Gallagher Byerly, Inc.

STATE OF COLORADO OFFICE OF THE STATE AUDITOR

AUDIT OF THE COLORADO DEPARTMENT OF PERSONNEL & ADMINISTRATION'S EMPLOYEE BENEFIT PROGRAM

JUNE 2003

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COLORADO STATE AUDITOR - REPORT ON EMPLOYEE BENEFITS

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EXECUTIVE SUMMARY

AUDIT PURPOSE AND SCOPE

The Office of the State Auditor contracted with Gallagher Byerly, Inc. to conduct a performance audit of the Department of Personnel & Administration's (Department's) state employee benefit program. The purpose of this audit was to evaluate the Department's policies and processes for selecting and financing health benefit plans for state employees, compare Colorado's health benefit plans to the plans of other public and private organizations, and determine the feasibility of self-insuring its medical and dental plans.

BACKGROUND

The State currently offers three types of fully-insured medical insurance coverage for its employees to choose from:

- HMO (Health Maintenance Organization): a managed system of health care that provides a comprehensive array of medical services on a prepaid basis to enrolled persons living within a specific geographic region. The State currently offers four HMOs to state employees.

- EPO (Exclusive Provider Organization): a variation of a preferred-provider organization in which coverage is not provided outside the preferred-provider network for non-emergent care, except in those infrequent cases where the network does not have an appropriate specialist. The State currently offers one EPO to state employees.

- PPO (Preferred Provider Organization): a benefit plan that contracts with network providers to obtain lower costs for plan members. Plan participants do have coverage for non-network providers, but at lower reimbursements than an in-network provider. The State currently offers one PPO to state employees.

In 2003, there are about 25,300 state employees enrolled in one of the three types of medical plans described above. Of this amount, 52 percent are enrolled in an HMO, 14 percent in the EPO, and 34 percent in the PPO. Premiums for the plans totaled $122.9 million. The State and its employees share in these premium costs, with the State paying 50.7 percent of the total premium and the employee paying 49.3 percent.

The State also offers two fully-insured dental options which are provided by Delta Dental. One is a basic program (Basic) with limited benefits, while the second offers a more comprehensive level of coverage (Basic Plus). For both plans, members can access either network dentists or non-network dentists, with the level of benefits the same, other than the fact that members using non-network providers are potentially subject to charges which are not considered usual, customary, and reasonable. In 2003, there are a total of 32,700 state employees enrolled in one of the plans, with 63

percent in the Basic plan and 37 percent in the Basic Plus plan. Premiums for the plans totaled $15 million, with the State paying 42.5 percent and employees paying 57.5 percent.

KEY FINDINGS

The State's overall medical and dental coverages and level of contributions are significantly below those offered by other public and private employers. We have estimated the total annual cost to increase benefits to prevailing market levels to be approximately $8 million. In addition, the State's contribution to medical and dental premiums is below its peers. We have estimated the additional funds needed to bring employee cost-sharing to prevailing market levels ranges from approximately $26 million to $49 million. There are other indirect solutions, however, which involve changes in the State's policies and procedures that would release existing funds to help offset the needed additional money to improve employee cost-sharing.

The State's 3-tier rate structure is not commonly used by other large employers. The State currently employs a 3-tier structure as a basis of determining premium distribution among family members. Most large employers use a 4-tier structure. In addition, the Department does not mandate the rate tier ratio set by the carriers. The rate tier ratio is the difference in premiums between employee-only coverage and the other tiers (e.g., employee + 1 dependent or employee + 2 or more dependents). Most large employers dictate the rate tier ratio because it allows them to equalize all carriers in rate setting so that the carriers cannot position their premiums to target different health risk groups.

The State's statutory requirements related to the types of medical plans offered may preclude cost-effective plan designs for Colorado. Section 24-50-606, Colorado Revised Statutes, requires the Department to offer two HMOs (if available) in addition to any other plans offered in certain geographic areas. This requirement limits the State's purchasing power and reduces its ability to effectively manage its overall medical risk. Only two of the other states surveyed have specific laws/requirements in place relative to the number and types of offerings to be provided to employees. More typically, plan selection is predicated on the plans that meet established objectives as to choice, cost effectiveness, and risk management.

The State's eligibility provisions are not comparable with other large public and private sector plans. The State's practice of allowing individuals who work a minimum of eight hours per month to be eligible for benefits is unusual. The prevailing practice is to require a minimum of 80 to 120 hours per month for benefit eligibility. We have estimated the annual cost savings resulting from increasing the minimum number of hours required for benefit eligibility to 20 per week to be approximately $700,000 per year.

In addition, the State's current practice of providing a full contribution for part-time employees is not prevailing. The prevailing practice of most large employers surveyed was to provide a partial or pro-rated contribution for part-time employees. If the State

were to reduce its contribution for eligible part-time employees to 50 percent of what is provided full-time employees, it would save approximately $1.2 million per year.

The State's annual open enrollment policy is also different than other large plans' practices. The State has a true annual open enrollment in which employees and their dependents can enter or exit the medical plans every year with no restrictions. About half of the large employers surveyed restrict entry enrollment opportunities to a one-time election when employees begin their employment. The State's current practice of allowing free entry at annual open enrollments (other than when there is a legitimate change in family status) can create significant unnecessary adverse selection against its medical plans by allowing individuals to time their need for non-emergent health plan services with the next enrollment period.

The State needs to evaluate the costs and benefits of self-insuring its medical plans. The State will spend about $122.9 million in Calendar Year 2003 on health insurance premiums for its fully-insured medical plans using several insurance carriers. Based on our analysis of data provided by the Department for the years 2000-2003, we found that self-insurance may be a more cost-effective financing mechanism for the State's medical plans and should be evaluated thoroughly. However, before making such a switch to self-insurance, the advantages and risks must be carefully considered.

Among the advantages of self-insurance are potentially lower fixed costs of about $3 million to $6 million annually, greater flexibility in plan design to offer a more competitive health benefits package, and the ability to maximize the State's buying power for prescription drugs. In addition, consolidating all participants into a single risk pool could create the opportunity to take better advantage of the size, experience, and broad demographics of the State's entire group of participants in setting premium rates. On the other hand, self-insuring transfers the financial risk to the State and requires the State to maintain adequate reserves. In addition, self-insurance will require the State to increase its investment in infrastructure to effectively manage a self-insured plan. Using the most current information available, the Department should conduct a comprehensive analysis of the costs and benefits of self-insuring the State's medical health plan.

The State should consider self-insuring its dental plans. Self-insuring dental plans is very common among large employers because there are relatively low reserve requirements, claims costs are predictable, and risk and other margins do not have to be applied to the contribution rates. We have estimated the first year savings of the State converting its dental plan to self-insurance to be $4.1 million. From these savings, we have estimated that the entire incurred but not reported reserve could be funded in the first year and still leave a surplus of almost $1.8 million that could be used to improve benefits and/or lower employee contributions.

Our recommendations and the responses of the Department of Personnel & Administration can be found in the Recommendation Locator.

RECOMMENDATION LOCATOR
Agency Addressed: Department of Personnel & Administration

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
1	20	Use the results of survey of state employees who are not participating in the State's health plan to make appropriate plan adjustments aimed at increasing employee participation.	Agree	January 2004
2	22	Consider modifying the medical benefit plan by eliminating the current 3-tier premium rate structure in favor of a 4-tier rate structure with consistent tier ratios for all fully-insured plans.	Agree	January 2004
3	24	Consider proposing legislation to eliminate specific statutory mandates on the numbers and types of medical plans offered and streamline carrier choices.	Agree	January 2004
4	27	Re-evaluate the minimum employee work requirement; re-evaluate eligibility for foster children and grandchildren; analyze the costs and benefits of more restrictive open enrollment policies; and limit employees' ability to change their elections, and that of their dependents, to the annual enrollment opportunity.	Agree	January 2005
5	28	Consider alternatives for partial employer contributions to the health benefits of eligible part-time employees.	Agree	January 2004
6	29	Establish reporting requirements to capture appropriate pricing, claims, and utilization data in order to fully inform plan funding and design decisions regardless of whether the State remains fully-insured or elects to switch to self-insurance.	Agree	January 2004

RECOMMENDATION LOCATOR
Agency Addressed: Department of Personnel & Administration

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
7	38	Analyze the most recent and comprehensive demographic and financial information on the plan to evaluate financing options and benefit designs for a possible State self-insurance plan.	Agree	January 2005
8	41	Pursue a Dental Provider Organization (DPO) in those geographic areas having adequate network access, maintain a statewide indemnity plan with a passive network for those areas with inadequate network access, and consider an increase in the annual maximum benefit.	Agree	January 2004
9	42	Evaluate the costs and benefits of self-insuring the State's dental plan.	Agree	January 2005
10	45	Implement on-line enrollment and re-evaluate the appropriate level of plan communication and mailing expenditures accordingly.	Agree	October 2003
11	48	Prescribe a single format for carrier responses and contract reporting, require carriers to provide a full accounting of all drug rebates received from drug suppliers, require carriers to fully disclose their subrogation policies, and request detailed retention exhibits from carriers.	Agree	March 2004
12	50	Require carriers to submit information on pooling point assumptions, information on projected employee and member enrollment upon which rates are based, and complete full retention exhibits in a specified format. Require HMOs to use the same rate tier ratios in their proposals.	Agree	March 2004

BACKGROUND AND METHODOLOGY

The State currently offers the following three types of medical insurance coverage for its employees to choose from:

- HMO (Health Maintenance Organization): a managed system of health care that provides a comprehensive array of medical services on a prepaid basis to enrolled persons living within a specific geographic region. HMOs emphasize preventive care and, except for emergencies, do not provide coverage for treatment provided outside their defined services area.[1] Kaiser, PacifiCare, Rocky Mountain, and San Luis Valley are the four HMOs currently offered to state employees.

- EPO (Exclusive Provider Organization): a variation of a preferred-provider organization (PPO—see below) in which coverage is not provided outside the preferred-provider network for non-emergent care, except in those infrequent cases where the network does not have an appropriate specialist.[1] Anthem currently offers a statewide EPO to state employees.

- PPO (Preferred Provider Organization): a benefit plan that contracts with network providers to obtain lower costs for plan members.[1] Unlike an EPO, plan participants in a PPO do have coverage for non-network providers, but at lower reimbursements than for in-network providers. Anthem currently offers a statewide PPO plan to state employees.

All of these programs are fully-insured, meaning that the carriers have the ultimate financial risk. Their rates are based on the actual/projected claims costs associated with the State's enrollment. The following table reflects these offerings, and also indicates the number of enrollees and estimated annualized premiums for Calendar Year 2003 based on eligibility:

[1] Group Benefits: Basic Concepts and Alternatives. Barton T. Beam, Jr. 2002

CALENDAR YEAR 2003 ENROLLMENT AND ESTIMATED PREMIUMS		
Program	**Enrollment**	**Annualized Premiums**
Kaiser HMO	8,257	$35,500,000
PacifiCare HMO	4,016	$21,900,000
Rocky Mountain HMO	562	$3,500,000
San Luis Valley HMO	265	$1,500,000
Anthem EPO	3,550	$19,900,000
Anthem PPO	8,650	$40,600,000
TOTALS	**25,300**	**$122,900,000**

Source: Department of Personnel & Administration data.

The State and its employees share in these premium costs, with the State paying 50.7 percent of the total premium and the employee paying 49.3 percent.

The State also offers two dental options. One is a basic program (Basic) with limited benefits, while the second offers a more comprehensive level of coverage (Basic Plus). Both are fully-insured, indemnity plans with a passive network. An indemnity plan is one that reimburses people for expenses that they have incurred. That is, members can access either network dentists or non-network dentists, with the level of benefits the same, other than the fact that members using non-network providers are potentially subject to charges which are not considered usual, customary, and reasonable. Both options are provided through Delta Dental, with enrollment and estimated annualized premiums for Calendar Year 2003 as follows:

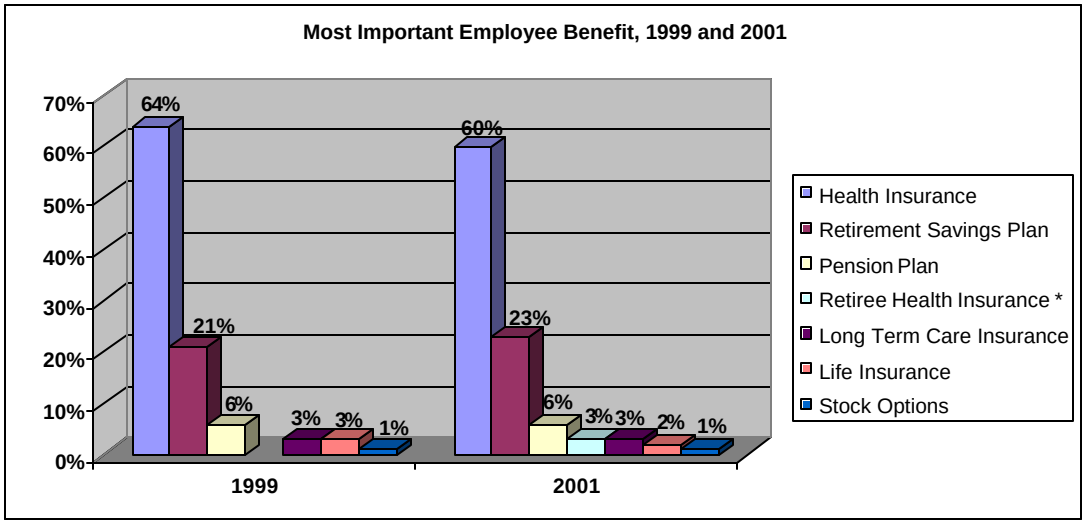
CALENDAR YEAR 2003 ENROLLMENT AND ESTIMATED PREMIUMS		
Program	**Enrollment**	**Annualized Premiums**
Basic dental	20,700	$7,800,000
Basic Plus dental	12,000	7,200,000
TOTALS	**32,700**	**$15,000,000**

Source: Department of Personnel & Administration data.

For dental, the State pays 42.5 percent of the total premium and employees pay 57.5 percent.

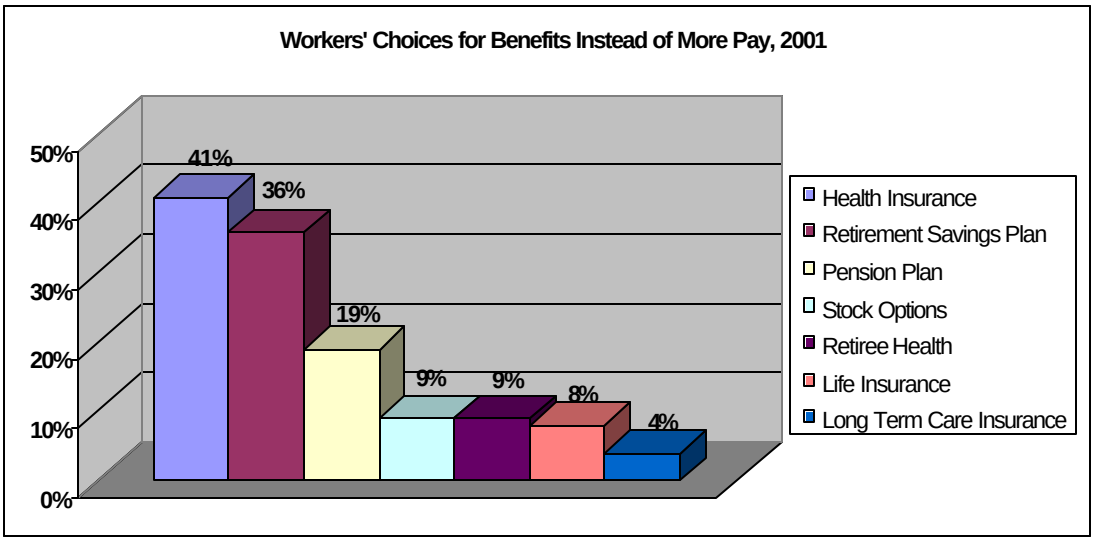
Employee benefits have become an increasingly important component of employees' total compensation. Of all benefits, health benefits are clearly the most important to employees, and are instrumental in attracting and retaining employees. The three charts on the following pages illustrate the importance of health benefits.

VALUE OF BENEFITS TO EMPLOYEES
May 2003



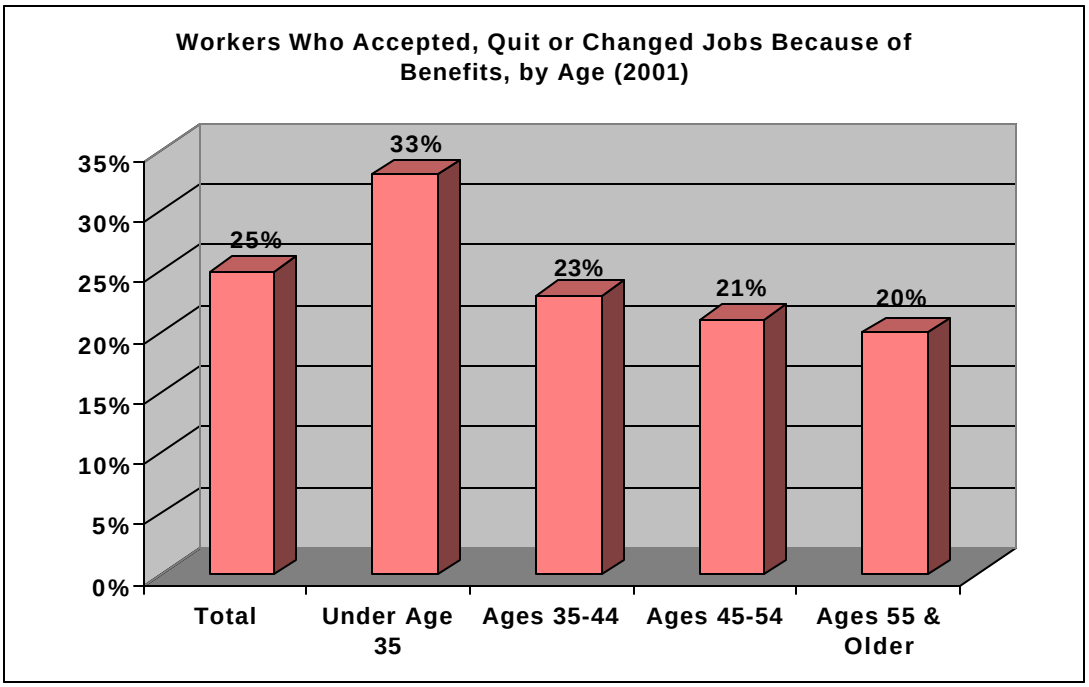
Source: Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc., 2001 *Value of Benefits Survey.*
*Retiree health insurance added to survey in 2001, not ascertained in 1999.

VALUE OF BENEFITS TO EMPLOYEES
May 2003



Source: Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc., 2001 *Value of Benefits Survey.*

VALUE OF BENEFITS TO EMPLOYEES
May 2003



Source: Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc., 2001 *Value of Benefits Survey.*

A key component of this project is the comparison of the State's practices with that of other public and private employers. Throughout our report, we compare the plan design, funding, and administration provisions of the State with a number of different benchmarks.

We attempted to identify plans that were viewed as having greater relevance to the State. The two specific attributes believed to be most important were:

- Size – benefits practices vary dramatically between small employers and larger employers, and thus our specific surveys focused on employers with at least 1,000 employees.

- Geographic coverage – we attempted to include employers with multiple locations spread across a state.

While certain corporations meet these criteria to a degree, the most similar universe is other state health plans. As such, the primary focus of our survey work, and correspondingly, our comments, is on the practices of other state health plans. A total of 11 other states were identified and surveyed based on regional proximity and similar geographic characteristics to Colorado. These states include:

- Arizona
- Idaho
- Iowa
- Kansas
- Nebraska
- Nevada
- New Mexico
- Oklahoma (includes two different agencies charged with the administration of benefits for state employees)
- Oregon
- Utah
- Washington

In addition, select Colorado public employers located along the Front Range were identified and surveyed, based primarily on size. These entities included:

- City of Aurora
- City of Colorado Springs/Colorado Springs Utilities
- City and County of Denver
- City of Fort Collins
- Larimer County
- Pueblo County

It was also important to include the private sector. Larger corporations responding to our comparison survey included:

- Ball Corporation
- Corporate Express
- Leprino Foods

Finally, to provide additional perspective, we extracted existing survey data from a number of sources. It is important to note that this body of information reflects 2002 data. These sources include:

- Mercer National Survey of Employer-Sponsored Health Plans 2002
- Colorado Mountain States Employers Council: "2002 Survey of Colorado Health & Welfare Plans"
- Watson Wyatt 2002/2003 Survey Report on Employee Benefits
- 2002 MetLife Benefits Benchmarking Report
- Towers Perrin 2002 HR Delivery Systems
- Hewitt Associates: "Enrolling On-line for Benefits Continues To Be Number One Choice for U.S. Employers"
- Hay Benefits Report 2002
- Kaiser Family Foundation Employer Health Benefits 2002 Annual Survey
- Workplace Economics, Inc. 2002 State Employee Benefits Survey

In those sections of this report where we were asked to assess current Department procedures for plan selection, premium rate negotiations, cost sharing, and plan marketing, we obtained source documents and data from the Department of Personnel & Administration (Department). These source documents were then compared to a number of normative sources, survey results, accepted industry practices, and the extensive large health plan experience of the project team.

Highlights of our findings have been summarized and addressed in our narrative throughout the remainder of this report.

MEDICAL INSURANCE

BENEFIT LEVELS

We found that the State's benefit levels are consistently less comprehensive than other public and private organizations surveyed. This holds true for all types of service. This means that, although the State's plans cover the same medical services and are comparable to other plans, the State's plans require significantly more employee out-of pocket costs for an equivalent level of coverage. The State's medical plans have the following characteristics:

COMPARISON OF KEY HMO/EPO BENEFIT PROVISIONS			
TYPE OF SERVICE	Colorado HMOs/EPO[1]	Typical HMO	Variance
Office visit copays	$25-$50	$10-$15	$15-$35
Individual deductible	$0-$2,000	Not Applicable	$0-$2,000
Individual out-of-pocket maximum	$2,000-$3,000	$1,000-$1,500	$1,000-$1,500
Inpatient hospital copays	$1,000/admit; $250-$750/day; $1,000-$3,000 max	$0-$250	$1,000-$2,750
Outpatient surgery copays	$125-$350	$0-$100	$125-$250
Prescription drug copays: Generic/formulary/non-formulary[2]	$15/$40/$60	$10/$15/$30	$5/$25/$30

COMPARISON OF KEY PPO BENEFIT PROVISIONS			
TYPE OF SERVICE	Colorado PPO (In-Network)[1]	Typical PPO (In-Network)	Variance
Office visit copays	20% after deductible	$15-$20/10%-20%	0%-10%
Individual deductible	$2,000	$200-$300	$1,700-$1,800
Individual out-of-pocket maximum	$5,000 + deductible	$1,000-$2,500	$2,500-$4,000+
Inpatient hospital copays	20% after deductible	10%-20%, after deductible	0%-10%
Outpatient surgery copays	20% after deductible	10%-20%, after deductible	0%-10%
Prescription drug copays: Generic/formulary/non-formulary[2]	$15/$40/$60	$10/$15/$30	$5/$25/$30

[1] See page 7 for definitions of plan types.

[2] Generic drugs are those whose patents have expired. Formulary drugs are those name brand drugs that have been determined to be most effective, based on an assessment of quality and cost. Non-formulary drugs are name brand drugs that do not fall under the formulary classification.

Source: Gallagher Byerly, Inc. analysis of Department and survey data.

We have broadly estimated that the cost to reduce employee out-of-pocket expenses and enhance the HMO level of benefits from the current plan design to market level would increase HMO premium costs by about 8 percent. Applying this percentage to the current overall enrollment, and assuming that the State funded 100 percent of that increase, the annual increase in expenditures is estimated at roughly $8.2 million in 2003 dollars.

We have also included a variety of plan design benchmarking information from a number of other surveys. These data also show consistently more comprehensive benefit provisions. However, it is important to note that all of this survey data is based on 2002 plan provisions. Given the rapidly changing dynamics of plan design in our current environment, we would urge caution in reaching any definitive comparisons, based on this information. Nonetheless, it is instructive that the findings from the 2002 plan design data are generally consistent with our findings in the actual 2003 survey work we did for this audit.

In the following sections we discuss some of the causes of the benefits gaps and a few potential solutions for cost cutting.

STATE'S CONTRIBUTIONS TO COST

The State currently shares a much smaller portion of the cost of medical coverage than other employers. Our findings on the State's low contribution rates are consistent with the Department's 2003 Total Compensation Survey Report. According to the Report, for medical insurance costs only, the percentage differences between the state's 2002 contributions and the market contributions by rate tier are:

- Employee only: state contribution is 30.7 percent below market.
- Employee plus one: state contribution is 37.9 percent below market
- Employee plus family: state contribution is 37.1 percent below market.

In light of the above, it is also important to note that the State currently does not cover retirees within its employee benefit programs. It is common for state health plans to cover both active and retired participants. As such, most of these state health plans also implicitly subsidize retirees participating in their plans. That is, irrespective of any formal contribution toward the cost of coverage, retiree premiums are developed by blending their experience with that of active employees. As retiree costs are typically higher on a per capita basis than active employees, this means that the premium paid by active employees is artificially higher than would otherwise be the case if the rates were based *only* on the experience of active employees. This means that the proportion of costs being borne by the State, as a percentage of total premium costs, is arguably even lower than might otherwise be estimated, when compared to other states.

In order to offer a competitive medical plan, employer contributions need to be in line with prevailing practices. Based on our various findings, and as indicated in the 2003 Total Compensation Survey Report, the State lags the market in funding a competitive share of the total cost of health care. Assuming no change in the underlying cost of the coverage, if the State were to increase its funding of premiums to make employer contributions competitive, we estimate that the State would need to increase funding levels by anywhere from $26 million to $49 million on an annualized basis, in 2003 dollars depending on where the State wants to benchmark itself relative to its peers. This relates only to medical, and does not contemplate any other changes in eligibility or plan design referenced elsewhere in the report.

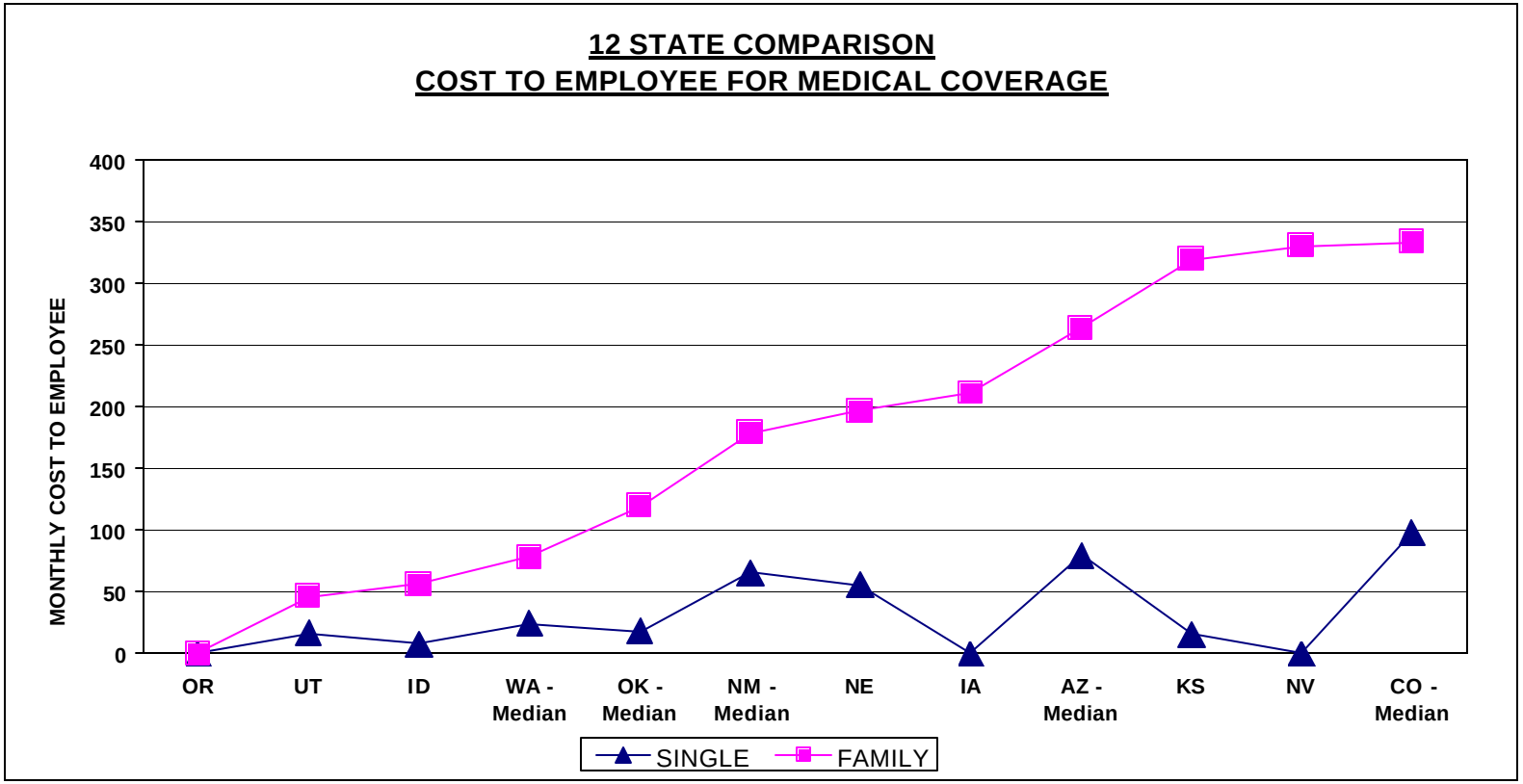
EMPLOYEES' COST-SHARING

State employees pay a large portion of the cost of their medical coverage. The lowest, and most prevalent (based on enrollment of 8,650 employees) monthly cost to State employees for single medical coverage is $76.04, and $272.34 for family coverage. These premiums are associated with the State's PPO program, which has significant employee cost sharing within its plan provisions – i.e., $2,000 deductibles, $5,000 out-of-pocket coinsurance maximums, and separate prescription drug copays.

As illustrated in the next chart, Colorado has the highest employee and family monthly employee contribution costs when compared to the other 11 regional states surveyed.

COLORADO STATE AUDITOR - REPORT ON EMPLOYEE BENEFITS

STATE COMPARISON OF EMPLOYEE COSTS FOR MEDICAL COVERAGE



NOTES

Nevada, Oklahoma and Washington costs include medical, dental, life and disability (NV and OK only) insurance.
Kansas and New Mexico costs vary according to the employees' salary and type of plan/coverage level chosen.
Nevada rates also include vision and travel accident coverage. Employees are offered self-funded and fully funded plan options.

COST VARIANCES

Arizona ranges from $25.00 to $135.36 for single coverage and $125.00 to $403.44 for family coverage.
Colorado ranges from $35.50 to $160.44 for single coverage and $166.10 to $501.76 for family coverage.
Kansas rates also vary based on FT or PT status. Cost shown represents typical FT employee in middle salary range.
New Mexico ranges from $50.70 to $81.12 for single coverage and $137.91 to $220.65 for family coverage.
Oklahoma provides employees with a benefits allowance of $272.82 for employee only coverage and $625.95 for family coverage. Medical rates range from $183.28 to $309.98 for single coverage and from $511.36 to 864.84 for family coverage.

RESOURCE

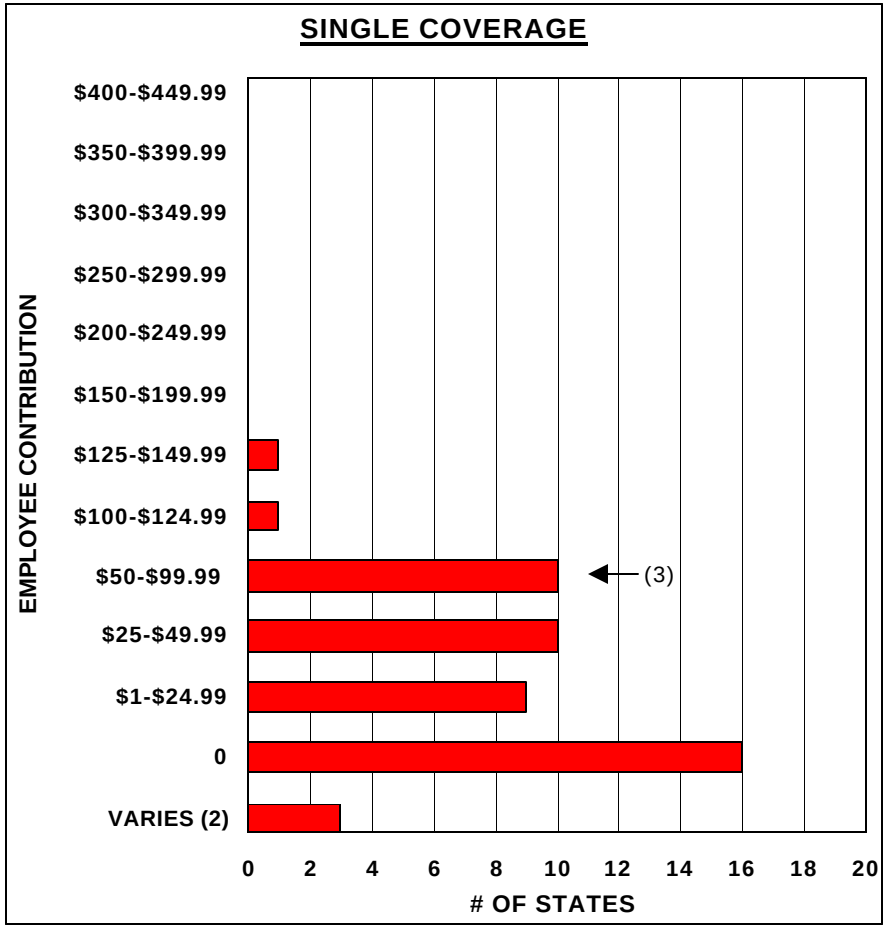
Data obtained from *Workplace Economics, Inc. 2002 State Employee Benefits Survey.*

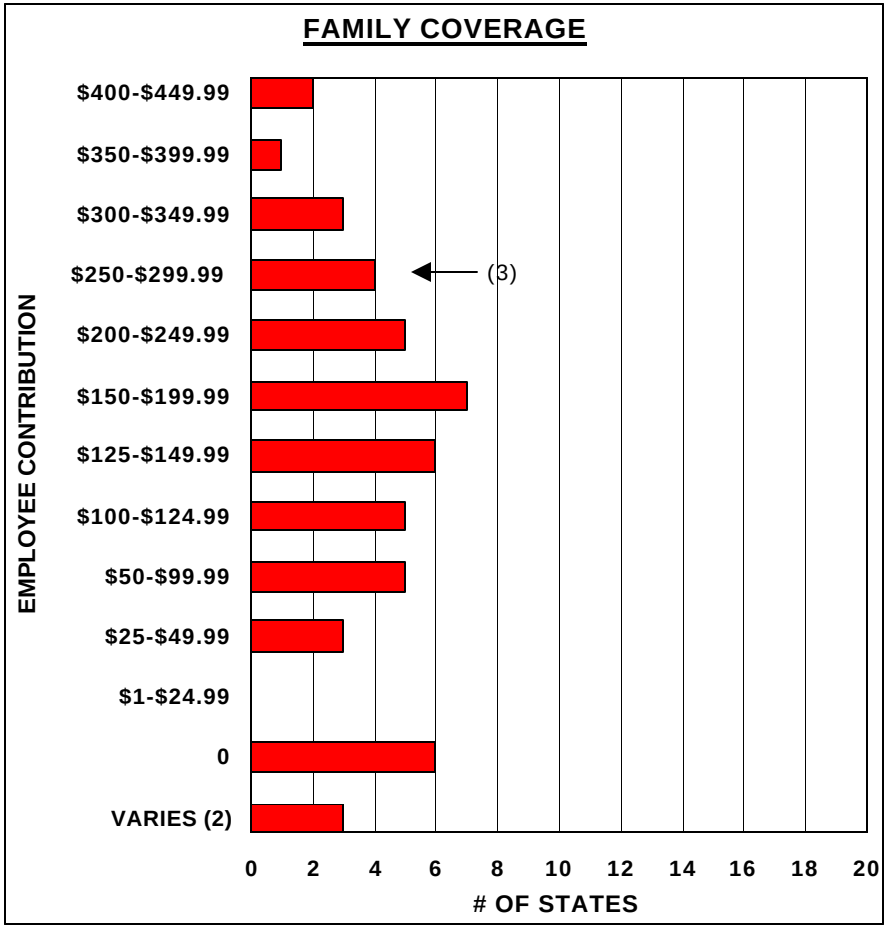
The average employee contribution for the lowest cost medical option offered by the 11 other states is $19.64 per month compared to $76.40 (289.0 percent higher) for Colorado. Four of the 11 other state programs offer at least one medical option at no cost to the employee for single coverage, while 6 of the 11 plans have an employee-only premium for their lowest cost plans of less than $10.00/month. For family medical coverage, the average employee contribution for the lowest cost options offered by the other 11 states is $138.84, compared to $272.34 (96.2 percent higher) for Colorado. It is noteworthy that the highest cost plan for the other states is only $.04 (4 cents) per month higher than Colorado's least expensive plan.

According to our independent analysis, which included results from a 2002 study by Workplace Economics, Inc., Colorado had the 41st highest employee medical contribution for employee coverage among 46 reporting states, and 40th among the 46 states for family medical coverage. Sixteen states (35 percent) offered single coverage with no employee contribution. Overall, the average employee contribution for all states was $30.61 for single coverage, compared to the Colorado statewide plan with the largest enrollment (PPO) of $76.04 (148.4 percent higher). The average employee contribution for family coverage was $157.65, compared to the Colorado PPO plan of $272.34 (72.7 percent higher). The following chart reflects employee contributions for single and family coverage among all 50 states.

COLORADO STATE AUDITOR - REPORT ON EMPLOYEE BENEFITS

MONTHLY EMPLOYEE CONTRIBUTIONS (Full-time Employees)
50-STATE COMPARISON
MEDICAL PLANS [1]





NOTES:

(1) Employee contribution includes dental coverage for the following eight states: FL, IN, NJ, NY, ND, NV, OK and WA.

(2) Employee contributions vary based on salary, plan chosen or county where employee resides.

(3) Colorado falls into these ranges with employee contributions as follows: Single Coverage = $76.04 and Family Coverage = $272.34.

RESOURCE:

Data obtained from *Workplace Economics, Inc. 2002 State Employee Benefits Survey.*

Among other larger Colorado public and private employers, the monthly employee contributions generally are lower than for the State. Other survey data also suggest that employers generally are absorbing a larger portion of the medical costs. According to a Kaiser study, the average 2002 employee contribution for single coverage ranges from $36-$44, depending on the type of coverage, and $163-$182 for family coverage. According to the Mountain States Employer Council, employee contributions averaged $45-$52 for single coverage, and $230-$260 for family coverage in 2002. Again, it is important to note that the level of reimbursement being provided in these cases is generally more comprehensive than that being provided by the State.

The cost of health care is a national issue confronting large and small employers alike. Given the State's budget constraints, additional funding is not a realistic option in the foreseeable future. Additionally, we include a note of caution that the overriding objective of the State's total compensation philosophy is to recruit and retain a qualified workforce by offering competitive compensation. "Total compensation" is made up of base and premium pay, non-monetary benefits, and retirement benefits in addition to health and life benefits. We note that it is beyond the scope of our engagement to determine if the deficit in benefits, which we note in this section, is more than offset by better than prevailing pay, non-monetary and retirement benefits. Non-benefit components could, theoretically, compensate for the benefits and make the overall compensation package "prevailing" in the labor market. Nonetheless, health benefits remain a critical part of the total compensation package and need to be addressed.

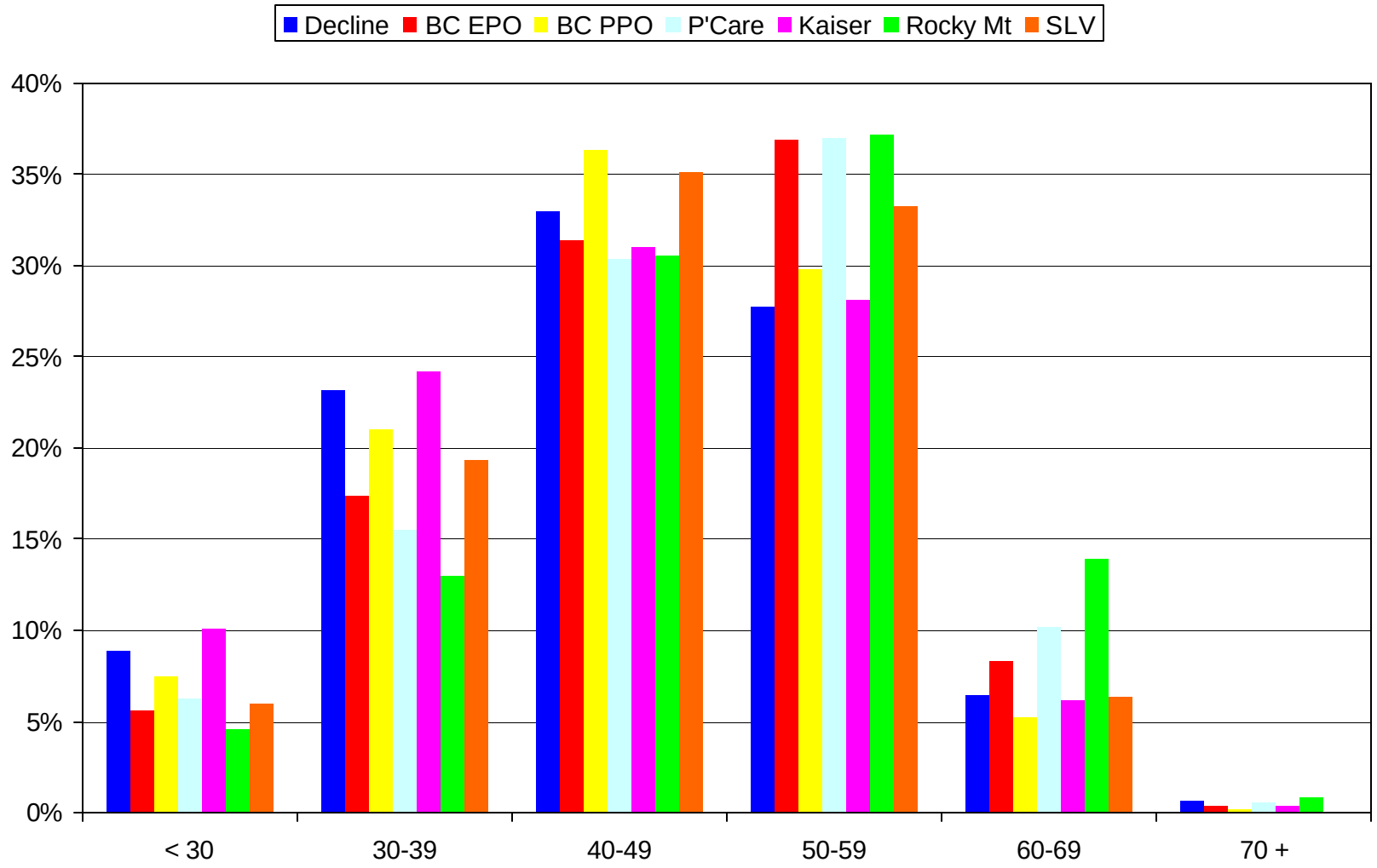
How, then, does the State cope with rising costs in its attempts to develop a competitive benefits package? To address the significant gaps between the State and prevailing benefits practices and contribution rates in the tight fiscal environment, we focused our efforts on possible improvements to the Department's plan designs and the program as a whole. Our analyses and recommendations are set forth below. While it is unlikely that the areas for improvement will solve the problem entirely, the Department should be attempting to curb costs and improve benefits by exploring the feasibility of each of the recommendations. We then discuss self-insurance as a potential alternative for the State.

PARTICIPATION IN THE PLAN

We analyzed employee enrollment and found a significant number and distribution of employees not electing any medical coverage. The chart on the next page shows enrollment by age and plan type. We found that 30 percent of eligible employees elected in 2003 not to enroll in a medical plan. Further, 44.8 percent of the employees under age 40 are not covered. The average age of employees enrolled in the plans is 45.5. Obviously, the absence of close to half of the younger population in the insured group raises the average age of the covered group and the average cost of coverage for those who are enrolled. The younger group is typically the least costly group from a claims perspective.

COLORADO STATE AUDITOR - REPORT ON EMPLOYEE BENEFITS

Percent of Enrollment in Colorado Medical Plans by Age by Plan



The Department recently surveyed nonparticipants in its health plans to find out why they are not participating. Of the approximately 1,400 state employees responding to the survey, 87 percent indicated that they have other health insurance, while 13 percent indicated that they do not have any insurance. Of the respondents that have health insurance, 70 percent stated that they are covered under their spouse's employer-sponsored plan. The percentage of state employees without any coverage should be of concern to the State because its benefit design and contribution strategies may be indirectly adding to the number of uninsured in Colorado. In addition, significant non-participation may actually raise the average costs of the State's plan. Given the substantial degree of non-participation noted above, the DPA should use the results of the survey to make appropriate plan design and contribution adjustments aimed at attracting those employees into the plan.

Recommendation No. 1:

The Department of Personnel & Administration should use the results of its survey of state employees who are not participating in the State's health plan to make appropriate plan adjustments aimed at increasing employee participation.

Department of Personnel & Administration Response:

Agree. The Department found, through its survey of state employees who are not participating in the State's health plan, that the high premium cost to employees is the primary reason employees are not participating in the health care programs offered. In order to address these cost issues, the Department did make significant changes to the benefit design of all its fully-insured programs for the 2003 plan year by increasing the amount of deductible/coinsurance and copayments. In addition to the minimal increase to the State contribution for 2004, we will work to address cost issues during the evaluation and negotiation of the 2004 plan year programs. We will also continue to evaluate plan designs by incorporating an enhanced disease management program and by providing comprehensive consumer education.

Implementation Date: January 2004

RATE TIERS

One issue of concern with the State's current plans is the rate structure for employees and their dependents. The State currently employs a 3-tier structure as a basis of determining premium distribution among family members. That is, employees have the following three options for covering themselves and their dependents:

- Employee only
- Employee plus one dependent (spouse or child)
- Employee plus two or more dependents

According to statute, the State's 3-tier structure must be in place through Calendar Year 2003.

It is relatively rare among large employers to use a 3-tiered structure. Most large employers use a 4-tier rate structure, as follows:

- Employee only
- Employee plus spouse
- Employee plus children
- Employee plus family

By adopting a 4-tier structure, the Department would enable state employees to better compare the family coverages available to each employed parent and determine the best mix of coverage for the family without overpaying. For example, a family with one parent who is a state employee, two children and a working spouse who has access to a different medical insurance plan with a 4-tier rate structure, cannot easily compare whether the kids should be enrolled in the State's plan or the spouse's plan. Colorado's 3-tier structure requires the employee to pay for the spouse and the two children even though the employee may want to cover only the two children with the State and cover the spouse under the spouse's own employer-sponsored plan.

Having established the number of tiers, most large employers then dictate the rate tier ratios. By tier ratio, we mean the difference in premiums between employee only coverage and other tiers. For example a ratio of 2.94 means that the family premium is 2.94 times the rate for employee only coverage. Colorado allows its carriers to determine these ratios. Currently, family rate tier ratios for the medical plans range from a low of 2.62 (Anthem plans) to a high of 2.94 (Kaiser). From our experience, most state health plans mandate the rate tier ratios in order to equalize all carriers in rate setting. There is an important reason for standardizing rate tier ratios. Differing ratios allow carriers to position their premiums to target different health risk groups. One health carrier could thereby end up with a less healthy or more healthy group than another provider.

We recommend the Department mandate the tier ratios under a 4-tier structure. Mandated tier ratios will minimize the adverse impact of carriers targeting certain risk

groups for inclusion or exclusion through their rate pricing. A 4-tier rate structure will enable state employees to make more informed choices.

Recommendation No. 2:

The Department of Personnel & Administration should consider modifying its medical benefit plan by eliminating the current 3-tier premium rate structure in favor of a 4-tier rate structure with consistent tier ratios for all fully-insured plans.

Department of Personnel & Administration Response:

Agree. The Department will evaluate a 4-tier rate structure with consistent tier ratios for all fully-insured plans with its evaluation of the renewals/RFP considerations for the 2004 plan year.

Implementation Date: January 2004

NUMBER OF PLAN CHOICES

The State offers four Health Maintenance Organizations (HMO), one Exclusive Provider Organization (EPO), and one Preferred Provider Organization (PPO). Most other plans we reviewed limit the number of options to less than what the State provides. However, according to Section 24-50-606(1), C.R.S., the Department is required to offer two HMOs (if available) in addition to any other plans offered in certain geographic areas. The law applies in the City and County of Denver, and the counties of Adams, Arapahoe, Boulder, Douglas, El Paso, Jefferson, Larimer, Pueblo, and Weld, and in each county that has at least 500 residents who are state employees. This requirement:

- Limits the State's ability to select plan offerings based on quality, value, and overall benefits philosophy.
- Can provide a distinct advantage to certain HMOs who might be the only carrier or one of a limited number of HMOs maintaining operations within a given county.
- Limits the State's purchasing power.
- Reduces the State's ability to effectively manage its overall medical risk.

Among the other 11 states surveyed, only two states (Oklahoma and Washington) have specific laws/requirements in place relative to the number and types of offerings to be provided to employees. More typically, the selection of plans is predicated on the plans that meet established objectives as to choice, cost effectiveness, and risk management.

We found that those states in our survey that do not have legally mandated plan options still have adequate choice for their employees. All of the states surveyed offer more than one plan. HMOs or Point of Service (POS) plans are offered where deemed viable, with a statewide PPO or indemnity plan also commonly offered. Among Colorado public and private employers surveyed, multiple plans are also commonly offered. HMO and PPO plans are most prevalent. We believe the Department should pursue legislation to eliminate specific statutory mandates as to the numbers and types of plans offered and then develop the most cost-beneficial plan that meets choice, cost-effectiveness, and risk management objectives.

It is noteworthy that many private employers with geographically diverse employee populations are moving away from traditional HMO provisions, or are eliminating HMOs as plan offerings altogether. There would be merit in considering a replacement for the majority of the HMO offerings that would consist of a more comprehensive POS and PPO plan design. This would more readily allow consolidation of plan vendors, enhance the overall risk management, and be more conducive to self-insuring, if the State elected to go in that direction. Of course, this could only be done in conjunction with a change in the law regarding the requirements relative to HMO offerings.

Limiting choices must be carefully balanced with benefit designs and cost. Currently, there is a disproportionate distribution of risk in the lower cost plan options. Kaiser has 28.4 percent of the State's total covered employee population. For the age group of 0-39, it has approximately 40 percent of the population. Kaiser's penetration in the 0-40 age group is even more significant when one considers that it has a limited service area. This age group generally is the segment of plan members that medical carriers desire in order to offset the higher risk, older population. Given the State's contribution levels, it is understandable that people in the younger age groups gravitate to Kaiser as a low cost option. Employees residing outside the Kaiser service area must select from higher cost options. The data clearly indicate that the non-Kaiser medical carriers have a higher percentage of older state employees. This has a distinct impact on their premium rates, which reflect the relatively higher age segment that they must underwrite.

Regardless of whether or not the State fully insures or self-insures, which is discussed in greater detail later in the report, the statutory restriction on plan design may preclude cost-effective plan designs for Colorado. We recommend the State consider revising the statute to eliminate this restriction. Although the Department could seek a legal opinion from the Colorado Attorney General on the authority to self-insure without offering two HMOs in the designated counties, this would not allow the Department to offer fewer than two HMOs under a revised fully-insured plan. In addition, this is a broad policy issue that may best be addressed by the General Assembly.

Recommendation No. 3:

The Department of Personnel & Administration should consider:

a. Proposing legislation to eliminate specific statutory mandates on the numbers and types of medical plans offered.

b. Streamlining its carrier choices.

Department of Personnel & Administration Response:

a) Agree. The Department has made several attempts to eliminate specific statutory mandates relative to the number and types of plans offered. We will again work with appropriate parties during the 2004 legislative session to introduce the necessary changes.

b) Agree. We did reduce the number of carrier choices in 2003 from those offered in 2002 from seven to five. We will consider the number of carrier choices to be offered through our benefits evaluation for the 2004 plan year.

Implementation Date: January 2004

EMPLOYEE ELIGIBILITY AND ENROLLMENT

The Department's current plan design is significantly more generous than prevailing practices regarding who is eligible and when they may enroll. These practices are detailed below.

Who is eligible: The key provisions of the State's health plan eligibility requirements may be summarized as follows:

- Initial eligibility – 1st of month on or after date of hire, with no pre-existing condition limitations.
- Minimum work requirements – 8 or more hours per month.
- Dependent eligibility – to age 19, and to age 24 if full-time student.
- Foster children – considered eligible dependents with appropriate documentation of legal guardianship.

- Grandchildren – considered eligible dependents, if a child of a covered dependent. Legal guardianship by the grandparent is required if the parent ceases to be a covered dependent of the grandparent.

- Annual enrollment – no restrictions on new enrollment, even if coverage was previously declined, and no pre-existing condition limitations for employees or dependents.

- Dependents – employees participating in the cafeteria plan pre-tax premium payment cannot change dependent elections during the course of a plan year except for a qualified family status change (e.g., birth of child, marriage, or divorce). Employees not enrolled through the cafeteria plan provision can drop dependents at any time during the year and re-enroll at the next open enrollment or earlier if a qualified family status change occurs.

- Other public entities – not eligible to participate in the State program.

The following provides the general practices among the 11 other state health plans surveyed in each of the above categories:

- Initial eligibility – most common provisions provide for coverage on or after 1st of month following employment; next most common is 1st day of month on or after 30 days from date of employment, with no pre-existing condition limitations.

- Minimum work requirements – by far the most prevalent minimum work requirement is 20 hours per week.

- Dependent eligibility – to age 19, and to age 24-26 if full-time student; one state has no student status requirement – only requires dependent to meet IRS definition of dependent.

- Foster children – typically not considered eligible dependents unless employee documents legal guardianship.

- Grandchildren – typically not considered eligible dependents unless employee documents legal guardianship.

- Annual enrollment – generally, no pre-existing condition limitations for employees or dependents; one state imposes 90-day waiting period, another requires medical underwriting. Several have an annual “switch” enrollment only, which means that participants may switch between plan offerings but may not enroll for the first time in subsequent years after initial rejection of coverage.

- Dependents – generally, dependents cannot be added/dropped at any time during the year except for a qualified family status change (e.g., birth of child, marriage, or divorce).

- Other public entities – statutes in a variety of other states allow other public entities to participate in the state health plan. The rules and provisions for such participation vary.

We recommend the Department revise the minimum work requirement to 20 or more hours per week to qualify for benefit eligibility. It is estimated that this will allow the State to realize annual savings of about $700,000 in 2003 dollars. In addition, it is an uncommon practice to allow grandchildren to be covered if they are not the legal dependent of the employee. The Department should restrict eligibility to those cases where the employee is the legal guardian. The Department should also restrict eligibility for foster children to those for whom written documentation is provided substantiating legal guardianship. The Department should also consider the fact that, based on income, foster children are Medicaid-eligible and therefore have access to federal funding for health benefits.

When employees may enroll: The State currently allows a true "open" annual enrollment, by which employees/dependents not currently enrolled can be enrolled with no restrictions. Other large employers typically restrict enrollment opportunities to a one-time election when employees begin their employment. The State's process can be problematic. This complete open enrollment can expose the State to material adverse selection. By adverse selection, we mean the disproportionate likelihood that individuals will be more inclined to enroll and pay considerable employee contributions only when faced with a specific medical condition, whether on the part of themselves or dependents. This is counter to the notion of spreading risk, and can lead to more rapidly escalating premiums, which in turn increases the cost and the likelihood that employees *not* facing specific medical conditions will be pressured into dis-enrolling. This spiral can become increasingly acute, leading to what is often referred to as the "death spiral."

The State's practice of allowing employees to drop dependents at any time during the year is rare among employers, and adds an additional element of adverse selection to the program. We recommend that the State limit employees' ability to drop dependents to the annual enrollment opportunity, other than for qualified family status changes.

The Department should consider limiting enrollment of employees and their dependents during the annual enrollment period. One approach to such a limitation would be to only allow employees to switch existing coverage among plan offerings. Employees would not be allowed to establish coverage for themselves/dependents if they have not previously chosen to be covered. The Department would allow covered employees to enroll additional dependents upon qualified family status changes, and could periodically evaluate the merits of ad hoc opportunities to expand the permissible enrollment during designated annual enrollments. Another approach used by New Mexico Public Schools, is to impose pre-existing condition limitations, to the extent allowed by the Health Insurance Portability and Accountability Act, at open enrollment for participants not previously covered under the plan.

Recommendation No. 4:

The Department of Personnel & Administration should consider appropriate modifications to its medical plan eligibility by:

a. Re-evaluating the minimum employee work requirement.

b. Re-evaluating eligibility for foster children and grandchildren.

c. Analyzing the costs and benefits of more restrictive open enrollment policies that minimize adverse selection.

d. Limiting employees' ability to change their elections, and that of their dependents, to the annual enrollment opportunity, other than changes consistent with qualified family status changes.

Department of Personnel & Administration Response:

a) Agree. The Department has been working on an analysis of the minimum employee work requirement since December 2002. We will have the analysis completed by mid-July 2003 in order to bring recommendations forward to incorporate any applicable changes by January 2004.

b) Agree. We will evaluate eligibility for foster children and grandchildren by January 2004.

c) Agree. We will analyze cost/benefits of more restrictive open enrollment policies during FY04 with appropriate changes included for the 2005 plan year.

d) Agree. It is correct that employees electing after-tax premium deductions may drop coverage anytime during the plan year. Employees who drop coverage may not elect to come back into the plan until the next open enrollment other than through a qualified status change. We will evaluate this practice to see if there are any unintended consequences to the plan in conjunction with "c" above.

STATE CONTRIBUTIONS TO PART-TIME EMPLOYEES

Another area where we found the State's plans more generous than others is its health benefits contributions to part-time employees. The State contributes the same amount of money to the health insurance premiums of both part-time and full-time employees. This means that an employee working *8 hours per month* receives the same employer contribution as a full-time employee working *173 hours per month*. Whether or not the Department changes the eligibility of part-time employees, as discussed above, the Department should reconsider the level of employer contribution to the health benefits of the State's part-time employees.

States included in our survey were evenly split as to their contributions on behalf of full-time employees versus eligible part-time employees (generally 20 hours of work or more per week). That is, about one-half do not differentiate their employer contributions between full-time and part-time employees, and roughly one-half do. Two states surveyed have instituted a sliding employee contribution schedule, varying by salary. This is a growing trend in general among private and public sector plans. The prevailing practice among large public and private employers other than the states we surveyed is to offer a reduced employer contribution for part-time employees. The typical employer contribution for part-time employees ranges from 50 percent to75 percent of that for full-time employees. Assuming that employer contributions are reduced to 50 percent of that for full-time employees, the State would save approximately $1.2 million annually based on current enrollment and 2003 plan costs. We recommend the Department consider reducing the employer contribution for part-time employees.

Recommendation No. 5:

The Department of Personnel & Administration should consider alternatives for partial employer contributions to the health benefits of eligible part-time employees.

Department of Personnel & Administration Response:

Agree. The Department is conducting an analysis of eligibility for permanent part-time employees to be completed by mid-July 2003. Included in the analysis is evaluation of the State contribution. We will consider alternatives for partial employer contributions to the health benefits of eligible part-time employees.

Implementation Date: January 2004

ADEQUACY OF DATA

Another issue of significance is data management. Overall, we found that the Department does not collect some of the information necessary to effectively manage the state health benefit program. For example, as we discuss later in the report, the Department does not require carriers to provide information on how drug rebates will be calculated and paid to the State or on their subrogation policies and procedures. The Department also does not have information on the design and operation of the carriers' disease management programs and the diagnoses covered. The Office of the State Auditor found similar problems in its 1997 audit of Employee Health Benefits. For example, the audit found that the Department did not have sufficient information to ensure the accuracy or timeliness of claims payments.

Accurate claims data is essential to effective plan management. A data warehouse would be invaluable for future claim and utilization analyses, actuarial modeling, and plan pricing. In a fully-insured environment, the Department can work with the carriers to develop information reporting requirements. In a self-insured environment, the Department will simultaneously need to establish reporting requirements for its third-party administrator.

While having access to data in a self-insured environment is critical, it is very desirable and increasingly common among larger employers to require substantial reporting/data from their carriers under a fully-insured environment. Carriers are now more forthcoming in their willingness to provide data, and a group the size of the State should have the leverage to require extensive data reporting. We recommend that the State establish specific reporting requirements of its vendors, along with appropriate justification for any deviation from such requirements.

Recommendation No. 6:

The Department of Personnel & Administration should establish reporting requirements to capture appropriate pricing, claims, and utilization data in order to fully inform its plan funding and design decisions regardless of whether the State remains fully-insured or elects to switch to self-insurance.

Department of Personnel & Administration Response:

Agree. The Department will re-evaluate its reporting requirements, including those relative to drug rebates and subrogation.

In our May 2003 carrier renewal letter, we requested that all current carriers provide the design and operation of their disease management programs and diagnoses covered.

The Department does track and apply annual performance standards regarding the accuracy and timeliness of claims payments. Carriers not meeting the required

standards, are assessed a penalty consisting of a percentage of the annual premium paid by the State. We agree that continuous improvement to performance requirements is important. We will review contract language to ensure that these requirements are changed, as necessary.

Implementation Date: January 2004

SELF-INSURANCE

BACKGROUND

According to Department staff, prior to Calendar Year 2000 the State was self-insured for more than 15 years. The Department had about 80 percent of its enrolled members in self-insured options, with the balance in fully-insured HMOs in those geographic areas where such plans offered coverage. In 1999, the Department was faced with a number of problems with its self-insured plan. Among these problems were concerns about the Department's ability to successfully manage the program's large third-party administrator. In a 1997 Performance Audit, the Office of the State Auditor identified problems with the Department's third party administrator, including claim payment inaccuracy, slow claims processing times, and poor coordination of benefits. The audit report concluded that the Department needed to improve its plan administration. In addition to problems with management of the program, health care costs were on the rise and private fully-insured plans were negotiating arrangements with health care providers. As a result, commencing with Calendar Year 2000, the State switched to a fully-insured plan in an attempt to eliminate the financial risk and save money.

Since Calendar Year 2000, the State has purchased fully-insured medical (including prescription drugs) and dental coverage. The plan as it stands today has six carriers, each of whom establish rates based on their claims experience and projections. Each participating carrier separately experience-rates its coverage with the State in some fashion. There is no blending of experience and rates for the medical plans. Each carrier is expected to stand on its own with the rates it offers. Health care cost increases coupled with already low State contributions resulted in significant benefit design modifications in 2003 that further reduced state employee coverages.

As part of our audit we evaluated the advantages and disadvantages of self-funding medical benefits plans. Large public and private employers are struggling with the most cost beneficial method of providing health benefits. How to cover the financial risk of providing a health care benefit – whether through a fully-insured, partially-insured, or self-insured plan – is one of the most critical issues facing employers today. We analyzed the feasibility of the State returning to a self-insured plan from a financial perspective and then looked at benefit design options.

COST ANALYSIS

We first looked at how states of similar size and demographics financed their plans. For the 11 states we surveyed, the medical plan funding methods for the most prevalent programs are:

- Minimum Premium: 1
- Fully-insured: 3
- Self-funded: 7

Arizona, which is one of the 11 other states in our survey, is in the midst of a study to determine the feasibility of converting from fully-insured to self-funding Oklahoma has seen the number of HMOs offered to its employees diminish from eight to the current two over the past five years. Iowa uses minimum premium funding for its indemnity plans and retains its own reserves, an essential element of self-funding. A minimum premium arrangement operates similarly to a self-insured arrangement, in that the plan sponsor agrees to a fixed fee which includes the carrier's various administration and operating fees, plus a risk charge. Then, the plan sponsor reimburses only those claims actually paid, up to an agreed upon maximum.

New Mexico, which offers two statewide managed indemnity plans and three regional HMOs, self-insures all plans. The other states generally self-insure their indemnity plans and insure their HMOs. At least three states, Oklahoma, Washington, and Nevada, have risk-adjusted their insured HMOs to reduce adverse selection against their managed indemnity plans. Risk adjustment is an actuarial technique that is used to compensate for the tendency of HMOs to attract the healthier and younger participants by increasing the HMO rates based on a risk-adjustment margin.

According to a 2002 survey conducted by William M. Mercer, 32 percent of government plan sponsors self-fund HMO coverage, and 64 percent self-fund PPO coverage. Among all large employers, 9 percent self-insured their HMO coverages in 2002, and 92 percent self-funded their PPO plans, according to the Mercer study.

Over one-half of all large Colorado employers self-fund some aspect of their medical programs, according to a 2002 survey conducted by the Mountain States Employers Council. In addition, over one-half of larger private and public employers responding to our survey self-fund one or more of their medical programs.

In addition to comparing Colorado's financing to that of other large employers, we compared the projected 2003 annual costs of the State's current fully-insured medical and dental plans to self-funded costs had the State elected this form of funding at the start of this year. We started by creating actual total health plan costs for 2001 and 2002 and then projecting costs for 2003 (including incurred but not reported, or IBNR reserves). Next, we developed estimated self-funded fixed costs. As explained in greater detail below, for variable costs we assumed that paid claim costs would be the

same under insured and self-funded plans and used State carriers' actual projections provided with their 2003 renewal proposals.

Cost projections for self-insurance include fixed and variable costs, as well as necessary reserves. Fixed costs include all charges other than claims costs, such as claims administration, medical utilization management, stop-loss insurance premiums and retention charges. Retention charges include such items as commissions, premium taxes, risk charges and profit. Variable costs are those expenditures directly attributable to paying claims (e.g., costs of medical care). Sufficient reserves must be set aside to handle both fluctuating (unanticipated) claims costs each year and for IBNR claims if the plan ever ceases to be self-insured. Our discussion of each of these financial components follows.

FIXED COSTS

The fixed-cost estimates we used are based on our recent experience with local self-funded plans using third-party administrators or Administrative Services Only (ASO) contractors and other service providers, such as utilization management organizations. Claim costs are assumed to be the same for 2003 under an insured and self-funded medical program. Savings could potentially come from reducing fixed costs (e.g., various administrative expenses and stop-loss insurance) and reducing retention charges.

For the medical plans, based on information provided by the Department, our analysis indicates that projected fixed costs (including stop-loss insurance) would be less than the current insured plans' fixed costs. Our state plan survey results show typical medical self-funded plan fixed costs of 5 to 7 percent. Retention charges (less reserves) for a typical insured plan are 10 to 12 percent of premiums. This means the State could save 3 to 5 percent in fixed costs under a self-funded plan. Given the State's 2003 projected total medical premium of $122.9 million, we estimate Colorado's medical plan fixed costs to be $3.7 million to $6.1 million less if the State had self-funded in 2003.

The reasons for this cost difference are many, but the most notable follow:

- Carriers' retention charges are less under a self-insured Administrative Services Only (ASO), or third-party administrator, arrangement than under a fully-insured plan. Under an ASO arrangement, the insurance carrier performs all of the claims processing and other functions as under an insured arrangement, but with the plan sponsor assuming the risk. Because insurance carriers acting as ASO contractors are not at financial risk, various risk and margin charges built into the insured rates are eliminated. Although these types of charges must be built into the State's self-funded reserve, which we have included in our analysis, they will be lower overall in a self-insured environment.

- Stop-loss insurance coverage, also known as pooling in a fully-insured plan, is more efficiently offered through one umbrella approach under self-funding than separate pooling arrangements under multiple insured carriers. For the smaller carriers used by the Department, these charges could be a significant portion of the premium. A stop-loss or pooling provision insulates the insurer/plan sponsor from significant losses associated with infrequent, but catastrophic claims. As the size of the risk pool increases, the predictability, and correspondingly, the ability to tolerate such large claims increases, thereby decreasing/eliminating the need for such protection. Consolidating all self-funded plans under one stop-loss insurance policy would result in considerable savings to the State. These projected savings are included in our analysis.

It is important to note that we did not examine the required administrative resources the Department would need to administer a self-insured plan. Our analysis does not include these program costs, which are likely to be higher than present levels for a self-insured plan.

VARIABLE COSTS

Variable costs are those that fluctuate and must be accurately predicted in order to minimize the threat of financial volatility in a self-funded environment. They include expenditures for medical care and related benefits, such as inpatient and outpatient care, medical equipment, and prescription drugs. Adequate reserves must be set aside to handle higher than anticipated variable costs.

The Department provided us with claims data, which we used to project future costs. As mentioned above, our analysis assumes that variable claim costs would be the same under the current fully-insured plans and a newly established self-funded plan. It can be argued that self-funding, with its ability to carve out a prescription drug plan and utilization/disease management, would result in lower claim costs than compared to the current multiple plan insured arrangement. However, to maintain a conservative approach to our analysis, we have assumed parity of claims under the two funding methodologies for 2003. Our analysis included a review of carrier actual claim experience for plan years 2000, 2001, and 2002 for volatility and trends in claims experience.

Based on the data provided by the Department, the State's projected total claims costs for 2003 are approximately $102.2 million. We estimate that if the State had self-insured in 2003 it would have needed a 5 percent reserve for claims fluctuations, or about $5.1 million. We urge caution, however, because we did not undertake a comprehensive analysis of the State's claims volatility over an extended period of time to determine precisely how much money the Department should set aside as a reserve for unexpectedly high claims. Although we believe the size of the State's risk pool, even with Kaiser carved out, is sufficiently large to make 5 percent an appropriate starting point for a fluctuating claims reserve, the Department's analysis should take account of any additional claims fluctuation experience from its previous period of self-insurance.

In addition, the State's level of risk tolerance may dictate a claims fluctuation reserve of up to 10 percent. Based upon its comprehensive analysis, the Department may need to increase the fluctuating claims reserve accordingly.
A separate reserve for incurred but not reported (IBNR) claims is necessary to finance those claims that, at any given time, have been incurred by plan participants, but not yet paid by an insurer or claims payor. These IBNR claims are the responsibility of the plan (or the insurer under an insured arrangement) and should be "funded" by establishing and maintaining reserves. They can create financial obligations years into the future after a plan ceases coverage (claims run-out).

IBNR reserves can be partially funded by the cash flow created during the conversion to self-insurance. Conversion from fully-insured to self-funding creates a one-time "windfall" due to the run-out of claims from the insured plan while contributions are collected for the self-funded plan. Claims are not usually paid until 30-60 days after being incurred. During this period, the self-funded plan develops a portion of the reserves needed for its IBNR. Our reserve analysis takes this self-funded reserve windfall into consideration.

Assuming that the State had self-funded this year, it would need a total reserve of $27.2 million as of December 31, 2003. This amount consists of our recommended IBNR reserve of $22.1 million (including claim administration run-out expenses) and a first year claims fluctuation reserve of $5.1 million (5 percent). We estimate that $23.4 million (86 percent) of the total recommended reserve would have been accumulated as a result of the one-time windfall upon converting to self-funding. That leaves approximately $3.8 million that would need to be funded in future contribution rates.

One approach to funding the additional needed IBNR reserves of $3.8 million is to add the entire amount into the first year's self-funded contribution rates. Had the State self-funded this year and chosen to fund the entire IBNR in year 2003, it would have added approximately 3.3 percent to the medical premium rates based on total projected costs of approximately $116.8 million to $119.2 million. These projected premium rates are based on the State's fully-insured costs of $122.9 million, reduced by projected fixed cost savings of $3.7 million to $6.1 million if the State had self-insured this year.

A more realistic and common approach is to fund the balance of the needed IBNR over a two- to three-year period. Most plans do not attempt to fund the entire IBNR in the first year of self-funding. Instead, they elect to systematically fund the needed additional reserve above the level provided by the self-funding conversion windfall over several years. The IBNR funding decision is dependent upon the State's risk tolerance and needs to be carefully considered. Our analysis assumes that the State would fund its full IBNR over three years, which we project would require an increase of 1.27 percent in the annual contribution rates, or $4.23 per month per employee over the thirty-six month period. In addition, the three year reserve amortization costs would be reduced by almost half if the State used the projected first year surplus of $1.9 million from self-insuring its dental plan, which is discussed in greater detail later in the report.

STOP-LOSS COVERAGE

Stop-loss insurance is extra coverage that provides protection for catastrophically large claims against an insurance plan. This type of insurance can be on a per member basis or on an aggregate basis. For example, in a self-insured plan, per member stop-loss pays the balance of all claims for a member for the remainder of the year after the employer pays a deductible, which is determined by the level of coverage purchased. As one might expect, lower deductibles create higher premiums for the stop-loss coverage because more risk has been shifted to the stop-loss carrier. The other type of stop-loss coverage is aggregate. This insurance pays after the employer's total claims for the entire plan exceed a certain dollar ceiling in one year.

Given the size of the State's consolidated medical risk pool, specific and aggregate stop-loss insurance may not be necessary in the long run, but could be considered to mitigate the risk in the early years. The State's plan would be of sufficient size to be actuarially creditable and, therefore, its claim risk should be predictable without stop-loss coverage. To ease the transition to self-funding, the State could purchase aggregate stop-loss insurance only in order to cap its first year maximum claim liability. Specific stop-loss coverage, technically then, would not be required for the self-funded medical plan. Unfortunately, there are few, if any, carriers that will offer aggregate without specific stop-loss. If the State wants the first year assurance of stop-loss coverage, and aggregate-only cannot be purchased, it could then buy specific coverage with a large deductible. Our analysis reflects the estimated costs of $200,000, $300,000, $400,000, and $500,000 deductible policies. In our cost savings analysis, we have assumed a $300,000 specific deductible and aggregate stop-loss insurance. Actually, a deductible of $500,000 would not be unreasonable for a group the size of the State.

COST ANALYSIS CONCLUSION

Based on the data provided by the Department it appears that the State could save around $3 million to $6 million in annual fixed costs by self-insuring. In addition, while not part of this study, the State could potentially reduce claims costs with a more centralized and controlled approach to claims management. In the next section we offer the primary advantages and disadvantages of self-insurance for the State's consideration.

ADVANTAGES AND DISADVANTAGES OF SELF-INSURANCE

For a large public sector entity like the State, the decision to self-insure is not straightforward, as can be seen by the following summary of the advantages and disadvantages of self-insuring. The decision to self-insure medical plans is a very complicated one, with substantial risk for the State and its employees.

ADVANTAGES

Self-funding the medical, drug, and dental plans could result in more centralized control and management for the State. Instead of the real control residing with the carriers in an insured environment, self-funding redirects the control back to the employer.

Self-funding can offer more flexibility in plan design. Rather than having to select from the carriers' insurance plans, self-funding allows the State to design its plans according to its unique needs. Self-funding its medical plans would enable unbundling of services that can be better and more easily provided by third-party, carve-out providers. Consolidating prescription drugs is the most obvious example.

Finally, self-funding could allow the blending and cross-subsidization of contribution rates. There may be situations such as relatively high costs in one geographic area of the State, where intentional cross-subsidization of rates may be desirable and equitable for employees residing in that area. Further, offering a catastrophic medical plan is difficult when all the other plans are insured. Under the current fully-insured environment, blending of rates is impossible. Statewide self-funding eliminates the barriers to cross-subsidization as well as facilitating the use of a true catastrophic medical plan. Statewide blending of rates may raise compensation equity issues for State employees, which the Department must take into account. However, we believe such self-insured blending may be more equitable than the current arrangement, in which employees in areas outside the Front Range with limited plan choice are paying very high rates or dropping coverage entirely. The most cost-effective arrangement for the entire group of State employees is the one that takes full advantage of its size and demographic breadth.

DISADVANTAGES

There are also disadvantages related to self-insuring. If financial projections of the number and severity of claims vary substantially from actual experience, the State would need to increase the plan's funding. While this is somewhat mitigated by the size of Colorado's plan, large plans are not immune to volatility and market shifts.

Another area for consideration is the increased administrative effort and expense of successfully managing a self-insured plan. Self-insured plan sponsors generally experience an incremental increase in effort and expense in the administration of the program. As part of its comprehensive analysis of self-insurance, the Department needs to carefully consider the appropriate level of resources (internal and/or contracted) to competently administer a self-insured plan. We are told that the Department abandoned self-insurance after 1999 in part because of the difficulty in effectively managing and monitoring its large contracts. The Department would need to include in its infrastructure analysis performance benchmarks, effective monitoring systems, and timely and complete reporting of data from its third-party administrator and other contractors.

The existence of Kaiser and its popularity among state employees is another issue the Department must take into account. To our knowledge, Kaiser will not offer self-funded plans, nor will Kaiser allow drugs or mental health/substance abuse services to be carved out. Given the fact that Kaiser currently has more than 8,000 covered employees, allowing it to remain insured while all the other coverages move to self-funding poses the potential for significant adverse risk for the other plans. Options available to the State with respect to Kaiser, should self-funding be pursued are: freezing enrollment, eliminating the plan, risk-adjusting Kaiser or refining/expanding Kaiser's offerings to provide a viable level of benefits or services outside of the Kaiser health care delivery system. In any event, we do not recommend that Kaiser remain fully-insured while all other coverages are self-funded without some actions to reduce the actuarial impact on the non-Kaiser medical plans. As noted earlier in the report, some other states have risk-adjusted their HMO premiums to minimize adverse selection against other plan options.

Finally, the State must be prepared for the fiscal pressures of maintaining reserves. States, especially in the current environment, may have difficulty rebuilding adequate reserves.

OTHER CONSIDERATIONS

There are other policy issues that the State should consider when contemplating self-funding. With over 25,000 employees enrolled in its plans this year, the State government is among the largest consumers of health insurance coverage in Colorado other than the Medicaid program. The market impact of switching from a fully-insured to a self-insured plan needs to be explored. Additionally, depending on how the program is implemented, there could be an impact on Cover Colorado. Cover Colorado is the state program that uses commercial insurance policies to fund health insurance for Colorado citizens who are otherwise uninsurable. If the State decided to self-fund without stop-loss insurance (as its size could justify), currently it would not be subject to a Cover Colorado assessment.

SUMMARY

We recommend that the State consider self-insuring its medical plans by undertaking a thorough analysis of the implications. First, the Department should reexamine underlying data supporting such a move. Second, with the most current information available, the Department needs to evaluate the costs and benefits. Third, the Department should evaluate the human and financial resources (internal and external infrastructure) necessary to cost-effectively administer self-insurance. Finally, the Department needs to develop a comprehensive administrative and financial plan to make the conversion to self-insurance. In Appendix A we discuss various options the Department should consider in designing a self-insured medical benefits plan.

Recommendation No. 7:

The Department of Personnel & Administration should analyze the most recent and comprehensive demographic and financial information on the plan to evaluate financing options and benefit designs for a possible State self-insurance medical plan. Key to this analysis should be consideration of financing issues, reserve levels and risk tolerance, administrative infrastructure and support, the effect of self-insuring on the market, appropriate levels of control, and benefit design.

Department of Personnel & Administration Response:

Agree. The Department will initiate an analysis of all appropriate data, infrastructure and support, market, appropriate controls and benefit design for the purpose of evaluating the return of the State to self-funding. We will utilize other health care experts (e.g., Division of Insurance, carriers, consultants) in order to gather and evaluate the collected data. We will also work closely with the Legislature to explore all aspects in determining the appropriate approaches for returning to self-funding.

Implementation Date: January 2005

DENTAL INSURANCE

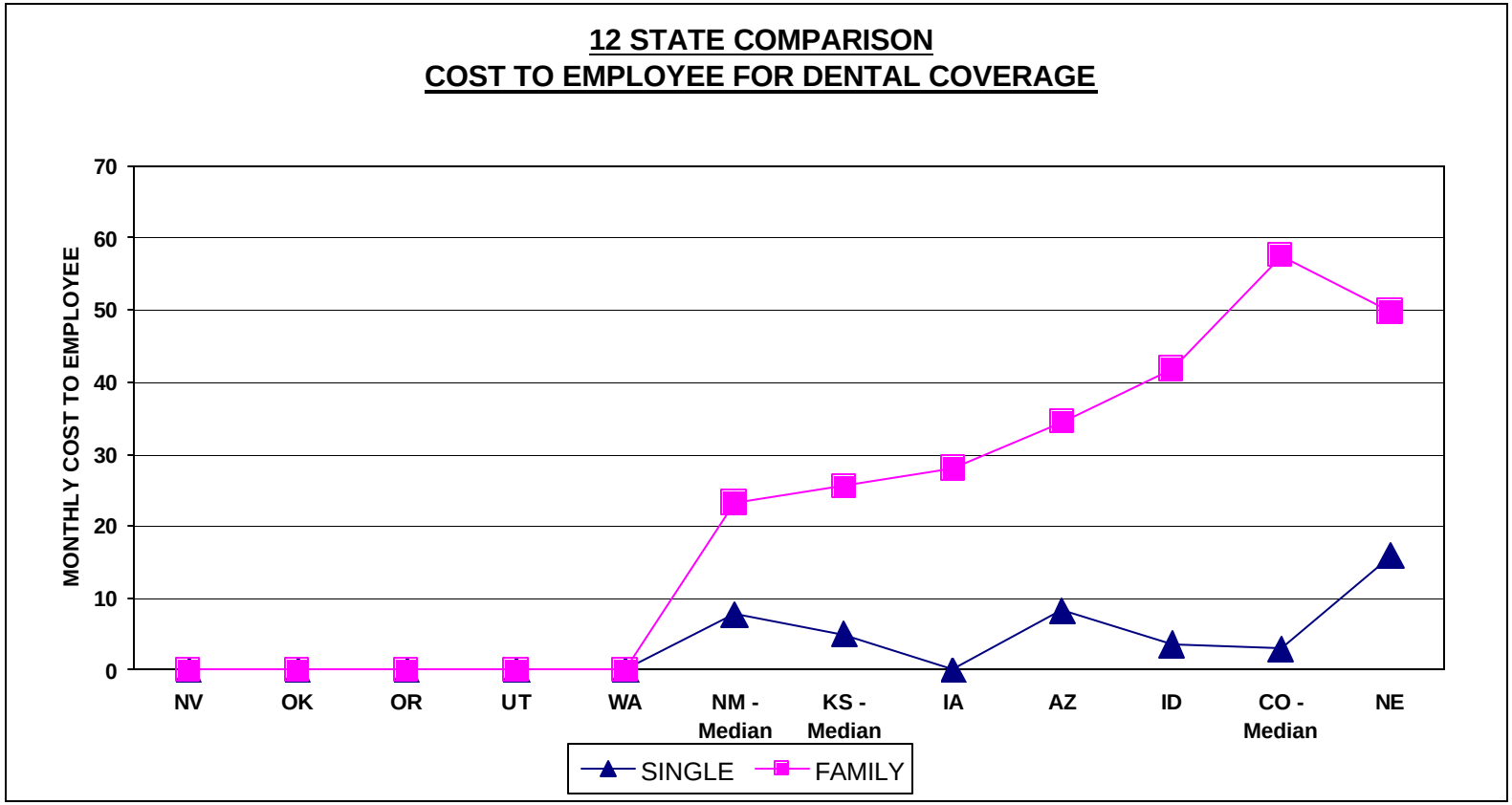
BACKGROUND

The dental program is also less than competitive, in terms of what is funded. The State currently offers two dental options, Basic and Basic Plus. They both utilize a "blind" network – that is, there is a network of dentists that agree to discount arrangements, but there is no explicit plan design element that encourages members to utilize these dentists. This type of passive PPO network is not uncommon for a population that is spread over a broad geographic area with substantial rural penetration, given the difficulty in contracting with providers in these areas. However, the State may have adequate network access where most of its employees reside and could avoid having a passive network across its entire plan.

Similar to our findings related to the medical plan, the State's dental benefit package is not in line with prevailing practices. The monthly employee contribution for the State's dental plan most comparable to that offered by a majority of employers (Basic Plus) is $8.08 for single coverage, and $84.22 for family coverage. For the plan with a much more basic level of benefits (Basic), the monthly cost is $0 and $41.74, respectively. Six of 11 states we surveyed offer a reasonably comprehensive dental plan at no cost to employees for single coverage, with a high of $18.12 among the remaining five. The employee contribution for family coverage ranges from $0 - $56.84, with an average of $19.07. The following chart illustrates Colorado's employee contributions in comparison to other states surveyed. Employee dental contributions among larger Colorado public and private employers are somewhat lower, on average, particularly for family coverage.

COLORADO STATE AUDITOR - REPORT ON EMPLOYEE BENEFITS

STATE COMPARISON OF EMPLOYEE COSTS FOR DENTAL COVERAGE



NOTES

Arizona costs are shown for an indemnity/PPO plan which has the highest enrollment of the three available.
Nevada, Oregon and Washington costs are included in medical coverage costs.
Kansas and New Mexico costs vary according to the employees salary and type of plan/coverage level chosen.

COST VARIANCES

Colorado ranges from $0.00 to $5.48 for single coverage and $41.74 to $73.46 for family coverage.
Kansas rate also varies by FT or PT status and employee's tobacco user status with smokers paying additional $10.00 per month.
New Mexico ranges from $5.96 to $9.53 for single coverage and $17.88 to $28.60 for family coverage.
Oklahoma provides employees with a benefits allowance of $272.82 for employee only coverage and $625.95 for family coverage. Dental rates are $19.98 for employee only plus additional $19.98 for spouse and/or $14.84 for child ($39.88 children).

RESOURCE

Data obtained from *Workplace Economics, Inc. 2002 State Employee Benefits Survey.*

Due to the relatively low employer contribution, the Department has been forced to balance the employee premium cost with the level of benefits. That is, if the State were to offer a more comprehensive set of benefits, the premiums would be higher. To the extent these higher costs are borne by employees, adverse selection concerns become more acute. As costs go up, increasing numbers of employees avoid dental coverage until they identify a need for treatment. This means that employees may move in and out of the dental plans rather than staying in from year to year. Therefore, the goal for the dental plans should be to structure them in such a way as to attract and retain employees in the plans.

The Basic Plus plan is in line with that offered in other states and by other employers, although the annual maximum benefit of $1,200 is lower than the prevailing limit of $1,500. An increase in the annual benefit maximum to $1,500, which is suggested, would have a corresponding annual cost impact of about $250,000.

Again, similar to medical coverage, the State needs to re-evaluate its dental plan. The State could benefit by replacing the passive DPO provisions with explicit plan design differentials in the more comprehensive Basic Plus plan in geographic areas where the market allows. The benefits would be structured much like a medical PPO, in that the benefits would be better for in-network service, in order to create incentives for employees to use network providers. We believe that annual savings of roughly $500,000 can be realized from this approach without an increase in benefits.

Recommendation No. 8:

The Department of Personnel & Administration should re-evaluate its dental plan offerings by:

a. Pursuing a Dental Provider Organization (DPO) in those geographic areas having adequate network access, including different benefit levels to encourage use of network providers.

b. Maintaining a statewide indemnity plan with a passive network for those areas with inadequate network access.

c. Considering the costs and benefits of an increase in the annual maximum benefit.

Department of Personnel & Administration Response:

a) Agree. The Department will re-evaluate its dental plan offering during the renewal and negotiation of the plan for the 2004 plan year.

b) Agree. In its May 2003 renewal letter to the carrier, we requested plan design options for any applicable changes to the program for 2004.

c) **Agree.** The Department will evaluate a change to the annual maximum benefit. Distribution of the State contribution amount that includes health, life and dental is key to evaluating the cost and benefits of an increase to the annual maximum benefit.

Implementation Date: January 2004

DENTAL SELF-INSURANCE

We also reviewed the feasibility of self-insuring the dental plan. Similar to the method we used for our analysis of the medical plan, we estimated the costs of a self-insured dental plan using historical data.

For the dental plan, had it been self-funded this year, we project the needed IBNR reserve as of December 31st to be $2.2 million. We estimate that $4.1 million (or more than 100 percent) would have been accumulated as a result of the windfall from conversion to self-funding. We estimated the savings from self-insuring this year to be $1.9 million. The reasons for the savings are much the same as for the medical plan, namely, as noted above with medical insurance, carrier risk and margin charges will be lower in a self-insured dental plan. These reduced costs have been included in our financial analysis of self-insurance for the State.

Also, for the dental plans, the premium rates significantly exceed what appears to be necessary to cover expected claims costs. Our analysis indicates that IBNR reserves would have been fully funded in 2003 through the self-funding conversion windfall described above.

Our analysis used average fixed costs from our current clients. It is entirely possible that the State, with its number of employees, could obtain fixed costs below the levels that we estimated. As previously noted for the current medical plans, the State is also paying risk and pooling charges in its dental premiums. We recommend the State consider self-insuring its dental plans independent of the more difficult decision on how best to fund medical plan benefits. Again, we urge the Department to evaluate the costs and benefits of self-insuring dental using the most recent data.

Recommendation No. 9:

The Department of Personnel & Administration should evaluate the costs and benefits of self-insuring its dental plan.

Department of Personnel & Administration Response:

Agree. The Department will evaluate its dental plan for the purpose of self-insuring during the renewal process and negotiation of the plan for the 2005 plan year. We will incorporate the dental evaluation with that of the health plan evaluation for self-funding and in conjunction with the Department's requirement to submit an RFP for the 2005 plan year. In this way, the Department may fully consider all financing options and benefit designs for both programs.

Implementation Date: January 2005

PROCESS IMPROVEMENTS

We also identified some areas where the Department could make improvements to its current process that could save costs and make the process more efficient and consistent.

PLAN MARKETING PRACTICES

This section addresses practices currently used by the Department to market (communicate) its health plans to its employees. The Department currently uses a web site to provide some generalized information to employees on an ongoing basis and during open enrollment. In addition, complete open enrollment packets are mailed to employees' homes because the Department is unable to reach all eligible state employees by electronic means. Agency representatives are trained by Department staff, who in turn, are available to convey information to employees. Because the State has a true annual open enrollment, it is necessary to mail complete open enrollment packets to all eligible employees each year. The estimated annual cost for these mailings is over $120,000, not including labor and assembly costs. A $1.00/employee monthly assessment, which generates over $300,000 per year, is built into current premium rates for communications expenses.

In addition, the actual enrollment process is conducted manually, with employees completing forms and Department staff entering the information into payroll. According to the Department, it plans to conduct open enrollment on-line for the upcoming plan year. Four of the 11 states surveyed currently employ on-line enrollment applications. Most states not already offering on-line enrollment plan to do so within the next 1-2 years. In addition, according to the Mercer study, nearly two-thirds (63 percent) of all large employers used on-line applications for their enrollment for the 2003 plan year and according to the Hewitt study, the number of employers utilizing on-line enrollment applications has increased 36 percent since 2000.

The State should move forward with its plans to implement on-line enrollment and conduct a separate assessment of how the $300,000 in communication fees are utilized. If the State changes to an annual "switch" enrollment, it would need to provide comparative summary information only to employees currently covered. Covered employees desiring more detailed plan information would be directed to visit the carriers' web sites or contact the carriers directly to have materials mailed to them. This approach would save the State considerable postage costs as well as reduce the labor required for total group mailings.

Recommendation No. 10:

The Department of Personnel & Administration should improve plan marketing by implementing on-line enrollment and re-evaluating the appropriate level of plan communication and mailing expenditures accordingly.

Department of Personnel & Administration Response:

Agree. The Department recognizes and agrees that implementing on-line enrollment improves plan marketing. Effective with the open enrollment for the 2004 plan year, employees will be utilizing a web based on-line enrollment process. The implementation process started June 2003 with testing scheduled for August and September 2003. Agency and employee communications are currently being developed with an initial communications piece being mailed directly to employee home addresses in the latter part of July 2003. Progressive communications will be made in August and late September 2003. Extensive training will be conducted closer to the roll out for agency personnel.

Implementation Date: October 2003

PLAN SELECTION PROCEDURES

The objectives of this subsection were to assess the procedures, processes, and tools used by the State in selecting health care vendors for 2003. To do this assessment, we reviewed the Request for Proposal (RFP) document released in 2002 for coverage effective in 2003. We compared the State's RFP to ones used by Gallagher Byerly, Inc. (GBI) as well as RFPs that have been used by other state health plans. While the RFP in general was very detailed and thorough, we offer the following observations.

- **Plan designs were fixed.** Respondents were not explicitly encouraged to provide alternative plans that might be beneficial for the State. Also, respondents were asked to submit a benefits strategy plan with their proposals although no required format was dictated. By not providing a prescribed format in the RFP for benefit strategy statements, objective evaluation of what the carriers provided is difficult at best. Also, by not encouraging the carriers to propose alternative plan designs, the State missed an opportunity to have carriers submit creative and innovative plan designs that could increase enrollment.

- **Questions about carriers' subrogation policies and procedures were not asked.** The State should be aware of each of its carrier's policies towards administering claims with potential third-party liability. This now becomes especially relevant as the State moves from a no-fault to a tort based automobile

insurance environment in 2003. Subrogation (third-party claim recovery including auto insurance) procedures vary greatly among carriers. Lax or inadequate subrogation procedures could add to paid claims and thereby cause unnecessary rate increases.

- **Retention charges were to be itemized, but there was no standardized format to be followed.** Premium tax was not isolated as a separate retention line item. By statute, premium taxes may not be charged to the State or its political subdivisions. If the State knows a carrier's itemized retention costs, it can challenge expenses that are either abnormally high (e.g., risk charges) or inappropriate (e.g., premium taxes on public sector plans).

- **No questions were asked about how drug rebates would be calculated and whether and how they would be paid to the State.** Once the rebate assumptions for each carrier are fully disclosed, the State can either negotiate a sharing of these rebates or require tangible proof that they are being used to offset medical plan rate increases. Carriers that reveal rebate formulas below industry averages can be challenged and made to explain the variances in their rebate savings.

- **No specific format or diagnoses were listed for disease management programs.** The interaction between drug and medical disease management programs was probed in the RFP, but no specific reports or formats were required. Without specific information on the design and operation of a carrier's disease management program and the diagnoses covered, the State cannot evaluate the program's capability with its overall disease management strategy. For example, if asthma is identified as a major contributor to claim costs, the State should be able to confirm that each carrier has a program for this diagnosis and it is clinically effective. We have worked with other states that receive comprehensive disease management reports from their vendors. Therefore, we would expect an employer the size of the State to require in future RFPs similar data in a common format that is prescribed in the bid document. Also, rather than have the carrier indicate what disease management programs it can offer, we suggest that in the future the State be more proactive and name the programs it wants included in its disease management programs and require all carriers to uniformly comply with that RFP requirement.

- **The reporting format and frequency was not specified or required.** Current Health Plan Employer and Data Information Sets (HEDIS) reports were requested. However, no indication was given as to how they were to be used or evaluated by the State. If each carrier provides claims and utilization reports in different formats and frequencies, it would be very difficult for the State to analyze aggregated data. By mandating the format and frequency of reports, the State will have the common data needed to make critical plan performance decisions.

- **Every bidder was required to agree to provide an extensive "Process Audit" every three years at its expense.** From our experience, this is an unusual requirement. We have not, in our previous state plan experience, encountered a request for process audits. To provide such information is time-consuming and costly for the carriers. It is outside the scope of this study to evaluate the cost-benefit of such reports for the State, but their value should be reassessed.

- **Respondents had to agree to comply with the State's manual and paper enrollment process and then meet aggressive identification card turn-around standards.** The RFP did indicate that the State was moving towards on-line enrollment, but no dates were given.

- **Respondents were required to conduct annual employee satisfaction surveys by mail, but no specified format was dictated.**

The Department should change its RFP format before it is reissued. If carriers are asked to provide general information such as their benefit strategies, the format should be prescribed in the RFP so that the State gets the consistency needed to make qualitative evaluations. The same holds true for such issues as employee communications and surveys. By providing the desired format, equitable comparisons can better be made. Similarly, for ease of analysis and consolidation, required carrier claims reporting and financial experience data should all comply with a specified format. Carriers should also be asked to provide full retention exhibits. Not only would such information allow a comparison of each carrier's costs, it would also allow an assessment of whether premium taxes and other expenses possibly not applicable to the State are being correctly charged.

Unless the underlying need and value of a periodic Process Audit can be demonstrated relative to the time and expense of preparation and review by the State, consideration should be given to eliminating this requirement.

Given the State's size, it should require, at a minimum, a full accounting of all drug rebates that its carriers received from drug suppliers. If the carriers claim that premiums are offset by rebates they receive, financial verification of this should be required in the RFP. Alternatively, and especially if the State moves to a carve-out drug program in the future, it should require either full or substantial rebate sharing with its Pharmacy Benefit Manager (PBM).

Carriers should also be asked to fully disclose their subrogation policies. Subrogation is the process by which payments from third parties, such as auto insurance, are used to offset an employer's health plan claims. The greater the subrogation savings, the lower the State's claim costs. The State should review these policies and determine if they are acceptable. Being experience rated, the State has a direct vested interest in how subrogation negotiations are handled on its behalf. This means that, because the State ultimately pays its own claims under an experience rated insured contract, the greater the subrogation savings the lower the premium cost to the State in the future.

Although it makes direct comparisons among bidders more difficult, the State should consider allowing alternative plan designs rather than just the ones prescribed in the RFP to be submitted. This could help remedy situations such as the one that occurred last year when no new carriers responded to the State's RFP.

Recommendation No. 11:

The Department of Personnel & Administration should improve its Request for Proposals (RFP) for fully-insured plan selection by:

a. Prescribing a single format for carrier proposal responses and contract reporting on various items, such as benefit strategies, claims reporting, financial experience data, and employee surveys.

b. Requiring carriers to provide a full accounting of all drug rebates received from drug suppliers.

c. Requiring carriers to fully disclose their subrogation policies.

d. Requesting detailed retention exhibits from carriers.

Department of Personnel & Administration Response:

a) Agree. The Department staff work to consistently improve RFP requirements. Considerations for improved RFPs involve annual evaluation of the information and/or requirements needed in order to select and administer any of the state offered programs. We do currently encourage alternative plan quotations, but we can be more explicit in our request. We will work toward prescribing a single format for carrier proposal responses in order to enhance the benefits strategy plan currently outlined in all RFPs.

b) Agree. We will reevaluate RFP language to incorporate full accounting of all drug rebates received from drug suppliers.

c) Agree. The Department will re-evaluate RFP language to require disclosure of subrogation policies.

d) Agree. We agree that detailed retention exhibits should be included and we will appropriately incorporate into the next RFP for health care services for the 2005 plan year.

Implementation Date: March 2004

PREMIUM RATE NEGOTIATIONS

The objectives of this evaluation were to assess the procedures, tactics, and tools used by the Department to negotiate premium rates for the 2003 plan years. We found that the State required all carriers to complete identical renewal worksheets. Although comprehensive, the worksheets did not request the pooling points used by the carriers to develop their premium rates. Pooling refers to the level at which individual claims are not directly attributed to a group's specific experience, but rather pooled with that carrier's entire book of business. This mitigates the potential volatility of claims experience that can result from an unusual volume of unanticipated large/catastrophic claims in a given year.

The worksheets required carriers to disclose their enrolled member assumptions, but not the actual number of enrolled employees. This is important, in that the composition of enrollment (i.e., employees, spouses, and dependent children) has a significant effect on overall risk.

The worksheets did not appear to require that all carriers use the same dependent rate tier assumptions. As noted earlier in our discussion of rate tiers, this means that premiums assessed to specific tiers (i.e., employee only, two-party and family) can be established in a way to attract certain types of enrollment on a carrier-by-carrier basis. This in turn can skew the relative risk being taken on by each carrier.

In future negotiations, the Department should require carriers to complete full retention exhibits using a specified format, which would fully itemize all expenses, risk charges, and profit assumptions ("retention charges"), used to develop proposed premium rates. As discussed previously, collecting this information in a specific format would allow the Department to compare the carriers' cost structures and confirm that premium taxes are not mistakenly included in retention. The Department should also request the carriers provide pooling point assumptions used in their premiums. This will allow the Department to determine if the pooling points set by the carriers are appropriate given the State's level of risk tolerance. The pooling points can then be negotiated relative to the premiums as necessary. Carriers should also be asked to provide both their projected employee enrollment as well as the actual number of enrolled employees that were used in their renewals. This would allow the Department to confirm the rate tier structures of each offer. Finally, as noted earlier in the report, the Department should have each HMO propose using the same rate tier ratios. These ratios can be modified, but by requiring consistency in the renewals it will prohibit competing HMOs from varying their rate tiers unfairly to enroll only the desirable single employees and not families. This recommendation supplements the earlier comment by suggesting express provisions for future RFPs regarding rate tier consistency.

Recommendation No. 12:

The Department of Personnel & Administration should improve its rate negotiation procedures for fully-insured plans by including the following in the Request for Proposals (RFP):

a. Requiring submission of information on pooling point assumptions.

b. Requiring submission of projected employee and member enrollment upon which rates are based.

c. Requiring carriers to complete full retention exhibits in a specified format which fully itemize all expenses, risk charges, and profit assumptions used to develop proposed premium rates.

d. Requiring HMOs to use the same rate tier ratios in their proposals.

Department of Personnel & Administration Response:

a) Agree. The identification of the pooling point will be added to the next worksheet for RFPs released in 2004.

b) Agree. The renewal worksheets formally requested the carrier to identify the number of enrolled members. Only informally through follow-up discussions with the carriers did the Department and their consultant request and receive assumed number of enrolled subscribers. We will require that projected employee and member enrollment be provided with the next RFP/renewal release.

c) Agree. In the past the Department has requested the carriers to complete full retention exhibits. This has produced only minimal value as different carriers classify various types of expenses differently. We will develop standard formatting when possible. The Department does consider the cumulative value of retention charges when it negotiates a carrier's premium rate, which, at a minimum breaks-down administrative expense and profit (or surplus) assumptions.

d) Agree. We will re-evaluate and appropriately add same rate tier ratios to the next scheduled RFP release.

Implementation Date: March 2004

APPENDIX A

SELF INSURED MEDICAL PLAN OPTIONS

Based on our analysis of Colorado's current situation and the comparative peer group, we recommend the Department consider a self-funded medical plan with the design characteristics described in this section. The overall plan design structure should offer employees three basic choices. Each of these plan components is described below in two illustrative modules for offering a combination of medical offerings while maximizing a self-insured arrangement. By grouping the plans into modules, one can see how they interrelate. Elements of the two modules can be blended together, although there are practical reasons for keeping the modules as presented. The first module is the more realistic for the State of Colorado as an employer, but the second is possible and should be examined by the Department.

Option One – Self-Insured Medical

This module would consist of a basic Preferred Provider Organization (PPO), a comprehensive PPO or Point of Service (POS) plan, and an Exclusive Provider Organization (EPO)—all self-insured—with carve-outs for prescription drugs and (potentially) behavioral health. A POS plan is a hybrid managed care arrangement that combines aspects of a traditional medical expense plan with an HMO. At the time of medical treatment, a participant can elect whether to receive treatment within the plan's network (which is usually the same or similar to the carrier's HMO network) or outside the network. Higher plan reimbursement will occur for in-network services than out-of-network services.

The current, basic statewide indemnity PPO would be retained. The rates would be set to require a nominal employee contribution for single coverage. A second plan choice would be either a comprehensive PPO or, better still, a POS plan. The third plan offering, to the extent access to care allows in each geographic area, would be an Exclusive Provider Organization (EPO), which is generally the self-insured equivalent of an HMO. Employees that either do not have a local preferred provider or those intentionally choosing to go out-of-network would have coverage, albeit at higher out-of-pocket exposure.

For all plans, we suggest that the majority of cost sharing provisions—other than office visits and preventive services—be converted to coinsurance, replacing flat copays. Coinsurance provisions incorporate an inherent cost-indexing feature.

Ideally, the State would offer only a statewide self-insured HMO/EPO to round out its medical plan offerings. If not available (due to service area or political constraints), then the State could offer a number of regional HMO/EPOs—self-insured to the extent possible. Depending on the employee population density, more than one HMO/EPO

could be offered in an area. In those areas with low density, only one HMO/EPO would be offered to create the critical mass needed for efficient operation.

The basic PPO plan should require a nominal ($10 or less per month) employee contribution for single coverage. In the short run, this may add costs to the State, as it would have to contribute for additional eligible employees. However, over time, by enrolling the younger employees, the overall plan costs per employee should decline, thereby making all coverages (including dependents) more affordable.

Plan Module (Option) Two – Self-Insured Medical

This module would be similar to Module 1, except an additional, self-insured triple option would be added. The triple option plan allows employees to elect, on a point of service basis, between HMO/EPO, PPO and non-network providers, with out-of-pocket expenses ranging from the lowest in the HMO/EPO setting to highest out-of-network. Due to the number of choices available and the less managed approach, it would be the most expensive coverage option.

The State of New Jersey has an interesting variation to the options noted above for its HMO offerings. It allows an HMO to remain fully-insured until it reaches a certain size (in its case, 5000 covered contracts). Once it reaches the minimum size for self-funding, the HMO must then agree to convert to self-funding in order to be offered by the State. If the immediate move to self-funding is not practical in Colorado, it could adopt a transition strategy similar to New Jersey's.

Summary of Self-Insurance Design Options

The first module (PPO, POS, statewide and/or regional HMO/EPOs with a single carve-out PBM) is the simpler and more easily administered. It also would attract more bidders as not all offer the triple option plan contained in Module Two. PPO and HMO plans are available in most regions of the state. Given the State's covered population, carriers or other providers wishing to offer self-funded options may be encouraged to expand their networks statewide if not already available. In terms of the number of HMO/EPOs offered, we think the best strategy is to minimize the number, not only for ease of administration, but also to provide enough potential subscribers for a company to submit a competitive bid to provide administrative services. In metropolitan areas, such as Denver and Colorado Springs, where there are numerous HMOs to choose from, the State may wish to allow more than one HMO to operate. The RFP bidding process would reveal the financial benefits of offering more than one HMO/EPO in a given market.

Module Two is also feasible for the State. However, as mentioned, there may not be sufficient competition to make a triple option plan attractive. If only one or two carriers can provide such a plan, the State may end up paying more for administration due to the lack of real price competition. Further, the triple option plan may not be affordable to many employees at the current State contribution levels.

A sound self-insurance plan would also include carve-outs for prescription drug, disease and utilization management. The Department should utilize a single carve out Pharmacy Benefit Manager (PBM). In addition, given the relationship between disease and prescription drug treatments, disease management should be fully integrated with the PBM. The Department should also pursue a single "center of excellence" network for high intensity services such as transplants.

There may also be merit in carving out mental health and substance abuse (MH/SA) into one statewide program. Advantages to this approach are consistency of service and treatment, leverage with providers and consolidated utilization and cost data. Potential disadvantages include inadequate statewide network coverage, the perceived inconvenience of using an additional vendor, and the potential lack of care coordination with the underlying medical management process. As a self-insured plan, it is critical that mental health costs be managed aggressively and consistently around the state. These objectives could be accomplished by a single statewide carve-out MH/SA provider.

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