TO: The Honorable Chairman and Members
of the Board of County Commissioners

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

SUBJECT: Follow-Up Audit of UHC Health Claims

DATE: February 23, 2012

For your review and filing in the Official Records, I am enclosing a copy of the follow-up
audit dated February 23, 2012 on the above-referenced audit.

I hope you find this report helpful in ensuring Pinellas County government provides the
best possible service to our citizens.

cc: Robert S. LaSala, County Administrator
Jim Bennett, County Attorney
Peggy Rowe, Director, Human Resources
David Blasewitz, Employee Benefits Manager, Human Resources
Claretha N. Harris, Chief Deputy Director, Finance Division
Ernst & Young
FOLLOW – UP AUDIT OF UHC HEALTH CLAIMS

Audit Services
Division of Inspector General

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

Hector Collazo, Jr., CFE, CFS, CISA, CIG, CIGI, CRISC
Director/Inspector General/Chief Audit Executive
Division of Inspector General**

Ken Green, CIGA – Senior Inspector General Auditor
Flo Riggie, CIA, CIGA, CISA, CRISC, ITIL-F – Inspector General Auditor II

FEBRUARY 23, 2012
REPORT NO. 2012-05

*Regulated by the State of Florida
**Accredited Office of Inspector General
By the Commission of Florida Law Enforcement Accreditation
February 23, 2012

The Honorable Chairman and Members
of the Board of County Commissioners

We have conducted a Follow-Up Audit of United Health Care (UHC) Health Claims. The objectives of our review were to determine the implementation status of our previous recommendations.

Of the six recommendations contained in the audit report, we determined that two have been implemented, two have been partially implemented, and two have not been implemented. The status of each recommendation is presented in this follow-up review.

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

Respectfully Submitted,

Hector Collazo, Jr., Director
Division of Inspector General

Approved:

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

*Regulated by the State of Florida
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INTRODUCTION

Scope and Methodology

We conducted a follow-up audit of the United Health Care (UHC) Health Claims. The purpose of our follow-up review is to determine the status of previous recommendations for improvement.

The purpose of the original audit was to:

1) 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.
2) Identify aspects of the Plan which could be enhanced to be more cost-beneficial to the County and/or members of the Plan.

To determine the current status of our previous recommendations, we surveyed and/or interviewed management to determine the actual actions taken to implement recommendations for improvement. We performed limited testing to verify the process of the recommendations for improvement.

Our follow-up 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. Our follow-up testing was performed during the month of October 2011. The original audit period was fiscal year 2007 through fiscal year 2008. However, transactions and processes reviewed were not limited by the audit period.

Overall Conclusion

Of the six recommendations in the report, we determined that two were implemented, two were partially implemented, and two were not implemented. We commend management for implementation of two of our recommendations and continue to encourage management to fully implement the remaining recommendations.
### Status

<table>
<thead>
<tr>
<th>OFI NO.</th>
<th>PREVIOUS RECOMMENDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Claims Paid By United Health Care Totaling $549,845 Should Be Recovered.</td>
</tr>
<tr>
<td></td>
<td>We recommend Pinellas County's Human Resources Department recover all overpayments to UHC.</td>
</tr>
<tr>
<td>2</td>
<td>Controls Need To Be Enhanced Through Amending The POS Health Benefit Plan.</td>
</tr>
</tbody>
</table>
|         | We recommend management:  
<p>|         | 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. |
| 3       | Members Have No Knowledge Of Contracted Rates, And Can Not Choose Providers Which Minimize Costs. |
|         | We recommend management immediately designate economy providers for member use, negotiate a process with UHC where contracted rates may be |</p>
<table>
<thead>
<tr>
<th>OFI NO.</th>
<th>PREVIOUS RECOMMENDATION</th>
<th>IMPLEMENTATION STATUS</th>
</tr>
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<tr>
<td></td>
<td>disclosed to members, and identify and contract with an independent employee medical benefits advocacy program.</td>
<td>Implemented  Acceptable Alternative Partially Implemented Not Implemented Not Applicable</td>
</tr>
<tr>
<td>4</td>
<td>Plans For Medicare-Eligible Retirees Should Be Reviewed.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>We recommend management evaluate the current Medicare-eligible retiree plans and consider the feasibility of eliminating the traditional plan.</td>
<td>✓</td>
</tr>
</tbody>
</table>
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 Health Care.

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, and 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.
STATUS OF RECOMMENDATIONS

This section reports our follow-up on actions taken by management on the Recommendations for Improvement in our original audit of the UHC Health Claims. The recommendations contained herein are those of the original audit, followed by the current status of the recommendations.

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

![Bar chart showing overpayments](chart.png)
A. Overpayments agreed to by UHC.

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

![Bar chart showing overpayments by category](chart.png)

<table>
<thead>
<tr>
<th>Category</th>
<th>Error 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. 1.B.

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:

<table>
<thead>
<tr>
<th>$381,212 OVERPAYMENTS DISPUTED BY UNITED HEALTH CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>$250,000</td>
</tr>
<tr>
<td>$15,740</td>
</tr>
<tr>
<td>$64,772</td>
</tr>
<tr>
<td>$9,976</td>
</tr>
<tr>
<td>$40,724</td>
</tr>
</tbody>
</table>

- Assistant to the Surgeon — non-doctor
- NOBLX Claims
- Coordination of Benefits
- Timeliness of Claims submission
- Miscellaneous
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. 2.B. 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 a 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 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 Recommended:

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

Status:

Partially Implemented.

Management Response:

Subsequent to release of the audit report in May 2009, the HR Department, UHC, and members of the Inspector General staff participated in multiple meetings to further quantify the amounts of overpayment and determine those which could be recovered. Most (94%) of the amount HR determined to be outstanding was collected. Collection of additional funds was recommended by Inspector General staff; however, based on the post audit meetings and related information reviewed since that time, it was then and still is our opinion that further collection is not merited.

Inspector General Comments:

We continue to encourage HR to review the claims that they are in disagreement with and to recover the remaining $408,993 overpayment on claims.
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 Recommended:

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.

Status:

A. Not Implemented.

B. Not Implemented.

C. Partially Implemented.

Management agrees with this recommendation and has implemented it, except in specific circumstances where members choose network facilities for procedures, which include services of both network and non-network providers. We continue to encourage management to reimburse all non-network providers at non-network terms.

Management Response:

A & B. HR has not implemented recommendations to set claim filing time requirements, nor have we set reimbursement limits. These we do not intend to do. HR management and our contracted health care consultant believe the practices followed by UHC are within acceptable industry standards, and are appropriately followed by UHC in the processing of Pinellas County claims.

Inspector General Comments:

A. We continue to encourage management to establish requirements for timely submission of claims, review claims for timeliness of submission, and to deny claims not submitted within time requirements.

B. We continue to encourage management to consider adoption of Medicare prevailing rates as the usual and customary rate and for non-participating providers to be paid at rates not to exceed the usual and customary rate.

C. We continue to encourage management to reimburse all non-network providers at non-network terms.
3. **Members Have No Knowledge Of Contracted Rates, And Can Not Choose Providers Which Minimize Costs.**

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:

### BRAIN MRI-OUTPATIENT

<table>
<thead>
<tr>
<th></th>
<th>Rate</th>
<th>Member Co-Pay</th>
<th>Plan Cost</th>
</tr>
</thead>
<tbody>
<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><strong>Potential Cost Savings</strong></td>
<td><strong>$228.60</strong></td>
<td><strong>$2,056.40</strong></td>
<td></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.

### CT SCAN FACE AND JAW-OUTPATIENT

<table>
<thead>
<tr>
<th></th>
<th>Rate</th>
<th>Member Co-Pay</th>
<th>Plan Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest</td>
<td>$1,459.00</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><strong>Potential Cost Savings</strong></td>
<td><strong>$123.40</strong></td>
<td><strong>$1,110.60</strong></td>
<td></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.

### COLONOSCOPY-OUTPATIENT

<table>
<thead>
<tr>
<th></th>
<th>Rate</th>
<th>Member Co-Pay</th>
<th>Plan Cost</th>
</tr>
</thead>
<tbody>
<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><strong>Potential Cost Savings</strong></td>
<td><strong>$306.10</strong></td>
<td><strong>$2,754.90</strong></td>
<td></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 Recommended:

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.

Status:

Implemented.

The on-line treatment cost estimator now permits the member to select individual providers and compare costs for professional services. The estimator also gives a range of costs for facilities in which the physician might provide the services.
Management Response:

UHC implemented a tool in 2010, enhanced in 2012, which will permit the member to select a medical procedure and compare not only the physician fees, but the facility charges for the procedure. The latest enhancement will also show the members’ financial obligation after taking into account any deductible or coinsurance to be paid by the member.

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 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>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$274.47</td>
</tr>
<tr>
<td>Couple</td>
<td>$496.80</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<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>$189.21</td>
<td>31%</td>
<td>$85.26</td>
<td>$1,023</td>
</tr>
<tr>
<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 Recommended:

Management evaluate the current Medicare-eligible retiree plans and consider the feasibility of eliminating the traditional plan.
Status:

Implemented.

Employees hired on or after January 1, 2011 are not eligible for employer subsidy for retiree health care costs with the exception of the employer funded health insurance subsidy, which is mandated as part of the Florida Retirement System benefits. Also, retirees newly eligible for Medicare on or after July 1, 2011 must participate in the less costly Medicare Advantage plan.

Management Response:

HR accomplished this by proposing and having BCC approval to do exactly that. Eligibility changes were made which offer the lower cost plan as the only option for new Medicare members as of July 1, 2011.
DIVISION OF INSPECTOR GENERAL

KEN BURKE, CPA
CLERK OF THE CIRCUIT COURT
PINELAS COUNTY, FLORIDA

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Division of Inspector General
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Clearwater, FL 33756

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