New Jersey State Legislature
Office of Legislative Services
Office of the State Auditor

Statewide Analysis of Health Benefit Costs in School Districts

School Year 2007-2008
The Honorable Jon S. Corzine
Governor of New Jersey

The Honorable Richard J. Codey
President of the Senate

The Honorable Joseph J. Roberts, Jr.
Speaker of the General Assembly

Mr. Albert Porroni
Executive Director
Office of Legislative Services

Enclosed is our report on the audit of the Statewide Analysis of Health Benefit Costs in School Districts for the School Year 2007 - 2008. If you would like a personal briefing, please call me at (609) 292-3700.

Stephen M. Eells
Assistant State Auditor
October 22, 2008
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Statewide Analysis of Health Benefit Costs in School Districts

Scope

We have completed a statewide analysis of health benefit costs in school districts for the school year 2007 - 2008. Our analysis included a review of the health benefits offered, means of obtaining those benefits, and the costs.

Each district is required through contractual agreement with its employees to provide health benefits. School districts may participate in the State Health Benefits Program (SHBP) or obtain private coverage from insurance providers.

Objectives

Our objectives were to analyze school district health benefits for levels of coverage offered to employees and the degree of plan customization, and to gain an understanding of the level of coordination of benefits. In addition, we reviewed the methods of obtaining benefit plans and the reasonableness of the costs associated with the plans.

The audit was conducted pursuant to the State Auditor’s responsibilities as set forth in Article VII, Section 1, Paragraph 6 of the State Constitution and Title 52 of the New Jersey Statutes.

Methodology

Our audit was conducted in accordance with Government Auditing Standards, issued by the Comptroller General of the United States.

In preparation for our testing, we studied legislation and administrative code. Provisions that we considered significant were documented and compliance with those requirements was verified by interview and observation. We also reviewed loss ratio reports and interviewed district personnel to obtain an understanding of how plans were procured.

A nonstatistical sampling approach was used. School districts were sorted according to their participation in either private health plans or the SHBP. The majority of the sample was chosen from the districts that obtained private health plans. Districts were randomly selected.
Conclusions

We found the types and levels of coverage offered by the district are driven by the covered employees bargaining units’ contracts. These contracts are as unique as the school district. Benefit plan services are relatively standard; however, customization occurs within the deductible and co-pay amounts and the covered benefit period. Coordination of benefits exists within the medical and dental plans; however, it does not exist in the prescription drug plans. Additionally, renewal rates and brokers fees need to be examined more thoroughly.

Background

Each school district operates with a Board of Education or a Board of Trustees that provides direction. School districts operate as independent units. They may obtain health benefit coverage for their employees either through the State Health Benefits Program (SHBP) or private carriers. The majority of the school districts (66 percent) procure their benefits from private carriers.

Expenditures for health benefits are a significant operating cost. Health benefit costs can be paid utilizing several different funding methodologies. Typically larger districts pay their claims and an administrative fee on a monthly basis to their health insurance carrier. Other districts pay a capitation (premium) fee that is calculated utilizing a claims experience rating for a particular group or district and/or a manual rate (based on demographics). The majority of the school districts sampled paid their health benefits through a capitation fee calculated by the carriers. Health benefit brokers can be utilized to obtain these benefits from private carriers. They solicit bids from health, dental, and prescription drug carriers. Brokers can be paid either a consulting fee or a commission based on the benefits obtained. The commissions of three major carriers that we interviewed are paid through the provider insurance company and are reflected in the premiums.
Coordination of Benefits for Prescription Drug Plans

Although the law is very specific on the coordination of benefits for the medical and dental areas of health benefits it is silent to the prescription drug area. New Jersey Administrative Code (N.J.A.C.) 11:4-28 Appendix A states coordination of benefits is a provision that allows a carrier to coordinate what the carrier pays or provides with what another plan pays or provides. This appendix also outlines the rules for the order of benefit determination. Per these rules benefit plans are determined to be primary or secondary. A primary plan pays or provides services or supplies first, without taking into consideration the existence of a secondary plan. The benefit plan provided to an employee from a district is considered the primary plan of the employee; however, it may not be the primary plan for the spouse/partner or dependents. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage of all plans under which the person is covered. Since the law does not provide for coordination of benefits for prescription drugs, individuals covered by two plans may utilize the plan with the lower co-pays thereby resulting in higher health benefit costs to that member’s plan. Premium and/or claim billings are increased when spouses/partners or dependents utilize the prescription drug benefits that would otherwise be processed under the covered person’s primary plan if the coordination of benefits rules applied. Additionally, we reviewed each state’s employee benefits website and noted 21 states coordinate benefits for prescription drugs.

Recommendation

We recommend the coordination of benefits administrative code be updated to include prescription drug plans.
A review of renewal premiums and brokers commissions needs to be performed.

Premiums and Brokers Fees

We requested summary claims data (loss ratio reports) from 18 of the 20 sampled school districts. The two districts excluded participated in the State Health Benefits Plan for their medical benefits. Of the 18 districts we requested data from; eight responded with usable data, six did not respond, one did not have data available since they are in a pool with other entities, two districts sent incomplete data, and one district was self-insured. Of the eight districts that responded with usable data, there were some months missing within the time frame requested; consequently, we utilized the data that we received.

Generally the reports contained monthly totals of amounts paid by carriers (claims), premiums billed by carriers to the districts, numbers of contracts and members covered, and the loss ratio (the claims divided by the total premium). Premiums paid by the district are meant to cover the claims paid by the carrier, an administrative fee that covers the processing of the claims and an underwriting profit (if the carrier is for profit). According to the New Jersey Commercial Health Market report of 2005 generated by the New Jersey Department of Banking and Insurance, the average loss ratio (percentage of premium utilized for direct claim payments) for the commercial market is 80 percent. The remainder of the premium, 20 percent, is utilized to administer the system including claims processing, broker commissions, taxes and profit.

We utilized the months of data received from the eight districts over a three-year period. The most complete year of data was school year 2006-2007. Within those eight districts we received data for 17 plans. We added 20 percent representing costs to administer the system to make a more accurate comparison to the premiums paid. Summary information follows:
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<td>Numbers of districts with six or more months of complete data available for evaluation</td>
<td>4</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Number of plans evaluated</td>
<td>9</td>
<td>17</td>
<td>12</td>
</tr>
<tr>
<td>Number of plans with lower claims (including costs to administer the system) than premiums</td>
<td>7</td>
<td>11</td>
<td>10</td>
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<tr>
<td>Percentage of plans with lower claims (including costs to administer the system) than premiums</td>
<td>78%</td>
<td>65%</td>
<td>83%</td>
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The majority of the plans are reviewed and renewed on an annual basis. The data we received on all the plans for the three years evaluated indicated that only four plans received decreases in premiums following the two renewal periods. Although half of the business administrators stated that they reviewed the claims data available and utilized this information during the renewal process, premium increases were not consistent with plan performance. For example, within three districts during school year 2005-2006 five of the six plans experienced lower claims (including costs to administer the system) than premiums paid. During school year 2006-2007 all six experienced lower claims (including costs to administer the system) than premiums paid. Three plans incurred increased premiums at July 2006 and premiums for all six plans increased at July 2007. During school year 2007-2008 five of the six plans experienced lower claims (including costs to administer the system)
than premiums paid. It does not seem reasonable that these increases in premiums would be acceptable. In addition, one carrier does not provide claims data; therefore business administrators are making decisions without claims data.

Brokers are utilized by the school districts to negotiate renewal premiums, review products available, and assist in the procurement of health benefit plans. Through conversations with district personnel, we were told brokers are paid either as a consultant via a direct payment from the school district or through commission payments reflected in the premiums paid by the school district to the carrier. All 20 districts we sampled had a broker. Two districts paid the broker via a consulting fee ranging from $30,000 to $39,000. The remaining 18 districts’ brokers were paid on a commission basis. At our initial interview four of the districts knew the percentages the brokers were paid. Based on this information, we calculated the commissions and they ranged from $121,000 to $178,000 per district. The remaining 14 districts knew the broker was paid on a commission basis but did not know what percentage of their premiums was paid to the brokers. Upon follow-up two districts were able to provide the percentage and/or dollar amount paid to the broker, five districts indicated that the broker’s commission is included in the premium but did not indicate the percentage or amount, four districts were unaware that the broker’s commission was included in the premium and three did not respond to our follow-up questions. Services provided by the broker in one of the two districts paid via consulting fee were found to be no different than services provided by those brokers paid on a commission basis.

**Recommendation**

We recommend that business administrators review experience information carefully and perform comparisons annually in order to obtain the most competitive premium. We also encourage them to obtain the broker’s commission percentage, calculate the amount
paid to the broker, and review its reasonableness and effect on total premiums.
Mr. Stephen M. Eells, Assistant State Auditor  
Office of Legislative Services  
Office of the State Auditor  
125 South Warren Street  
P.O. Box 067  
Trenton, NJ 08625-0067  

Dear Mr. Eells:  


The New Jersey Department of Education (DOE) has received and reviewed the findings and recommendations contained in the Office of Legislative Services (OLS) Audit Report of the Department of Education, Statewide Analysis of Health Benefits in School Districts for the period July 1, 2007 to June 30, 2008. The findings and recommendations along with our responses are as follows:  

Finding Number 1, Page 3 – Coordination of Benefits for Prescription Drug Plans  

Although the law is very specific on the coordination benefits for the medical and dental areas of health benefits, it is silent to the prescription drug area. N.J.A.C. 11:4-28, Appendix A states that coordination of benefits is a provision that allows a carrier to coordinate what the carrier pays or provides with what another plan pays or provides. This appendix also outlines the rules for the order of benefit determination.  

Since the law does not provide for coordination of benefits for prescription drugs, individuals covered by two plans may utilize the plan with the lower co-pays thereby resulting in higher health benefit costs to that member’s plan. Premium and/or claim billings are increased when spouses/partners or dependents utilize the prescription drug benefits that would otherwise be processed under the covered person’s primary plan if the coordination of benefits rules applied.  

Recommendation Number 1  

OLS recommends the coordination of benefits administrative code be updated to include prescription drug plans.
Department Response to Finding Number 1

The Department of Education does not promulgate insurance regulations, and therefore cannot provide a meaningful response to this recommendation other than that it appears to be appropriate. The Department does recommend, however, that the Department of Banking and Insurance receive a copy of this report for comment since it is responsible for promulgating Chapter 11 of the New Jersey Administrative Code and would have authority to make the recommended amendments to the rules.

Finding Number 2, Page 4 – Premiums and Brokers Fees

OLS auditors requested summary claims data (loss ratio reports) from 18 of the 20 sampled school districts. The two districts excluded participated in the State Health Benefits Plan for their medical benefits. Of the 18 districts they requested data from, eight responded with usable data, six did not respond, one did not have data available since they are in a pool with other entities, two districts sent incomplete data, and one district was self-insured. Of the eight districts that responded with usable data, there were some months missing within the time frame requested; consequently, they utilized the data that they received.

The auditors utilized the months of data received from the eight districts over a three-year period. The information included data for 17 plans. The majority of the plans are reviewed and renewed on an annual basis. The data received on all the plans for the three years evaluated indicated that only four plans received decreases in premiums following the two renewal periods. Although half of the business administrators stated that they reviewed the claims data available and utilized this information during the renewal process, premium increases were not consistent with plan performance. For example, within three districts during school year 2005-2006 five of the six plans experienced lower claims than premiums paid. During school year 2006-2007 all six experienced lower claims than premiums paid. Three plans incurred increased premiums at July 2006 and premiums for all six plans increased at July 2007. During school year 2007-2008 five of the six plans experienced lower claims than premiums paid. It does not seem reasonable that these increases in premiums would be acceptable. In addition, one carrier does not provide claims data; therefore business administrators are making decisions without claims data.

The auditors also reported that brokers are utilized by the school districts to negotiate renewal premiums, review products available, and assist in the procurement of health benefit plans.

Recommendation Number 2

OLS recommends that business administrators review experience information carefully and perform comparisons annually in order to obtain the most competitive premium. They also encourage them to obtain the broker’s commission percentage, calculate the amount paid to the broker, and review its reasonableness and effect on total premiums.
Department Response to Finding Number 2

Health benefits represent a significant portion of a school district’s budget and the review of available data is important for proper budgeting and expenditure of funds. Pursuant to N.J.S.A. 18A:55-3, as a condition for the receipt of State aid, a school district must examine all available group options for every insurance policy held by the district and participate in the most cost effective plans. The department’s draft regulations require this examination no less than every three years since the district’s health benefits plan is subject to collective bargaining and it is not always possible to change the health coverage without reopening contract negotiations. Based on the audit’s recommendations, the DOE will consider including in the final regulations that the examination also include review of claims and other experience information, as well as any applicable broker fees.

In addition, the DOE’s regulations at N.J.A.C. 6A:23A-9.3 governing “Efficiency Standards for the Review of Administrative and Non-Instructional Expenditures and Efficient Business Practices” currently include indicators comparing the district expenditures to the comparative spending guide particularly in the areas of non-instructional costs. While changing health coverage may not be possible without reopening contract negotiations, this does not preclude the district from having and using this information annually to secure the lowest premium renewal rates for the district. Therefore, the Department will also consider amending the efficiency regulations to add a requirement that the district review annual claims data and the broker’s fee or commission prior to renewing benefit plans, in addition to the efficiency standards already required.

Moreover, school districts are subject to review through the New Jersey Quality Single Accountability Continuum ("NJQSAC") process which monitors, among other things, fiscal efficiency. Currently, one fiscal indicator is whether, prior to each renewal, the district receives alternative quotes for health plans to ensure maximum savings. The Department will consider amending the NJQSAC indicators during the next rulemaking proceeding to include additional efficiency standards to monitor whether districts obtain and analyze claims data prior to the annual renewal of health insurance and consider the cost of using the services of a broker for health insurance matters.

Finally, the audit noted that at least one carrier refused to provide claims history information to the district or to the auditors. Clearly, a failure to provide such information would stymie efforts by the Department to require districts to analyze claims information in order to obtain more competitive premiums. Therefore, consideration should be given to requiring, by legislation or regulation, that carriers provide their clients with annual claims data in order for districts to make informed decisions on premium rates.
The DOE trusts that our responses satisfy the concerns raised in the audit report. If you have any questions or need further information, please contact Robert J. Cicchino at 984-5593.

Sincerely,

[Signature]

Lucille E. Davy
Commissioner

LED/JH/RJC/response to OLS audit of health benefits in school districts
c: John J. Hart
   Katherine Attwood
   Donna Arons
   Robert Cicchino