (PBM): acts as a link between the parties involved in the delivery of prescription drugs to health plan members with a drug card program. Clients use PBMs to design, implement, and manage their overall drug benefits.

Point of Service (POS) plan: a medical plan that provides network and non-network healthcare services. The member is responsible for co-payment amounts when network providers are used. If non-network providers are utilized, services are subject to a deductible and co-insurance amount.

Preferred Provider Organization (PPO): an arrangement with providers whereby discounted rates are given to plan members. Benefits are paid at a higher level when network providers are used.

Self-funded plan: the employer assumes the functions, responsibilities, and risks of an insurer. The employer maintains a separate fund that is financed with employer and employee contributions. When employees file claims for healthcare services, those claims are paid for with monies from that fund. The employer assumes the risk that medical claims for a given time period might exceed the premiums that have been collected.

Subscriber: the employee or member who elects coverage under Missouri Consolidated.

Third Party Administrator: a company contracted to administer a self-funded plan and/or process member claims.