INTERNAL AUDIT DIVISION
CLERK OF THE CIRCUIT COURT

AUDIT OF
UHC HEALTH CLAIMS
HUMAN RESOURCES DEPARTMENT

Ken Burke, CPA*
Clerk of the Circuit Court
Ex Officio County Auditor

Robert W. Melton
Chief Deputy Director
Internal Audit Division

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Hector Collazo, Jr., CFE, CFS, CISA, Internal Audit Manager

MAY 18, 2009
REPORT NO. 2009-11

*Regulated by the State of Florida
May 18, 2009

The Honorable Chairman and Members
of the Board of County Commissioners

We have conducted an audit of UHC Health Claims, Human Resources Department. Our audit objective was to evaluate UHC’s performance in processing claims, including compliance with the Plan and contracts with providers, and whether it is in accordance with industry standards. As part of this process, we also attempted to identify aspects of the Plan which could be enhanced to be more cost-beneficial to the County and/or members of the Plan. We contracted with Dillabough & Associates to provide the specialized expertise required in this audit.

We conclude that UHC’s overall performance, including compliance with the Plan and its contracts with providers in processing claims, is adequate and in accordance with industry standards. We noted areas where the County’s Plan could be enhanced to reduce medical care costs to the County and/or its members. Opportunities for Improvement are presented in this report.

We appreciate the cooperation shown by the staff of the Human Resources Department during the course of this review.

Respectfully Submitted,

Robert W. Melton
Chief Deputy Director
Internal Audit Division

Approved:

Ken Burke, CPA*
Clerk of the Circuit Court
Ex Officio County Auditor
*Regulated by the State of Florida
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<td>21</td>
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EXECUTIVE SUMMARY

We have conducted an audit of claims processed by United Health Care (UHC), the County’s third party administrator for its employee and retiree health benefit plans. The audit period included claims processed under the agreement for Fiscal Year 2007-2008 with United Health Care. In order to meet our objectives, we engaged the firm of Dillabough & Associates, a consulting firm specializing in health care claims’ audits, to perform a comprehensive audit of the performance of UHC.

We conclude that UHC’s overall performance, including compliance with the Plan and its contracts with providers in processing claims, is adequate and in accordance with industry standards. However, we noted some Opportunities for Improvement.

During our audit of claims paid by United Health Care (UHC), we found claims totaling $549,845 that we believe should not have been paid. United Health Care agrees with our conclusion on claims totaling $168,633, and disagrees on claims totaling $381,212. Overpayments, which UHC agrees with, include miscalculation of charges, coordination of benefits, surgical assistant billing error, and Medicare eligibility coordination.

Payments to some assistant surgeons were found to be excessive. In one instance, two surgeons were paid $5,270 for a complex case while the first assistant nurse (non-doctor) was paid $19,719, or 3.74 times what the surgeons were paid. UHC argued this situation was allowable. Other disputed practices include nonparticipating providers being paid as though they are participating (resulting in more cost) in certain circumstances, and paying claims regardless of the timeliness of submission. In addition to recommending recovery of the items tested, we recommended the requirements for UHC be changed to clearly remedy these practices.

Under the current plan, UHC is paying non-participating providers 80% of the amount billed, whether or not it is within range of the usual and customary rates for the procedure. These payments pay non-participating providers up to four times the amount that would be paid if the provider was participating. In our test items, we found no claim that was reduced to the reasonable and customary rate.

Members have no knowledge of contracted rates, and can not choose providers which minimize costs. Rates for covered services vary significantly, resulting in a wide range of potential costs to the member and to the Plan. For example, for a similar health plan, we noted facility charges for a colonoscopy range from $419 to $3,480. If the person having a colonoscopy went to the facility with the highest charge, both the member and the Plan would pay over eight times more for the same procedure.

Our report contains a total of 6 recommendations for improvement.
INTRODUCTION

Synopsis

Our audit identified claims paid by United Health Care (UHC) on behalf of the County totaling $549,845 that we believe should not have been paid. Furthermore, under the current plan the County and employees are paying unnecessarily higher health care cost which can be reduced with some plan modifications and education.

Scope and Methodology

We have conducted an audit of claims processed by United Health Care (UHC), the County’s third party administrator for its employee and retiree health benefit plans. The audit period included claims processed under the agreement for Fiscal Year 2007-2008 with United Health Care.

The objective of the audit was to evaluate UHC’s performance in processing claims, including compliance with the Plan and contracts with providers, and whether it is in accordance with industry standards. As part of this process, we also attempted to identify aspects of the Plan which could be enhanced to be more cost-beneficial to the County and/or members of the Plan.

In order to meet our objectives, we engaged the firm of Dillabough & Associates, a consulting firm specializing in health care claims’ audits, to perform a comprehensive audit of the performance of UHC. To initially begin the audit, we received a claim data tape from UHC which contained all claims paid from April 1, 2007 to September 30, 2008. From these claims, two samples were selected. The first was a focused sample on specific types of claims, and the second was a completely random sample. Each sample consisted of 200 claims. Only claims exceeding $100 were selected. The statistical sample of 400 claims represented approximately $14,202,140 in total charges and $6,042,847 in paid claims. We also reviewed Plan documents and conducted interviews with UHC personnel and the County’s Human Resources Department.
Our audit was conducted in accordance with the International Standards for the Professional Practice of Internal Auditing and the Standards for Offices of Inspector General, and accordingly, included such tests of records and other auditing procedures, as we considered necessary in the circumstances. The audit period was April 1, 2007 to September 30, 2008. However, transactions and processes reviewed were not limited by the audit period.

**Overall Conclusion**

We conclude that UHC’s overall performance, including compliance with the Plan and its contracts with providers in processing claims, is adequate and in accordance with industry standards.

**Comparison of Results of the Stratified Sample**
(Excludes Disputed Claims)

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>UNITED HEALTHCARE AUDIT RESULTS</th>
<th>NATIONAL PERFORMANCE STANDARDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stratified/(Random)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Accuracy</td>
<td>98.3%</td>
<td>99%</td>
</tr>
<tr>
<td>Procedural Accuracy</td>
<td>98.0%</td>
<td>93%</td>
</tr>
</tbody>
</table>

**Comparison of Results of the Focus Sample**
(Excludes Disputed Claims)

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>UNITED HEALTHCARE AUDIT RESULTS</th>
<th>NATIONAL PERFORMANCE STANDARDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Accuracy</td>
<td>96.5%</td>
<td>99%</td>
</tr>
<tr>
<td>Procedural Accuracy</td>
<td>89.5%</td>
<td>93%</td>
</tr>
</tbody>
</table>
We noted areas where the County’s Plan could be enhanced to reduce medical care costs to the County and/or its members. Opportunities for Improvement are included in this report.

**Background**

The Human Resources Department is part of the Unified Personnel System of Pinellas County Government (UPS) which was created by a special act of the Florida legislature. It provides personnel services for the eleven Appointing Authorities who comprise the UPS.

Human Resources Department’s Mission:

To work in partnership with all Appointing Authorities within the Unified Personnel System in recruiting, developing and retaining the best possible workforce. We support a workplace environment that provides the highest standard of quality service, reflects our diverse community, and values personal growth, fairness and cooperation.

The Human Resources Department’s function areas are:

- Benefits
- Compensation
- Employee Communications
- Employee Relations
- Employment and Volunteer Services
- Records Administration
- Training and Development
Pinellas County offers several medical care plan options to its employees and retirees. The same plans are offered to retired employees, under age 65 or non-Medicare eligible, as to active employees. Medicare-eligible retirees are offered the choice of two plans.

**Permanent Employees Medical Care Plan Options:**

**Eligibility** - Group Health Plan coverage is available to all permanent employees scheduled to work a minimum of 20 hours per week. Enrollment of family members is subject to the eligibility provisions and pre-existing condition limitations of the Group Health Plan.

**Choice of Medical Plans** - The Group Health Plan provides a choice of two medical plans administered by United Healthcare.

Choice Plus offers both in-network and out-of-network benefits (two levels of coverage).

The two plans:

- Have the same network of hospitals and doctors.
- Are open access, which means they may use any network physician, do not have to select a primary care physician, and do not need a referral to see a specialist.
- Cover the same benefits, limitations and exclusions.

**Medicare-Eligible Retirees Medical Care Plan Options:**

**Eligibility**

A. Must be a participant in the FRS Pension Plan and are leaving County service to receive regular, early, or disability retirement benefits, or

B. Must be a participant in the FRS Investment Plan, are leaving County service and

1. meet the age and service requirements to qualify for normal retirement, i.e. age 62 and vested or 30 years of service (age 55 and vested or 25 years of service for Special Risk); or
2. have 6 years of creditable service and have reached age 59½.

C. The Health Plan also requires that you reside in the U.S.

**Non-Medicare Retirees** - If they or their covered dependents are not Medicare eligible, they may choose between the following plans administered by United Health Care. Choice Plus POS offers both in-network and out-of-network benefits (two levels of coverage).

1. Have the same network of hospitals and doctors.

2. Are open access, which means they may use any network physician, do not have to select a primary care physician, and do not need a referral to see a specialist.

3. Cover the same benefits, limitations and exclusions.

**Medicare Eligible Retirees/Dependents** - If they or their covered dependents are Medicare eligible, they have a choice of two other County benefit plans for Medicare members.

**Secure Horizons By United Health Care** - This plan is specifically designed for Pinellas County Government retirees offering medical, prescription, mental health and vision benefits. It is a Medicare replacement plan which offers significant savings to Medicare retirees.

**Traditional Plan (Plan Which Coordinates With Medicare)** - This plan is administered by United Health Care and coordinates with Medicare. It provides 100% of covered health services. Medicare is primary and the County group health plan is secondary.

United Health Group Incorporated* is the parent of United Health Care, one of the largest health insurers in the U.S. It was created in 1977 as United Health Care Corporation (it renamed itself in 1998). Through its family of businesses, United Health Group serves approximately 70 million individuals nationwide. (*United Health Group Website).

United Health Care’s network includes direct relationships with more than 560,000 physicians and caregivers, approximately 5,000 hospitals and care facilities, approximately 85,000 dentists and 64,000 pharmacies. More U.S. physicians accept UHC than any other insurance plan. United Health Group 2007 Earnings from Operations generated earnings from operations of $7.8 billion, up 12 percent over 2006.
United Health Care provides an interactive website (www.myuhc.com), which you may access to obtain claim information, print temporary Identification (ID) cards and order ID cards, locate providers, compare hospitals, check treatment costs and use as a library for health care topics.
Our audit disclosed certain policies, procedures and practices that could be improved. Our audit was neither designed nor intended to be a detailed study of every relevant system, procedure or transaction. Accordingly, the Opportunities for Improvement presented in this report may not be all-inclusive of areas where improvement may be needed.

1. **Claims Paid By United Health Care Totaling $549,845 Should Be Recovered.**

During our audit of claims paid by United Health Care (UHC), we found claims totaling $549,845 that we believe should not have been paid. United Health Care agrees with our conclusion on claims totaling $168,633, and disagrees on claims totaling $381,212. The overpayments are described below.

**CLAIMS TOTALING $549,845 THAT WE BELIEVE SHOULD NOT HAVE BEEN PAID**

- **Agreed Overpayments**: $168,633
- **Disputed Overpayments**: $381,212
- **Total Overpayments**: $549,845
A. Overpayments agreed to by UHC.

United Health Care has, to date, agreed with overpayments of $168,633, which are classified as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miscalculation of Charges</td>
<td>$138,231</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td>$14,219</td>
</tr>
<tr>
<td>Surgical Assistant</td>
<td>$12,166</td>
</tr>
<tr>
<td>Eligibility-Medicare Coordination</td>
<td>$4,017</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$168,633</strong></td>
</tr>
</tbody>
</table>

1) Miscalculation of Charges:

Calculation of charges is normally a function of the automated claims system. In some circumstances, established programming may not be able to handle the needed calculations. In other situations, the programming may be incorrect. We identified $138,231 of net overpayments, composed of 19 errors, which were made because of calculation errors.
2) Coordination of Benefits:

Two errors, totaling $14,219, were identified with regard to coordination of benefit investigation. The Plan requires coordination of benefits with other insurance coverage.

3) Surgical Assistant:

Surgical assistants assist the surgeons when performing surgery. The surgical assistants may or may not be physicians. We identified one error totaling $12,166 that was not paid according to UHC’s normal payment protocol. We have further concerns with payments for surgical assistants. See Opportunity For Improvement No. 1B.

4) Eligibility-Medicare Coordination:

We noted one claim, totaling $4,017, which was Medicare-eligible and should have been paid by Medicare.

B. Overpayments disputed by UHC.

Overpayments totaling $381,212 have not yet been agreed to by UHC. They are as follows:
FEE FOR SERVICE CLAIM
ERRORS BY CATEGORY

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistant to the Surgeon/non-doctor</td>
<td>$64,772</td>
</tr>
<tr>
<td>NOBLX Claims</td>
<td>$40,724</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td>$9,976</td>
</tr>
<tr>
<td>Timeliness of Claims submission</td>
<td>$250,000</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>$15,740</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$381,212</strong></td>
</tr>
</tbody>
</table>

1) Assistant to the Surgeon – non-doctor:

Payments to some assistant surgeons were found to be excessive. We noted excessive amounts totaling $64,772. See Opportunity for Improvement No. 2B for further recommendations regarding this issue. In one instance, two surgeons were paid $5,270.04 for a complex case while the first assistant nurse (non-doctor) was paid $19,719.30, or 3.74 times what the surgeons were paid. In this instance, we believe the first assistant nurse was overpaid between $16,400 to $18,812.25.

2) NOBLX Claims - $40,724:

These are the non-participating (non-par) providers being paid at 100% for an UHC subscriber (employee) in an office setting. For example, the patient goes to a non-par provider for a CT Scan or MRI. United Health Care pays 100% of the bill instead of paying nothing because the service was provided by a non-par provider, which is outlined in the benefit design. United Health Care is stating that a non-par specialist referral is generated by

<table>
<thead>
<tr>
<th>SERVICE PROVIDED BY</th>
<th>CLAIM PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>TWO SURGEONS PERFORMING SURGERY</td>
<td>$5,270.04</td>
</tr>
<tr>
<td>FIRST ASSISTANT NURSE ASSISTING THE TWO SURGEONS</td>
<td>$19,719.30</td>
</tr>
<tr>
<td>DIFFERENCE PAID NURSE VS. SURGEONS</td>
<td>$14,449.26</td>
</tr>
</tbody>
</table>
the referring physician (usually the primary care physician) and the subscriber should be held harmless.

Issue: This is not a referral system. The contract reads, we only pay par provider unless it is an emergency situation which is not the case with NOBLX claims. Therefore, NOBLX claims are out-of-network and should not be paid at 100%.

3) Coordination of Benefits - $9,976.

4) Timeliness of Claims submission - $250,000:

These claims included payment of a claim for $236,691 that was submitted after the deadline for submission to UHC based on UHC’s contract with the provider. The remaining portion of the overpayments were also due to submission by the provider to UHC after the deadline required in the providers’ contract with UHC. For example, in one claim (ref #92921752201), the date of service was June 4, 2003 and the claim was processed and paid on July 23, 2008, five years after the date of service.

5) Miscellaneous - $15,740:

Overpayments by UHC to providers result in overpayments by Pinellas County to UHC. These overpayments are due back to Pinellas County by UHC.

We Recommend Pinellas County’s Human Resources Department recover all overpayments to UHC.

Management Response:

The Human Resources (HR) staff is eager to work with UHC to quantify and expedite the process of recovering funds as appropriate. In the prior claims audit, UHC was prompt in agreeing to and disbursing the recovered funds. It is our understanding after discussions with both Dillabough and with UHC that some of the identified overpayments from Mr. Dillabough are being disputed by UHC and are being reviewed for resolution. We have separated these issues below to further clarify the circumstances of the claims.

Dillabough notes excessive payments of $64,772 for "non-doctor assistant to the surgeon fees." These are services provided by nurses or physician assistants who are not subject to provider contracts negotiated by UHC. Therefore, there is no contracted network rate. In keeping with the industry standard, UHC processes claims as "in network" when the surgery was performed by a network physician in a network facility. If the procedure is performed by a nurse or physician assistant, our member would incur a financial
penalty referred to as balance billing unless it is processed in network. This means that the member would pay the balance of the cost for the service even though they were not able to select the assistant surgeon. HR will enter into an in-depth discussion with UHC to fully understand the process and determine what measures can be taken to limit the County's financial liability without shifting the costs to our employee members.

The second area of recovery involves non-office based lab and diagnostic processing (NOBLX) claims in the amount of $40,724. In these instances, claims submitted by an in-network physician also included lab work or imaging ordered by the doctor and performed by a non-network provider. Similar to the instance described above, for payment purposes, UHC considers this procedure as "in-network" in order to avoid the balance billing issue. Again, this is an industry standard. Unlike the circumstance discussed above, many of these claims are submitted to UHC's shared savings program that ultimately results in a reduced payment and Pinellas County receives a reimbursement.

The position of HR in relation to both of the above circumstances is that only in circumstances where the employee member has control of the selection of the service provider should out of network reimbursement rates apply. Per our discussions, this practice is consistent with your recommendation. Human Resources will enter into discussion with UHC on this practice and pursue any appropriate changes.

The final and most significant area of claims recovery involves timeliness of claims submission amounting to $250,000. Human Resources agrees that any statutory requirements in this area, as well as the UHC processing guidelines, must be followed. We will aggressively pursue recovery in either of these instances. It is our understanding that UHC has not yet completed its review of many of these claims in question. Some of the claims in question involve payments made after the initial and timely filing. Others involve coordination where Medicare is the primary carrier. Where Medicare is primary, it is not unusual for more than a year to pass before Medicare reimburses the provider, which triggers the billing of UHC. We will review UHC's final determination on the processing of the Medicare claims before taking further action.

Internal Audit Reply:

Payments to the non-doctor Assistant to the Surgeon are excessive, regardless of whether these providers were in or out of network. We are also concerned that the members could be balance billed for excessive charges by any provider. The issue is the overcharging for services as noted in this finding (i.e., a non-doctor charging 3.74 times what the surgeons/doctors were paid) for conducting the actual surgery is not only unreasonable, but unconscionable as well). UHC, the County and/or our members should only pay for what
is reasonable and customary for services provided. We continue to strongly urge management to implement our recommendation.

2. Controls Need To Be Enhanced Through Amending The POS Health Benefit Plan.

During our claims benefit audit, we identified several enhancements that should be made to control costs and to help ensure claims are paid properly by UHC. They are as follows:

A. Timeliness of Claims Payment: Currently, the County’s contract with UHC does not limit the time frame in which claims can be submitted. There is some protection against payment of old claims through contracts that UHC has with its providers. However, this control is not always effective. In our sample of claims tested, we identified $250,000 in claims that were paid outside UHC’s allowed time frame for claim submission. We estimate that $350,000 in annual savings could be achieved through implementing a stipulation in the Plan stating that claims must be submitted within 15 months. This period could be reduced further, since the standard industry requirement is six to twelve months.

B. Usual and Customary: Under the current plan, UHC is paying non-participating providers 80% of the amount billed, whether or not it is within range of the usual and customary rates for the procedure. These payments pay non-participating providers up to four times the amount that would be paid if the provider was participating. In our test items, we found no claim that was reduced to the reasonable and customary rate. The current trend for employers is to use the Medicare prevailing fee schedule by location as the criteria for the usual and customary rate. By adopting this amendment to the plan, significant monies could be saved.

C. Non-Participating Providers: United Health Care is treating non-participating providers as though they are participating providers under some circumstances. This situation occurs when participating providers write a prescription, which the patient takes to a non-participating provider for the procedure. We noted examples including sleep studies, radiology and lab work. If the patient takes the prescription to the provider and it is non-participating, it is paid at the network rate because the referring physician was in the network. When the patient has a choice of providers to use, the Plan...
should require they choose a network provider to use participating rates. Otherwise, non-participating rates should be used.

With the rise in health care costs, it is essential that the County’s Plan take advantage of trends in the industry. The enhancement of controls and required practices will ultimately result in lower overall Plan costs.

We Recommend management:

A. Requirements for timeliness of submission of claims be established and followed. Claims should be denied if they are not submitted within the established time requirements.

B. Non-participating providers be paid at rates not to exceed the usual and customary rate. Consideration should be given to adopting Medicare prevailing rates as the usual and customary rate.

C. When the patient has a choice of providers, reimburse non-network providers at non-network terms.

Management Response:

My staff and I agree that timely claim submission requirements should be followed by UHC or any other claims administrator. As mentioned in the previous section, other factors influence the ability of the medical provider to file the claim which can place long delays on the process. Our staff will examine what, if any, plan amendments could improve this process and reduce the financial impact on the County.

Your report asks that HR consider the application of usual and customary rates for out of network providers. Mr. Dillabough did not indicate this was a major concern, but noted it as an area for potential savings. UHC provides two programs, Shared Savings and Facility Reasonable and Customary Savings, which negotiates with non-network providers. Resulting savings are shared between the County and UHC. Only 3.7% of claims’ expense for County employees is with out of network providers meaning opportunities for savings are minor.

As noted in the previous section, my staff and I agree with your recommendation that when members have a choice of providers, selecting non-network providers should result in non-network claim processing.
3. Members Have No Knowledge Of Contracted Rates, And Can Not Choose Providers Which Minimize Cost.

A listing of network providers is readily available to members of the Plan. However, rates for covered services vary significantly, resulting in a wide range of potential costs to the member and to the Plan. Although UHC restricts public disclosure of contract-specific information, we were able to obtain the rates from a UHC competitor who makes its contract rates available to its members. From our review, they are comparable to UHC’s rates. Example rate variances and required payments are as follows:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Rate</th>
<th>Member Co-Pay</th>
<th>Plan Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BRAIN MRI-OUTPATIENT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest</td>
<td>$2,710.00</td>
<td>$271.10</td>
<td>$2,438.90</td>
</tr>
<tr>
<td>Lowest</td>
<td>$  425.00</td>
<td>$ 42.50</td>
<td>$  382.50</td>
</tr>
<tr>
<td>Potential Cost Savings</td>
<td>$228.60</td>
<td></td>
<td>$2,056.40</td>
</tr>
</tbody>
</table>

As this table indicates, if a member having a brain MRI went to the facility with the highest charge, both the member and the Plan would pay over six times more for the same procedure.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Rate</th>
<th>Member Co-Pay</th>
<th>Plan Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CT SCAN FACE AND JAW-OUTPATIENT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest</td>
<td>$1459.00</td>
<td>$145.90</td>
<td>$1,313.10</td>
</tr>
<tr>
<td>Lowest</td>
<td>$ 225.00</td>
<td>$ 22.50</td>
<td>$  202.50</td>
</tr>
<tr>
<td>Potential Cost Savings</td>
<td>$123.40</td>
<td></td>
<td>$1,110.60</td>
</tr>
</tbody>
</table>

As this table indicates, if the person having a face and jaw CT scan went to the facility with the highest charge, both the member and the Plan would pay over six times more for the same procedure.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Rate</th>
<th>Member Co-Pay</th>
<th>Plan Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COLONOSCOPY-OUTPATIENT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest</td>
<td>$3,480.00</td>
<td>$348.00</td>
<td>$3,132.00</td>
</tr>
<tr>
<td>Lowest</td>
<td>$  419.00</td>
<td>$ 41.90</td>
<td>$  377.10</td>
</tr>
<tr>
<td>Potential Cost Savings</td>
<td>$306.10</td>
<td></td>
<td>$2,754.90</td>
</tr>
</tbody>
</table>
As this table indicates, if the person having a colonoscopy went to the facility with the highest charge, both the member and the Plan would pay over eight times more for the same procedure.

As a result of the lack of the ability of members to factor cost into their decisions relating to providers, members and the County are paying more than six times the cost if they had used one of the lower cost providers. According to our consultant, cost does not necessarily rate to quality of care. In fact, lower cost providers may provide better care than some of the higher cost providers.

The County could address this issue in three ways.

1. Amend the agreement with United to publish contracted rates to the members of the Plan, similar to the practice of Aetna, a competitor.

2. If that is not possible, the County could identify a few providers of each procedure, and designate that provider as an “economy provider.” This would allow members who are concerned about minimizing their health care expenditures to patronize those providers.

3. Identify and contract with an independent employee medical benefits advocacy program. This program would provide employees with the information and assistance to:

   • Make informed decisions regarding their medical care.
   • Make informed decisions regarding employee and employer medical costs.
   • Educate and provide medical counseling in order to ask the right questions when seeking treatment.
   • Compare physicians (i.e., level of experience) and medical facilities.
   • Select an independent second opinion.

This would save the County (and the employee) significant funds through merely providing more information to the member to facilitate their choice.

We Recommend management immediately designate economy providers for member use, negotiate a process with UHC where contracted rates may be disclosed to members, and identify and contract with an independent employee medical benefits advocacy program.
Management Response:

Mr. Dillabough provided exhibits from another claims administrator's participant website that allows members the option of comparing costs for selected services by network providers. In some instances, this may allow members to "shop price" for their healthcare needs producing savings for both themselves and the County.

UHC does not currently have this type of tool. They do, however, have on-line treatment cost estimators which give employees a reasonable expectation of the cost for medical procedures. The cost estimators also provide information on deductibles, coinsurance and other out of pocket costs. UHC also has a premium provider designation for many physician types and facilities. This designation rates both the cost and effectiveness of treatment. The UHC Nurseline and member services’ staff are trained to direct employees to these providers. UHC and my office provide robust communication of these programs and will continue to do so. While procedure cost is important, positive clinical outcomes have a greater impact on total plan cost and employee health and productivity over time.

My staff will actively work to implement as many tools as possible to assist employees in identifying quality and cost effective treatment options.

Internal Audit Reply:

We placed a call to the Nurseline to attempt to obtain a list of lower cost facilities for a Colonoscopy. The nurse stated she did not have that information and transferred us to Members Services. They also stated they did not have this information; they stated they could only provide Plan Coverage percentages. They said the only way to obtain this information is to call around to the providers. We continue to strongly urge management to implement our recommendation.

4. Plans For Medicare-Eligible Retirees Should Be Reviewed.

Retirees who are eligible for Medicare have two County Health Benefit Plans from which they may choose, a traditional plan or the Secure Horizons Plan. Both plans involve the coordination of benefits with Medicare, and Medicare pays first. The Secure Horizons Plan was established within the last few years and closely resembles the various Medicare Advantage plans that may be purchased in the open market. However, the benefits regarding co-pays closely resemble the County plan offered to employees. However, the County also offers a traditional plan which has extraordinary benefits compared to the marketplace in the current environment. For most claims, there are no out-of-pocket costs to the employee. The County pays 100% of

The County offers a Plan with extraordinary benefits.
the cost that Medicare does not pay. Based on the data provided by Pinellas County Human Resources, it is evident that there are significant cost savings, not only to the County, but also the retirees. The table below highlights these savings.

<table>
<thead>
<tr>
<th>Traditional Medicare Plan</th>
<th>Monthly Cost</th>
<th>Secure Horizons Plan</th>
<th>Monthly Cost</th>
<th>Savings</th>
<th>Monthly Savings</th>
<th>Annual Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$274.47</td>
<td>Single</td>
<td>$189.21</td>
<td>31%</td>
<td>$ 85.26</td>
<td>$1,023</td>
</tr>
<tr>
<td>Couple</td>
<td>$496.80</td>
<td>Couple</td>
<td>$378.42</td>
<td>24%</td>
<td>$118.38</td>
<td>$1,420</td>
</tr>
</tbody>
</table>

Human Resources have implemented an educational plan to get current retirees to convert to the Secure Horizons Plan with some limited success. They estimate, for Fiscal Year 2010, the converted retirees to Secure Horizons may realize a cost savings of $400,000.

These plans should be reviewed in light of the current environment and current practices in the industry. The review should include, but not be limited to, whether offering only the Secure Horizons Plan would provide adequate retiree coverage and whether it would be cost-beneficial to eliminate the traditional plan.

**We Recommend** management evaluate the current Medicare-eligible retiree plans and consider the feasibility of eliminating the traditional plan.

**Management Response:**

The HR department has long been considering alternatives that will allow the County to continue to offer quality healthcare to our retired employees and their families at affordable costs. Work in this area began in 2003 and the changes have already produced positive results. Most notably, the introduction of the Secure Horizons plan produced approximately $400,000 in annual savings to the County as well as savings to members. Through our partnership with our healthcare consultant, my staff will continue to seek innovative and effective solutions in this area.