MARTIN E. SEGAL COMPANY

Report to the Legislative Committee on Employee Hospital and Medical Benefits

March 18, 1985

Report to the Legislative Committee on Employee Hospital and Medical Benefits

March 18, 1985

Martin E. Segal Company

MARTIN E. SEGAL COMPANY
CONSULTANTS AND ACTUARIES

1810 WATER PLACE
ATLANTA, GEORGIA 30339
(404) 955-4003

March 18, 1985

Legislative Committee on Employee
Hospital and Medical Benefits
State of North Carolina
Raleigh, North Carolina

Gentlemen:

We are pleased to present this report on our findings regarding the State of North Carolina's plan for Employee Hospital and Medical Benefits.

We look forward to presenting this information to you today and responding to any comments or questions you may have.

Very truly yours,

Clark J. Yaggy
Vice President

CJY/pb

REPORT TO THE
LEGISLATIVE COMMITTEE ON
EMPLOYEE HOSPITAL AND MEDICAL BENEFITS

March 18, 1985

In providing the Comprehensive Health Benefit Plan, the State of North Carolina offers a tremendous benefit to its employees/retirees. While the plan has experienced some problems in the past, the focus of our work has been to concentrate on the potential for continued improvement in the future, rather than to assess blame or critism for the past. We hope our report is useful in this regard, and we commend the State for its desire to lay a groundwork which will perpetuate this important and valuable benefit program for many years to come.

OUTLINE OF REPORT HIGHLIGHTS

A. Change structure of plan management within State.

1. Appoint full-time Administrator who would also be Chairman of Board and tenth Board member
2. Change three Board positions to include two employees and one retiree
3. Establish Plan Participant Advisory Committee
4. Establish Professional Advisory Committee
5. Expand staff
    a. Cost management programs
    b. Health education and illness prevention programs
    c. Train Health Benefit Representatives (HBR's)
    d. Membership functions
    e. Long range planning
    f. Provider relations
    g. Improve communications

B. Retain EDS Federal Corporation

1. Not appropriate to replace them with another vendor or with State
2. Reduce EDS's role in:
    a. Cost management
    b. Report evaluation and analysis
    c. Membership
    d. Provider relations
3. Improve customer relations
4. Improve systems, backlog, processing time

C. Other changes

1. Change orientation from EDS' plan to State's plan
2. Cost management programs
3. Alternate health care delivery forms
4. Strengthen HBR role
5. Communicate positively about plan
6. Institute health education and illness programs
7. Study retiree costs and implications for future
8. Remove plan from statutes

REPORT

I. Plan Management and Structure

Overview: It was generally acknowledged by all those we interviewed that the State of North Carolina's health benefit plan has problems and, while we cannot pretend to have as great a sense of these problems in our relatively brief review as do others who have been more intimately involved over a longer period of time, we can see symptoms of the problems in many of the areas we focused on in our interviews and discussions. What is particularly frustrating to those who are involved with the plan is that it is basically a good one, and one which should run more smoothly than it has. It is quite apparent to us that the plan is administered much more efficiently today than it was six months ago and certainly more efficiently than in its very early stages. And we hope some of the suggestions made later in our Review of Plan Design and our Review of Plan Administration will alleviate some of the frustrations and perceived problems attributed to the plan currently.

We have some observations and recommendations regarding the plan's management and structure which we hope will be helpful in producing a better overall feeling about what is indeed a very excellent plan, one which can and should be the source of great pride among those who operate and manage it and among its participants.

a. Plan needs more full-time management from State government. The current Board of Trustees is to be applauded for its efforts in bringing the program out of its initial troubles and bringing it to the point it is today. However, in our opinion, the management needs more full-time management and policy direction.

b. Currently, there is no formal means of providing the necessary two-way communication between the plan's management and the people most affected by the plan's policy decisions (i.e., plan participants).

c. Currently, there is no means of taking advantage of what could be valuable advisory input and assistance from health professionals throughout the state.

d. As detailed in later sections of our report, we feel it necessary to significantly expand the plan's management staff. Additional functions for which more staff is necessary are:

(i) Plan and execute cost management programs

(ii) Plan and execute intensive health education and illness prevention programs

(iii) Assist in the upgrading of the HBR and general health education functions

(iv) Administer the membership functions now incorporated into the EDS duties

(v) Provide long range planning, analysis and evaluation of various policy alternatives for presentation to top management of the plan.

(vi) Plan and execute a more intensive provider relations program.

(vii) Assist in improving communications among the claims administrator, plan management, the legislature, the Plan Participant Advisory Committee, the Professional Advisory Committee, HBR's and other groups who need to be aware of the current status of the benefit plan.

e. Devising the most effective way to incorporate these improvements into the plan within the structure of State government is perhaps outside of our area of responsibility. There do seem to be several alternatives. One of which we have suggested earlier to some people is to place management of the plan within an existing State agency.

A better alternative, however, might be one which incorporates the improvements in a., b., c. and d. above and also takes advantage of both the autonomy of the current Board of Trustees structure and of the "outside" perspective provided by current Board appointees. Accordingly, as a suggestion for better plan management, we offer the following:

(i) Appoint a tenth member of the Board of Trustees who would function as both Chairman of the Board and as the full-time, salaried Administrator of the State's health benefits plan. This Board Chairman/ Administrator would serve a four year term.

(ii) Of the current nine Board positions, appoint two employees (Governor would appoint one and President of the Senate would recommend the other for appointment by the General Assembly) and one retiree

(recommended by the Speaker of the House for appointment by the General Assembly). These three appointees would be people eligible for and covered by the plan. They would serve two-year terms but would be replaced if their employment ceased or their plan eligibility was otherwise terminated.

(iii) The Governor, President of the Senate and Speaker of the House would each remain responsible for appointing/recommending two other Board members, none of whom could be a State employee, member of General Assembly, State officer, anyone receiving or eligible to receive benefits under the plan, or anyone who provides services, equipment or supplies under the plan.

(iv) To foster improved communication with the Legislature, the Board would be required to report periodically to the Legislative Committee, but no less often than once every six months.

(v) The Board Chairman/Administrator should design an internal plan management structure to meet the needs of the expanded duties discussed in d. above. He should then hire individuals with strong backgrounds in the field of endeavor called for by the duties of the job he has created.

(vi) Establish a Plan Participant Advisory Committee, made up of appointed representatives of covered employees and retirees. They would provide advisory input to management and become, along with the three employee/retiree board members, the method by which the interests of the plan participants are represented.

(vii) Establish a Professional Advisory Committee for purposes of providing advisory input to management from physicians, hospitals, other providers and health professionals across the State. These people would be of great assistance in matters of provider relations, health education, illness prevention programs, establishment of negotiated provider network arrangements, new medical procedures and technology, claim appeals, etc.

f. This plan has come to be known as the EDS plan, and it isn't. It's the State's plan and it is an excellent one and the

State ought to get the credit for the tremendous benefit it is providing. We suggest a new orientation at EDS to include:

(i) Checks should be printed that say "State of North Carolina", not "EDS".

(ii) The phones at EDS should be answered, "State Health Benefit Plan" or some such phrase, but not "EDS".

(iii) All letters, forms, EOB's and other items of communication which make reference to EDS should be similarly changed.

g. We suggest deleting the details of the benefit schedule from the statutes. Codifying the plan in North Carolina law takes away much of the plan flexibility which was gained when the initial decision was made to self-insure these benefits. To alleviate concerns that benefit schedule changes might not be given as thorough a hearing if they are not codified in law, we suggest the creation of a plan document which has virtually all of the sanctity of statutes, which can be changed only upon written approval by all state functions or positions which might be named in a revised statute, but which can undergo such change with more flexibility than is allowed by what we assume to be cumbersome and sometimes untimely restrictions imposed by the statute amending process. Giving more flexibility to the schedule of benefits would also facilitate a new Case Management function described later in our report.

h. Whether or not to maintain a fully funded Incurred Claims Reserve is a policy decision to be made by the State. Although such a Reserve is not as necessary for a governmental unit as it is with an entity for whom bankruptcy or termination of operations is always a possibility, however remote, we believe there are some considerations which merit review by the State:

(i) This Reserve could be borrowed against if unexpectedly high claims occur which require payment before the legislature can vote an emergency appropriation.

(ii) If State policy is not to use funds to pay dependent costs, an emergency appropriation could not be used to pay unexpectedly high dependent claims. But the Reserve could be borrowed against until employee contributions could be increased to recover the debt.

(iii) Should the State ever decide in the future to return to a fully-insured plan, the Reserve would pay the run-out of self-insured claims, thus alleviating the need to tap the treasury for these claims at a time when the new insurer is also expecting full monthly premium payments.

(iv) A fully-funded Reserve can generate interest earnings sufficient to cover the contract administrator's fees.

i. We have been asked to comment on the concept of splitting the groups of participants in the plan. If this idea contemplates creating separate plan management structures for a "dependent" plan and an "employee" plan, we are opposed to that. The State must maintain responsibility for making all of the decisions for all plan participants, regardless of which portions of the plan are funded with State dollars and which are funded with employee dollars.

Maintaining a single plan structure produces the necessary flexibility for the plan to make decisions, such as:

(i) Whether to make each group self-supporting in terms of collected premiums vs. claims.

(ii) Whether to partially subsidize retirees by combining with actives.

(iii) Whether to partially subsidize dependents by combining with employeees/retirees.

(iv) Whether to create different benefit schedules for different groups.

Maintaining a single plan structure also makes it much easier to contract with contract administrators, auditors, consultants, HMO's, PPO's and other potential providers to the system.

j. We have been asked to comment on the State's performing the claim paying functions as opposed to contracting those duties to an independent contractor like EDS. Of 23 states whose benefit plans are self-insured, only two (Utah, Louisiana) administer their own claims. Unless unusually favorable circumstances exist, as may be the case in the two states mentioned, our opinion is that a state government better serves its participants by contracting with a professional claims administration firm for the following reasons:

(i) Data processing hardware and software used in large claims processing systems must be maintained at state-of-the-art levels in order to operate most efficiently. Professional claims administrators can more quickly respond to required software changes and to changing capital investment needs for hardware.

(ii) Outside contractors are in the business of claims processing full-time, and are better able to keep up with changes in the industry.

(iii) Large claims processing systems depend on efficiency for their success and management frequently has to make quick hire/fire decisions to maintain the right work force to operate the system. Civil service employment circumstances may not be conducive to this.

(iv) A properly constructed contract with a for-profit vendor can produce production and service incentives that can lead to more efficiency than may be obtainable in a civil service environment.

k. Retiree health benefit costs may be a ticking time bomb that need to be measured and dealt with in an orderly manner over the coming years. Longevity is improving, health care costs are escalating, people are retiring at younger ages, state government is employing constant or decreasing numbers of people and Medicare payment levels are being tinkered with in each round of federal tax reform. All these factors mean that retiree health care costs are continuing to become a larger and larger portion of the total health care bill. This may be leading to a time when funding for these costs on a current basis is too great a burden on limited State funds. We urge the State to study the implications of these emerging problems and perhaps consider some pre-funding of these costs during the employees' working lifetime.

II. Review of Plan Design

Overview: The plan's schedule of benefits is one of the richest in the country. Whether this schedule can continue or must be changed is essentially a funding/budget decision to be made by the State and our assignment has not included a detailed review of future cost projections of the plan. Other plans faced with similar decisions have considered such things a raising deductibles, lowering co-payments and raising out-of-pocket maximums. It must be recognized that these are essentially cost-shifting changes which, while they do indeed lower the monthly cost of funding a schedule of benefits, are generally considered not to have long range cost containment implications.

We suggest that the State's focus should be on the establishment of a more complete and coordinated long range plan of cost containment or, as we prefer to call it, cost management. Decisions made in this regard by the State of North Carolina, due to the tremendous number of people covered by the plan and due to the fact that the plan is a product of State government, will have profound implications on the way medical care is delivered to all of the State's citizenry. Earlier we suggested that the State enhance its staff to include health planners and to seek the advice of health professionals willing to volunteer to serve on a Professional Advisory Committee so that the long range plan of cost management is properly formulated and executed.

1. Benefit Structure

a. Changes in deductible, co-payment, out-of-pocket maximums, etc. are legitimate changes for purposes of alleviating short term budget/funding problems. However, these changes produce cost-shifting rather than cost management and must be viewed in that light.

b. Some reduced funding could be achieved by eliminating special, 100% coverage for accident-related injuries. There is no logical reason why an accident expense should qualify for any higher reimbursement than other expenses, and EDS could process some of these claims more quickly if the date of accident and a description were not as critical an item on the claim form as now.

c. Some co-insurance and deductible changes can be considered in a coordinated cost management effort to provide incentives and disincentives in conjunction with such programs as second surgical opinion, pre-treatment certification, outpatient surgical care, etc.

d. Ultimate cost management steps should be the result of the careful and coordinated long range planning effort by the State we urged earlier. The following programs should be considered in that process:

(i) Expand second surgical opinion program to include additional surgical procedures which EDS statistics and national studies could identify as additional savings targets for such a program.

(ii) Second surgical opinion co-insurance penalty should be greater (e.g., 50% or 60% payment) for those expenses related to surgeries for which a second surgical opinion is required but not obtained.

(iii) More of the expenses related to the surgery (e.g., anesthesiologist, assistant surgeon, consulting physicians, etc.) should be the subject of co-insurance reductions when the penalty is applicable.

(iv) Refine ambulatory surgery incentive so that it excludes incentive payment for procedures which would not otherwise be done in a hospital.

(v) Develop a specific co-insurance incentive/disincentive system to prevent improper utilization of weekend hospital admissions and discharges.

(vi) Expand scope of hospital audits to include a full, on-site audit of all bills over $10,000 or over 15 inpatient days. Audit should focus on inappropriate medical care as well as inappropriate charges.

(vii) Consider implementing a hospital bill self-audit program to reward employees who find billing errors in hospital bills.

(viii) Continue maternity incentive program but develop co-insurance schedules which provide greater incentive for reduced inpatient utilization.

(ix) Cover routine immunizations. Studies indicate that the total cost of all necessary immunizations from birth to age 20 is still less expensive than one day's hospital room and board charge.

(x) Add a pre-admission and concurrent review program for all elective hospitalizations, including appropriate co-insurance incentives and disincentives when necessary prior approval is not sought.

(xi) Provide coverage for less expensive intermediary care facilities in situations where their use is possible, e.g., birthing centers, hospices, day hospital care for psychiatric problems, etc.

(xii) Consider separate deductibles or lower co-insurance for inappropriate use of hospital emergency room (i.e., situations not relating to an injury or to the onset of a sudden and serious illness).

(xiii) So long as the "UCR" concept is used, change it from current 90th percentile to 80th percentile.

(xiv) Create a Case Management function to assist with expensive medical catastrophies which could coordinate less expensive quality care among the patient, his physician and the plan.

(xv) Consider establishing more cost efficient prescription drug coverage. Alternatives: greater reimbursement for generic drugs, mail order drug program for chronic illness drugs, establishing fee reimbursement at Red Book prices plus a dispensing fee, and even establishing own dispensing pharmacy.

2. Alternative Health Care Delivery Forms

a. Encourage the development of quality Health Maintenance Organizations (HMO's) in the State and implement them within the plan when quality considerations are apparent.

b. Develop state-wide Preferred Provider Organizations (PPO's) among physicians and hospitals, encouraging discounts and insisting upon strong, effective peer review and utilization review mechanisms.

c. As an alternative to PPO's, develop a fee schedule and solicit physicians who agree to accept payment of the schedule amount as payment in full, in exchange for having their names included in a directory published by the State so that employees will know which doctors have agreed to abide by that fee schedule.

d. Consider implementing a similar pre-determined cost arrangement with hospital providers via the use of DRG's, per-diem payment arrangements or some other favorable, competitive negotiated arrangement. As a starting point, negotiate favorable arrangements with state-owned and operated hospitals.

3. Communications

a. Increased communications about alternatives, benefit schedule incentives and disincentives, etc. are absolutely crucial to the success of any long range cost management efforts.

b. The role of the Health Benefit Representative (HBR) must be upgraded by all employer units in the plan. The HBR job description needs to include past experience in some form of health or insurance related occupation, and the health benefit plan duties must be considered the HBR's primary, if not only, responsibilities.

c. HBR training must be more thorough, must be a joint effort between EDS and the State, must focus less on the routine instructions for filling out forms and more on the opportunities available for employees to seek full and greater benefit of a new health benefit plan restructured to include greater cost management opportunities.

d. Communications should stress the positive aspects of the State's restructured plan and the opportunities for fuller payment and maintenance of quality care. Cost management changes are not benefit reductions and should not be viewed as such. They must be thought of and communicated in a positive light. It must be clear that each cost management change has an advantage for the patient, e.g., Ambulatory surgery allows you to be home, Second surgical opinions produce peace of mind about impending surgery, etc.

e. Consider the establishment of a Health Care Coordinator who would be a liaison between patient and upcoming hospitalization and/or surgery. Employees would be required to contact these people for advice and direction about how to activate the pre-certification, second surgical opinion, ambulatory surgery, concurrent review and other provisions and programs of the plan that would affect their particular situation. Interfaces with the Health Care Coordinator would involve one-on-one discussions which would improve the personalization of

the plan and provide opportunities for greater satisfaction and greater ability to obtain increased benefits when proper cost management procedures were followed.

4. Health Education and Illness Prevention

   a. These subjects could be easily folded in with the whole communications process.

   b. Develop a coordinated health education and illness prevention program, using staff professionals and a Professional Advisory Committee.

   c. Use available State resources for this, e.g., medical school personnel, health education specialists, school nurses, county and state health departments and other such existing resources. Program could incorporate periodic mailings, payroll stuffers, movies, slide shows, health education workshops, public service radio and television spots.

   d. There are limitless possibilities for such a program which, when implemented, would incorporate the HBR function and all employing units as the program's focal point of information dissemination.

III. Review of Plan Administration - EDS Federal Corporation

Overview: Generally, EDS' current performance of its contract obligations is satisfactory. Some who are a part of the benefits system who would not agree, and we do conclude there are significant areas where improvement is called for. But overall, there are many more things that are right about EDS' work than are wrong. The general consensus among those we interviewed is that EDS has shown marked improvement from a near-disastrous start-up of the program in October, 1982, and it appears to us that improvement in performance has been particularly evident in the past six to eight months. While the claims adjudication process is not yet producing a level of performance that is entirely satisfactory, we feel EDS has the necessary resources to continue improving its performance and service.

EDS has created a highly mechanized (i.e., computerized) system to handle the tremendous volume of claims which must be processed. Such a system places an obligation on its operator to be extremely sensitive to the customer service aspects of the total operation. In other words, when the machinery errs or produces a "non-human" response, the operator must be prepared with personnel who can quickly and empathetically respond to questions, problems and complaints. A good many of the criticisms and comments we will be making regarding EDS' performance stem from the mechanical nature of the processing system now in place.

It is important, however, to recognize that the system is quite efficient. Even with the many edits against which each claim must be checked, the system still processes approximately 70% of the claims on the first pass through the system. And a good many of the remaining 30% are handled smoothly and quickly, once the reason for the processing edit is identified and satisfied. But the perception of the success of any claims processing system often depends on how well it handles the 10-15% of the claims which require more time, more customer interface and are more complex than the vast majority of claims the system deals with.

A. Review of Claims Processing Procedures

1. Claims Communications

a. Letters, forms and other hard-copy communications are generally clear and complete.

b. Some of the EOB notes could be more specific and more informative.

c. Phone communications are satisfactory.

d. We urge continued monitoring of in-coming phone traffic to assure fewer busy signals to callers.

e. We suggest the tone of all written communications be reviewed to insert more personalization.

f. We recommend that EDS develop or purchase "customer awareness" training programs such as used by airlines, hotels, etc.

2. Provider Communications

a. Routine communications between EDS and providers on day-to-day specific claim matters seem good.

b. More formal and more frequent general information exchanges are called for. Ongoing communication between medical societies and EDS and between hospital associations and EDS would be valuable.

c. The one provider meeting we attended was of questionable content. Very little useful information was exchanged.

d. It may be appropriate to develop a provider education program to convey claims processing details to hospital business office personnel and physician business office personnel.

3. Processing System

a. It is of modern design and is highly mechanized, perhaps more so than most other similarly-sized claims processing systems.

b. The system is currently processing approximately 70% of the submitted claims on their first pass through the system. The remaining 30%, which are kicked out because of the many necessary edits in the system, are processed with varying degrees of speed and accuracy.

c. Claims which have characteristics that require them to pass through more than one edit are the ones which take longest to finally process. EDS is giving priority to some programming changes which will shorten this process.

d. We also would encourage EDS to create a unit of "super examiners" who would handle the more complex claims and hand carry them through the system so as to save time and create fewer problems. These individuals would also interface with the employee who would then know that there was one person in charge of solving whatever set of complex claim problems might be involved.

e. EDS' Adjustments Department is the area where additional payments are authorized once the system determines that an adjusted payment is appropriate. The timing in this area must be improved so that it responds immediately once the decision is made that an adjustment is indeed called for. Nothing is more frustrating to a participant than having to wait for a long awaited check after finally having convinced others in the system that additional payment is due.

f. The system has the capability to capture and produce virtually any data formats and configurations which might be necessary for properly measuring any aspect of either the system's performance or the plan's performance.

g. There is some question as to whether or not EDS reviews the data reports for reasonableness before they are released.

h. There is also some question as to whether or not EDS has the capability to produce meaningful evaluation and analysis of the data it is producing. However, our opinion is that these functions ought to be accomplished by the State rather than by the State's contract claims administrator, as we have commented in other areas of our report.

4. Selected Claim Audits

a. As required by contract, EDS collects data relative to all hospital bills where ancillary charges exceed $5,000.

b. We find no evidence of other claim audits being done internally. Of course, the claims activity is audited by an outside auditor, contracted by the State, once a year.

c. We suggest a full, on-site audit on all hospital claims which exceed either $10,000 or 15 inpatient days. The purpose of the audit would be to review bills for indications of inappropriate care and/or indications of incorrect charges. The audits could be subcontracted to an outside agency. We suggest a six month pilot project to determine whether the audits are producing useful results and to help determine whether the audit selection criteria should be modified.

5. Claim Worksheets, Manual and Other Internal Tools

   a. In the claims processing and customer service areas, these internal documents appear to be thorough and complete.

   b. There are some cost containment areas where decisions must of necessity be somewhat subjective and where the claim approval criteria appear unclear. Ultimately, some decisions become the responsibility of EDS' medical director who is free to consult with provider experts in the State in making final determinations.

6. UCR and Utilization Guidelines

   a. UCR data is compiled and presented to the State for evaluation on an annual basis. Current policy decision by the plan's Board of Trustees is to use 90th percentile and, in our opinion, 80th percentile should be used.

   b. UCR profiles are not developed for physician services rendered outside of North Carolina. Rather than using North Carolina profile guidelines, we suggest EDS input HIAA National Surgical profiles for use in out-of-state situations.

   c. EDS' system has unlimited capabilities to collect and administer utilization guidelines. However, this is not now done to any great degree, except to the extent required by some of the cost containment provisions of the contract. We suggest that there are many opportunities for more utilization guideline criteria to be inserted into the system so that "outliers" can be identified and dealt with appropriately.

7. Security of Claims Processing

   a. We are satisfied that the EDS manual and electronic systems have appropriate security safeguards.

8. Internal Audit Procedures

   a. EDS has a satisfactory internal audit system in place for protection against financial malfeasance by its employees.

B. General Administration Procedures

1. Personnel

   a. One of the most impressive things about the EDS operation is that virtually all employees have a good sense of self-

satisfaction for the importance of the role that each plays in the overall operation.

b. Training and quality control appear to be adequate to protect the system against an inordinate amount of errors.

c. While there might have been some problems with employee turnover in the past, it does not currently appear to be unusually high.

d. Employees, from top to bottom, appear to be properly motivated and the overall atmosphere of the office is a cooperative one.

2. Bookkeeping

a. General bookkeeping procedures appear appropriate, although our assignment did not require a thorough review of these procedures.

b. The membership department appears to have appropriate procedures in place to properly bill and collect contributions required for conversion premiums and other situations where the employee is required to remit a payment directly to EDS to pay for his/her coverage.

3. Recordkeeping

a. Current and complete copies of important documents are maintained in appropriate places and are available to appropriate personnel when necessary.

b. Each employee who needs access to certain reference materials has a good sense of where to find the necessary information or at least who to ask for further guidance.

C. Review of Contract

a. For the most part, EDS effectively and correctly administers the benefits of the program as they are written. This means that we find EDS to be in substantial compliance with those provisions of their contract which describe eligibility, benefits, limitations and exclusions, and other such functions which relate directly to proper claims adjudication.

b. Our interviews and observations produced a rather large number of items in the above-mentioned categories which we feel should result in contract changes. The number of items, however, does not alter our opinion that EDS handles the basic claim adjudica-

tion functions properly and within the requirements of their contract.

c. The Reporting and Monitoring provisions of the contract were specifically redefined by the July, 1984, amendment. It appears that EDS either has produced or is in a position to produce all of the reports called for in the unamended portion of the basic contract and in the contract amendment.

d. We have some concern about whether EDS checks the validity of the report data before releasing it. There have been enough instances when a part of the data was incorrect or when the data in one report was not consistent with data in another report, thus calling into question the overall accuracy of the reports produced. In our opinion, it is EDS' responsibility to verify the accuracy of the data before they release reports and to be sure in this process that the data "hangs together".

e. To the extent that the contract and its amendment calls for an evaluation and analysis of the data produced, EDS does not appear in all instances to be able to do this with the degree of quality that is required.

f. On the other hand, in our opinion, the analysis and evaluation of reports is more properly the function of the management of the plan within the State, and should not be a responsibility contracted to EDS. The State has much more at stake in the proper analysis of the data it requests than does EDS.

g. With regard to the Cost Containment provisions of the contract, we have the following observations:

    (i) EDS did not comply with very many of the contractual cost containment provisions in the first months of operation.

    (ii) This was acknowledged by both the State and EDS when the July, 1984, plan amendment restructured this provisions and placed new time tables and requirements on EDS.

    (iii) In our opinion, many of the original contractual cost containment provisions are incomplete or ineffectual.

    (iv) EDS is due to implement a new series of cost containment provisions effective April 1 and report on these provisions by May 1, so it is a

bit premature to judge their compliance under the July, 1984 contract amendment.

(v) However, early indications are that EDS may not be able to produce a fully satisfactory response to these compliance requirements.

(vi) In our opinion, however, the contract requires EDS to perform cost containment evaluation and recommendation services that represent an abrogation of these responsibilities by the State. We feel strongly that the cost containment provisions which EDS has been required to study, evaluate, and make recommendations for are the responsibility of the State of North Carolina.

(vii) Specific suggestions about cost containment changes are included earlier in our Review of Plan Design section.

h. By all appearances, EDS has conformed to the requirements contained in the General Terms and Conditions portion of the contract.

2. Contract recommendations

a. For the most part, the July, 1984, amendment appears to have gone a long way toward repairing a strained initial relationship between EDS and the State.

b. Accordingly, we will not be suggesting changes in the amended contractual relationship, the various incentive payments, the audit arrangements, penalty payments and other provisions in that amendment which restructured the basic relationship between EDS and the State.

c. We do recommend that the State must accept the responsibility for formulating cost containment strategies and for determining what utilization and similar reports EDS should produce. Thus, the contract should be restructured to the extent that it requires EDS only to provide the necessary reports, to determine what additional administrative costs are involved in implementing changes and providing reports, etc. But the basic evaluation, analysis and formulation of utilization and cost containment provisions should not be a duty of the plan administrator.

d. The State should assume all functions currently handled by EDS' Membership Department. EDS handles this function

very well currently but, in our opinion, it is a function which should eventually be the State's direct responsibility. This will create more state contact with the HBR function and, more importantly, will make for a cleaner functioning of the eligibility records when and if the State implements HMO coverage as a dual choice for its employees.

e. We suggest EDS consider releasing checks twice a week instead of the current release on Tuesdays only.

f. Our interviews and observations produced several detailed contract revision suggestions, all of which are minor and in the nature of "fine tuning".

g. As mentioned earlier, we suggest EDS identify itself at every opportunity (phone, letters, forms, EOB's, checks) as "State Health Benefit Plan" rather than "EDS".

CURRENT PLAN MANAGEMENT STRUCTURE

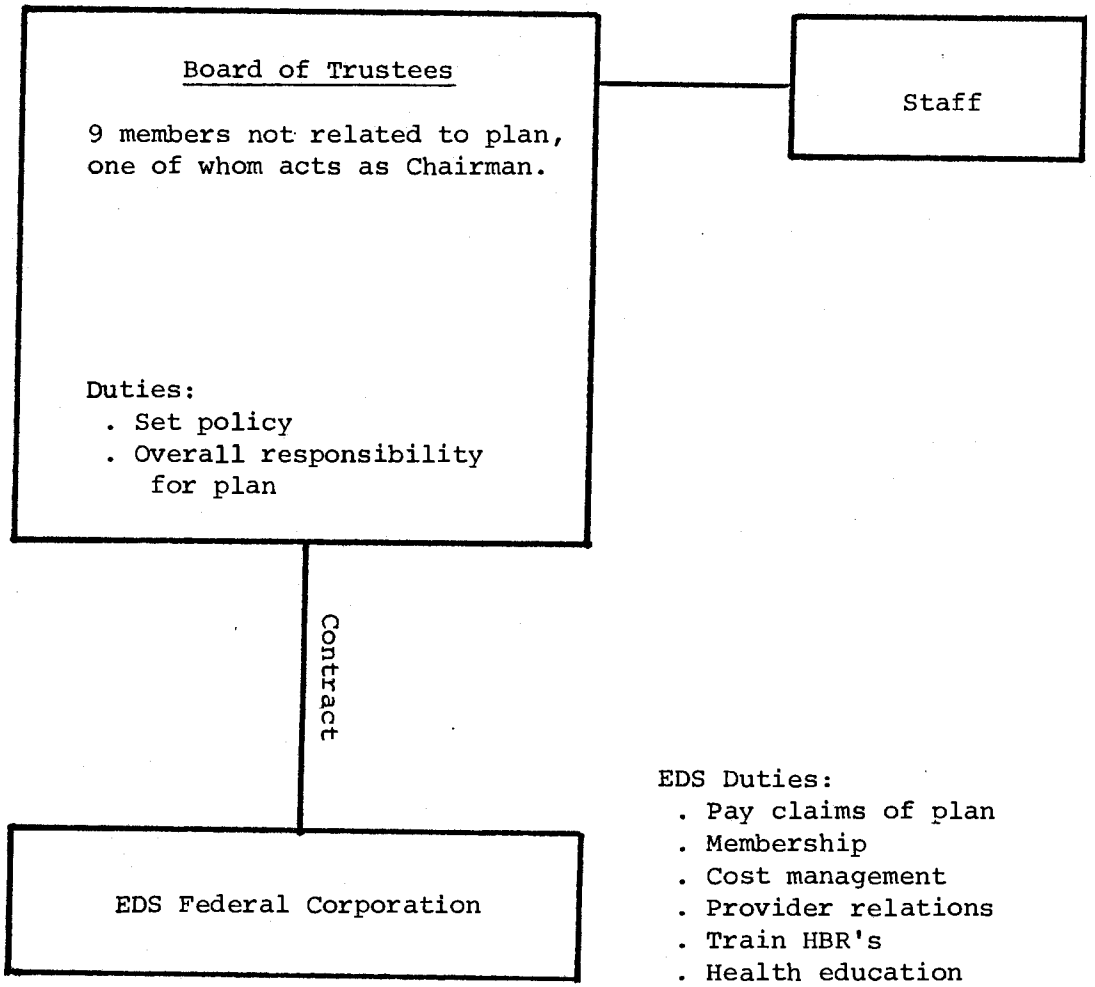
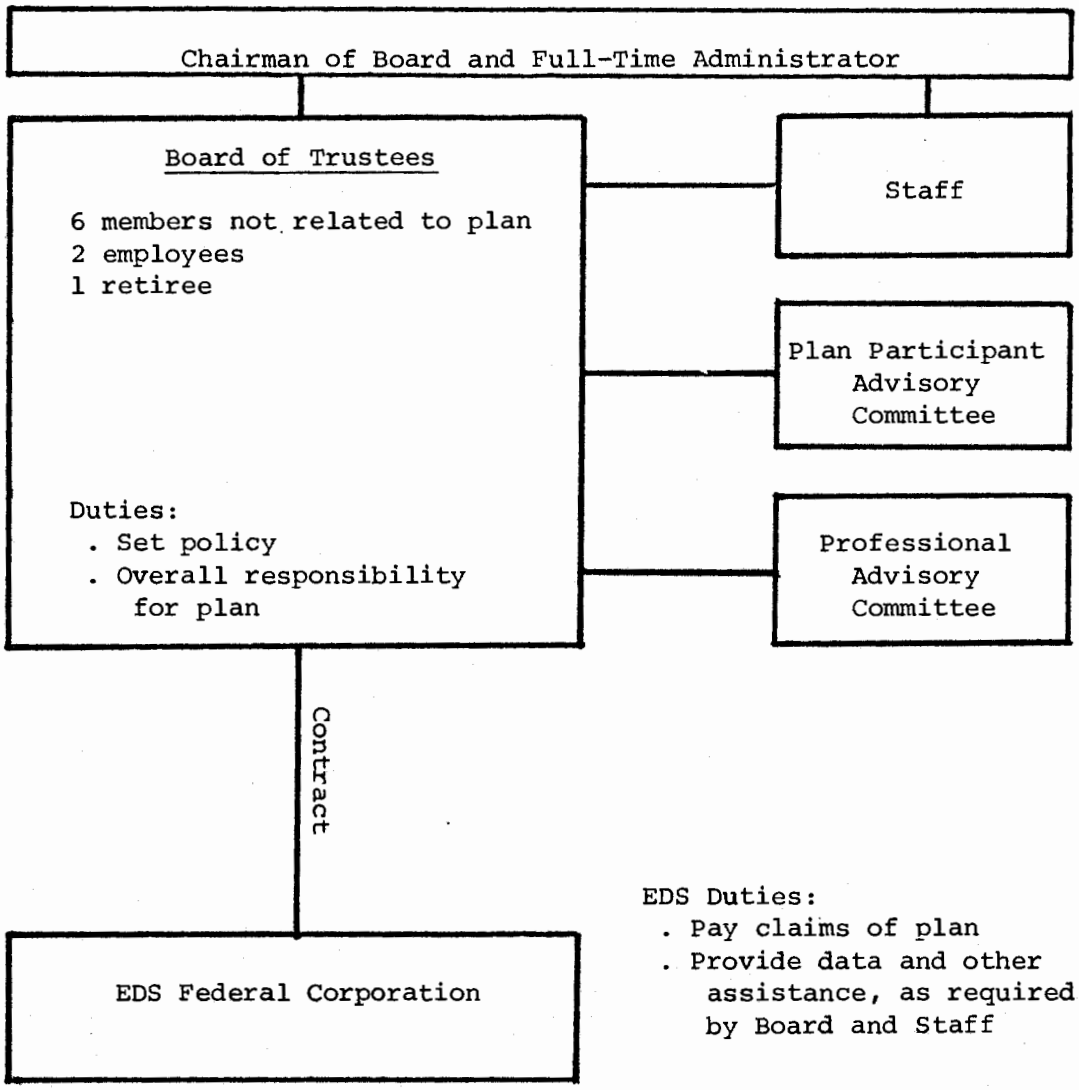


EXHIBIT I

PROPOSED NEW PLAN MANAGEMENT STRUCTURE



Staff Duties:
- . Manage plan for Board
- . Manage EDS contract
- . Planning and evaluation
- . Membership
- . Cost management
- . Provider relations
- . Train HBR's
- . Health education

EDS Duties:
- . Pay claims of plan
- . Provide data and other assistance, as required by Board and Staff

EXHIBIT II