

CITY OF SPOKANE ADMINISTRATIVE POLICY AND PROCEDURE	ADMIN 5800-10-05 LGL 2010-0026
<b>TITLE: RESERVE FOR SELF-INSURED EMPLOYEE MEDICAL AND DENTAL BENEFITS</b> EFFECTIVE DATE: August 12, 2002 REVISION EFFECTIVE DATE: October 1, 2010	

1.0 GENERAL

1.1 The City of Spokane has several in-house benefit programs. The State of Washington Health and Welfare Advisory Board and State Risk Manager have adopted financial safety and soundness guidelines for local government self-insured employee health benefit programs. These guidelines require that the City adopt a policy on how it will address expected claims and expenses, Incurred But Not Reported (IBNR) claims, as well as expenses for circumstances unknown or unforeseen (Loss Contingencies) in its program budgeting and funding.

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2.0 DEPARTMENTS/DIVISIONS AFFECTED

This policy shall apply to all City divisions and departments.

3.0 REFERENCES

Chapter 48.62 RCW  
City Resolution 02-75

## 4.0 DEFINITIONS

- 4.1 "Incurred But Not Reported (IBNR) Reserve" is defined as the liability for future payments on losses that have already occurred, but have not yet been reported to the self-insured, insurer, or re-insurer. This amount may be determined by a qualified actuary, consulting broker and/or third party administrator (TPA).
- 4.2 "Loss Contingency Reserve" is defined as each of the fund's liability for circumstances unknown or unforeseen in the budgeting and funding of the City's self-insured programs.

## 5.0 POLICY

- 5.1 The City of Spokane recognizes that adequate claim reserves are maintained to:
- a. Provide participants with the security that incurred claims will be paid;
  - b. Comply with State funding requirements and accepted accounting standards;
  - c. Allocate accrued expenses to the proper fund; and
  - d. Provide stability to the budgeting process.
- 5.2 The City Council directs that two (2) self-insured employee health benefit program reserves be established -- Incurred But Not Reported (IBNR) and Contingency Reserve.
- 5.3 The reserves to be established are also addressed in Governmental Accounting Standards Board (GASB) Statement #10, *Accounting and Financial Reporting for Risk Financing and Related Insurance Issues*. The Statement requires the recognition of a liability if it is probable that a liability has been incurred and if the amount can be reasonably estimated.

## 6.0 PROCEDURE

- 6.1 Annual Report.
- 6.1.1 The Risk Manager shall promptly file the annual report required by the State Risk Manager on the City's self-insured employee health

benefit programs. The report shall also be provided to the City Council Finance Committee.

6.2 Dedication and access to available reserves

6.2.1 The reserve accounts shall be dedicated one hundred percent (100%) for the City's self-insurance health benefit programs. Should the reserves created under this policy become insufficient to meet the obligations created by the City's self-insured program, the City shall take appropriate steps to commit the additional funds required to meet those obligations.

6.3 IBNR Reserve – Primary Financial Position

6.3.1 The Incurred But Not Reported (IBNR) Reserve shall be fully funded through the City's fiscal year period and adjusted at the end of each subsequent calendar year. The IBNR will be calculated and maintained by applying an actuarial method as established by at least a biannual review by a qualified actuary.

6.4 Loss Contingency Reserve - Secondary Financial Position.

6.4.1 The Loss Contingency Reserve will be calculated and maintained by applying an actuarial method as established by at least a biannual review by a qualified actuary.

6.5 Review of Policy

6.5.1 At a minimum, this policy shall be reviewed every two (2) years. A report shall be made to the City Council Finance Committee after the review. The review shall include an analysis of the following items:

- Change in person performing funding projections
- Actuarial recommendations
- Change in the process or methodology used to develop funding projections
- Expenses for paid claims, incurred but not reported claims, insurance cost exceeding annual program budget/revenue
- Type/amount/change or termination of stop loss coverage
- Significant increase/decrease in employees covered
- Changes in coverages offered
- Change in costs/rates
- Change in stop loss insurance carrier
- Change in budget, financial statements, and financial strategy plans

- Financial position as compared to actuarial recommended levels
- Changes in program administration
- Trends of above criteria.


7.0 RESPONSIBILITIES

The Risk Management Department shall administer this policy.

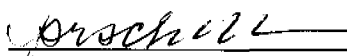
8.0 APPENDICES

Washington State Local Government Self-Insurance Program (LGSI) Guidelines for Self-Insured Employee Health Benefits Programs Conducting Independent Claims Review – adopted March 2002

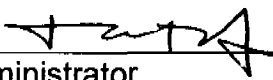
APPROVED BY:

  
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City Attorney (ASST)

9-7-10  
\_\_\_\_\_  
Date

  
\_\_\_\_\_  
Risk Manager

9/13/10  
\_\_\_\_\_  
Date

  
\_\_\_\_\_  
City Administrator

9-16-10  
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Date

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## **LOCAL GOVERNMENT SELF-INSURANCE PROGRAM (LGS)**

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### **Guideline for Local Government Self-Insured Employee Health Benefit Programs Conducting Independent Claims Reviews**

*Adopted March 2002 by the State of Washington Health and Welfare Advisory Board*

#### **PURPOSE:**

This guideline is to assist local government self-insured employee health benefits programs subject to **RCW 48.62** (programs) in conducting independent reviews of their third party claims administration. The claims process differs from a financial review, which is not addressed herein.

#### **POLICY:**

As provided in Washington Administrative Code **82-60-050(3)**, all programs are required to have an independent review of their third party claims administration conducted at least every three years. The State of Washington Health and Welfare Advisory Board (Board) and the State Risk Manager strongly support programs having appropriate operational and procedural elements (below) of their medical/pharmaceutical program independently reviewed more frequently than three years to assure claims are being paid accurately. The extent and frequency of claims reviews is dependent upon program and plan complexity, third party administrator (TPA) performance and previous claims reviews. A review focused on one or more specific performance area(s) below can more than offset review costs while assuring the plan is being correctly administered and protecting program employees. Dental and/or vision programs may be reviewed less often and/or as needed.

#### **CLAIMS REVIEW**

The program and firm conducting the claims review should develop the scope of the claims to be reviewed and the review evaluation criteria. The sampling basis used for the claims review can be based upon a random sampling, a specifically focused sampling (such as individuals for whom payments during a defined period exceeded a designated amount) or a combination. For a random sampling to be statistically representative of the entire program, it should be based on a larger, stratified selection of claims.

#### **Claims review audits may include:**

*Claims Sample Review*

Review claim sampling for:

- Consistency with third party administrator contract performance measures;
- Accurate inputting of all data including procedure codes, diagnosis codes, provider identification and charges
- Proper application of all plan exclusions and limitations, including annual and lifetime limits
- Correct recovery of stop loss/excess insurance and extent to which claims runs correctly aggregate multiple claims to one occurrence;
- Accurate and efficient administration of preferred provider arrangements (discount application, incentive benefits, efficiency of information transfer);
- Compliance with applicable governmental laws and regulations;
- Whether claim charges were covered by the plan when claims incurred;
- Appropriate tracking of deductibles and 'out of pocket' maximums;
- Proper coordination with other sources of insurance, including coordination of benefits (COB), Medicare and third party liability;
- Claim payments made to proper payee based on claimant assigned benefits to the provider;
- Charged amounts reviewed for reasonableness and suspect providers identified;
- Professional medical review of questionable charges and review of inpatient hospital charges for billing errors;
- Duplicate claim payments;
- Work-related claims are not paid;
- Claims are not paid for pre-existing conditions;
- Claim payments are properly authorized and documented;
- Charges are entered correctly and payments are properly coded as to service type;
- Claim overpayments are promptly identified and refunded to the Plan sponsor;
- Explanation of Benefits (EOB's) and other correspondence are clear and informative;
- Claims processed within a reasonable time period from date of receipt and requests for additional information are necessary and efficiently administered;
- Claimant is an eligible employee/dependent or qualified participant covered at the time claim was incurred. Accurate information supplied by plan sponsor and appropriate execution of eligibility verification;

- Negotiated fee arrangements (provider discounts, contracted fees) accurately administered and capitated service agreements are correctly accounted and not reimbursed separately;
- Claims are not paid until it is established services were properly referred and/or authorized including:
  - Applicable primary care physician authorization and/or service referral;
  - Plan authorization for specialty services, out of network services;
  - Compliance with utilization review programs such as hospital and surgical review, outpatient procedure review, case management and mental health network arrangements;

#### *Operational System Evaluation Review*

- Consistency with third party administrator contract performance measures;
- Data transfer between plan sponsor and claims administrator;
- Eligibility maintenance, including capacity for historical data, cross referencing, security measures, claims systems interactions (edits for waiting periods, dependent age limits, etc.);
- Controls for identifying plan maximums/limits (including system edits, flags for accumulators, etc.);
- Accurate interpretation and system programming of all plan provision;
- On line edits and features to assure medical claims processing accuracy, identify potential ineligible charges, flag questionable providers and/or charges requiring referral for medical review and prohibit duplicate payment;
- Operational ease, extent of manual intervention, audit trails, etc;
- Physical/access security and quality control within claims processing system;
- Provider maintenance and security (fraud control, etc.);
- Administration of preferred provider discounts and other negotiated fee arrangements;
- Capture of required data elements for processing/reporting;

#### *Operational Procedural Evaluation Review*

Evaluate TPA claims processing procedures including:

- Consistency with third party administrator contract performance measures;
- Establishing actual claims lag to determine/validate program IBNR;
- Procedures for call tracking and documentation;

- Correct crediting to program of all returned checks and/or overpayment recoveries;
- Procedures for following up on outstanding overpayments
- Claims submission procedures and forms;
- Enrollment, eligibility verification and record keeping processes;
- Procedures for tracking COBRA participants eligibility;
- Delegation and documentation of administrative responsibilities;
- Required claim documentation and procedures for investigating coordination of benefits, subrogation, work-related injuries;
- System for handling claims pending receipt of additional documentation;
- Quality assurance and internal audit systems;
- Interaction with managed care (utilization review and contacted) providers;
- Recording systems for production, backlog and turn-around time;
- Explanation of benefits (EOB's), claims denials and other communication with plan participants for consistency, readability and usefulness;
- Procedures for plan change documentation and implementation;
- Administrative guidelines and materials available to claims examiners;
- Customer service functions including inquiries, eligibility verification to providers;
- Efficiency of general work flow patterns;

## **ALTERNATIVE CLAIMS REVIEW PROCESSES**

The State Risk Manager and the State Health and Welfare Advisory Board have approved programs using the following measures to comply with Washington Administrative Code 82-60-050(3):

- When several public entities share the same third party claims administrator, programs may have a joint review performed, which examines the processing of a sampling of each activity's claims. In some instances, smaller programs have been permitted to review the report done for another program using the same TPA and relate the report findings to their own claims processing activities.
- Coordinate with the program broker having the program stop loss insurance carrier perform a review of the third party administrator's processing of program claims.