Department of the Treasury
Division of Pensions and Benefits
Health Benefits Administrator Contracts

July 1, 2016 to April 30, 2018

Stephen M. Eells
State Auditor
The Honorable Philip D. Murphy  
Governor of New Jersey  

The Honorable Stephen M. Sweeney  
President of the Senate  

The Honorable Craig J. Coughlin  
Speaker of the General Assembly  

Ms. Peri A. Horowitz  
Executive Director  
Office of Legislative Services  

Enclosed is our report on the audit of the Department of the Treasury, Division of Pensions and Benefits, Health Benefits Administrator Contracts for the period of July 1, 2016 to April 30, 2018. If you would like a personal briefing, please call me at (609) 847-3470.

Stephen M. Eells  
State Auditor  
July 18, 2018
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Scope

We have completed an audit of the Department of the Treasury, Division of Pensions and Benefits (division), Health Benefits Administrator Contracts for the period July 1, 2016 through April 30, 2018. Our audit included financial activities of the State Health Benefit Program Fund – State Active, State Health Benefit Program Fund – State Retired, State Health Benefit Program Fund – Local Education Active, State Health Benefit Program Fund – Local Education Retired, State Health Benefit Program Fund – Local Government Active, and State Health Benefit Program Fund – Local Government Retired. Each fund includes health benefits and prescription drug benefits for covered individuals. The Dental Expense Program was excluded from the audit. Additionally, member eligibility and logical access controls over the State Health Information Processing System (SHIPS) were relied upon since they were audited in our report dated December 20, 2016.

Fiscal year 2017 combined expenditures from the health benefits and prescription drug programs were approximately $7.1 billion representing subscriber and dependent health benefit coverage for 833,000 members, of which 64 percent were active and 36 percent were retired; and prescription drug coverage for 719,000 members, of which 58 percent were active and 42 percent were retired. The state portion of these expenditures was approximately $3.1 billion. The balance was expended by local governments, by school districts, and from employee contributions. We performed limited review and analysis of claims since the division contracts with a consultant to review claims for propriety. We focused our audit on the administrative costs of these programs paid to the administrators which totaled approximately $174 million.

Objectives

The objectives of our audit were to determine whether financial transactions made to the health benefits administrators were related to the health benefits programs, were reasonable, and were recorded properly in the accounting systems.

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

Methodology

Our audit was conducted in accordance with Government Auditing Standards, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provided a reasonable basis for our findings and conclusions based on our audit objectives.

In preparation for our testing, we studied legislation, the administrative code, circulars promulgated by the Department of the Treasury, and policies of the division. Provisions we considered significant were documented, and compliance with those requirements was verified.
by interview, observation, and through our testing of financial transactions. We also read the budget messages and contracts, reviewed financial trends, and interviewed the division’s personnel to obtain an understanding of the programs and the internal controls. Additionally, we relied on information provided by both internal and external systems which were either audited by us or other auditors.

A nonstatistical sampling approach was used. Our samples of financial transactions were designed to provide conclusions on our audit objectives, as well as internal controls and compliance. Transactions were judgmentally selected for testing.

**Conclusions**

We found that the financial transactions included in our testing were related to the health benefits programs, were reasonable, and were recorded properly in the accounting systems. In making this determination, we noted internal control weaknesses meriting management’s attention.

**Background**

The division offers benefits to eligible employees and retirees, and their dependents, participating in the State Health Benefits Program (SHBP) for state and local employers or the School Employees’ Health Benefits Program (SEHBP) for education employers. There are two contracted private vendors offering two types of health benefit products. The first and largest portion is the self-insured product in which the vendors act as administrators of the claims and bill the state for the cost of claims. The “administrators” are compensated by charging various administrative fees. The second is Medicare Advantage which is a fully-insured product that is premium-based, therefore the vendors act as “carriers” and are responsible for the cost of claims. This product is available to members who are enrolled in Medicare and acts as a comprehensive plan by combining Medicare and Medicare Supplemental Insurance to maintain the same level of coverage for the member. Additionally, the state contracts with a consultant to periodically review claims to ensure integrity.
Administrative Services Only Fees

Self-billed Administrative Services Only Fees are derived using incorrect rates.

The Administrative Services Only Fee (ASO Fee) is paid to the administrators and acts as the only compensation due unless additional fees are mutually agreed upon between the State of New Jersey and the administrator for the self-insured health benefits plans. The ASO Fee is determined by applying the specific fee rate to the number of participating employees/retirees. The ASO Fee rates are adjusted annually and are based on plan type: Preferred Provider Organization (PPO) plans, Health Maintenance Organization (HMO) plans, High-Deductible Health Plans, and Tiered Network plans; and employee/retiree groups: State Employee Group (active and retired), Local Government Employer Group (active and retired), and the School Employees’ Health Benefits Program (active and retired). The ASO Fee rates are submitted to the Office of Information Technology (OIT) for input into SHIPS prior to the start of the calendar year. The fee is self-billed by the division and paid to the administrators on a monthly basis.

We reviewed the monthly ASO Fee payments made by the division to the administrators for accuracy. Samples of five monthly payments were judgmentally selected for each administrator. Of the five monthly payments, three to each administrator were found to have errors in the calculations performed by the division as outlined below.

- The errors we found in the payments to one administrator were caused by an additional fee being improperly included in the ASO Fee rates for active members across all health benefits plans in calendar years 2016 and 2018. This fee was billed separately to the division by the administrator and should not have been included as part of the ASO Fee. The errors resulted in total overpayments of $1.7 million by the division for ASO Fees during calendar years 2016 and 2018 as of April 30, 2018.

- The errors we found regarding the other administrator were caused by a higher HMO rate being improperly applied to all active members of a PPO plan and a fee not being properly included in the ASO Fee rate for all members of the Tiered Network plan. Both errors were found in calendar year 2016 ASO Fee payments with the Tiered Network plan error partially offsetting the PPO plan error. The errors resulted in a net overpayment of $425,000 by the division.

Recommendation

The division should verify that proper ASO Fee rates are submitted to OIT and the rates are properly input into SHIPS by OIT. Verification of proper ASO Fee rates should also be performed at various times throughout the year to ensure proper ASO Fee calculations and
The division is not tracking all billable units for other fees.

In addition to the monthly ASO Fee, one of the administrators also bills the division for various administrative fees (non-ASO Fees) each month. These fees are based on annually adjusted fee rates and the applicable member group. We reviewed eight of the non-ASO Fees billed to the division by the administrator and tested them for accuracy. We judgmentally sampled monthly payments for each of the fees we reviewed.

We could not verify the accuracy of non-ASO Fee payments made by the division to the administrator for two of the eight non-ASO Fees we reviewed. One of the non-ASO Fees was billed for all active members and New Jersey resident retirees who are not enrolled in a Medicare Advantage plan. However, the division does not produce summary reports of retired members based on residency. As a result, testing could not be performed on this fee for all billable member groups. We noted non-ASO Fee payments were made by the division without proper verification. The payment of billed fees without any form of verification by the division could lead to higher healthcare costs for both the SHBP and SEHBP.

Recommendation

Reports should be generated by the division to track all applicable groups of billable members in the SHBP and SEHBP for non-ASO Fees. The division should require all administrators to use division membership lists for non-ASO Fee calculations. Non-ASO Fees calculated and billed by the administrators should be verified by the division to ensure fee payment propriety.

Medicare Advantage Plan Premium Billing

The division does not reconcile enrollment and billing discrepancies associated with members on Medicare Advantage plans.

The state offers Medicare Advantage (MA) plans to eligible members of the SHBP through the two carriers and to eligible members of the SEHBP through one of these carriers. This carrier offered MA plans throughout the audit period while the other began offering MA plans in the beginning of calendar year 2017. Retirees who are enrolled in one of two specific health benefits plans from one carrier or one of four specific plans from the other carrier are automatically transferred to an MA plan upon Medicare enrollment. However, one carrier’s MA
plans do not cover members who have been diagnosed with End Stage Renal Disease (ESRD), which is more commonly known as kidney failure. Even though an individual who has been diagnosed with ESRD can receive a kidney transplant and be considered cured of the disease, the carrier is permitted to continue to classify the individual as having ESRD. These members would continue to be covered under the self-insured plans with Medicare being the primary health insurer.

The division does not maintain an accurate list of members with ESRD and therefore cannot maintain an accurate list of members on the MA plans offered by one of the carriers. While Medicare and MA plan coverage is ultimately determined by the Centers for Medicare & Medicaid Services (CMS), critical MA plan enrollment information from CMS is reported to the carriers but not to the division. Enrollment information is then reported to the division by the carriers. A portion of MA plan premiums is paid to the carriers by CMS. As a result, Membership Monthly Reports (MMRs) are produced by CMS which identify billing adjustments including credits for members billed in error. The MMRs are also distributed to the carriers but not to the division because it is not permitted to receive MMRs directly from CMS. Therefore, the flow of critical information concerning both enrollments and billing adjustments flows from CMS through the carriers and then to the division. Reconciliations are not performed between the division’s lists of members on MA plans and lists reported by the carriers. Since the division cannot obtain MMRs directly from CMS, members could incorrectly be listed by the carrier on a self-insured plan instead of an MA plan where the carrier has more liability.

The MA monthly premium payments for two tested invoices from one carrier were found to be inconsistent with reports generated from SHIPS. Division records generated from SHIPS indicated a larger number of members on MA plans than indicated on the carrier’s invoices. In contrast, our review of billed member lists from that carrier revealed 997 members from one month and 468 members from the other month tested were billed for MA premiums even though those members were not on MA plans according to SHIPS. The division was billed for MA premiums in both months for a total of 156 members who were not actually enrolled in an MA plan in either month. This carrier reports monthly billing adjustments to the division to correct billing errors from previous months.

The division does not have enough control over the MA plans offered as part of the SHBP and SEHBP. It relies on the carriers as its source of critical enrollment and billing information. Reliance on the carriers for this information creates a risk of greater liability for healthcare costs and incorrect premium payments for healthcare coverage by the division.

**Recommendation**

The division should obtain from the carriers an accurate list of members exempt from MA coverage due to medical conditions. The division should also perform reconciliations of the MA plan member lists supplied by the carriers with the lists generated by SHIPS.
Observations

Claims Cost Analysis

The division does not periodically evaluate the effectiveness of the carriers’ ability to negotiate claims discounts.

For active employees and non-Medicare eligible retirees, the SHBP and the SEHBP are self-insured. The division contracts with carriers to administer the various health benefits plans. It is the carriers’ responsibility to negotiate with the healthcare providers to ensure the state receives favorable discounts for the procedures the providers perform.

We analyzed procedure codes and found large cost variances when comparing costs between carriers for the same plans. Additional review of the carriers’ negotiated costs at the same healthcare providers for the same procedures showed similar inconsistencies. While the division contracts with a consultant to periodically review a sample of claims for adjudication concerns, neither the division nor its consultant evaluates how effective the carriers negotiate discounts with the providers.

Differing Administrative Fee Structures

The methods in which the administrators bill for their administrative fees are inconsistent.

The division contracts with two administrators to manage the health benefits plans. The administrators are paid an ASO Fee to process claims and provide access to a quality healthcare network. The state advertises a Request for Proposal and lists all services the division will require of the administrator. Both administrators are compensated for their services by self-billed ASO Fees. The ASO Fees for one administrator covers all provided services, while the other is permitted to separately bill for some of the same services. The separately billed fees by this administrator are based on different subsections of the member population. This difference in billing makes comparing total fee costs between administrators labor-intensive. Additionally, since the other fees are billed over different populations, monthly reconciliations to ensure proper billing are also complicated.
TO: John Termyna, Assistant State Auditor  
FROM: John D. Megariotis, Acting Director  
SUBJECT: Final Response to OLS Audit

Administrative Services Only Fees

The administrative services only fees paid to Horizon, Aetna and Optum are self-reported by the DPB. We calculate the full member counts for the month, the partial and retroactive member counts for the month, and apply the appropriate ASO fee by carrier and member status (Active/Retired) and make monthly payments accordingly.

The ASO fees for each plan year are based on each vendor’s RFP response and subsequent contract. Due to a miscommunication regarding the ASO fees for one administrator, $0.60 per active employee per month was added to the ASO fee, when it had already been included in the ASO fee. This occurred in calendar years 2016 and 2018. The overpayment totaled $3,204,398.20 and was recovered through a credit against the June 26, 2018 claims billing.

The ASO fees regarding the other administrator were as a result of typographical errors in the annual data load. We are working with them to recover the $425,000 overpayment. The DPB has instituted additional proofreading procedures as well as quarterly audits of ASO fee calculations to prevent this from occurring in the future.

Billing of Non-Administrative Services Only Fees

Several of the other fees referred to are billed on a per member per month basis, as well as a non-Medicare member per month basis, and a per employee per month basis. These fees are for radiology management and pre-authorizations, pain management fees, and recovery services fees. Reports calculating each of these has been requested from the administrators and will be reviewed against the appropriate non-ASO fees upon receipt.

Additional fees are for members who are patients attributed to a patient centered medical home and represent care coordination services provided by the members’ primary care physicians.
Other fees paid are service charges levied by other states and Graduate Medical Education fees required by CMS.

The medical plan RFP that is under development will require an all-inclusive ASO fee and no additional fees will be permitted.

**Medicare Advantage Plan Premium Billing –**

The State offers Medicare Advantage (MA) plans to eligible members of the SHBP through both administrators, and to eligible members of the SEHBP through one administrator. Enrollment in an MA plans requires submission of the member’s enrollment information to CMS and subsequent approval (communicated to the administrators). Relying on the administrators reporting prevents the DPB from paying both the MA premium and the ASO fee (for the self-insured membership).

When migrating the 60,000 + SHBP Medicare eligible retirees to the MA plan effective 1/1/17, existing ESRD members were rejected by CMS. Based on the legal interpretation of guidelines in the Medicare Managed Care Manual and Code of Federal Regulations at the time by the administrator, it was concluded the rejections were correct and attributable to the waiver provision needed to be applied in order to enroll ESRD members in the plan. Therefore, the members remained in the Medicare supplemental programs. A recent legal review by the administrator has determined that they can pursue an exception with CMS and we are taking those steps now. As of the writing of this response, there were approximately 500 members that were identified as ESRD, and will be moving off of the supplemental plans, into the MA plans effective 1/1/19.

**Claims Cost Analysis-**

Claims audits are performed by the contracted health care consultant according to a regulated schedule as outlined in the contract. The claims are audited on financial accuracy to ensure that the plan isn’t being over charged and that payments are being made according to the plan provisions. Network charges usually fall outside a financial claims audit. Most financial arrangements made between the providers and the administrators are proprietary.

We will begin to work with our health care consultant to gather detailed claims information that not only lists financial claim information, but will list numerous other fields that can be analyzed (i.e. procedure codes, provider information, geographical information etc.). We will also work to develop new business methodology and try to identify new cost savings through numerous approaches with the new data.

**Differing Administrative Fee Structures –**

The next contract cycle for our self-insured medical plans will be effective for 01/01/2020 and the RFP is currently under development. As such, new pricing sheets along with detailed specifications on ASO fees are being incorporated into the RFP to ensure transparency with future ASO fees. This will also allow for better auditing since future ASO fees from vendors will be able to be analyzed along the same parameters.