State of Colorado
Office of the State Auditor

Performance Audit of the
Employee Benefits Program
Department of Personnel and Administration

October 2010

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October 22, 2010

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of the Employee Benefits Program within the Department of Personnel and Administration. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government. The State Auditor contracted with Sjoberg Evashenk Consulting, Inc. to conduct this audit. The report presents our findings, conclusions, and recommendations, and the responses of the Department of Personnel and Administration.

Respectfully submitted,

Marianne P. Evashenk
President

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Glossary of Terms and Abbreviations

Benchmark Employers – Employers surveyed as part of the audit that are comparable to the State, including 12 similarly situated states in terms of size and geographic proximity to Colorado, and 10 similarly situated local employers, including two cities, five counties, and three private employers.

Benefits Ad ministration System – The State's online benefits enrollment and administration system.

Choice Plus Definity – A Health Savings Account-eligible, high deductible Preferred Provider Organization (PPO) medical plan option offered by the State and administered by UnitedHealthcare Insurance Company (UnitedHealthcare).

Choice Plus – A standard PPO medical plan option offered by the State and administered by UnitedHealthcare.

Coinsurance – A fixed percentage of the cost of medical care that plan participants must pay after the deductible has been met.

Copay – A fixed dollar amount that plan participants must pay each time they use specified services provided by their plan.

CPPS – Colorado Personnel and Payroll System. State system that maintains data on employee demographics, employee salaries, and job classifications.

Deductible – A base amount of health fees that must be paid by plan participants before the plan will pay most benefits.

Department – The Department of Personnel and Administration. A principal department in state government that oversees the state personnel system and is responsible for administering the State's Employee Benefits Program.

Fully–Insured Plans – Benefit plans in which the plan sponsor purchases group benefit plan insurance from an insurance carrier that bears the financial risk of plan costs if the premiums collected do not cover all claims and administrative costs.

Group Benefit Plans Reserve Fund – A common law trust fund established by the General Assembly to cover the payments of premiums, claims, and other administrative fees and costs associated with the State's group benefit plans.

HMO – Health Maintenance Organization. A health plan that offers comprehensive medical services to enrolled participants by designated health care providers within a specified geographic service area ("in-network").

Kaiser – Kaiser Foundation Health Plan. An insurance company under contract with the Department of Personnel and Administration to provide two HMO medical plan options for Colorado state employees.

Kaiser HMO – A standard HMO medical plan option offered by the State and provided by the Kaiser Foundation Health Plan.

Kaiser HDHP – A Health Savings Account-eligible, high deductible HMO medical plan option offered by the State and provided by the Kaiser Foundation Health Plan.

Out-of-Pocket Costs – Costs of health care that plan participants are required to pay in addition to premiums, including copays, deductibles, and coinsurance.

Pharmacy Benefit Manager – The third-party administrator responsible for processing pharmacy claims and establishing which prescription drugs are covered by the plan.

Pooled "Paid Time-Off" Leave – An arrangement under which most types of personal time off (e.g., annual leave, sick leave, and personal days) for an employee are pooled into a single "bank" of hours that can be used for whatever purpose the employee chooses.

PPO - Preferred Provider Organization. A health plan that offers enrolled participants the ability to choose health care providers from a list of specially designated "preferred providers" ("in-network") as well as non-designated providers ("out-of-network").

Premium – The charge for providing medical coverage to an individual or family.

Premium Stabiliz ation Reserve – A fund established by the Department of Personnel and Administration to pay claims and other benefit plan costs that exceed premiums and other revenues collected.

Risk Pool – The pool of individuals whose medical costs are combined to calculate premiums.

Self-Funded Plan – Benefit plans in which the plan sponsor (e.g., the State) bears the financial risk to the extent that premiums do not cover all claims and administrative costs.

Director – State Personnel Director. Head of the Department of Personnel and Administration and responsible for administering the state personnel system.

Stop Loss Insurance – An insurance policy purchased by a plan sponsor requiring an insurer to pay claim costs that exceed a specified "attachment point," or dollar threshold. *Specific* stop loss insurance requires the insurer to pay all claims for a specific plan member once that member's claims exceed a specified dollar threshold in one year. *Aggregate* stop loss insurance requires insurers to pay all claims once the total claims for all plan members exceed a specified dollar threshold in one year.

Third-Party Administrator – A private company that administers health plans and processes related claims on behalf of the plan sponsor. UnitedHealthcare is the third-party administrator for the State's self-funded PPO plans.

SJOBERG EVASHENK CONSULTING, INC

Report Summary

Performance Audit of the Employee Benefits Program
Department of Personnel and Administration
October 2010

Purpose and Scope

This performance audit of the Employee Benefits Program, within the Department of Personnel and Administration (Department), was conducted by Sjoberg Evashenk Consulting, Inc. (Sjoberg Evashenk) under contract with the Office of the State Auditor. The purpose of this audit was to evaluate how the State's Employee Benefits Program compares with benchmark employers and the effectiveness of the Department's management of the program. The scope of this audit included a review of group benefit plan selection, costs, and benefits; plan eligibility and enrollment; claims management; and administration of plan contracts. We performed audit work from April through October 2010. Sjoberg Evashenk gratefully acknowledges the assistance and cooperation extended by Department staff.

We conducted this performance audit in accordance with generally accepted government auditing standards. 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 the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Overview

Group benefits are one component of the State's total compensation package and include medical, dental, life, and disability benefits. All classified employees within the state personnel system, as well as non-classified employees of the legislative and judicial branches, and elected or appointed state officials are eligible for the State's group benefit plans. In addition to group benefits, the State also provides employees with leave benefits, such as annual and sick leave. The State's goal with respect to employee benefits is to offer benefits similar to those provided by comparable employers [Section 24-50-602, C.R.S.]. In Fiscal Year 2010, the State and employees contributed about $281 million dollars to group benefits, with state agencies paying nearly $200 million (71 percent) of this amount. Of the $281 million, over $243 million (86 percent) was spent on medical plans, which provide the focus for this report.

As of July 2010, approximately 29,100 of the State's more than 38,300 eligible employees (76 percent) were enrolled in a state medical plan. The State provides four different medical plan options for state employees, each with a different benefit and cost structure. Two of the plans are Health Maintenance Organization (HMO) plans, which are provided by the Kaiser

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Foundation Health Plan and offer medical services by designated health care providers within a specified geographic service area. The two HMO plans are fully-funded, which means that Kaiser bears the financial risk to the extent that the premiums do not cover the cost of claims and other expenses. The other two plans are Preferred Provider Organization (PPO) plans, which are administered by UnitedHealthcare Insurance Company (UnitedHealthcare) and offer enrolled participants the ability to choose their health care providers from designated "preferred providers" as well as non-designated providers. The State self-funds the PPO plans and bears the financial risk to the extent that premiums do not cover the cost of claims and other expenses.

Key Findings

Structure and Design of Benefit Plans

We reviewed the structure and design of the State's benefits plans and compared the type, level, and cost of benefits provided by the State with benefits provided by benchmark employers. In general, the type of benefits provided by the State is comparable to those provided by other employers. However, both the State and employees may be paying more for medical benefits than is necessary. Improving the structure and design of the State's benefit plans in the following areas could help reduce costs by up to $16.7 million:

Risk pool. The State does not include individuals in HMO plans in its self-funded risk pool. As a result, the State's self-funded risk pool is significantly smaller than existed when the State moved to self-funding in July 2005, and its participants have higher-risk demographics than those in the fully-insured HMO plans. When the State created its self-funded plans in Fiscal Year 2006, 62 percent (about 15,300) of the individuals enrolled in the State's medical plans were enrolled in a self-funded plan, and thus in the State's risk pool; this percentage decreased to 49 percent (about 14,200) in Fiscal Year 2011. The smaller risk pool for the State's self-funded plans and the higher-risk demographics of the individuals in the pool increase the overall cost of the self-funded plans. The Department's actuary estimated that if the individuals enrolled in the fully-insured HMO plans were included in the self-funded risk pool, the overall cost of the self-funded plans would decrease by about $2.3 million in Fiscal Year 2010 as a result of the change in demographics alone.

Plan benefits and costs. Colorado state employees contribute more toward the cost of their medical plans than employees of benchmark employers. State employees pay a greater share of premium costs than employees of benchmark employers. For example, in Fiscal Year 2011 for the "employee plus spouse" enrollment tier, the State contributed 62.8 percent of total premium costs for the PPO plans and 60.7 percent for the HMO plans compared with an average contribution of 86.3 percent by benchmark employers for PPO plans and 82.3 percent for HMO plans. In addition, employees enrolled in the State's PPO plans are subject to significantly higher out-of-pocket cost provisions than employees of benchmark employers. For example, the individual out-of-pocket maximum for employees in the State's PPO plans is at least $500 more than what employees of benchmark employers have to pay.

Part-time employees. The State's policies related to part-time employees are more generous than benchmark employers. The State does not have minimum work requirements for employees to be eligible for state contributions to benefits, and the State contributes the same amount to benefits for part-time and full-time employees. Neither of these practices is consistent with those of comparable employers. If the State were to implement a policy that

prorates state contributions based on minimum work requirements for part-time employees, we estimate the State's medical benefit costs would decrease by about $4.4 million for Fiscal Year 2011.

Administration and Oversight of Plan Costs

We reviewed the Department's administration of benefit plans and found the Department does not have the appropriate administrative and oversight infrastructure in place for the following key areas to adequately control the costs associated with self-funding:

Eligibility verification. The Department does not ensure that only those individuals meeting statutory eligibility criteria are enrolled in the State's benefit plans. Prior to January 2004 employees were not asked to provide documentation to support their dependents' eligibility during open enrollment. Additionally, even though as of Fiscal Year 2007 employees are required to provide documentation to show that dependents enrolled in a state benefit plan meet statutory eligibility criteria, the Department cannot ensure that employees are complying with this requirement. Finally, the Department has never conducted an eligibility audit of employee dependents enrolled in a state benefit plan. Eligibility audits performed by other organizations have found that between 2 percent and 5 percent of enrolled dependents are not eligible for benefits. If this is true in Colorado, it could mean that the State is paying as much as $8.4 million each year for ineligible dependents.

Enrollment data. The Department does not reconcile the enrollment information in the Benefits Administration System with information in the payroll system. As a result, the Department could potentially not be collecting more than $35,000 each month, or $420,000 annually, from employees and state agencies due to discrepancies between payroll systems and the Benefits Administration System. The Department also does not reconcile enrollment data provided on invoices from third-party administrators with the Department's enrollment data.

Contract monitoring. The Department does not receive sufficient information from its third-party administrators and insurance carriers to adequately monitor and manage costs and the quality of services provided, specifically with respect to cost-recovery efforts, claims appeals processing, and pharmacy benefit management.

Claims verification. The Department does not provide sufficient oversight of its third-party administrator and pharmacy benefits manager to ensure that these entities are processing claims in accordance with the contract and the PPO plan documents. Since moving to self-funding in Fiscal Year 2006, the Department has never audited its third-party administrator's claims processing. Conservative estimates suggest that plan sponsors can expect to recover about 1 percent of total claims costs through a claims audit. For Colorado, this would equal about $1.27 million for Fiscal Year 2011.

Our recommendations and the responses from the Department of Personnel and Administration can be found in the Recommendation Locator and in the body of this report.

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RECOMMENDATION LOCATOR Agency Addressed: Department of Personnel and Administration				
Rec. No.	**Page No.**	**Recommendation Summary**	**Agency Response**	**Implementation Date**
1	17	Mitigate the risks of self-funding by structuring medical plans to ensure a sufficiently large and diverse risk pool and consider options to bring employees currently enrolled in the HMO plans into the risk pool. These options include: determining if Kaiser is willing to offer self-funded plan options; risk adjusting Kaiser premiums; freezing enrollment in Kaiser plans to current participants; and eliminating all fully-insured plans.	Agree	July 1, 2011
2	22	Improve the State's use of stop loss insurance in conjunction with the premium stabilization reserve by: (a) reevaluating annually whether to purchase specific or aggregate stop loss coverage, whether the attachment point should increase, and whether to seek competitive proposals for stop loss insurance and (b) continuing to fund the premium stabilization reserve until a sufficient balance is maintained for several years.	Agree	Ongoing
3	32	Continue to evaluate plan designs to identify opportunities for reducing employee costs. Opportunities may include: (a) increasing HMO out-of-pocket costs; (b) adjusting PPO out-of-pocket costs to be more consistent with comparable employer offerings; and (c) decreasing "Choice Plus" PPO plan deductibles and out-of-pocket maximums. Make recommendations to the General Assembly that cost-savings realized from implementing recommendations be used to increase the State's contribution to premiums.	Agree	Ongoing
4	36	Evaluate options for revising policies related to the State's contribution to benefits for part-time employees, and pursuing statutory change as necessary. Options should include: (a) establishing minimum work requirements for part-time employees to be eligible for state contributions and (b) prorating state contributions based on hours worked. If parts (a) and (b) are implemented, provide guidance to state agencies on how to administer these changes.	Agree	July 1, 2011

RECOMMENDATION LOCATOR Agency Addressed: Department of Personnel and Administration				
Rec. No.	**Page No.**	**Recommendation Summary**	**Agency Response**	**Implementation Date**
5	39	Evaluate current leave polices compared with other employers and determine if changes are needed, including: (a) determining whether the State's 10-day per year sick leave accrual rate is consistent with comparable employers and pursuing necessary statutory changes and (b) pursuing a pooled "paid time–off" leave system.	Agree	June 30, 2011
6	44	Implement sufficient controls over the benefit enrollment process to ensure that only eligible individuals are enrolled in plans. Controls should include: (a) conducting eligibility audits of enrolled participants and (b) implementing system controls in the Benefits Administration System requiring benefit administrators to scan and approve documentation verifying eligibility before completing enrollment.	Agree	June 30, 2011
7	49	Ensure that accurate enrollment data are used for payroll and to pay plan administrators and insurance carriers by: (a) routinely reconciling enrollment data in the Benefits Administration System with data in the payroll systems and (b) "self-billing" insurance carriers and administrators or reconciling invoiced enrollment data.	Agree	Ongoing
8	53	Improve the ability to monitor contractor performance by requiring that: (a) insurance companies, third-party administrators, and pharmacy benefit managers provide more complete and comprehensive performance reports and (b) the Department be notified in advance of formulary changes to prescription drugs so that it can evaluate an approve such changes.	Agree	January 31, 2011
9	55	Strengthen oversight of claims for self-funded plans by: (a) conducting periodic and timely audits of the administrator's claims processing and (b) renegotiating and strengthening contract provisions to allow more flexibility with respect to claims audits.	Agree	a. June 30, 2012 b. January 31, 2011
10	58	Evaluate the cost-benefits of a comprehensive wellness program and, based on the results of the evaluation, take appropriate steps to develop and implement a wellness program.	Agree	June 30, 2011

Overview of the Employee Benefits Program
Chapter 1

Benefits are one of the primary factors employees consider when looking for employment opportunities. The State of Colorado recognizes the importance of employee benefits and provides a comprehensive benefits package to its employees. A key policy of the State is to provide prevailing total compensation to employees to ensure the recruitment, motivation, and retention of a qualified and competent work force [Section 24-50-104(1), C.R.S.]. Group benefits are one component of the State's total compensation package and include medical, dental, life, and disability benefits [Section 24-50-603(9), C.R.S.]. According to statute [Section 24-50-603(7), C.R.S.], all classified employees within the state personnel system, as well as non-classified employees of the legislative and judicial branches, and elected or appointed state officials are eligible for the State's group benefit plans. In addition to group benefits, the State also provides employees with leave benefits, such as annual and sick leave.

The State Personnel Director (Director), who is the Executive Director of the Department of Personnel and Administration (Department), has been authorized by statute to administer and manage the State's group benefit plans. The Director's authority includes, among other responsibilities, designing the benefit plans offered to employees, determining the eligibility for employees and dependents to enroll in benefit plans, and contracting with benefit providers [Section 24-50-604, C.R.S.]. The Director has delegated the day-to-day administration and management of the State's group benefit plans to the Employee Benefits Unit within the Department's Division of Human Resources.

The scope of this audit included a review of the group benefits and leave benefits provided by the State to eligible employees.

Group Benefit Plans

The State's goals with respect to benefits are to offer benefits similar to those provided by private and public employers and to provide each employee with benefit choices and the education needed to customize a benefit package that meets the employee's needs [Section 24-50-602 and Section 24-50-104(4), C.R.S.]. Group benefit plans offer state employees the opportunity to obtain insurance coverage that is subsidized, at least in part, by the State and is available at an overall cost that is typically less than employees would be able to purchase on their own. In Fiscal Year 2010 the State and employees spent almost $281 million dollars on group benefit plans. Of this amount, nearly $243 million (86 percent) was spent on medical plans; over $15 million (5 percent) was spent on dental plans; $20 million (7 percent) was spent on life, disability, and other benefit expenditures; and about $2.6 million (1 percent) was spent on Department administration and oversight. Medical plans represent the overwhelming majority of state dollars spent on group benefit plans and provide the focus for this report.

Medical Plans

State employees have many choices when it comes to medical benefits. They can choose to enroll in a medical plan or choose not to enroll in a plan. Employees can also choose to enroll just themselves in a plan or they can enroll their spouses and dependents as well. Finally, employees can choose from a selection of four different medical plan options, two of which are offered statewide and two of which are offered in certain regions of the state. Each of the four plans has a different benefit and cost structure. As of July 2010, approximately 29,100 of the State's approximately 38,300 eligible employees (76 percent) were enrolled in a state group medical plan.

For Fiscal Year 2011 the State offered its employees a choice between the following two types of medical plans:

- **Health Maintenance Organization (HMO) plans.** An HMO plan offers comprehensive medical services to enrolled participants by designated health care providers within a specified geographic service area, or "in-network." Medical services received from non-designated health care providers or from outside the specified geographic service area are considered "out-of-network" and are generally not covered, except in emergency situations. HMOs generally require participants to select a primary care physician who is responsible for managing and coordinating all of a participant's healthcare needs. Typically, participants must obtain a referral from their primary care physician before going to see a specialist. The Department contracts with the Kaiser Foundation Health Plan (Kaiser) to provide two HMO plans for state employees. One plan provides comprehensive benefits with lower out-of-pocket costs and higher premium costs ("Kaiser HMO"), and the other plan is considered a "high-deductible health plan" that provides benefits with higher out-of-pocket costs at a lower premium cost ("Kaiser HDHP"). The Kaiser HDHP plan is a Health Savings Account-eligible option for participants. According to the Department, the Kaiser HMO plans are offered to state employees in only 23 of the State's 64 counties; these 23 counties are primarily in metropolitan areas and along the Front Range.

- **Preferred Provider Organization (PPO) plans.** A PPO offers enrolled participants the ability to choose their health care providers from a list of specially designated "preferred providers" ("in-network") as well as non-designated providers ("out-of-network"). The PPO covers a larger percentage of the costs for services provided by in-network providers than it does for out-of-network providers. PPOs allow participants to select a primary care physician and go to specialists without a referral. The Department contracts with UnitedHealthcare to administer two PPO plans for state employees. One plan provides comprehensive benefits with lower out-of-pocket costs and higher premium costs ("Choice Plus"), and the other plan is considered a "high-deductible health plan" that provides benefits with higher out-of-pocket costs at a lower premium cost ("Choice Plus Definity"). The Choice Plus Definity plan is a Health Savings Account-eligible option for participants. Under the terms of the contract, UnitedHealthcare also serves as the pharmacy benefit manager for the PPO plans.

As the pharmacy benefit manager, Prescription Solutions, a subsidiary of United Health Group, is responsible for processing all pharmacy claims for PPO participants. The State's PPO plans are offered to employees statewide.

Each of the HMO and PPO medical plan options offer four tiers of enrollment: (1) employee only, (2) employee plus spouse, (3) employee plus child(ren), and (4) family. The premium, or the cost of enrolling in a medical plan, varies depending on the plan and the tier of enrollment. The State and the employee each pay a share of the premium. The State pays a fixed amount for each tier, regardless of the plan, and the employee pays the balance of the premium. The State's long-term goal with respect to premiums, as established in the Department's Annual Compensation Survey Report, is to contribute a dollar amount equal to 100 percent of the average dollar amount that other employers contribute to medical plan premiums for their employees. In addition, beginning with the Fiscal Year 2012 plan year, the Department implemented a new goal for the State, which is to ensure the employer and employee shares of premium contributions are consistent with comparable employers. The State's Fiscal Year 2011 contribution to medical plan premiums equaled approximately 95 percent of the average dollar amount contributed by other employers. This was about 5 percent more than the State's contribution of 90 percent in the two previous years. The increase in the State's contribution rate for Fiscal Year 2011 was due to additional one-time contributions from the State's General Fund and the Group Benefit Plans Reserve Fund, which resulted from a legal settlement with Kaiser. In addition, as recognized in the Director's letter to the Governor and General Assembly that accompanies the Department's Annual Compensation Survey Report, the State's share of premium contributions is lower than other employers.

The following exhibit shows, for each plan and tier, the monthly cost of premiums as allocated between the State and employees and the number of employees enrolled. As mentioned previously, in Fiscal Year 2010 the State and employees paid, in total, about $243 million for medical benefits for the approximately 29,100 enrolled employees and their dependents.

Exhibit 1: State Medical Plans – Premiums and Enrollment
Fiscal Year 2011

Enrollment Tier	PPO HMO Choice Plus	PPO HMO Choice Plus Definity	PPO HMO Kaiser HMO	PPO HMO Kaiser HDHP
Employee Only				
State Share	$370	$370	$370	$370
Employee Share	69	7	84	9
Total Monthly Premium[1] $439		**$377**	**$454**	**$379**
Enrollment[2]	4,582	2,529	7,308	538
Employee plus Spouse				
State Share	$625	$625	$625	$625
Employee Share	335	199	369	204
Total Monthly Premium[1] $960		**$824**	**$994**	**$829**
Enrollment[2]	1,302	828	1,505	88
Employee plus Child(ren)				
State Share	$661	$661	$661	$661
Employee share	125	13	152	17
Total Monthly Premium[1] $786		**$674**	**$813**	**$678**
Enrollment[2]	1,571	653	2,940	115
Family				
State Share	$916	$916	$916	$916
Employee share	391	205	436	211
Total Monthly Premium[1] $1,307		**$1,121**	**$1,352**	**$1,127**
Enrollment[2]	1,414	1,329	2,255	193
TOTAL ENROLLMENT	**8,869**	**5,339**	**14,008 934**	

Source: Sjoberg Evashenk Consulting's summary of Department of Personnel and Administration enrollment statistics and open enrollment plan documentation.

[1]Monthly premiums are those in place for Fiscal Year 2011.

[2]Enrollment numbers are as of July 2010.

Medical Plan Funding

Group medical plans can be either self-funded or fully-insured. From January 2000 through June 2005 all of the State's medical plans were fully-insured. However, since July 2005 the State has taken a combination approach and self-funds the PPO plans and fully-insures the HMO plans. In the self-funded PPO plans, the State and employees pay a fixed monthly premium, which is used to cover the cost of claims and plan administration. With self-funding, the State bears the risk to the extent that the premiums do not cover claims and administrative costs. This means that if the amount of claims made by plan participants and administrative costs exceed the amount of premiums collected, the State will have to pay for the excess costs using its own funds. To protect against this risk, the Department purchases "specific" stop loss insurance, which means that an insurance company pays all costs for a participant's specific claims exceeding a certain dollar amount. For Fiscal Year 2011 the Department purchased specific stop loss

insurance from UnitedHealthcare to cover claim costs exceeding $200,000. In addition, in Fiscal Year 2011 the Department contracted with UnitedHealthcare to serve as the third-party administrator for the PPO plans and process all claims on behalf of the State. Prior to Fiscal Year 2010 the Department contracted with Great-West/CIGNA to serve as the third-party administrator.

In the fully-insured HMO plans, the State and employees pay a fixed monthly premium to a third-party insurance company that bears the financial risk for the plans. This means that the insurance company, rather than the State, bears the financial risk if the premiums collected do not cover all claims and administrative costs. However, the insurance company will consider any losses when setting future premium rates. In Fiscal Year 2011 the Department contracted with Kaiser as the insurer for the two fully-insured HMO plans.

We discuss medical plan funding further in Chapter 2.

Other State Employee Benefits

- **Dental.** The State provides dental benefits for state employees and their dependents. In Fiscal Year 2010 the State and employees spent, in total, about $15 million for dental benefits and as of July 2010, there were almost 31,000 state employees enrolled in a group dental plan. The State offers its employees two dental plans—"Basic" and "Basic Plus." The "Basic" plan provides a less extensive array of benefits at a lower cost than the "Basic Plus" plan. The dental plans also offer four tiers of enrollment: (1) employee only, (2) employee plus spouse, (3) employee plus child(ren), and (4) family. The State self-funds the dental plans and the Department contracts with Delta Dental to provide third-party administrator services for both plans. The premium for the dental plans varies depending on the plan and the tier of enrollment. The State and the employee each pay a share of the monthly premium. The State pays a fixed amount for each tier, regardless of the plan, and the employee pays the balance of the premium. The State's long-term goal is to contribute a dollar amount equal to 100 percent of the average dollar amount that other employers contribute to health plan premiums for their employees. According to the Director's letter that accompanies the Department's Annual Compensation Survey Report, the State's Fiscal Year 2011 contribution to premiums equaled 85 percent of the amount other employers contribute for their employees. In addition to premiums, employees incur out-of-pocket costs for the dental plans.

- **Life and Accidental Death and Dismemberment.** The State provides for a basic life and accidental death and dismemberment (Life/AD&D) insurance policy for each state employee in the amount of $50,000, at no cost to the employee and with no enrollment required. Life/AD&D insurance pays, in the event of an accidental death, benefits in addition to any life insurance held, or in the event of dismemberment, fractional amounts of the policy based on the nature of the loss. Employees have the option of purchasing additional amounts of Life/AD&D insurance in increments of $10,000 up to $500,000. Premiums are based on the

amount of coverage and age of the employee. Optional Life/AD&D insurance is also available to cover dependent spouses and children. The Department contracts with Minnesota Life Insurance Company to provide Life/AD&D coverage.

- **Disability.** The State provides short-term disability insurance to employees, at no cost to the employee and with no enrollment required. The coverage pays up to 60 percent of pre-disability income for up to 150 days following a required 30-day waiting period, or exhaustion of the employee's sick leave, whichever is greater. Employees can also purchase long-term disability insurance with premiums determined by salary, age, and retirement plan vesting status. The Department contracts with Standard Insurance Company to provide disability coverage**.**

- **Leave.** The State provides several different types of leave for employees. Permanent state employees earn approximately 6.66 hours of sick leave per month, up to a statutory maximum of 80 hours per year. The maximum accrual limit for sick leave is 360 hours. In addition, employees earn annual leave at a rate of 8 hours to 14 hours per month, depending on years of service. The maximum accrual limit for annual leave is also dependent on employees' years of service; the maximum cap is 336 hours for employees with more than 16 years of service. Annual and sick leave accruals are prorated for part-time employees. Other categories of leave include holiday, bereavement, jury duty, military, family/medical, and administrative. The State allows leave sharing among employees. We discuss leave further in Chapter 2.

Fiscal and Organizational Overview

In Fiscal Year 2011 the Employee Benefits Unit, within the Division of Human Resources, was appropriated $2.6 million and 10 FTE for operations. The Unit is responsible for administering employee group benefit plans, including medical, dental, disability, and life. The Unit's responsibilities and duties include:

- Designing group benefit plans, including executing contracts with plan administrators.

- Determining premiums and fees for group benefit plans and requesting funding through the annual budget process.

- Monitoring, with the assistance of an independent actuary, the performance of each plan and each plan administrator.

- Determining, in conjunction with state departmental benefits administrators, employee and dependent eligibility for enrollment in group plans.

- Managing the enrollment process, including special enrollments (e.g., the premium subsidy program for low-income employees with children).

- Working with state departments and employee partnerships to identify potential group benefit plan improvements.

The following exhibit shows the State's revenue and expenditures for group benefit plans for Fiscal Years 2006 through 2010.

Exhibit 2: State Employee Benefits Revenue and Expenditures
Fiscal Years 2006 through 2010
In Millions

REVENUE						
Type	**2006**	**2007**	**2008**	**2009**	**2010**	**Percent Change 2006-2010**
State Paid Health Insurance Premiums	$94.6	$122.2	$146.9	$178.3	$196.0	107%
Member Paid Health Insurance Premiums	$75.1	$70.0	$77.1	$71.0	$66.6	-11%
Other Revenue[1]	$17.3	$20.7	$14.3	$14.4	$19.9	15%
TOTAL REVENUE	**$187.0**	**$212.9**	**$238.3**	**$263.7**	**$282.5**	**51%**
EXPENDITURES						
Type	**2006**	**2007**	**2008**	**2009**	**2010**	**Percent Change 2006-2010**
SELF-FUNDED PLAN EXPENDITURES						
Medical						
Medical Claim Costs	$72.6	$79.3	$87.3	$87.0	$94.2	30%
Third-Party Administrator Fees	$23.5	$28.2	$15.9	$18.9	$17.3	-26%
Pharmacy Benefit Claims Costs	$11.4	$13.6	$16.1	$16.3	$16.6	46%
Dental						
Third-Party Administrator Fees	$1.0	$0.9	$0.9	$1.0	$1.1	10%
Dental Claim Costs	$10.8	$12.0	$12.2	$12.8	$14.2	31%
FULLY-INSURED PLAN EXPENDITURES						
Medical Premiums	$53.5	$63.9	$76.8	$89.5	$115.0	115%
Life (Basic & Optional)	$6.8	$7.8	$7.4	$8.5	$7.9	16%
Disability (Short- & Long-Term)	$3.6	$2.9	$3.5	$3.8	$4.1	14%
Misc Plan Expenditures	$7.3	$7.4	$8.5	$7.5	$7.9	8%
ADMINISTRATION						
Department Administrative Expenditures	$1.1	$1.3	$1.3	$2.1	$2.6	136%
TOTAL EXPENDITURES	**$191.6**	**$217.3**	**$229.9**	**$247.4**	**$280.9**	**47%**

Source: Sjoberg Evashenk Consulting's analysis of Department of Personnel and Administration-generated Trial Balances from the State's accounting System, COFRS, for Funds 719, 91e and 91s for Fiscal Years 2006 through 2010.

[1] Other revenue includes drug rebates under the self-funded Great-West/CIGNA PPO plans in place during this period, stop loss reimbursements, fines and penalties assessed against plan administrators, interest income, and other sources.

Audit Scope and Methodology

The State Auditor contracted with Sjoberg Evashenk Consulting, Inc., to conduct this performance audit. The purpose of this audit was to evaluate how the State's Employee Benefits Program compares with other employers and the effectiveness of the Department's administration and oversight of the program. The scope of this audit included a review of group benefit plan selection, costs, and benefits; plan eligibility and enrollment; claims management; administration of plan contracts and management of third-party administrators; and follow-up on prior audit recommendations.

As part of the audit work, we reviewed relevant statutes, rules, policies, procedures, prior audit reports, and other documentation related to the Department's responsibilities. We also interviewed Department staff and representatives of the State's partnership with two certified employee organizations. We evaluated the Department's processes, procedures, and practices and analyzed benefit plan information, including trends in enrollment and costs between Fiscal Years 2003 and 2010. We collected benchmark data to compare the State's group benefit plans and leave benefits with that of other similarly situated employers, including 12 similarly situated states, in terms of size and geographic proximity to Colorado, and 10 similarly situated local public and private employers, including two cities, five counties, and three private employers. In addition, we reviewed published market surveys that contain benefit information from both public and private employers within Colorado, as well as regional and national surveys and data compiled by the Federal Bureau of Labor Statistics.

Although the scope of this audit included all group benefits provided by the State to its employees, we did not have any findings related to dental, life, or short-term disability benefits.

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Structure and Design of Benefit Plans
Chapter 2

As discussed in Chapter 1, benefits, especially health benefits, are one of the most important factors employees consider when looking for employment opportunities. Therefore, it is important that the State, as an employer, provide a competitive benefits package to attract and retain a competent and qualified workforce. The General Assembly, recognizing the importance of providing a comprehensive and competitive array of employee benefits, adopted a policy in 1972 for the State to provide prevailing compensation and benefits to employees [Section 24-50-104, C.R.S.], and set a goal in 1994 for the State to provide group benefits similar to those commonly provided in private industry [Section 24-50-602, C.R.S.].

There are two primary factors for employers to consider when structuring and designing a benefits package—the type and level of benefits that will be provided and the cost of those benefits to the employer and the employee. The Department of Personnel and Administration (Department) is responsible for administering and managing the State's group benefit plans. This includes determining the structure of the plans, designing the type of plans that will be provided, and determining the cost of those plans. To help when making these decisions, the Department conducts an annual compensation survey based on published comparative compensation and benefit data to determine the type and level of benefits provided by other employers as well as the amount other employers contribute to the cost of benefits for their employees. The Department uses this information to develop recommendations, which it makes annually to the Governor and the General Assembly regarding the benefit plans to be provided for the next fiscal year and the amount the State should contribute toward the cost of those plans. These recommendations are meant to further the State's policy of providing prevailing compensation levels and its goal of providing 100 percent of the average dollar amount that other employers contribute to premiums as well as the goal of ensuring the percentage of premium costs shared by the State and employees is consistent with cost sharing provisions found with other employers.

We reviewed the effectiveness of the Department's administration and management of the State's group benefit plans and compared the type, level, and cost of benefits provided by the State to its employees with benefits provided by other comparable employers. In general, we found that the type of benefits provided by the State is comparable to that provided by other employers. However, we found that both the State and employees may be paying more for medical benefits than is necessary and that by improving its management and administration of the State's benefit plans, with an emphasis on medical plans, the Department could help reduce costs. This report presents a comprehensive set of solutions to address both the structural and administrative issues we identified during the audit. If implemented, these solutions could potentially help the State and employees realize cost savings of up to $16.7 million, including potential cost savings resulting from increased oversight of employee eligibility and enrollment and claims processing, reducing state contributions to some part-time employees in a manner

consistent with comparable employers, and reevaluating the Department's procurement of stop loss insurance.

In this chapter we present our findings related to the structure and design of the State's benefit plans and make recommendations for changes that will help reduce the cost of benefits for both the State and employees. Specifically, we identified issues related to self-funding, plan design, part-time employee benefits, and leave. In Chapter 3 we present our findings related to the Department's administration of the State's benefit plans. These findings address issues such as eligibility verification, the accuracy of enrollment data, contract monitoring, and wellness programs. The primary focus of this report is on state medical benefits, which account for nearly $243 million, or 86 percent, of the $281 million spent on group benefits during Fiscal Year 2010.

State Medical Plans' Funding Structure

Over the past ten years, the State's medical plans have gone from being exclusively fully-insured to the current situation where both fully-insured and self-funded plans are offered to state employees. From January 2000 to June 2005 all of the State's medical plans were fully-insured. When a plan is fully-insured, the employer, in this case the State, and its employees pay a fixed monthly premium to a third-party insurance company that bears the financial risk for the plans. This means that if the amount of claims made by plan participants exceeds the amount the insurance company collects in premiums, the insurance company is responsible for covering those excess costs. Insurance companies consider losses when setting future premium rates. However, if the insurance company collects more in premiums than it has to pay out for claims, then the insurance company retains the excess premiums. An employer can negotiate with the insurance company regarding the type of service (e.g., emergency room visits or inpatient services) and level of costs (e.g., deductible and copay amounts) the plans will provide. Since the insurance company bears all risk under a fully-insured plan, it ultimately establishes the design and price of available plans. For Fiscal Year 2011 the State offered two fully-insured medical plan options to state employees—both are Health Maintenance Organization (HMO) plans provided by the Kaiser Foundation Health Plan (Kaiser). One plan offers standard medical coverage with balanced premium and out-of-pocket costs, and the other is a high-deductible medical plan with lower premium costs and higher out-of-pocket costs.

Although there are advantages to offering fully-insured plans, many large employers self-fund their health benefits because there is the potential to produce cost-savings compared with a fully-insured approach. If self-funded plans are managed efficiently and the risk associated with the plans is appropriately mitigated, as discussed below, employers have the potential to retain any excess premiums that insurance carriers can retain under fully-insured plans. In addition, self-funding gives employers access to detailed plan utilization data that they can use to design plans, including the type and level of benefits offered, that are consistent with the employers' benefit strategies and meet the needs of employees. For these reasons, in July 2005 the State moved to self-funding for its Preferred Provider Organization (PPO) medical plans. The State and its employees pay a fixed monthly premium to cover the cost of claims and the State bears the risk to the extent that the premiums do not cover the costs of the claims and the benefits provided.

This means that if the amount of claims made by participants exceeds the amount of premiums collected, the State pays the excess using its own funds. For Fiscal Year 2011 the State contracted with UnitedHealthcare Insurance Company (UnitedHealthcare) to serve as the third-party administrator for the PPO plans, which means that United is responsible for processing all PPO claims on behalf of the State. In addition, the State was able to design the PPO plans in accordance with the State's benefit strategy and determine what type and level of benefits would be provided by these plans to best meet employees' needs. With the assistance of an actuary and considering the costs of the third-party administrator, the Department sets the premium rates for the self-funded plan options.

Self-funding provides the State with the potential to realize cost-savings if the risk associated with self-funding is appropriately mitigated. As noted previously, the State's risk with self-funding is that the amount of claims will exceed the amount of premiums collected and the State will have to pay the excess using its own funds. There are essentially three ways that the State can mitigate the risk associated with self-funding:

- **Risk Pool.** The most important way that employers, including the State, can mitigate the risk associated with self-funding is to maintain a sufficiently large and balanced pool made up of participants representing both lower- and higher-risk demographics such as age, geography, and overall health. In general, a risk pool consists of all of the individuals whose medical costs are combined to calculate premiums. By spreading the risk across a large number of individuals with a balance of low and high risks, actuaries are able to determine premium levels that will be stable over time; as the size of the risk pool increases, the predictability of the claims experience is improved. Having a sufficiently large and diverse risk pool means that the insurer is able to subsidize and offset the significant claim costs incurred by some higher-risk participants with low claim cost for lower-risk participants.

  However, the size of a risk pool does not necessarily translate into lower premiums. Just as a pool with more individuals with a lower risk of incurring high medical costs can result in lower premiums, a large pool with a disproportionate share of higher risk individuals will have higher premiums. The State's Fiscal Year 2011 risk pool is composed of the approximately 28,400 participants (including about 14,200 employees and their dependents) enrolled across the State's two self-funded medical plans.

- **Stop Loss Insurance.** Many employers, including the State, seek to mitigate the financial risk of self-funding claims by purchasing stop loss insurance from an insurance carrier. Stop loss insurance is used to protect the Group Benefit Plans Reserve Fund against losses incurred as a result of catastrophically large medical claims by paying claims that exceed a prescribed "attachment point." The Group Benefit Plans Reserve Fund is a common law trust fund established to cover the payments of premiums, claims, and other administrative fees and costs associated with group benefit plans [Section 24-50-613(2)(a), C.R.S.]. Generally, stop loss insurance takes effect once a certain amount has been paid by the self-funded

plan. Stop loss insurance can be purchased on a per member basis or in aggregate. Specific stop loss insurance means that the insurance company pays a participant's claims in excess of a certain dollar amount in one year. This is referred to as the attachment point. Aggregate stop loss insurance means that the insurance company pays all claims after the employer's total claims for the entire plan exceed a certain dollar amount in one year, or the attachment point. Employers that purchase aggregate stop loss insurance must have a sufficient premium stabilization reserve to cover all claims up to the attachment point.

As with other types of insurance, the lower the attachment point for stop loss insurance, the higher the premium because more risk has been shifted from the State to the stop loss insurance carrier. Because of this, self-funded plan sponsors must periodically weigh the costs and benefits of purchasing stop loss insurance and determine what type of coverage, aggregate and/or specific, and attachment points would best meet the sponsors' risk strategies. Plan sponsors should base these decisions on plan utilization trends, available fund reserves, and the overall level of risk the sponsor is willing to accept. The Department has chosen to purchase specific stop loss insurance, which for Fiscal Year 2011 covers costs in excess of $200,000 per participant. The State pays for the cost of stop loss insurance premiums through an administrative fee of nearly $40 per enrolled employee per month that is included in the premium charged. According to the Department, it has not purchased aggregate stop loss insurance since moving to self-funding in July 2005 because the State has not had sufficient premium stabilization reserves. This issue is discussed further in Recommendation No. 2.

- **Premium Stabilization Reserves.** Employers, including the State, also mitigate the risk of self-funding by maintaining sufficient premium reserves to pay the cost of any claims, and other unanticipated costs, that exceed the amount of premiums collected and that are not covered by stop loss insurance. Based on the Department's actuary and industry standards, the recommended practice for an organization the size of the State, with the demographics of the State's risk pool, and with the type of stop loss insurance purchased by the State is to maintain a premium stabilization reserve (PSR) of at least 10 percent of projected claim costs for the year. For the first five years of self-funding, the State's premium stabilization reserve has ranged from about 0 percent of estimated claims costs to about 13 percent. The State ended the Fiscal Year 2010 plan year with a reserve of $16.8 million, or about 13 percent of projected claim costs for the plan year. The Department funded the State's premium stabilization reserve, in part, through premiums collected in excess of claims costs. In addition, during Fiscal Years 2006 through 2009 the Department charged employees participating in the State's self-funded plans a "PSR" fee that was added to their monthly premiums. The PSR fee ranged from $0 to an estimated $36 per employee per month during these four years. The Department temporarily discontinued the PSR fee for Fiscal Years 2010 and 2011.

Implementation of Self-Funding

We reviewed the Department's implementation of self-funding for the State's medical plans and found that overall the Department could improve the structure of its plans in several key areas to reduce costs for the State and its employees. Specifically, the Department has not structured the State's medical plans to ensure a sufficiently large and diverse risk pool. In addition, although the Department's use of stop loss insurance in conjunction with the premium stabilization reserves has been necessary to mitigate the risk to the State of self-funding, it has also contributed to increases in premiums. As a result, the State has not realized the full cost-savings made possible by self-funding. We discuss issues related to the State's risk pool and stop loss insurance and the premium stabilization reserve in the next sections.

Risk Pool

The single most important factor in managing the risk of self-funding is to maintain a sufficiently large risk pool of plan participants representing a balance of lower- and higher-risk levels. We found, however, that while overall enrollment in the State's medical plans has increased by more than 4,000 employees since 2006, its self-funded pool—which currently includes only 49 percent of state employees enrolled in medical plans—has shrunk by more than 1,000 employees during the same period, and its demographics are not as favorable as the fully-insured plan. As discussed above, the State's risk pool includes only those employees enrolled in the State's self-funded PPO plans; those enrolled in the Kaiser HMO plans are currently not included in the State's risk pool because, as a fully-insured plan, Kaiser assumes all risk associated with the plans. For Fiscal Year 2011 only about 14,200 employees of the approximately 29,100 enrolled in medical plans subscribed to the State's PPO plans. This is a significantly smaller risk pool than existed when the State moved to self-funding in July 2005. As the following exhibit shows, since Fiscal Year 2006, when the State created its self-funded plans, participation in the State's fully-insured HMO plans has increased from 38 percent to 51 percent in Fiscal Year 2011. During this same time period enrollment in the self-funded PPO plans fell from 62 percent to 49 percent.

Exhibit 3: Number and Percentage of Medical Plan Enrollment By Fully-Insured and Self-Insured Plans Fiscal Years 2006 through 2011

Type of Plan	2006		2007 2		008		2009 2		010		2011	
Fully-insured	9,523	38%	9,314	38%	10,655	39%	11,889	42%	14,193	49%	14,942	51%
Self-Funded	15,294	62%	14,890	62%	16,637	61%	16,371	58%	14,606	51%	14,208	49%
Total	24,817	100%	24,204	100%	27,292	100%	28,260	100%	28,799	100%	29,150	100%

Source: Department of Personnel and Administration medical plan enrollment statistics.

In addition, employees enrolled in the State's self-funded PPO plans were found by the Department's actuary to reflect higher risk demographics than those in the fully-insured

HMO plans. This renders the self-funded risk pool more volatile and prone to catastrophic claims. An August 2009 assessment by the Department's independent actuary compared the demographic risk associated with employees enrolled in the State's self-funded plans with employees enrolled in the fully-insured plans. The actuary found that employees in the fully-insured HMO plans reflect lower risk demographics, including age, gender, and family size, than employees in the self-funded plans. Further, the actuary estimated that if the employees enrolled in the fully-insured plans were included in the State's self-funded risk pool, the overall cost of the self-funded plans would decrease by 2.3 percent, or about $2.3 million in Fiscal Year 2010 as a result of a change in demographics alone.

The volatility and decreased participation in the State's self-funded risk pool is due in part to the structure of the State's medical plans. The Colorado Office of the State Auditor's 2003 Audit of the Colorado Department of Personnel and Administration's Employee Benefits Program emphasized the potential significant risks of adverse selection if the State allowed both fully-insured and self-funded medical plans. The report stressed that the Department should take preventive actions if the State moved to self-funding to minimize the potential of adverse selection or significant reduction in the size of the State's risk pool. According to the report, these preventive actions could include risk-adjusting the Kaiser premiums, freezing enrollment in the Kaiser plans, or eliminating the Kaiser plan altogether. However, when the Department implemented self-funding in Fiscal Year 2006, it allowed the HMO plans to remain fully-insured and it did not take sufficient steps to offset the impact of this decision on the State's self-funded plans.

Further contributing to the decrease in the size of the State's self-funded risk pool is the manner in which the State designed its self-funded PPO plans as compared to its fully-insured HMO plans. As we will discuss further in Recommendation No. 3, the fully-insured HMO plans are in greater parity to HMO plans offered by other comparable employers than the State's PPO plans. Also, the State's PPO plans subject employees to significantly higher out-of-pocket costs than do the HMO plans. For example, the individual out-of-pocket maximums for the PPO plans are $3,000 and $5,000 compared with $1,000 for the HMO plans. At the same time, the HMO plan premiums are only about $180 per year more than the PPO plans. The significantly lower out-of-pocket costs required of the HMO plans likely contribute, at least in part, to more employees choosing the fully-insured HMO plans over the self-funded PPO plans, or what is known as adverse selection. This adverse selection has impacted the State's risk pool, and thus, increased the State's risks associated with self-funding.

The Department should structure the State's medical plans in a way to ensure that the State can maintain a sufficiently large risk pool with participants who represent a balance of low and high risk levels to mitigate the risks to the State of self-funding. To accomplish this, the Department should continue to evaluate options available to bring existing employees who are currently enrolled in a fully-insured HMO, or new employees, into the State's risk pool without negatively impacting the cost or quality of care for state plan participants. These options may include the following:

- Working with Kaiser to determine whether Kaiser would be willing to offer a self-funded HMO plan option in Colorado. Under this scenario, the State could contract with Kaiser to provide third-party administrator services, similar to the services provided by UnitedHealthcare for the PPO plans. While it is unclear whether Kaiser will offer medical plans under a self-funded model in Colorado, there are indications that Kaiser may be moving into the self-funded market. If Kaiser determines that it is not in its best interest to administer a self-funded plan for the State of Colorado, the State could offer its own self-funded HMO plan options.

- "Risk adjusting" Kaiser premiums to minimize adverse selection against the State's PPO plan options and increase the State's risk pool. Risk adjusting premiums—that is, incorporating into Kaiser premiums all costs incurred by the State as a result of offering Kaiser plans under a fully-insured model—is an appropriate method of offsetting the additional risk borne by the State. This load factor would go to the premium stabilization reserve. The State's decision to offer fully-insured HMO plan options creates an inherent risk to the State's overall plan design. It is reasonable that the State and all employees enrolled in state medical plans share in the risk of offering the breadth of plans offered by the State. Risk adjusting Kaiser premiums would serve one important purpose: it would ensure all state employees enrolled in a state medical plan participate in the overall risk pool regardless of which plan they enroll in.

- Freezing enrollment in the fully-insured HMO plans to current participants only. All current employees not enrolled in an HMO plan and all new employees would only have the option of enrolling in a self-funded PPO plan or, if the State chooses, a possible self-funded HMO plan. This would stop the migration of employees into fully-insured plans.

- Eliminating the fully-insured HMO plans altogether. If fully-insured plans are eliminated, then all participating employees would be enrolled in a self-funded plan and be part of the State's risk pool, and thus, mitigate the risk to the State of self-funding.

Recommendation No. 1:

The Department of Personnel and Administration should mitigate the risk to the State of self-funding by structuring the medical plans in a way to ensure that the State can maintain a sufficiently large risk pool with participants who represent diverse risk levels. To accomplish this, the Department should consider the options available to bring employees who are currently enrolled in a fully-insured Health Maintenance Organization (HMO) into the State's risk pool. These options may include:

- Working with the Kaiser Foundation Health Plan (Kaiser) to determine whether Kaiser would be willing to offer a self-funded HMO plan option in Colorado.

- Risk adjusting Kaiser premiums to minimize adverse selection against the State's PPO plan options and increase the State's risk pool.

- Freezing enrollment in the Kaiser HMO plans to current participants.

- Eliminating the fully-insured HMO plans altogether.

Department of Personnel and Administration Response:

Agree. Implementation date: July 1, 2011.

The Department is cognizant of the need to manage the self-funded risk pool. Historically, the Department has monitored the risk pool, examined trends, and adjusted plan designs in an effort to mitigate adverse selection with the fully-insured plans to the degree possible. In fact, the evaluation committee for the State's health plans Request for Proposals determined to award both the self-funded third-party administrator contract to UnitedHealthcare and the fully-insured contract to Kaiser "contingent upon the use of strategies, including risk adjustment and plan design within the self-funded plan to mitigate any negative effect on the self-funded plan by co-existing with Kaiser." The option of risk adjusting the fully-insured premiums was considered last year but ultimately not implemented as it was determined to not be necessary given the selected plan designs. The Department will continue to evaluate all options to best manage the self-funded risk pool.

Stop Loss Insurance and Premium Stabilization Reserve

As discussed above, stop loss insurance and premium stabilization reserves can be used individually or in conjunction with one another to manage the risk of self-funding, which is the risk that the State will not collect enough in premiums to cover all employee health care claims. Stop loss insurance and premium stabilization reserves are designed to mitigate this risk in different ways. Specific stop loss insurance minimizes the impact of catastrophic claims on the Group Benefit Plans Reserve Fund's overall resources, while aggregate stop loss insurance and premium stabilization reserves ensure total plan costs do not create a liability that exceeds Fund resources. As noted previously, the State has not purchased aggregate stop loss insurance, but has opted instead to purchase specific stop loss insurance and maintain premium stabilization reserves. The cost of maintaining stop loss insurance and premium stabilization reserves ultimately impacts total premium costs paid by the State and its employees. Therefore, it is important that the State effectively manage both to keep premium costs down.

We reviewed the Department's use of stop loss insurance and the premium stabilization reserve to mitigate the risk to the State of self-funding. We found that the Department needs to reevaluate how it uses stop loss insurance in conjunction with the premium stabilization reserve to mitigate the State's risk that claims will exceed the Fund's

available balance. When the State first went to self-funding in July 2005, its premium stabilization reserve was not sufficient to absorb the impact of catastrophically large claims. As a result, the State purchased specific stop loss insurance with an attachment point of $50,000 per participant, essentially protecting the Fund against all large claims. As the State's reserve balance increased, the State increased its stop loss attachment point; in Fiscal Year 2011 the attachment point was set at $200,000 per participant. Purchasing specific stop loss coverage has proved, however, to be a costly method of mitigating the impact of excessive claims costs. According to the Department's internal assessment, specific stop loss coverage has cost the State approximately $55.1 million from Fiscal Year 2007 through Fiscal Year 2010. During this same period, the State's self-funded PPO plans recovered approximately $48.2 million from the specific stop loss coverage, resulting in a net cost to the State of $6.9 million.

The Department's decision to purchase specific stop loss insurance and build a premium stabilization reserve during the first years of self-funding appears appropriate and consistent with industry practice. However, with the State entering its sixth year of self-funding, the Department should reevaluate how it can mitigate the risk of self-funding while keeping premium costs down. Specifically, the Department should continue to consider how it can employ competitive procurement procedures to secure the best stop loss insurance plan at the lowest cost and reevaluate the cost-benefit of purchasing either specific or aggregate stop loss insurance, or both. If the Department continues to purchase specific stop loss insurance, it should continue increasing the stop loss attachment point as long as the State maintains sufficient premium stabilization reserve balances and demonstrates that it is increasingly able to absorb catastrophic claim costs. Finally, the Department should reconsider its approach to funding the premium stabilization reserve. We discuss each of these suggested approaches below.

- **Seek Competitive Proposals.** When recently procuring specific stop loss insurance, the Department included the insurance as part of the services to be provided by its third-party administrator, UnitedHealthcare, and did not solicit competitive proposals as a distinct scope of service from stop loss insurance carriers. As a general rule, employers should undergo competitive solicitation procedures for distinct services to ensure that they obtain the most competitive cost for those services.

  As discussed previously, for Fiscal Year 2011 the Department added nearly $40 per month to employee premiums to pay for specific stop loss insurance premiums. This fee applies only to employees enrolled in the State's self-funded PPO plans and not to employees enrolled in the State's fully-insured plans. According to a 2010 AEGIS Risk Medical Stop Loss Premium Survey, the average premium for specific stop loss insurance at a $200,000 attachment point (the same attachment point as the State) ranged between approximately $25 and $31. This means that the State may be paying as much as $15 more per employee per month for specific stop loss insurance than the average. If the $25 average premium amount was applied to the State, it would result in an estimated cost savings of about $2.6 million. This amount will vary based on the specific needs of each employer, including their specific risk pools and unlimited lifetime

maximum benefits. To provide the best and most affordable benefits for state employees, the Department should annually reevaluate whether it could obtain lower stop loss insurance premiums by seeking competitive proposals.

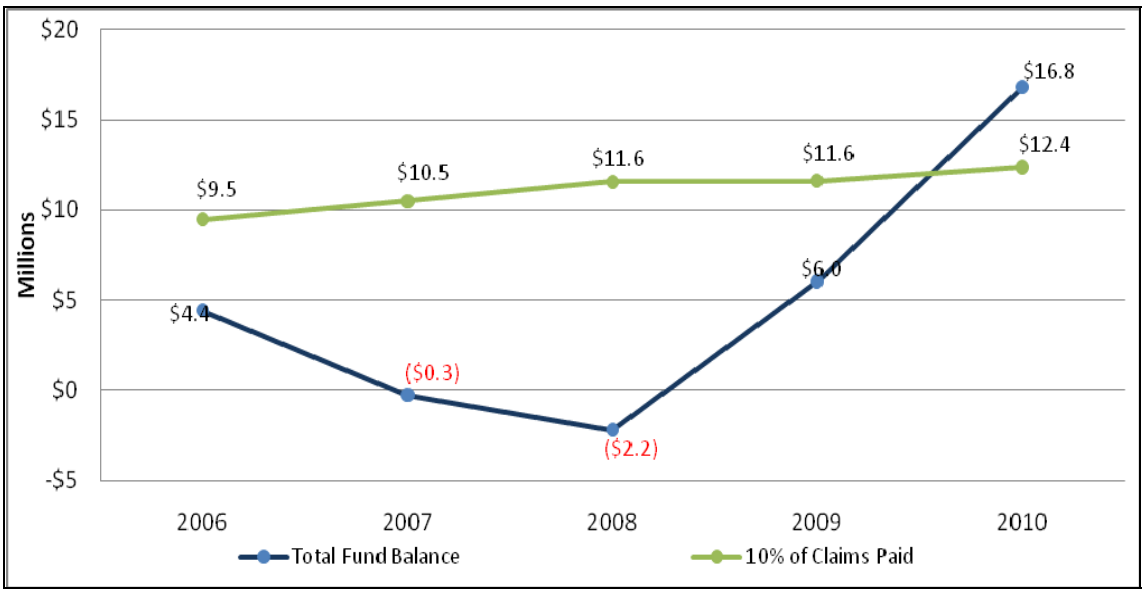
- **Increase the Specific Stop Loss Attachment Point and Consider Aggregate Stop Loss Insurance.** As discussed previously, specific stop loss insurance is designed to protect the Group Benefit Plans Reserve Fund by ensuring that individual catastrophic claims are not too large for the Fund to absorb. As the State's premium stabilization reserve increases, the State demonstrates that it can maintain a sufficient premium stabilization reserve over time, and the State's risk pool increases in size, the premium stabilization reserve will be able to absorb larger claims. When this occurs, the Department will be able to increase its specific stop loss attachment point, currently set at $200,000 per participant. This may result in lower premium costs for employees. For example, according to the 2010 AEGIS Risk Medical Stop Loss Premium Survey, the average premium amount for an attachment point of $500,000 would range from $8 to $11 per employee per month—a potentially considerable savings from the current premium of almost $40 per employee per month.

  Furthermore, if the State's premium stabilization reserve becomes sufficiently large to absorb the level of catastrophic claims observed over time in the State's risk pool, specific stop loss insurance may no longer be needed at all. The Department may be able to purchase aggregate stop loss insurance to ensure that aggregate claim costs do not exceed available premium funding and premium stabilization reserve levels. The per employee per month cost for aggregate stop loss coverage is often lower than for specific stop loss coverage. However, as mentioned previously, if the State increases its specific stop loss attachment point and/or adds aggregate stop loss insurance it may need to maintain larger premium stabilization reserves. The actual cost-savings and required reserve amounts will depend both on actuarial assessments of the State's specific risk pool and soliciting competitive premium rates from multiple carriers. Industry best practices suggest that by a plan sponsor's fifth year of self-funding, there should be sufficient reserves to eliminate or significantly reduce specific stop loss coverage. Therefore, the Department should continue to annually monitor its premium stabilization reserve and when reserves are sufficient, it should consider the cost-benefit of purchasing aggregate stop loss insurance in lieu of or in combination with specific stop loss insurance.

- **Fund the Premium Stabilization Reserve.** Maintaining an adequate premium stabilization reserve balance is key to the State's ability to manage the risk of self-funding. Maintaining an adequate reserve is also crucial to raising or, if possible, eliminating attachment points. While industry standards suggest reserve balances could range between 5 percent and 30 percent of projected claim costs, the actual reserve should be based on the employer's specific risk pool and the type of stop loss coverage purchased. For large employers like the State, a typical benchmark for an adequate reserve threshold is at least 10 percent of projected claim costs for

the year, or approximately 25 percent for aggregate stop loss coverage. During the first four years of self-funding, the State was not able to maintain an adequate reserve balance to mitigate the risk of managing a self-funded plan, as illustrated in the following exhibit. Only for the past year, Fiscal Year 2010, has the State's premium stabilization reserve balance exceeded the recommended 10 percent minimum threshold.

Exhibit 4: Premium Stabilization Reserve Fund Balances
Fiscal Year 2006 through Fiscal Year 2010 (In Millions)



Source: Department of Personnel and Administration-generated Trial Balances for the State's accounting system, COFRS, for Funds 91e and 91s (Group Benefit Plans Reserve Fund), for Fiscal Years 2006 through 2010.

Fluctuations in the reserve balance are expected as actual claims costs will vary from projections, resulting in the potential that premiums collected may not cover the cost of claims. Because of this, the goal for a self-funded plan should be to consistently maintain reserves at a sufficient level to ensure the stability of the plan. PSR fees are typically included in plan premiums until an employer is able to consistently maintain adequate reserves over several years. As noted previously, from Fiscal Year 2006 to Fiscal Year 2009 the Department included a PSR fee in the monthly premiums charged to employees participating in the State's self-funded PPO plans. The Department discontinued this fee for Fiscal Years 2010 and 2011 because its projections showed there would be adequate reserves for the upcoming plan years. However, the State's premium stabilization reserve exceeded the recommended 10 percent minimum threshold only at the end of Fiscal Year 2010, which was not a sufficient amount of time to justify eliminating the PSR fee. If the amount of claims filed had exceeded the Department's projections, the premium stabilization reserve could have been reduced to insufficient levels. Without the PSR fee there would have been no

way to replenish the fund balance. This could have resulted in the State not having sufficient funds to pay claims and administrative costs for the year. Until the State has been able to consistently maintain an adequate premium stabilization reserve fund balance over several years, the Department should continue to charge a minimum PSR fee.

Recommendation No. 2:

The Department of Personnel and Administration should take steps to improve its use of stop loss insurance in conjunction with the premium stabilization reserve to mitigate the risk to the State of self-funding. This should include:

a. Continuing to reevaluate annually whether to purchase specific or aggregate stop loss coverage, or both; whether to increase the attachment point for stop loss insurance as appropriate; and whether to seek competitive proposals for stop loss insurance.

b. Continuing to fund the premium stabilization reserve until the State is able to maintain a sufficient balance of at least 10 percent of projected claims costs over a period of several years.

Department of Personnel and Administration Response:

Agree. Implementation date: Ongoing.

The Department will continue its annual evaluation of stop loss insurance for the self-funded medical plan options. As an example, the Department has increased the attachment point since initiating self-funding from $50,000 to $200,000 as the premium stabilization reserve has grown. When the State changed to self-funding, specific stop loss coverage was determined to be the most prudent option for initial self-funding. We believe specific stop loss coverage continues to be appropriate at this time. As noted by the auditor, if the decision is made to purchase aggregate stop loss coverage, which should have a lower premium, larger reserves will be required to protect the plan. The Department will continue to evaluate the premium stabilization reserve (PSR) to ensure an adequate reserve is maintained based upon the type and amount of stop loss insurance in place.

Plan Benefits and Costs

As mentioned previously, statutes establish that the State's policy is to provide prevailing total compensation to employees to ensure the recruitment, motivation, and retention of a qualified and competent work force [Section 24-50-104(1), C.R.S.]. Group benefits are one component of the State's total compensation package, with medical benefits being the most important to employees. The impact of medical expenses and benefits on

employee families and their finances can be significant. According to statute, providing benefits, including medical benefits, similar to those commonly provided by private and public employers, and providing each employee with benefit choices and the education needed to customize a benefit package that meets the employee's needs is intended to enable the State to attract and retain qualified employees [Section 24-50-602 and Section 24-50-104(4), C.R.S.].

As discussed in Chapter 1, the State provides employees with PPO and HMO medical plan options—including standard health plans with copays, coinsurance, and deductible requirements, and "high-deductible" Health Savings Account-eligible plans that require plan members to pay the full cost of medical care until the deductible is reached, and a percentage of medical costs thereafter. All of the State's medical plans provide the same types of benefits. For example, all of the plans provide for:

- Preventive services
- Inpatient hospitalization services
- Primary and specialty doctor visits
- Laboratory services
- X-rays
- Emergency room services
- Urgent care services
- Prescription drugs

However, the cost of the benefits provided by the State's medical plans varies depending on the specific plan. There are essentially two types of costs associated with all of the State's medical plans. The first is the cost of premiums. A premium is the charge for providing medical coverage to an individual or family. Premiums are set by the insurer at an amount that is designed to cover the cost of claims submitted by healthcare providers, the cost of administering and processing the claims, as well as other administrative and overhead costs. For the State's self-funded PPO plans, the State sets the premium amounts; for the State's fully-insured HMO plans, Kaiser sets the premium amounts. Generally, both the employer and employee pay a portion of the cost of monthly premiums. In Colorado for Fiscal Year 2011 the State is paying a fixed amount equal to 95 percent of the average dollar amount contributed by other comparable employers and the employee contributes the remaining amount to meet the full premium cost. The State contributes the same dollar amount toward premium costs for each plan within each enrollment tier. However, the dollar amount and the portion of the State's contribution to the cost of monthly premiums varies depending on the enrollment tier selected by the employee (i.e., employee only, employee plus spouse, employee plus child(ren), or family) because premium costs differ for each tier.

The second type of cost is "out-of-pocket" costs. Out-of-pocket costs are those costs that employees are required to pay in addition to premiums. Out-of-pocket costs typically include the following:

- **Copays**—A copay is a fixed dollar amount that employees must pay each time they use a service provided by their plan. Copay amounts vary depending on a specific plan and type of service. In Colorado for Fiscal Year 2011, copays for services other than prescription drugs range from $10 for an annual physical exam to $1,000 for inpatient hospital care.
- **Deductibles**—A deductible is a base amount of health fees that must be paid by an employee before the plan will pay most expenses. Deductible amounts vary depending on a specific plan. In Colorado for Fiscal Year 2011, individual deductibles range from $0 for the HMO plans to $1,500 for the PPO plans.
- **Coinsurance**—Coinsurance is a fixed percentage of the cost of medical care that an employee must pay after the deductible has been met. For example, once any deductible has been met, an employee may be responsible for paying 20 percent of the cost of a service and the plan would pay 80 percent. In Colorado for Fiscal Year 2011, employee coinsurance rates range from 0 percent for the HMO plans to 20 percent for some services provided by the PPO plans.

There is an inverse relationship between premium costs and out-of-pocket costs. Lower premiums typically require higher out-of-pocket costs, and vice versa. Striking the best balance between overall premium costs and employee out-of-pocket costs is a persistent challenge for benefit plan administrators.

We compared the type and cost of medical benefits provided by the State to its employees with the benefits provided by other comparable employers. We surveyed 12 similarly situated states, in terms of size and geographic proximity to Colorado, and 10 similarly situated local employers, including two cities, five counties, and three private employers. We refer to these employers as "benchmark employers." In addition, we reviewed published market surveys of public and private employers within Colorado, as well as regional and national surveys and data compiled by the Federal Bureau of Labor Statistics.

Overall, the type of medical benefits provided by the State are similar to those provided by benchmark employers. All of the benchmark employers offer the same array of services listed above. However, we found that Colorado state employees contribute more toward the cost of their medical plans than do employees of the benchmark employers. In fact, state employees pay a greater percentage of overall premium costs than do employees of benchmark employers. Additionally, employees enrolled in the State's PPO plans are subjected to significantly higher out-of-pocket cost provisions in certain key areas than employees enrolled in similar plans offered by benchmark employers. These issues are discussed further in the following sections.

Premium Costs

A premium is the charge for providing medical coverage to an individual or family, and generally both the employer and employee pay for a portion of the cost of monthly premiums. We found that the State contributes less of the total percentage of medical plan premiums than benchmark employers. As discussed previously, the State

contributes a fixed percentage—currently set at 95 percent, including the standard 90 percent state contribution and additional one-time contributions for Fiscal Year 2011—of the average *dollar amount* contributed by other comparable employers. In doing so, the State has historically not based its contribution on the *percentage* of total premium costs paid by other comparable employers—or, employee-employer cost-split. As a result, Colorado state employees contribute more to the cost of care than do employees of benchmark employers, either by contributing a higher percentage of premium costs or paying more in out-of-pocket costs. As illustrated in the following exhibit, in all tiers and for both types of plans, the State's percentage of premium contributions is less than the average of our benchmark employers. In fact, the State contributes less than any of our benchmark employers for premiums for the "employee plus spouse" and "family" tiers of the PPO plans.

Exhibit 5: Percentage of Total Medical Premium Costs[1] Paid by Employer By Enrollment Tier Fiscal Year 2011

Type of Plan	Employee Only		Employee plus Spouse		Employee plus Child(ren)		Family	
	Colorado	Average	Colorado	Average	Colorado	Average	Colorado	Average
PPO	81.3%	88.9%	62.8%	86.3%	81.1%	86.8%	67.6%	85.9%
HMO	78.6%	89.1%	60.7%	82.3%	78.4%	83.4%	65.4%	81.6%

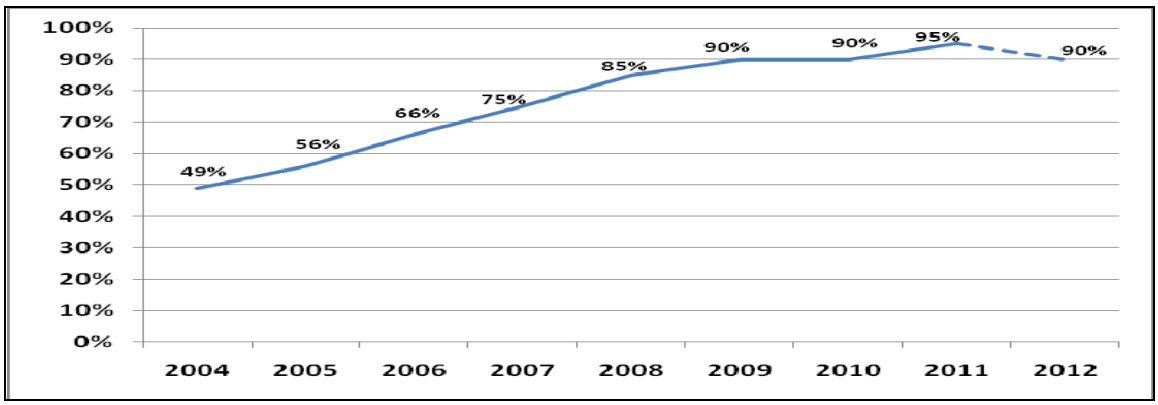
Source: Sjoberg Evashenk Consulting's analysis of State of Colorado plan documents and plan documents issued by benchmark employers.

[1] Total medical premium costs include both the employer and employee share.

The amount the State actually contributes toward premiums each year is determined by the General Assembly, based on available funding and recommendations made by the State Personnel Director through the Department's annual compensation survey. During the annual compensation survey process, the Department collects information on comparable employer contributions to the cost of medical coverage based on each tier of coverage (e.g., employee only, employee plus spouse, employee plus child(ren), and family). The State does not differentiate contribution levels based on the medical plan selected or whether employees select self-funded or fully-insured plans.

With respect to the *dollar amount* contributed, the State's contribution level to medical premiums has increased substantially over the past eight years—from 49 percent of the average dollar amount contributed by other employers in Fiscal Year 2004 to 95 percent (including additional one-time funding) in Fiscal Year 2011, as shown in Exhibit 6.

Exhibit 6: State's Contribution Levels as a Percentage of Dollar Value Comparable Employers Contribute to Plan Premiums Fiscal Years 2004 through 2012



Source: Sjoberg Evashenk Consulting's analysis of Department of Personnel and Administration records, rate development worksheets, and annual compensation reports.

The State's primary goal for premiums, as set forth in the Department's Annual Compensation Survey, has been to contribute 100 percent of the average dollar amount contributed by other comparable employers; however, due to fiscal constraints, the State has not yet reached its goal. In Fiscal Years 2009 and 2010, the State's contribution level remained constant at 90 percent. Although the State's contribution level increased to 95 percent in Fiscal Year 2011, as mentioned previously, this was due to one-time additional funding. The State Personnel Director has recommended that state contributions go back to the equivalent of 90 percent for Fiscal Year 2012.

When the State's contribution to premiums is less than what other comparable employers contribute, state employees end up paying a greater share of premiums for similar plans than employees in other organizations. Further, since the State contributes a fixed dollar amount and employees pay the remaining amount to reach the full premium, if the cost of the full premium increases, employees must cover the additional costs. This includes cost increases resulting from inefficiencies in plan administration and lax cost controls, both of which are discussed further in Chapter 3.

To address the impact of state contributions on the employee-employer cost split identified in Exhibit 5, the Department's Fiscal Year 2010 Annual Compensation Survey report for the upcoming 2011-2012 plan year has incorporated an evaluation of the percentage of premium contributions shared by the employer and the employee (i.e., the "cost-split") into its recommendations for state contribution levels. By adding this element, the State will be able to evaluate how both the State's dollar and percentage contribution to benefits compares with benchmark employers. This is consistent with the State's total compensation philosophy, which is to provide prevailing compensation and benefits.

Employee Out-of-Pocket Costs

Out-of-pocket costs are those costs that employees are required to pay in addition to premiums and typically include copays, deductibles, and coinsurance. We compared out-of-pocket costs for employees enrolled in the State's medical plans with out-of-pocket costs for employees of other organizations. We found that while out-of-pocket costs for employees enrolled in the State's HMO plans are comparable to those costs paid by employees of other organizations, state employees enrolled in PPO plans are subject to significantly higher out-of-pocket cost provisions than employees in other organizations.

We conducted two separate analyses. First, we reviewed performance reports provided by the State's previous third-party administrator, Great-West/CIGNA, for the Fiscal Year 2008 through 2010 plan years. These reports include information specific to Colorado on the out-of-pocket costs incurred by all employees as well as normative rates based on Great-West/CIGNA's overall book of business. Normative rates are the average of the rates for all of the plans administered by a carrier. Normative rates can be useful to assess how one plan—in this case, the State's PPO plans—compares with other plans administered by the same carrier. As the following exhibit shows, in each of the three years reviewed, Colorado state employees enrolled in the State's self-funded PPO plans were required to pay a greater portion of their total medical costs than employees in other plans administered by Great-West/CIGNA.

Exhibit 7: Comparison of Total Benefit Costs[1] Paid by Plan and by Member

	Great-West/ CIGNA Normative	State Self-Funded PPO Plans		
		FY 2008	FY 2009	FY 2010
Amount Paid by Employee	15%	22.6%	23.8%	21.1%
Amount Paid by Plan	85%	77.4%	76.2%	78.9%

Source: Great-West/CIGNA performance reports for Plan Years 2008 through 2010.
[1] Total benefit costs includes out-of-pocket costs.

Second, we compared plan provisions related to out-of-pocket costs for the State's PPO plans with provisions for PPO plans offered by our benchmark employers. We found that in several key areas employees in the State's PPO plans pay significantly higher out-of-pocket costs than employees of benchmark employers. For example, as the following exhibit shows, the $5,000 individual out-of-pocket maximum for employees in one of the State's PPO plans is at least $500 more than the highest individual out-of-pocket maximum required by benchmark employers. The difference is most pronounced between the State's PPO plans and local employers, where the highest individual out-of-pocket maximum is $3,000.

Exhibit 8: Comparison of Key Out-of-Pocket Costs for State of Colorado PPOs and Benchmark Local Employers and States Fiscal Year 2011 Plan Year			
	State of Colorado PPOs	**Benchmark Local Employers**	**Benchmark States**
Individual Out-Of-Pocket Maximum	$3,000/$5,000	$1,500 - $3,000	$1,000 - $4,500
Individual Deductible	$1,500	$0 - $1,000	$0 - $2,500
Inpatient Copay	$1,000	$125 - $300	$75 - $600
Urgent Care Copay/Coinsurance	$75 copay 20% coinsurance	$25 - $100	$35 - $45
Emergency Room Copay/Coinsurance	Subject to deductible, 20% thereafter	$70 - $150 copay, 15% - 25% thereafter	$100 - $300
Source: Sjoberg Evashenk Consulting's analysis of State of Colorado plan documents and plan documents issued by benchmark employers.			

The disparity between the State's PPO plans and those offered by other employers means state employees enrolled in the self-funded plans are potentially subjected to more out-of-pocket costs than employees of other organizations. This could significantly impact the State's ability to recruit and retain highly qualified individuals, particularly those with health concerns that require heavy use of employer-sponsored medical plans. In addition, the higher out-of-pocket costs for employees in the State's PPO plans may be reducing the State's self-funded risk pool, which increases the risks to the State of self-funding, as discussed in Recommendation No. 1. The fact that the State's PPO plans have significantly higher out-of-pocket costs is likely a contributing factor to why more employees are enrolling in the State's HMO plans instead of the PPO plans.

Impact of Costs on Enrollment

The cost of the State's medical plans to employees has a direct impact on employee enrollment in the plans. The State's most recent *Classified Employees Compensation & Benefits Survey*, issued in 2008, included responses from about 10,400 of the 33,000 state classified employees at that time—a response rate of 31 percent—and found that for employees, the most significant factor when choosing a particular state medical plan was first, the cost of employee monthly contributions to premiums and second, employee out-of-pocket costs. As the State's contribution to medical plans has increased in recent years, so has employee enrollment in the plans. Employee enrollment has increased from 67 percent in Fiscal Year 2003 to 76 percent in June 2010. However, the State's employee participation rate continues to remain below comparable organizations. As the following exhibit illustrates, average enrollment rates typically exceed 80 percent for our benchmark employers as well as employees in public administration, large (500 or more employees) organizations, and other state government agencies, according to the Federal Bureau of Labor Statistics.

Exhibit 9: State Employee Medical Plan Enrollment Rates Compared with National Trends	
Organization	**Enrollment Rate**
Colorado State Government	76%
Benchmark Employers	92%-97%
Other Type of Employer	
Public Administration	86%
500 Employees or More	82%
State Government	87%

Source: Sjoberg Evashenk Consulting's analysis of Department of Personnel and Administration, benchmark, and Federal Bureau of Labor Statistics data.

According to the *Classified Employees Compensation & Benefits Survey* discussed above, about 66 percent (6,600) of the approximately 10,000 state employees who are not enrolled in the State's medical plans have health insurance through another source (e.g., spouse's employer). Of the remaining 34 percent, 24 percent did not enroll in state medical plans because the plans were too expensive and the remaining 10 percent did not enroll for other reasons.

Employees and prospective employees heavily weigh premium and potential out-of-pocket costs when assessing the value of benefit plans. High employee benefit costs are generally a disincentive to enrollment and can have a negative impact on the State's ability to recruit and retain qualified individuals.

Modifications to Plan Design

To maintain competitive benefit plans, the State, like comparable employers, must strike a balance between premiums and out-of-pocket costs required of their employees. The Department has chosen to offer its HMO plans with competitive premiums and low out-of-pocket costs. Conversely, for the State's PPO plans, the Department has opted to maintain employee premium shares at a competitive level while requiring significantly higher out-of-pocket costs. The Department's approach to setting premium amounts and out-of-pocket costs for the State's HMO and PPO plans negatively impacts the Group Benefit Plans Reserve Fund in two ways.

First, by offering very competitive fully-insured HMO plans and less competitive self-funded PPO plans, the Department is increasing the likelihood that adverse selection will occur and employees will opt out of the self-funded PPO plans in favor of the fully-insured HMO plans. The HMO plans require employees to contribute minimally higher premium costs than the PPO plans—a difference of approximately $15 per month or $180 per year—and potentially much lower out-of-pocket costs. As discussed previously, adverse selection reduces the State's self-funded risk pool, thus increasing the risk to the State. If the State's self-funded risk pool is not sufficiently large and made up

of participants representing both lower- and higher-risk demographics, there is an increased likelihood that claims will exceed the premiums collected.

Second, the Department's design of the State's two PPO plans encourages employees to choose the plan with lower employee premium amounts. The Choice Plus Definity PPO plan has significantly lower employee premium costs for all enrollment tiers and lower individual and family out-of-pocket maximums than the Choice Plus PPO plan. In addition, the in-network individual and family deductibles are the same for both PPO plans. The Choice Plus Definity Plan generally requires plan members to pay the full cost of care for all services, with the exception of preventive services, until the deductible is reached. However, the lower premiums and out-of-pocket maximums make the plan more attractive to some employees than the Choice Plus Plan. For higher-risk employees, the Choice Plus Definity Plan may be less costly in the long term than the Choice Plus Plan. This is because employees only have to pay $3,000 before reaching the out-of-pocket maximum in the Choice Plus Definity Plan, compared with $5,000 for the Choice Plus Plan. We believe that this plan design increases the risk that the Choice Plus Definity Plan could be more costly to the State and the Group Benefit Plans Reserve Fund than the Choice Plus Plan because the low premiums with the Definity Plan may potentially not cover the claim costs incurred by these individuals. The following exhibit compares the employee premium amounts for each enrollment tier, and individual and family deductibles and out-of-pocket maximums for the State's two PPO plans.

Exhibit 10: Comparison of Employee Share of Premium Costs and Key Provisions for the State PPO Plans Fiscal Year 2011

	Colorado "Choice Plus" PPO	Colorado "Choice Plus Definity" PPO
Employee Share of Premium Costs		
Employee Only	$69	$7
Employee plus Spouse	$335	$199
Employee plus Child(ren)	$125	$13
Family	$391	$205
Key Provisions	**Network/ Non-Network**	**Network/ Non-Network**
Individual Deductible	$1,500/$3,000	$1,500/$4,500
Family Deductible	$3,000/$6,000	$3,000/$9,000
Individual Out-of- Pocket Maximum	$5,000/$10,000	$3,000/$6,000
Family Out-of-Pocket Maximum	$10,000/$20,000	$6,000/$18,000

Source: Sjoberg Evashenk Consulting's analysis of State PPO Choice Plus and Choice Plus Definity plan documents.

Striking the right balance between out-of-pocket costs and premium costs is essential to providing competitive group benefit plans at the lowest possible cost to employees and the State. As illustrated above, not only are the State's PPO plans not competitive with other employers' PPO plans in terms of out-of-pocket costs, but their design may contribute to adverse selection and overall increased plan costs. Lowering out-of-pocket costs borne by employees must be a priority for the State. There are steps that the Department can take to reduce overall plan costs and incrementally bring the State's medical plan offerings more in line with those offered by comparable employers, thus increasing the competitiveness of the State's plans. These steps include:

- Changing certain HMO benefit elements that would not affect the competitiveness or comparability of the plans but would reduce premium costs and bring out-of-pocket costs more in line with the PPO plans and decrease the risk of adverse selection (assuming the implementation of Recommendation No. 1). These changes include:
    - Increasing the out-of-pocket maximum from the current $1,000 to a higher amount, $1,500 or $2,000;
    - Increasing the copay for non-formulary prescription drug benefits;
    - Increasing the individual deductible amount to be more consistent with other employers.
- Lowering the "Choice Plus" PPO plan out-of-pocket maximum and deductible provisions to a level equal to or lower than the level of the "Choice Plus Definity" PPO plan levels.
- Lowering PPO copay, coinsurance, and deductible provisions to be more consistent with other employers.

Although these changes would significantly decrease out-of-pocket costs for many PPO plan participants, they would also likely result in a modest increase in overall premium costs. We recognize that unless the State increases its contribution to premiums, these increases will be borne by employees, which may offset the benefit that plan participants receive from lower out-of-pocket costs. However, rather than placing the additional premium costs on employees, the State could use savings identified through the recommendations identified in this report to increase its contribution to premiums. Throughout this report we make recommendations, which, if implemented, will result in potential cost-savings to the State of approximately $16.7 million annually. For example, as discussed in Recommendation No. 4, the State could save as much as $4.4 million annually by implementing minimum work requirements for part-time employees to be eligible for a state contribution to benefits and pro-rating the State's contribution amount for these employees based on the number of hours worked. In addition, as discussed in Recommendation No. 6, the State could potentially save up to $8.4 million each year in premiums, claims, and administrative costs by identifying and discontinuing benefits for ineligible dependents. If these recommendations are implemented and cost-savings are realized, the State could use these savings to bring the State's contribution to medical benefits and plan provisions more in-line with benchmark employers without increasing the State's overall contribution to employee benefit plans. However, the General

Assembly would have to approve the use of these cost-savings to increase the State's share of premiums.

Recommendation No. 3:

The Department of Personnel and Administration should continue to evaluate the plan design of the State's Preferred Provider Organization (PPO) and Health Maintenance Organization (HMO) plans to identify opportunities to incrementally reduce employee out-of-pockets costs. Opportunities may include:

a. Increasing some HMO out-of-pocket costs to be more consistent with comparable plans and the State's PPO plans, in conjunction with implementation of Recommendation No. 1.

b. Adjusting PPO copay, coinsurance, and deductible provisions to be more consistent with comparable employer offerings.

c. Decreasing "Choice Plus" PPO plan deductibles and out-of-pocket maximums to a level equal to or lower than the "Choice Plus Definity" PPO plan.

As appropriate, the Department should make recommendations to the General Assembly that cost-savings realized from implementing the recommendations in this report be used to increase the State's contribution to benefits.

Department of Personnel and Administration Response:

Agree. Implementation date: Ongoing.

The Department will continue adjusting plan designs in an effort to reduce employee out-of-pocket expenses and to be more consistent with comparable employers. It is important to understand the critical role funding plays in being able to improve plan designs while keeping costs affordable for both the State and employees. In other words, all adjustments in design will cost. Similarly, any reduction in out-of-pocket costs can shift those costs to higher premiums. For a number of years, the Department's total compensation strategy, as well as the annual compensation survey reports, has recognized that the State's medical plan lags the market of comparable employers in both employer contribution and design related to out-of-pocket costs. Both aspects must be addressed, but it is a matter of funding. Historically, the priority was to close the gap in employer contributions before significantly addressing the costs associated with plan designs so affordability would not be negatively impacted. The Department began reporting on cost sharing in the annual compensation report and letter for Fiscal Year 2012. The Department will continue to measure both premium and out-of-pocket costs in developing recommendations for state contributions. We will also continue to pursue value-based designs to ensure a balance in quality and cost that avoids unintended consequences such as overuse of certain services. As

noted by the auditor, some increased costs to the State can be offset by applying the savings from measures such as a dependent eligibility audit and pro-rated state contributions to part-time employees. The Department will evaluate such opportunities and the application of cost-savings to improve state contributions for the consideration of the General Assembly to the extent possible. Finally, it is important to understand that this is an incremental process that occurs over a number of plan years.

Part-Time Employees

The State Employee Group Benefits Act (Act) provides that, in general, all employees under the state personnel system, as well as employees within the legislative and judicial branches, and all elected or appointed officials are eligible for each of the State's group benefits [Section 24-50-603(7), C.R.S.]. Additionally, statute [Section 24-50-604(3), C.R.S.] grants the State Personnel Director the authority to adopt procedures to determine benefit eligibility requirements and the percentage of the state contribution to health benefits for all employees who work less than full-time and who were hired on or after January 1, 2005. According to State Personnel Rules and the State Plan Document for group benefits, to be eligible for the State's group benefits, an employee must fall into one of the statutory groups discussed above and be employed on a full-time or part-time basis, working the normal hours set by the employer. Department policy states that employees must work only a minimum of one regular work day per month to be eligible for the state contribution for benefits; the policy does not specify a minimum number of hours for that work day. Statute [Section 24-50-609(2)(b)(I), C.R.S.] requires the State to contribute the same amount toward benefits for all eligible employees, regardless of whether they are part-time or full-time employees.

We reviewed the percentage of full-time and part-time employees enrolled in the State's medical and dental plans and displayed the results in the following exhibit. As the exhibit shows, approximately 5.3 percent of all employees enrolled in one of the State's medical plans are part-time and 5.6 percent of all employees enrolled in one of the State's dental plans are part-time.

Exhibit 11: Medical and Dental Plan Enrollment By FTE Percentage Fiscal Year 2010			
Plan	**Percentage FTE**	**Number of Employees Enrolled**	**Percentage**
Medical	**100% (full-time)**	27,190	94.7%
	99% - 75%	542	1.9%
	74% - 50%	556	1.9%
	49% - 25%	160	0.6%
	Less than 25%	262	0.9%
	Total	28,710	100%
Dental	**100% (full-time)**	28,579	94.4%
	99% - 75%	595	2.0%
	74% - 50%	633	2.1%
	49% - 25%	182	0.6%
	Less than 25%	287	0.9%
	Total	30,276	100%

Source: Department of Personnel and Administration-generated benefit plan enrollment statistics.

We reviewed the State's eligibility provisions and contribution amounts for part-time employees and found that the State's practices are more generous than other comparable employers. Specifically, we found that the State does not have minimum work requirements for employees to be eligible for the state contribution to benefits and the State contributes the same amount to benefits for part-time and full-time employees. Neither of these practices is consistent with the practices of comparable employers. Most of the other public sector employers we contacted require employees to work at least 20 hours per week (i.e., 0.5 FTE) to be eligible for employer benefit contributions. In the private sector, we found that employers generally require employees to work at least 32 hours per week (i.e., 0.8 FTE) to be eligible for employer contributions. However, as discussed above, Department policy requires that employees work only one regular work day per month to be eligible for state benefit contributions. The policy does not specify how many hours constitute a "regular work day." If the Department were to implement a policy requiring employees to work at least 20 hours per week to be eligible for a state contribution to medical benefits, we estimate that the State's benefit costs would decrease by about $2.6 million for Fiscal Year 2011.

We also found that the Department's policy on minimum work requirements does not specify how these requirements should be applied for seasonal employees. As a result, there are inconsistencies in how state agencies apply eligibility criteria for their seasonal employees. According to the Department, some agencies allow seasonal employees to utilize eight hours of accrued leave each month during the off-season to remain eligible for a state contribution for benefits in that month. Other agencies, however, do not provide their seasonal employees with this option and thus, their seasonal employees are only eligible for state contributions during the months they are working. Further, the Department reports that it cannot assess how agencies are applying eligibility provisions for part-time employees because state agencies do not always enter employee status (i.e.,

FTE percentage) in the various payroll systems used throughout the State in a consistent manner. Some agencies designate seasonal employees as "full-time" in the payroll system because they work full-time during a particular season, while other agencies designate these employees as "part-time" because they only work for part of the year. These full-time or part-time designations only impact eligibility determinations, not the calculation of pay.

In addition, we found that the State's policy of contributing the same amount to benefits for part-time employees as full-time employees is not consistent with other comparable employers. The majority of our benchmark employers prorate the employer's contribution to benefits based on the part-time status of the employee. For example, an employee who works 20 hours per week (i.e., 0.5 FTE) would receive 50 percent of the amount the state contributes to benefits for a full-time employee. In Colorado, however, employees who work only eight hours per month, for example, will receive the same state contribution toward their benefits as employees who work full-time. The Director's Letter that accompanied the Department's Fiscal Year 2011 Annual Compensation Survey included options for revising the State's policy of contributing the same amount toward benefits for part-time and full-time employees. One option presented in the letter was to prorate the state contribution amount for benefits based on the number of hours an employee works per week, which is consistent with the approach used by other comparable employers. If implemented, we estimate that the approach outlined in the Director's letter would reduce state benefit costs by approximately $4.4 million for Fiscal Year 2012. The following exhibit shows the proration schedule for this approach.

Exhibit 12: State Personnel Director's Proration Option for State Employee Benefits Contributions for Part-Time Employees

Employee Hours Worked Per Week	Prorated State Contribution as a Percentage of Total State Contribution
Less than 10 hours per week	0%
Between 10 and 20 hours per week	25% to 50%
Between 20 and 30 hours per week	50% to 75%
More than 30 hours per week	100%

Source: State Personnel Director's August 6, 2010, Annual Compensation Letter.

A part-time employee's status can be determined based on a monthly average of hours worked during a prior period or on actual hours worked during the payroll period in which employer contributions are deducted.

As discussed previously, statute requires the State to provide prevailing total compensation to its employees and to provide benefits that are comparable to those provided by private employers. However, the State's policies with respect to part-time employees' eligibility for state contributions and the amount of the state contribution exceed prevailing practice among comparable employers. Given the limited state

resources available to contribute to employee group benefit plans, funds invested toward paying full benefits for part-time employees should be redirected toward providing comparable benefits to full-time employees. The money the State could save by implementing minimum work requirements for employees to receive a state contribution and reducing the state contribution amount for part-time employees could be used to help bring the benefit levels for full-time employees up to prevailing rates.

The Department should continue to evaluate options for revising policies related to the State's contribution to health benefits for part-time employees. These options should include establishing minimum work requirements for part-time and seasonal employees to be eligible for state contributions to benefit plans and prorating the State's contribution to benefits for part-time employees. The Department should work with the General Assembly to pursue any necessary statutory changes. As noted previously, the State Personnel Director's authority to adopt procedures related to the State's contribution to benefits for part-time employees only applies to those employees hired on or after January 1, 2005. Statutory changes will be needed to implement changes for *all* current part-time employees. If the changes discussed above are implemented, the Department should also provide guidance to all state agencies on how to properly designate part-time and seasonal employees in the agencies' payroll systems to ensure that eligibility and contribution provisions are applied appropriately and consistently.

Recommendation No. 4:

The Department of Personnel and Administration should continue to evaluate options for revising policies related to the State's contribution to benefits for part-time employees, and work with the General Assembly to pursue any necessary statutory changes. These options should include:

a. Establishing minimum work requirements for determining eligibility for state contributions to benefits for part-time and seasonal employees.

b. Prorating the State's contribution to employee benefits based on the number of hours employees work during a week.

If the changes recommended in part (a) or (b) are implemented, the Department should provide guidance to all state agencies on how to designate part-time and seasonal employees in the agencies' payroll systems.

Department of Personnel and Administration Response:

Agree. Implementation date: July 1, 2011.

The Department will work with the General Assembly to evaluate options related to the State's contribution to health (medical and dental) benefits for part-time employees and on any necessary statutory changes. The Department will also

provide guidance to state agencies on the consistent designation of part-time and seasonal employees.

Leave

The State provides employees within the state personnel system with various types of leave benefits. These include annual, sick, holiday, bereavement, jury duty, military, injury, and administrative leave. With the exception of annual leave, all employees receive the same amount of leave regardless of their years of service with the State. For example, according to statute [Section 24-50-104(7), C.R.S.] no employee can earn more than 10 days of sick leave per year. However, the amount of annual leave an employee earns varies depending on how long the employee has been working for the State. According to State Personnel Rules, employees with:

- Up to 5 years of service earn 8 hours per month, or 12 days each year.
- Six to 10 years of service earn 10 hours per month, or 15 days each year.
- Eleven to 15 years of service earn 12 hours per month, or 18 days each year.
- Sixteen or more years of service earn 14 hours per month, or 21 days each year.

Annual, sick, and holiday leave benefits are prorated for part-time employees.

We reviewed the State's leave provisions along with those of the benchmark employers in our survey, and found that for most categories of leave, the State provides a benefit amount similar to the benchmark employers. However, we identified two areas where the State's leave policies are not consistent with other employers. First, we found that the State provides employees with fewer hours of sick leave each year than our benchmark employers. The benchmark employers we surveyed typically provide employees with 12 sick days per year, compared with the 10 days provided by the State.

Second, we found that the State's policy of providing employees with separate sick and annual leave is not consistent with a growing trend among employers. Many employers offer a pooled "paid time-off" benefit to their employees. Under this arrangement, most types of personal time off (e.g., annual leave, sick leave, and personal days) are pooled and accrued at a single rate and may be used for any leave purpose. How employees use the pooled time off is up to them. In other words, it does not matter whether an employee is sick, going on vacation, or just wants a day off for any reason, time from the single bank of leave is used. While not the prevailing practice among our benchmark employers, offering a pooled "paid time-off" benefit is a growing trend among employers, in lieu of separate leave allowances. One large local government that we surveyed recently implemented a pooled "paid time-off" program and requires all new hires to be part of the pooled plan, but allows existing employees the choice

of converting to the pooled system or remaining in the traditional system of separate leave allowances.

Because pooled-rates offer greater flexibility in usage and will likely be eligible for cash payment at some point, employers generally offer reduced accrual rates for pooled leave than those afforded when sick and vacation leave are accrued separately. The flexibility afforded to employees and the single benefit aspects of the program are generally viewed positively by both employees and employers. This flexibility provides employees with greater chances of using their accumulated leave during the year. For example, an employee who is rarely sick will have more leave available for other purposes under a pooled leave plan. Because pooled leave is generally viewed positively by employees, it is a benefit that employers can use to help attract and retain qualified and competent employees. It also reduces employers' need to monitor employees' use of sick leave.

Depending on the provisions adopted for administering a pooled leave plan, it may also offer a measure of cost containment. The effectiveness of cost savings is dependent upon existing policies regarding leave accrual, sick leave payout policies, and the manner in which the benefits are implemented. Ultimately, any potential cost savings resulting from a conversion to a "paid time-off" plan would be dependent upon whether the State's compensated absences liability is reduced during the conversion. Currently, the State is obligated to pay out 100 percent of annual leave up to the maximum accruals, upon an employee's death, retirement, or termination, and if the employee meets certain criteria, the State must also pay out 25 percent of unused sick leave. Generally, similar to annual leave, pooled leave allows a 100 percent payout upon death, retirement, or termination, but it can also be capped at certain maximum balances. In concept, long-term cost savings can be achieved by implementing a pooled leave program if the compensable programs' total "paid time-off" liability does not exceed the existing combined accrual amounts—up to 336 hours of annual leave and 90 hours of sick leave payout potential at retirement, for a total maximum accrual liability of 426 hours.

The Department attempted to implement a pooled "paid time-off" plan for state employees in 2007 and 2008 in response to a recommendation made by the Colorado Office of the State Auditor in its Performance Audit of the Department of Personnel and Administration's 2003 Annual Total Compensation Survey report. The Department developed a comprehensive plan for converting employees and their current leave balances to a pooled "paid time-off" leave system. According to the Department, it sought to strike a balance between reducing the State's compensated absences liability and providing additional flexibility in leave benefits to state employees when developing the plan. The plan established a "paid time-off" maximum accrual amount of 392 hours, to accommodate actual sick leave trends, which amounted to an average of 50 hours of sick leave taken per employee per year. While the State has been unsuccessful in implementing this plan, we believe the potential benefits of a "paid time-off" plan warrant further consideration by the State—whether it is the Department's existing plan or a newly devised plan.

Given the State's policy of providing prevailing total compensation to its employees and its goal of providing benefits that are comparable to those provided by private employers, the Department should evaluate the State's current leave policies and determine if adjustments are needed. Specifically, the Department should evaluate the State's sick leave accrual rate and determine if 10 days per year is consistent with comparable employers and determine the cost impact to the State of increasing employee sick days. On the basis of this evaluation, the Department should pursue any necessary statutory changes to employees' sick leave accrual rate. Additionally, the Department should continue to pursue a pooled "paid time-off" plan for state employees. Such a plan should ensure that employees who have accrued leave are able to retain existing leave balances after converting to a new plan. The Department should also consider giving current employees the option to continue to accrue leave under existing rules, or to opt into a "paid time-off" plan. However, if the State adopts a "paid time-off" policy, all new employees should be required to follow this plan.

Recommendation No. 5:

The Department of Personnel and Administration should evaluate the State's current leave policies compared with other comparable employers and determine if changes are needed. Specifically, the Department should:

a. Evaluate the State's sick leave accrual rate and determine if 10 days per year is consistent with comparable employers and the cost impact to the State of increasing the number of employee sick days. On the basis of this evaluation, the Department should pursue any necessary statutory changes to employees' sick leave accrual rate.

b. Continue to pursue a pooled "paid time-off" leave system for state employees that combines annual and sick leave into one leave pool, ensures increased flexibility and benefit to employees, and results in reduced compensated absences liability for the State.

Department of Personnel and Administration Response:

Agree. Implementation date: June 30, 2011.

The Department will continue to evaluate the sick leave accrual rate to determine if statutory change should be pursued as well as the potential implementation of a pooled "paid time-off" leave system.

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Administration and Oversight of Plan Costs
Chapter 3

The State's shift to self-funding requires it to exercise significant administrative oversight, which is typically not required for fully-insured plans. While fully-insured plans place the burden to control costs and increase profits on the insurance carrier, self-funding benefit plans places the full burden of controlling the cost of claims on the plan sponsor, such as the State. For self-funding to be successful, the plan sponsor, in this case the State, must have the administrative and oversight infrastructure in place to adequately control costs. This infrastructure should include establishing clear and comprehensive performance standards and reporting requirements for the third-party administrator. Once these performance standards and reporting requirements are in place, the plan sponsor must also implement routine procedures for reviewing and analyzing performance reports and the accuracy and effectiveness of the third-party administrator's claims processing. The plan sponsor should also verify the third-party administrator's compliance with contractual terms through independent claims and operational audits.

In this chapter we present our findings related to the Department's administration and oversight of state benefit plan costs. Overall, we found that the Department does not have the appropriate administrative and oversight infrastructure in place to adequately control the costs associated with self-funding. We identified areas where the Department needs to strengthen its administration and oversight of the State's self-funded plans to better ensure that these plans optimize their cost-saving potential. This includes enhancing internal controls to prevent enrollment of non-eligible individuals, ensuring accuracy and verification of State enrollment data, and adequately monitoring the third-party administrator through performance reports and audits. This chapter also discusses how the Department could potentially reduce costs to the State and employees by implementing a comprehensive wellness program.

Eligibility Verification

As discussed in Chapter 2, the State Employee Group Benefits Act (Act) provides that, in general, all employees under the state personnel system, employees within the legislative and judicial branches, and all elected or appointed officials are eligible for each of the State's group benefits [Section 24-50-603(7), C.R.S.]. According to Sections 24-50-603(5), 10-16-104(6.5), and 10-16-104.3, C.R.S., employees' dependents are also eligible for some state benefits. Statute defines eligible dependents to include:

- Spouse or domestic partner;
- Children, stepchildren, foster children, adopted children, or children placed for adoption, through the age of 19;

- An unmarried child through the age of 24, who is a full-time student, and for whom the employee is the major source of financial support or for whom the employee is directed by court order to provide coverage;

- An unmarried child of any age with a physical or mental disability and for whom the employee is the major source of financial support or for whom the employee is directed by court order to provide coverage; and

- An unmarried child under age 25, who is not a dependent as defined in Section 10-16-102, C.R.S., who has the same legal residence as the employee/parent OR is financially dependent upon the employee/parent.

The Department manages the employee enrollment process through an online enrollment system known as the Benefits Administration System (System) under a contract implemented in Fiscal Year 2007. During the annual open enrollment period, employees have full access to the System to enroll themselves and their dependents in the State's benefit plans. According to State Personnel Rule 11-7(G), agency benefits administrators are required to review pending actions, supporting documentation, and system reports in order to promptly approve elections, terminate coverage, investigate suspicious or questionable actions or data, correct errors, and verify continuing dependent eligibility. As such, employees must submit documentation to their benefits administrator to show that any dependents enrolled in one of the State's plans meet statutory eligibility criteria. Documentation may include items such as marriage certificates, birth certificates, or court orders. The Department relies on the agency benefits administrators to verify dependent eligibility before approving the dependent's enrollment and to scan the supporting documentation into the Benefits Administration System. When employees enroll in or make changes to their benefits outside of the annual open enrollment period, employees must demonstrate a "qualifying life event," such as marriage or birth of a child. Once an employee enters the enrollment change into the Benefits Administration System, his or her agency benefits administrator must review the change in the System and approve it before the change takes effect.

We reviewed the Department's benefits enrollment process and found that the Department's controls over this process are not adequate to ensure that only those individuals meeting statutory eligibility criteria are enrolled in the State's benefit plans. An effective enrollment system should ensure only legitimately eligible dependents are enrolled. For an employer the size of the State, this requires that employees provide documentation supporting their dependents' eligibility to their employer for review and approval at the time of enrollment. Under this approach, dependents cannot be enrolled in an employer's benefit plan unless they have been approved by the employer. In cases where this has not occurred, or to test whether such efforts have sufficiently controlled against ineligible participation, an employer could conduct a dependent eligibility audit of all dependents enrolled in a benefit plan. During the audit, employees are required to provide documentation to support their dependents' eligibility. These two approaches can be used in conjunction with one another. Once an eligibility audit has been conducted and eligibility has been verified for all current enrollees, an employer may only need to continue with the first approach of verifying eligibility prior to enrollment.

Conversely, an employer may opt to conduct periodic follow-up audits of dependents enrolled since the prior eligibility audit to ensure compliance with eligibility criteria.

We found that the Department has not fully implemented either of the verification approaches described above. Prior to January 2004, when the Department implemented online open enrollment, the enrollment process was paper-driven. Employees would submit written enrollment forms to their agency benefits administrator, who would scan and send the forms to a third-party administrator who entered the information into the state payroll system for payroll deductions, transmitted enrollment files to the insurance carriers, and forwarded a copy to the Department for recordkeeping. Employees were not asked to provide documentation to support their dependents' eligibility during open enrollment. However, employees were required to provide documentation to support mid-year changes to dependent benefit elections, and carriers typically required proof of full-time student status for adult children under 24 years of age. This means that the Department does not have complete documentation to support dependent eligibility for employees hired prior to January 2004. In addition, even though as of Fiscal Year 2007 employees are required to provide documentation to their agency benefits administrator to show that any dependents enrolled in a state benefit plan meet statutory eligibility criteria, the Department cannot ensure that employees and agency benefits administrators are complying with this requirement without reviewing every new enrollment file or by reviewing a sufficiently large sample. Finally, the Department has never conducted an eligibility audit of the employees and their dependents enrolled in a state benefit plan.

As a result of the lack of adequate controls over the enrollment process, the Department does not know if all of the individuals enrolled in the State's benefits plans meet statutory eligibility criteria. Eligibility audits conducted by other organizations have found that at least 2 percent to 5 percent of enrolled dependents are not eligible for benefits. If this is true in Colorado, it could mean that the State is paying as much as $8.4 million each year in premiums, administrative costs, and claims for ineligible dependents. The University of Colorado System recently completed an eligibility audit and found that nearly 1,000 dependents, or 5.6 percent of the dependents covered by the University, were ineligible. The University estimated that removing these individuals from the University's medical plans would save the University between $2 million and $4 million annually, or about 2 to 3 percent of its $120 million annual health care costs.

Regardless of whether an ineligible participant is enrolled in a self-funded or fully-insured plan, the State pays premiums and administrative fees based on the number of participants enrolled in the plan; thus, the State pays for each participant enrolled, eligible or ineligible. For example, as the following exhibit shows, the State pays an additional $246 per month in medical premiums for "spouses" in the "employee plus spouse" enrollment tier and $281 more per month in premiums for "children" in the "employee plus child" enrollment tier.

Exhibit 13: State Contribution Amounts for Medical Plans Fiscal Year 2011					
	Employee Only	**Employee + Spouse**	**Increment Increase**	**Employee + Child**	**Increment Increase**
State Contribution—Medical	$357	$603	$246	$638	$281
Source: Sjoberg Evashenk Consulting's analysis of Department of Personnel and Administration benefit data.					

In addition, for the self-funded plans, the State pays all claims costs. Therefore, all claims paid by the State on behalf of ineligible dependents that exceed the incremental amount paid by the employee in premiums are a loss to the State. With the State's contribution to benefits capped at a specific dollar amount, cost increases resulting from ineligible employees—whether through premium costs or claims costs—have a direct adverse impact on costs to employees.

The Department should implement sufficient controls over the enrollment process to ensure that only eligible dependents are enrolled in the State's benefits plans. First, the Department should ensure that all dependents currently enrolled in a state plan are eligible to receive benefits. This could be accomplished through an eligibility audit of all current enrollees that requires employees to provide documentation to verify their dependents' eligibility. The Department should consider contracting for this audit with a firm with the appropriate expertise. Going forward, the Department should continue to periodically conduct eligibility audits based on a sample of files.

Second, the Department should implement system controls in the Benefits Administration System that require benefit administrators to approve the documentation verifying dependent eligibility and to scan the documentation into the System before an employee's enrollment can be completed. Once eligibility for all current enrollees has been established through the audit, this system control would provide the Department with a way to ensure all new enrollees are eligible without having to review every enrollment file. Thereafter, audits could be conducted periodically based on a sampling of files.

Recommendation No. 6:

The Department of Personnel and Administration should implement sufficient controls over the benefit enrollment process to ensure that only eligible individuals participate in the State's benefit plans. These controls should include:

a. Conducting an eligibility audit for all individuals currently enrolled in the State's benefit plans. Once the initial audit is completed, the Department should continue to periodically conduct eligibility audits based on a sample of files.

b. Implementing system controls in the Benefits Administration System that require benefit administrators to scan and approve documentation verifying dependent eligibility before an employee's enrollment can be completed.

Department of Personnel and Administration Response:

Agree. Implementation date: June 30, 2011.

The Department is in the procurement process to contract with a third party to conduct an eligibility audit. The audit is anticipated to be conducted and concluded prior to the beginning of the next plan year, Fiscal Year 2012. In addition, the Department will implement improved controls around document verification, including requiring that proper documentation be approved and scanned into the Benefits Administration System.

Enrollment Data

In addition to verifying eligibility, it is also important that the Department ensure that current and accurate enrollment data are used for payroll purposes and to pay premiums to insurance carriers for fully-insured plans and administrative fees to third-party administrators for self-funded plans. When an employee enrolls in the State's benefit plans, the State withholds the employee's share of premiums from his or her monthly paycheck. The amount withheld is based on the enrollment data entered into the payroll system for the employee. The moneys withheld from the employee's paycheck are deposited into the Group Benefit Plans Reserve Fund, which is used to pay for benefits. For the fully-insured plans, the employees' share of premiums is paid to the insurance carrier and for the self-funded plans, the employees' share of premiums is used to pay claims and administrative costs. If the payroll system does not contain current and accurate benefit enrollment data, the State will not withhold the correct amount from the employee's paycheck to cover his or her premium costs.

Enrollment data are also used by the Department to determine how much to pay insurance carriers for fully-insured plans for the State's share of premiums and third-party administrators for administrative fees. In some instances, the Department's payments are based on enrollment data in the Benefits Administration System and in other instances the Department's payments are based on enrollment data provided by the insurance carriers and third-party administrators.

We reviewed the State's use of benefit enrollment data and found that the Department cannot ensure that accurate data are used for payroll purposes or to pay insurance carriers and third-party administrators.

Payroll

As discussed in Recommendation No. 6, the Department's Benefits Administration System maintains all current enrollment information for employees. Employee and state contributions are determined through the State's primary payroll system, the Colorado Personnel and Payroll System (CPPS), which uploads enrollment information from the Benefits Administration System to calculate the amount to deduct from employee paychecks. This means that when an employee first enrolls in benefit plans, makes changes to his or her benefit elections (e.g., adds or removes dependents), or terminates employment with the State, the Benefits Administration System automatically updates the payroll system so that the correct amount can be deducted. While the two systems interface, ensuring accurate payroll deductions and employer contributions requires benefit administrators located throughout state agencies to ensure all enrollment changes—such as employee separation—are timely updated and approved in the Benefits Administration System. Failure to update the Benefits Administration System in a timely manner will create discrepancies between the System and the payroll system, which could cause employees or the State to contribute more than they should, or it could cause the Group Benefit Plans Reserve Fund to pay third-party administrators or insurance carriers for individuals who are no longer enrolled in the State's plans. However, in addition to CPPS, state agencies and higher education institutions utilize as many as 12 other payroll systems that do not interface with the Department's Benefits Administration System. Without the type of interface that links CPPS with the Benefits Administration System, benefits administrators in these agencies and institutions must manually update their payroll systems to ensure enrollment information is accurate and appropriate amounts are deducted during the payroll process. Discrepancies would also occur if employee enrollment information was not timely updated in each of these payroll systems.

The primary way for the Department to ensure that current and accurate enrollment data are used for payroll purposes is to reconcile data in the Benefits Administration System with data in its payroll systems. By consistently reconciling Benefits Administration System and payroll data, the Department can identify instances where agency personnel have not accurately updated enrollment data. For example, if an employee terminates employment but the agency does not record the termination date in the Benefits Administration System before the Department submits official enrollment data to carriers or third-party administrators (e.g., the 10th of each month), there would be no payroll deduction but the State would be liable to pay the premium. In this case the reconciliation would determine that the agency was liable for paying the premium rather than the Group Benefit Plans Reserve Fund. A reconciliation would identify this discrepancy and the Department could notify the agency to update the Benefits Administration System and make a one-time adjustment to recover the appropriate premium amounts from the agency.

At the time of the audit, the Department was not reconciling the enrollment information in the Benefits Administration System with information in the payroll systems. According to the Department, prior to March 2009, staff reconciled enrollment data in the Benefits Administration System with payroll system data. Between July 2008 and March

2009, Department staff identified more than $320,000 in discrepancies between the two systems through the reconciliation process. These discrepancies impacted both the State and employees and resulted in over- and under-payments to the Group Benefit Plans Reserve Fund. For example, in one instance an employee's enrollment in the State's medical and dental plans had been entered in the payroll system of a higher education institution, but the change had not been approved in the Benefits Administration System. As a result, the institution was incorrectly submitting about $362 per month to the Group Benefit Plans Reserve Fund for the State's share of the premiums and the employee was having about $40 per month deducted from his or her paycheck for the employee share of premiums even though the employee had not yet been approved for benefits. In other cases, the state agency and employee were not paying enough for benefits. For example, in one case an employee's enrollment information was not properly uploaded from the Benefits Administration System into the State's payroll system. As a result, the state agency did not submit the State's contribution of $371 per month to the Group Benefit Plans Reserve Fund and the employee did not pay his or her contribution of $41 per month.

According to the Department, in 2009 the Benefits Administration System did not properly upload all enrollment changes into CPPS. In some cases, an employee may have been enrolled without CPPS reflecting the enrollment election. The Department believes subsequent changes, which now include a complete monthly upload of all enrollment data into CPPS, will prevent some of the discrepancies identified previously. Regardless of the nature of the discrepancies, the state agency is responsible for resolving them and correcting employer contributions and employee payroll deductions in the payroll system to appropriately reflect employee elections. The Department was unable to report to us if the discrepancies identified in the reconciliation process had been corrected as of July 2010.

On the basis of reconciliations conducted by the Department in the past, the State could potentially not be collecting more than $35,000 from employees and state agencies each month, or over $420,000 annually, due to discrepancies between the Benefits Administration System and the payroll system. These moneys could be used to offset administrative costs or employee premiums. According to the Department, the last month reconciled was March 2009; in part, this is because the Employee Benefits Unit accountant position was vacated in December 2009, and had not been filled as of the date of audit fieldwork. However, given the amount of the discrepancies that the Department identified in the past, it is important that the Department begin conducting reconciliations again. The Department should reconcile payroll system enrollment data with Benefits Administration System data on a monthly basis to identify discrepancies between the employee and State agency payments to cover premiums and what was actually submitted to the Group Benefit Plans Reserve Fund. The Department should follow up immediately with state agencies to resolve any discrepancies identified, including those identified for prior periods.

Premiums and Administrative Fees

As discussed previously, the Department uses enrollment data to determine how much to pay insurance carriers for fully-insured plans for the State's share of premiums and third-party administrators for self-funded plans in administrative fees. The State's share of premiums paid to insurance carriers is based on the employee's enrollment tier (e.g., "employee only" or "family"), and administrative fees are based on the number of individuals (employees and dependents) enrolled in a self-funded plan. The State "self-bills" its fully-insured HMO, life, and disability insurance carriers each month for the premium amounts owed by the State. "Self-billing" means that the Department uses its own enrollment data to determine how much to pay the insurance carriers based on prescribed premium amounts. For the State's self-funded PPO medical and dental plans, COBRA plan (which provides separated employees an option to maintain their enrollment in State medical or dental plans at the full cost to the former employee), and flexible spending accounts (which allows employees to use pre-tax dollars to reimburse their actual medical or dental expenses through a savings account administered by a third-party administrator), the administrators send an invoice to the Department that details the number of employees enrolled in the plans and the amount owed by the State for administration.

When the Department "self-bills," it uses enrollment data from the Benefits Administration System, which is the most current and accurate information available. This approach is appropriate and consistent with industry best practices. When the Department is invoiced by its third-party administrator, however, the Department pays the bill based on enrollment information provided by the administrator. Under this approach, the only way the Department can ensure that the State is paying the correct amount is to reconcile the enrollment data provided by the administrator to data in the Benefits Administration System.

We found that the Department does not reconcile the enrollment data provided on the invoices from the administrators with data in the Benefits Administration System. According to the Department, in the past, staff would reconcile the invoice enrollment data with the Benefits Administration System data prior to payment. The Department reported that although discrepancies were often found, they were minor, and the Department decided to discontinue the reconciliations and rely on the data provided by the third-party administrators. Although the discrepancies identified through the reconciliation may have been minor, over time, these amounts could add up to be more significant. Our limited review of May 2010 invoices revealed that Delta Dental administrative fee invoices reflected 68 more participants than the State's enrollment statistics revealed. In addition, May 2010 administrative fee invoices from three of the four medical plans offered by Great-West/CIGNA, the previous medical third-party administrator, included enrollment figures that did not correspond to the State's records. For example, for one plan Great-West/CIGNA charged the State for more employees than state records indicated were enrolled in the plan and for the other two plans charged for fewer employees than state records indicated were enrolled. These differences could be the result of timing differences between when the enrollment figures were extracted by third-party administrators or insurance carriers and when the Department determined its

official enrollment statistics. However, independent verification of third-party administrator and insurance carrier invoices is essential to ensuring the State does not pay excessive plan costs.

If the Department continues to allow third-party administrators to invoice the State, the Department has a responsibility to ensure that the invoices are accurate and complete. Therefore the Department should routinely reconcile the invoiced enrollment data and the Benefits Administration System data. A better and more cost-effective approach, however, would be to "self-bill" all third-party administrators and provide Benefits Administration System enrollment data to them along with the State's payment. By "self-billing" the Department would shift the responsibility of reconciling enrollment data to the third-party administrator from the State.

Recommendation No. 7:

The Department of Personnel and Administration should ensure that accurate enrollment data are used for payroll purposes and to pay premiums to insurance carriers for fully-insured plans and administrative fees to third-party administrators for self-funded plans by:

a. Routinely reconciling enrollment data in the Benefits Administration System with data in the State's payroll systems.

b. "Self-billing" all insurance carriers and third-party administrators using Benefits Administration System enrollment data. If self-billing is not an option, the Department should routinely reconcile the invoiced enrollment data with Benefits Administration System data.

Department of Personnel and Administration Response:

Agree. Implementation date: Ongoing.

The Department has reinitiated the processes to reconcile enrollment data in the Benefits Administration System and invoiced enrollment data with state payroll systems.

Contract Monitoring

As discussed previously, the Department contracts with the Kaiser Foundation Health Plan of Colorado (Kaiser) to provide fully-insured HMO plan options to state employees. Kaiser is responsible for all claims processing for these plans and bears all financial responsibility for the payment of these claims. However, the Department, as the plan sponsor, has an interest in ensuring that Kaiser provides adequate customer service to state employees enrolled in its plans. In addition, the Department contracts with

UnitedHealthcare Insurance Company (UnitedHealthcare) to serve as the third-party administrator and pharmacy benefits manager for the State's PPO medical plans for Fiscal Year 2011. UnitedHealthcare is responsible for processing, adjudicating, and paying all medical and pharmacy claims for services provided to enrolled employees and their dependents. The Department then reimburses UnitedHealthcare for the claims amounts paid on behalf of the State. As the plan sponsor, the State is financially responsible for all costs associated with the PPO plans and, therefore, has an interest in ensuring that UnitedHealthcare performs in accordance with contract and plan terms.

Typically, oversight of insurance carriers for fully-insured plans and third-party administrators for self-funded plans includes reviewing performance reports submitted by the contractors. Performance reports are required by the contracts and are intended to address quality measures related to the contractor's performance under the terms of the contract. In addition to performance reports, oversight of self-funded plans' third-party administrators typically includes conducting claims audits. Claims audits verify the accuracy of the information the administrator submits in its performance reports and determine if the contractor is processing claims in accordance with plan provisions. It is a best practice for sponsors of self-funded plans to utilize audits to ensure that third-party administrators are providing high-quality services and controlling claims-related costs. We reviewed the Department's monitoring of its third-party administrators' and insurance carriers' performance and identified concerns with both the performance reports and the claims audits, as discussed in the next two sections.

Performance Reports

The Department's contracts with its third-party administrators and insurance carriers include provisions that are meant to help the Department monitor contractor performance. These provisions include performance standards regarding benefits to be provided, costs to the plan, and quality-of-service indicators. Each contract requires the third-party administrators and insurance carriers to submit monthly, quarterly, and annual performance reports to the Department. These performance reports generally include information on:

- Timeliness—including up-to-date eligibility information, paying claims, responding to Department requests, and accurate report delivery.

- Customer service—including call abandonment rate, average speed to answer calls, call quality, mail order turnaround time, employee and member satisfaction, and claim payment lag times.

- Accuracy—including claims processing, dispensing prescription medications, and reporting.

- Costs—including stipulating to premiums and administrative fees, generally along with guarantees that fees will be fixed for a specified period of time.

- Plan utilization—including claims payments by month, claims costs by service, in-network/out-of-network utilization by employees, enrollment demographics, the most frequently used physicians and hospitals, and managed pharmacy critical indicators.

We reviewed the Department's monitoring of third-party administrators and insurance carriers, and their performance under their contracts with the State. Generally, the Department requires sufficient reporting when it comes to benefits, timeliness, customer service, utilization, and processing and reporting accuracy. However, the Department does not receive sufficient information from its third-party administrators and insurance carriers to adequately monitor and manage costs and the quality of services provided. Specifically, we found that the administrators and carriers do not provide sufficient information in the following areas:

- **Cost-recovery efforts.** The performance reports do not provide information on the types of recovery actions taken, the amounts of recovery efforts, or the status of recovery efforts. According to the Department's contracts, third-party administrators of self-funded plans are responsible for providing cost-recovery efforts including claim recovery and third-party liability recovery (subrogation) services, fraud and abuse management services, and negotiated discount and hospital bill services. Without this information on the cost-recovery efforts taken, the Department cannot determine the extent to which third-party administrators are engaged in such efforts, or the potential recoveries that may be realized as a result of these efforts.

- **Claims appeals processing.** The performance reports do not provide information on the type, reason, or status of appeals filed by employees. Appeals monitoring is critical to ensuring administrators and carriers provide quality services to state employees, and that their decisions comport with contractually-established plan provisions. According to the contract, third-party administrators are required to oversee the appeals process, but they are not required to report any information to the State regarding these appeals. Without this information, the Department will only be aware of employee concerns if an employee files a complaint with the Department. It is possible that such complaints may only be a fraction of the concerns raised by employees to the third-party administrators or carriers themselves.

- **Pharmacy benefit management activities.** The performance reports from UnitedHealthcare regarding Prescription Solutions, the pharmacy benefits manager for the State's self-funded PPO plans, do not provide information on costs, rebates, discounts, and other fees associated with pharmacy benefits, or provide the results of United's audits of retail, independent, and mail-order pharmacies. Pharmacy benefit costs are based on UnitedHealthcare's calculation of the average wholesale price of these benefits, and while United may change the method by which it calculates the average wholesale price or the "Maximum Allowable Cost," such changes must be formally incorporated into the State's contract with UnitedHealthcare. However, because UnitedHealthcare does not

provide the State with the cost information described above, the State does not have sufficient information to evaluate the impact of changes in pricing methods on the Group Benefit Plans Reserve Fund or on employees. Further, the Department does not have sufficient information to identify the true costs of pharmacy benefits, determine whether costs incurred under the existing contract remain competitive, or control costs either through increased administrative oversight or re-soliciting pharmacy benefit management services.

In addition, the Department does not receive reports on the results of UnitedHealthcare's audits of retail, independent, and mail-order pharmacies. Without this information, the Department cannot ensure that its pharmacy benefits manager is providing due diligence oversight of pharmacies or that the manager is exercising appropriate cost-control and cost-recovery efforts under the terms of the contract.

In addition, we found that the Department does not have sufficient approval authority over the drug formulary or receive adequate information from the administrator regarding changes to the formulary or the impact of these changes on drug pricing, dispensing, and administration fees. The drug formulary is a list of prescription medications that are covered under the plan. The Department's contract allows UnitedHealthcare to substitute a prescribed drug or make changes to the formulary and approve the "therapeutic interchange" of prescribed medications without the Department's approval. Therapeutic interchange refers to situations in which a pharmacist dispenses an alternative drug that is chemically different, but therapeutically similar, to a drug included in the formulary that has been prescribed by a physician. It is common for pharmacy benefit managers to establish formularies based upon a committee of pharmacists and physicians from various medical specialties, which reviews new and existing drugs and selects those to be included on the formulary based on safety, efficacy, and cost. The formulary is reviewed and updated annually, but is subject to change throughout the year, generally due to the availability of new drugs and if a medication is deemed to be unsafe. However, pharmacy benefit manager decisions regarding the inclusion or exclusion of drugs have the potential to impact plan costs and plan members. Therefore, it is important that the Department be notified of any changes to the drug formulary so that it can review the potential impact of and approve such changes.

The Department's practice of competitively procuring new contracts on a five-year basis and executing contracts with a one-year term and four one-year options enables the Department to take timely action to re-procure insurance carrier, third-party administrator, or pharmacy benefit manager services if it finds that a contractor is not meeting performance standards or existing services or costs are no longer competitive. To take advantage of this, however, the Department must have the information it needs to routinely and comprehensively monitor and assess the contractor's performance and costs. Therefore, prior to exercising the next-year option, the Department should improve its ability to adequately monitor its third-party administrators' and insurance carriers' performance by renegotiating contract provisions related to performance reports and the Department's authority with respect to pharmacy benefits. The third-party administrators and insurance carriers should be required under the terms of the contracts

to provide comprehensive performance reports addressing key areas such as cost-recovery efforts, claims appeals processing, and pharmacy benefit management activities, as appropriate. In addition, the Department should be allowed to evaluate the impact of formulary changes for prescription drugs and approve such changes.

Recommendation No. 8:

The Department of Personnel and Administration should improve its ability to adequately monitor insurance carrier, third-party administrator, and pharmacy benefit manager performance by renegotiating its contracts to strengthen provisions by:

a. Requiring that the insurance companies, third-party administrator, and pharmacy benefit manager provide more complete and comprehensive performance reports addressing key areas such as subrogation and cost-recovery efforts, claims appeals processing, and pharmacy benefit management activities, as outlined in this audit report.

b. Requiring that the Department be notified in advance of formulary changes for prescription drugs so that the Department can evaluate and approve such changes.

Department of Personnel and Administration Response:

Agree. Implementation date: January 31, 2011.

The Department agrees to renegotiate the current contracts to ensure more complete and comprehensive performance reports are obtained from providers. The Department will also incorporate a requirement for advance notice of formulary changes in order to evaluate and approve the changes. The ability to approve formulary changes is already in the contract with the third-party administrator so the Department will ensure it is implemented. We will evaluate if a contract with a Pharmacy Benefit Management specialist who possesses the clinical expertise to evaluate the impact of the proposed change to participants and costs is appropriate.

Claims Verification

According to the terms of the Department's contract, UnitedHealthcare is required to review all medical and pharmacy claims to determine if they are valid and allowable under the State's PPO plans. If UnitedHealthcare determines that a claim is valid and allowable, United processes the claim and pays the health care provider or pharmacy for the approved claim amount. UnitedHealthcare then submits weekly invoices to the Department for reimbursement of claim amounts paid on behalf of the State. With weekly claims invoices reaching into the millions of dollars, Department staff are contractually required to submit payment to UnitedHealthcare within four days of receiving the invoice. Because the State bears the financial burden for all medical and

pharmacy claims under self-funded plans, the State has an interest and a fiduciary responsibility to make sure that UnitedHealthcare is appropriately reviewing and approving all claims in accordance with the terms of the plans.

We reviewed the Department's monitoring of the claims process for its self-funded PPO plans and found that the Department does not provide sufficient oversight of its third-party administrator/pharmacy benefits manager to ensure that the administrator is processing claims in accordance with the contract and the PPO plan documents. The Department's monitoring consists almost entirely of reviewing claims-related performance reports. However, it is a best practice for sponsors of self-funded plans to utilize audits to ensure that third-party administrators are providing high-quality services and controlling claims-related costs. According to industry standards, auditing the third-party administrator may occur as frequently as needed, but typically should occur at least every three years. We found that since the State went to self-funding in Fiscal Year 2006, the Department has never audited its third-party administrator's claims processing. The Department did not conduct a claims audit of Great-West/CIGNA during the five years that Great-West/CIGNA served as the State's third-party administrator prior to the current contract with UnitedHealthcare. At the time of this audit, the Department did not have specific plans to audit claims processed by the current third-party administrator, UnitedHealthcare.

Because the Department has not conducted audits of its third-party administrator's claims processing, the Department does not know if its administrator is appropriately and accurately processing and paying claims in accordance with plan provisions. This can have a negative impact on the performance of the self-funded plan and result in increased claims costs, which may reduce the premium stabilization reserve, and ultimately increase employee out-of-pocket costs. The American Medical Association reported in its 2010 National Health Insurer Report Card that 20 percent of all medical claims are inaccurately processed. Conservative estimates suggest that plan sponsors can expect to recover about 1 percent of total claims costs through a claims audit. For Colorado, 1 percent of the State's projected claims costs for Fiscal Year 2011 alone would be about $1.27 million.

According to the Department, limited resources and other priorities have contributed in part to its decision to not conduct audits of its PPO third-party administrators in the past. Further, although the Department has a contractual right to audit UnitedHealthcare under its current contract, the Department's ability to conduct audits is hampered by more restrictive provisions in the contract than were found in contracts with its previous third-party administrator. Specifically, the Department's current contract with UnitedHealthcare limits the scope of any independent review to the current or immediately preceding calendar year with a maximum of 400 claims that can be audited from this period. This provision means that the Department could not perform a comprehensive audit that spans several years, but must instead perform an audit with a more limited scope. In addition, the contract only allows one audit per year and limits on-site inspections to once every two years. This limits the Department's ability to respond to complaints with an audit in a timely fashion. Finally, the contract does not allow the Department to contract for an audit with an outside firm that has an interest in

the results of the audit, a common method of structuring claims audits to minimize the cost to the employer.

The Department should strengthen its oversight of claims to ensure that its third-party administrator is accurately and appropriately processing and paying all medical and pharmacy claims. This should include conducting periodic and timely audits of the third-party administrator's claims processing to ensure that the administrator is paying only legitimate and covered claims. In addition, prior to exercising its next-year option, the Department should renegotiate its contract with UnitedHealthcare to allow the Department more flexibility with respect to conducting claims audits.

Recommendation No. 9:

The Department of Personnel and Administration should strengthen its oversight of claims for self-funded plans to ensure that its third-party administrator is accurately and appropriately processing and paying all medical and pharmacy claims by:

a. Conducting periodic and timely audits of the administrator's claims processing.

b. Renegotiating and strengthening the third-party administrator contract provisions to allow the State more flexibility with claims audits.

Department of Personnel and Administration Response:

a. Agree. Implementation date: June 30, 2012. The Department agrees that a periodic audit of claims processing by the third-party administrators is good practice. In fact, such audits were conducted on a regular basis when the plan was self-funded in the past. The Department will complete the procurement process to contract with an independent auditor to conduct a claims administration audit in Fiscal Year 2012, when one year of data under the new contract is available. Based on the findings, the Department will evaluate the appropriate frequency for future audits.

b. Agree. Implementation date: January 31, 2011. The Department will renegotiate the provisions of the current contract to allow more flexibility, including the ability to have claims administration audits conducted by an independent auditor.

Wellness Programs

Wellness programs consist of a series of opportunities and incentives provided to participants to maintain or improve their overall health. Organizations offer wellness programs to their employees to encourage them to lead healthier lifestyles. Besides the obvious benefit to employees in terms of their health and well being, wellness programs serve to contain or reduce the costs that an organization pays for its group medical plans.

While Colorado does not have a comprehensive wellness program, we found that it does offer employees some opportunities that are often found in wellness programs. These include several health program options offered by the State's two medical plan providers—UnitedHealthcare and Kaiser. These include nurseline, smoking cessation, healthy pregnancy, healthy back, healthy weight, bariatric, and various disease management programs. The State's contract with UnitedHealthcare also includes a "Wellness Credit" of $500,000 that the State can use to enhance its medical benefits during the term of the contract. In addition, the State offers an off-site State Employee Wellness Center facility that offers a variety of exercise equipment and weights, a staff of certified health professionals, exercise classes, personal training (initial consultation/goal creation session free, additional sessions for a fee), a wellness center newsletter, and Healthy Hero program, which spotlights state employees who make significant improvements toward a healthy lifestyle. The facility is available only to state employees and there is a $27 monthly fee for membership. Similarly, the State also offers a Work-Life Employee Discount Program that conveys a variety of discounted goods and services offerings including some health-related discounts for services such as gym memberships, acupuncture, online exercise programs and support, and YMCA membership. Employees are also afforded other health and well-being services through the Colorado State Employee Assistance Program (C-SEAP), which provides confidential counseling, workplace violence reduction, and workshops on workplace mental health.

Although the opportunities offered by the State are consistent with what many of our benchmark employers offered, a successful wellness program requires a more holistic and comprehensive approach. In many states, wellness program opportunities are available to all employees, regardless of whether they are enrolled in a state medical plan. However, Colorado limits the most substantive health-related components of the State's programs to those enrolled in the State's medical plans, which means that 25 percent of state employees are not significantly impacted by the programs. In addition, Colorado does not offer its employees some of the more common opportunities that wellness programs in many other states offer. For example, Colorado does not offer incentives for health risk assessments, smoking cessation programs, nutritional assistance, or other health incentives. Our benchmark survey revealed that other comparable employers typically offer wellness programs that combine both information-sharing and some type of health incentives. Many plans offer information on weight loss management, smoking cessation, motivational stories from other employee wellness participants, and links to other wellness websites (such as weight loss, stress reduction, and exercise sites). In addition, more structured wellness programs incorporate employee health assessments, nutritional assistance, disease management assistance, and wellness newsletters. The more comprehensive programs incorporate wellness incentives such as discounted health insurance premiums for participating in smoking cessation programs, gift cards for completing health risk assessments, free flu shots, subsidized gym memberships, as well as specialized services such as personal trainers, wellness seminars, and virtual and/or interactive health education and coaches.

Wellness programs around the country have a common goal—to create healthier and more productive employees. These programs are intended to assist employees and their family members in making voluntary behavior changes, which reduce their health and

injury risks, improve their health consumer skills, and enhance their individual productivity and well-being. Improving employee health may also translate into cost-savings for an employer through reduced health care utilization and claims, lower absenteeism, reduced sick and disability leaves, fewer on-the-job accidents and workers' compensation costs, and fewer early retirements due to medical and/or disability issues. A study conducted by the Wellness Council of America, found that, on average, employers can expect to see an average 28 percent reduction in health costs, 27 percent reduction in sick leave usage, and 32 percent reduction in workers' compensation costs when they have a worksite wellness program. The study also found that the average cost-benefit ratio for a wellness program is 1 to 5.5—that is, for every one dollar invested in a worksite wellness program, the organization receives $5.50 in return through reduced costs.

Given the potential benefits that a comprehensive wellness program can offer the State and its employees, the Department should evaluate the cost-benefits of developing a more comprehensive wellness program. Long-term health behaviors such as smoking, poor diet, and lack of exercise are very difficult to change and new behaviors are difficult to maintain. Thus, a successful workplace wellness program will need a mix of programming including information, motivation, behavior change, economic change, and cultural change. There are some basic steps the Department should take to develop an improved workplace wellness program:

1. Identify the State's wellness program focus, whether it will have a short-term or long-term focus, and determine whether dedicated funding is available to operate a substantive program.
2. Collect and analyze relevant data that will inform what wellness program elements might be most successful. These data might include employee demographics, medical claims by major diagnostic category, productivity statistics, sick leave usage, disability claims, and workers' compensation claims.
3. Analyze the "culture" of the State and its various worksites. This will require coordination with agency benefits administrators, who will play a critical role in disseminating information and promoting program features to state employees. Certain types of changes may be possible at some sites, but not at others.
4. Set five to eight objectives for the wellness program. Objectives should be based on the data collected and reasonable to achieve in short-, medium-, and long-term time frames.
5. Design and begin to implement a wellness program and, in doing so, consider employing a wellness consultant with expertise in the specific focus areas desired by the State.
6. Continue to collect appropriate data and evaluate whether the program is meeting its objectives. If not, consider how to revise or update the program.

Recommendation No. 10:

The Department of Personnel and Administration should evaluate the cost-benefits of developing and implementing a comprehensive wellness program into the State's group benefit plans. Based on the results of this evaluation, the Department should take appropriate steps to develop and implement a wellness program.

Department of Personnel and Administration Response:

Agree. Implementation date: June 30, 2011.

The Department will evaluate the cost-benefits of implementing a comprehensive wellness program into the group benefits plans. The State's medical plan options already have wellness plans for enrolled participants. However, financial incentives have not been used so the evaluation will include looking at potential funding strategies for such incentives. Department staff will work with the two providers in performing the evaluation with the goal of completing it by the end of this fiscal year.

The Department believes that the ultimate goal should be the trend that is developing in the market—an effective health management program that applies to the entire workforce, not just those enrolled. These programs are standalone and focused on productivity through change in a number of areas, such as health care costs, wellness, and absence management. Thus, the Department will continue to monitor developments in this area with an eye towards this broader goal.

APPENDIX

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Appendix A––Summary of Comparable Employers Included in Our Benchmark Survey

As part of this audit, we obtained and reviewed group benefit plan documentation from both private and public employers. We selected state benchmark participants based their geographic proximity to Colorado and their size, and selected local government and private sector employers from within the State based primarily on their size. We obtained information from the following 12 state employers and 10 local employers for inclusion in our analysis:

State Employers	**Local Employers**
Arizona	City of Boulder
Idaho	Denver City and County
Kansas	Adams County
Nebraska	Arapahoe County
Nevada	Boulder County
New Mexico	El Paso County
Oklahoma	Jefferson County
Oregon	Newmont Mining Company
South Dakota	North Colorado Medical Center
Utah	University of Denver
Washington	
Wyoming	

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