

**REVIEW OF THE  
STATE EMPLOYEES  
HEALTH INSURANCE FUND**

**OCTOBER 2011**

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**Auditor of  
Public Accounts**

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**COMMONWEALTH OF VIRGINIA**

## Executive Summary

The Commonwealth receives sound actuarial information to set employee health care premiums and reserves. Best practices indicate that the Commonwealth should, at a minimum, fund an actuarially determined “incurred but not paid” reserve. While there is no consensus on the funding of a contingency reserve, there does appear sound support for some actuarially determined funding of this reserve to prevent the reoccurrence of the funding issues from the late 1990’s and early 2000’s.

From 2007 to 2010, the State Health Insurance Fund (HIF) net assets exceeded 100 percent of the actuarially recommended reserve level, known as “overfunding.” To eliminate this overfunding, the Commonwealth has been providing a premium subsidy on behalf of active state employees, thereby allowing these employees and their agencies to pay less than the required monthly premium and using HIF net assets to make up the difference. Because the Commonwealth has no formal reserve funding policy, nothing prohibits Commonwealth management from taking actions that could drop net assets below the actuarially recommended level, and this occurred as of June 30, 2011.

Since the HIF reserves have fallen below the actuarially recommended amounts, the Departments of Human Resource Management, Planning and Budget, and the Governor will need to consider this as part of their analysis when proposing the fiscal year 2013 state health insurance premium rates and deciding whether to continue the current premium subsidy. The General Assembly will also need to consider this when reviewing the proposed rates and any subsidy during the legislative session.

The General Assembly may wish to consider establishing a reserve funding policy during the 2012 legislative session, before adopting the 2013 health insurance premium rates and choosing to continue other actions related to the HIF. Premium subsidies, withholding of interest, and low premiums all reduce state agency expenses and are attractive as a short-term fix to balance the Commonwealth’s budget during tight budgetary times. However, failure to set a reserve funding policy will likely end with the HIF net assets dropping too low, requiring additional General Fund support in the future to make it actuarially sound, similar to conditions that occurred in fiscal year 1997.

We performed this audit pursuant to the Appropriations Act Chapter 890 Item 1.2, 2-D, requiring the Auditor of Public Accounts to complete a financial review of the state employee health insurance fund and address the rate setting process and projected expenses compared to actual expenses. In addition to establishing a reserve funding policy, our report includes several recommendations to improve the HIF’s management.

– Table of Contents –

	<u>Page</u>
Executive Summary	
Chapter 1: Background	1-9
The Commonwealth’s Health Benefit Plans	1-4
How the Commonwealth Selects Its Plans	4-5
How the Commonwealth’s Self-Insurance Program Works	5-6
Accounting in the State Employees Health Insurance Fund (HIF)	6-9
Chapter 2: HIF Overview	10-20
Historical Perspective	10
Self-Insurance Advantages	11-12
Actuarial Standards	12
Actuarial Work	13
Premium Setting Process	13-17
Actuarial Reserves	17-18
Commonwealth HIF Reserve Expectations	18-20
Chapter 3: Financial Analysis of Medicare Retirees	21-22
Chapter 4: Financial Analysis of Active Employees and Pre-Medicare Retirees	23-30
Projected and Actual Expense Comparisons	23-27
Actions Taken to Reduce the Active Employee and Pre-Medicare Retiree HIF Net Assets	27-30
Concerns Regarding Subsidy to Kaiser Permanente HMO Plan Participants	30
Chapter 5: Looking Ahead	31-34
Revising Health Care Budgeting and Policy Setting	33-34
Chapter 6: Objectives and Conclusion	35-36
Reason for this Audit	35
Objectives	35
Scope	35
Methodology	36
Conclusion	36
Transmittal Letter	37
Agency Response	38
Responsible Officials	39

## Chapter 1: Background

### The Commonwealth's Health Benefit Plans

The Commonwealth of Virginia's Department of Human Resource Management (Human Resources) offers a variety of health benefit plans to its employees and retirees. Human Resources provides medical, dental, vision, and prescription coverage through a self-insurance program where the Commonwealth collects premiums to offset the expenses for treating employees, retirees, and their dependents. The plans available to individuals depend on whether they are an active employee, pre-Medicare retiree, or Medicare retiree, and the geographic region where the insured resides, as described in Charts 1 and 2 below.

The following chart describes all the health insurance plans offered to current and retired state employees.

**Chart 1**

<b>Active Employee/Pre-Medicare Retiree Plans:</b>	<b>Description</b>
COVA Care/COVA Connect (with basic dental)	Coverage includes doctor visits, inpatient and outpatient services, emergency room visits, diagnostics, lab tests, shots, x-rays, infusion services, outpatient therapy, behavioral health, prescription drugs, wellness and preventative services, and basic dental. The plan includes deductibles, out-of-pocket expense limits, co-pays, and maximum benefits.
+ Expanded Dental Option	Coverage includes complex restorative care such as inlays, crowns, dentures and bridgework, up to 50 percent after deductible; also covers 50 percent of orthodontics up to a lifetime maximum of \$2,000.
+ Routine Vision and Hearing Option	Coverage includes biennial eye exams, frames, lenses, and contact lenses up to maximums and limits after co-pays. Hearing benefits are limited to once every 4 years and includes exams and hearing aids up to maximums and co-pays.
+ Out of Network Option	Allows use of health providers that have not negotiated service rates with the Plan; however, Anthem only pays the claim up to the service rate negotiated with other providers. The employee is responsible for paying any balance due to the provider.
COVA High Deductible Health Plan (COVA HDHP)	This plan includes all the same benefits as the COVA Care plus Expanded Dental Option, except there are no employee/non-Medicare retiree premiums. Out-of-pocket expenses, such as deductibles and co-pays are significantly higher for each service area when compared to the basic COVA Care plan. For example, the annual deductible per person under this plan is \$1,750 compared to \$225 for the COVA Care plan.
Kaiser Permanente HMO	This plan includes all the same benefits as the COVA Care + Expanded Dental Option. Co-pays are lower and there is no deductible. The maximum dental benefit is \$1,000/year compared to \$2,000/year for COVA Care. The maximum "out-of-pocket" expenses are significantly higher. For example, the annual maximum "out-of-pocket" expense limit for one person is \$3,500 compared to \$1,500 with COVA Care, and for two or more persons it is \$9,400 versus \$3,000 with COVA Care.

Medicare Retiree Plans:	Description
Advantage 65	<p><u>Part A:</u> Hospital: Pays Medicare Part A deductible except for first \$100, Medicare Part A coinsurance, and 100 percent of allowable charges for eligible expenses for an additional 365 days. Skilled Nursing Facility: Pays Medicare Part A coinsurance (days 21-100) and pays the coinsurance amount for an additional 80 days per Medicare benefit period.</p> <p><u>Part B:</u> Does not pay Medicare Part B deductible, but does pay Part B coinsurance.</p> <p><u>Part D:</u> The level of coverage for prescriptions depends on whether the drug is part of the plan's formulary, the tier of the drug, and the coverage stage.</p>
+ Dental Benefits	Coverage includes diagnostic and preventive care at 100 percent of allowable charges, basic dental care such as fillings, extractions, root canal therapy and other endodontic services, and repair of broken dentures, re-cementing of existing crowns, inlays and bridges at 80 percent of allowable charges and complex restorative care such as inlays, crowns, dentures and bridgework, up to 50 percent of allowable charges.
+ Vision Benefits	Coverage includes biennial eye exams, frames, lenses, and contact lenses up to maximums and limits after co-pays.
Advantage 65 – Medical Only	This has all of the coverage above for the Advantage 65, but does not include Part D for prescriptions. The retiree may elect to add the Dental Benefits and Vision Benefits above.
Medicare Complimentary Option I	Benefits under this plan are identical to the Advantage 65 plan described above including the Dental and Vision Benefits.
Medicare Supplementary Option II	Benefits under this plan are identical to the Advantage 65 plan described above with the addition that this plan also pays the Medicare Part B deductible. This plan does not automatically include Dental and Vision Benefits but the coverage is an add-on. The Dental and Vision Benefits, if added, are identical to those described above under Advantage 65.

There are two groups of retirees; those that are under age 65, known as pre-Medicare retirees, and those over the age of 65 or disabled, known as Medicare retirees. Pre-Medicare retirees choose from the same health insurance plans offered to active state employees while Medicare retirees have separate insurance plans designed to supplement Medicare.

Active employees and retirees can choose to purchase coverage for themselves only, referred to as single; themselves plus one individual, referred to as plus one; or themselves plus two or more individuals, referred to as family. Under all plans the premiums increase as add-ons, such as expanded dental, vision and hearing, and number of covered individuals increase.

COVA Care is the health care plan that is available to all employees in Virginia, except for those

located in the Tidewater region. Employees in Tidewater must use the COVA Connect plan which has identical premium costs and offers similar coverage to COVA Care. Employees living in the Northern Virginia region can choose either COVA Care or Kaiser Permanente HMO.

The Advantage 65 plan is the only insurance plan available to new Medicare retirees. The Medicare Complimentary Option I and Medicare Supplementary Option II below are older plans and only retirees previously in the plan can continue within them. In most respects, the Option I and Option II plan benefits are identical to the Advantage 65 plan. The following chart shows the types of individuals and plan options available to them.

**Chart 2**

Plan Name	Employee/Pre-Medicare Retiree (Except Tidewater and Northern Virginia)	Employee/Pre-Medicare Retiree Northern Virginia	Employee/Pre-Medicare Retiree Tidewater	Medicare Retiree
COVA Care	✓	✓		
COVA Connect			✓	
COVA HDHP	✓	✓	✓	
Kaiser Permanente HMO		✓		
Advantage 65				✓
Medicare Complimentary Option I				✓
Medicare Supplementary Option II				✓

All Commonwealth health insurance plans are managed care plans. Managed care plans are ones where the insurance provider signs contracts with doctors; hospitals; clinics; and other health care providers, such as pharmacies, labs, x-ray centers, and medical equipment vendors; to set reimbursement rates for services. This group of contracted health care providers is the health plan's network. There are three types of managed care plans: Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO) and Point of Services.

Each type of managed care plan has its advantages and disadvantages, and the HMO and PPO plans are the most common among employee health insurance plans. Within the Commonwealth's managed care plans, all but Kaiser Permanente HMO are PPO's.

Under the HMO managed care plan type, the HMO organization agrees to cover the insured for a set price and contains costs by requiring the insured to select a primary care provider who serves as a gatekeeper for using specialists or having diagnostic tests performed. Also, under an HMO, typically the doctors and hospitals that accept the plan are part of the same tight network of providers.

Under the PPO managed care plan type, the insured can choose any provider within a larger network and there is no required referral to see a specialist. The PPO doctors agree to accept the negotiated reimbursement rate for services in order to accept the insurance policy administered under the PPO network.

The HMO grew in popularity during the early 1990's as a way to reduce healthcare costs by limiting the employee's choice of doctors and hospitals to a tight network and requiring referrals from a primary physician for costly procedures. By the late 1990's, the PPO emerged as larger networks of doctors and hospitals united to negotiate competitive reimbursement rates for services, and employees enjoyed the freedom to control their choice of doctors within the larger network. By 2010, PPO enrollment nationwide outnumbered HMO enrollment two to one.

In the early 1990's, Virginia offered a number of HMO plans which operated similarly to commercial insurance. The Commonwealth would transfer all the premiums collected to the HMO's who were responsible for controlling costs under their plan. If they successfully managed costs and had excess premiums, the HMO could realize a profit. However, if costs exceeded the premiums received, the HMO would assume the risk and realize a loss. By the mid-1990's, all of the HMO's, except Kaiser Permanente, had dropped the Commonwealth because they consistently lost money. In addition, employees had become frustrated with the primary care/referral process associated with HMO's.

Today, the only HMO still offered by the Commonwealth is Kaiser Permanente HMO, and it is only available to individuals living in Northern Virginia. Their premiums are slightly more expensive than the Commonwealth's PPO plans and they currently have about 2,000 state participants.

### **How the Commonwealth Selects Its Plans**

Human Resources has many considerations when designing the Commonwealth's health insurance plans. These considerations include Code of Virginia requirements, the Commonwealth's budget situation, premium cost to employees and retirees, and health care trends. Human Resources works with the Department of Planning and Budget (Planning and Budget), the Governor, and the General Assembly to design plans which are modern, attractive, affordable, and reasonable.

The Code of Virginia requires Human Resources to establish a health insurance plan for active and retired state employees and includes provisions for some specific medical conditions and procedures that the plan must cover. It does not describe any specific type of plan nor does it set copayment or out-of-pocket levels.

Human Resources has chosen to operate its health insurance plans as self-insured, except for the Kaiser Permanente HMO discussed above. The decision to operate the health insurance plans as self-insured is consistent with nearly all state governments and large employers. A self-insured health care program is an arrangement where the employer provides health benefits to employees and assumes all risk of benefit payments. The decision to operate the health insurance plans as self-insured rather than using commercial insurance is not a legislated mandate, but is a proven, cheaper alternative to purchasing commercial insurance.

Nearly every self-insured employer hires a third party administrator to operate the health insurance plan on the employer's behalf. Professional third-party administrators already have the

expertise to run the program and the reputation to negotiate with health care providers to obtain guaranteed service rates that are market competitive. They also have software and electronic claims filing mechanisms with doctors and hospitals to handle the processing of insurance claims. Professional third-party administrators can readily determine whether the employer's plan covers a service or whether the cost falls within the negotiated service rates; and they can handle claims related questions and disputes.

Oklahoma and Louisiana are examples of two states that currently handle insurance claims administration themselves, but they each began doing so years ago when their plans were relatively small. For the Commonwealth to start performing its own administration, it would require significant start-up costs to acquire the facilities, personnel, hardware, and software to handle this process.

In hiring a third party administrator and evaluating the plans they can negotiate on behalf of the Commonwealth, Human Resources monitors the insurance industry, national healthcare trends, federal and state legislation, and other states, to establish the Commonwealth's plan requirements and desired features. Human Resources communicates these requirements and features in a Request for Proposal (RFP) and invites potential administrators to submit proposals along with the estimated cost and service fees. Human Resources uses the proposals to competitively select administrators and award contracts.

Under all plans except Kaiser Permanente HMO, the Commonwealth uses a combination of third party administrators for the medical, dental, vision, mental health and pharmaceutical portions of its plan. Under PPO's the selection of doctors and hospitals are greater, therefore having multiple administrators based on an area of health expertise is useful in negotiating competitive service rates and to efficiently process insurance claims. We found that most PPO's use multiple administrators.

Annually, Human Resources re-evaluates the Commonwealth's health insurance plans, and with the assistance of the Commonwealth's actuary, Aon, determines how rising health care costs may impact future premium rates. Human Resources communicates with its administrators regarding new or revised plan features and their associated costs, and uses Aon to estimate how much any plan revisions would impact premium rates. For example, Human Resources may consider covering a new medical procedure and Aon helps to determine the effect this new procedure will have on premiums.

Human Resources submits their recommended plan design changes to Planning and Budget and they work with the Governor and legislature to finalize the health insurance plan features and premium costs for the next year. Our section titled Premium Setting Process offers a detailed description of this process.

### **How the Commonwealth's Self-Insurance Program Works**

Human Resources communicates available insurance plans and associated premiums to employees and retirees annually and offers an open enrollment period where participants can change plans and plan options. Human Resources collects monthly premiums from employees, agencies,



and retirees and deposits them into the Commonwealth's Health Insurance Fund (HIF). For active employees, both the employee and the Commonwealth pay a portion of the premiums. The amount paid varies depending on the employee's insurance plan and add-on options. For both pre-Medicare and Medicare retirees, the retiree pays the total premium.

For all plans except Kaiser Permanente HMO, when an insured participant receives treatment, the health care provider submits the insurance claim directly to the administrator for processing and payment. The administrator evaluates whether the claim is eligible under the Commonwealth's plan and verifies that it does not exceed the negotiated service rate. Human Resources uses the premiums they have accumulated in the HIF to reimburse the administrator for their actual cost paid to the health care provider, plus a service fee for handling the claim. This process is similar for medical, dental, vision, and prescription administrators.

When premiums exceed the actual cost of claims processed, the excess amount remains in the HIF as ending net assets. The Commonwealth can use this excess to fund reserves recommended by the actuary, hold this amount to pay claims in years where the premiums may be insufficient, use the amount to subsidize premiums by paying for employer or employee premium increases, or give premium holidays to agencies.

Should the Commonwealth elect to place the excess into a reserve, Aon assists the Commonwealth annually by recommending the minimum amount of reserve the HIF should hold. The actuarial reserve, as discussed later in the Actuarial Reserves section, is a recommended level of cash and investments reserved, or set aside, to pay insurance claims. These reserves consist of two components: "incurred but not paid" (IBNP) reserve and contingency reserve.

For the Kaiser Permanente HMO plan, Human Resources turns over all premiums collected to Kaiser who is then completely responsible for managing the claims and controlling costs. If Kaiser's actual costs are less than the premiums they receive, Kaiser keeps any excess funds. If their actual costs are higher, they must absorb the loss.

### **Accounting in the State Employees Health Insurance Fund (HIF)**

The HIF includes all the transactions for the state employees' and retirees' self-insured health programs. The HIF is included in the Commonwealth's accounting system, known as CARS, and is also reported in the Commonwealth's Comprehensive Annual Financial Report as a single fund; however, the HIF includes two distinct insurance programs: one for active state employees and pre-Medicare retirees, and another for Medicare retirees.

Chart 3 below shows the total revenues, expenses, and ending net assets of the HIF as they appear in CARS over the last five years. The ending net assets for the HIF ranged from a high of \$274 million in fiscal year 2008 to a low of \$198 million as of fiscal year 2011. Also shown below, are the actuary's recommended reserves for each fiscal year.

Chart 3

<b>Schedule of State Health Insurance Funds Revenues and Expenses(Cash Basis - CARS)</b>					
<b>For Fiscal Years Ending June 30</b>					
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Total revenue	\$885,364,142	\$979,555,609	\$956,218,820	\$943,385,745	\$959,983,755
Total expenses	<u>820,244,922</u>	<u>926,745,921</u>	<u>962,444,570</u>	<u>993,876,648</u>	<u>980,013,685</u>
Gain/(loss)	65,119,220	52,809,688	(6,225,750)	(50,490,903)	(20,029,930)
Beginning net assets	<u>156,506,797</u>	<u>221,626,017</u>	<u>274,435,705</u>	<u>268,209,955</u>	<u>217,719,052</u>
Ending net assets	<u>\$221,626,017</u>	<u>\$274,435,705</u>	<u>\$268,209,955</u>	<u>\$217,719,052</u>	<u>\$197,689,122</u>
<b><u>RESERVES</u></b>					
Restricted Reserves	\$ 10,979,143	\$ 10,979,143	\$ 10,979,143	\$ 10,979,143	\$ 18,090,708
Actuarial IBNP	<u>90,736,304</u>	<u>97,631,219</u>	<u>104,911,319</u>	<u>94,375,873</u>	<u>81,480,254</u>
Excess HIF net assets after Restricted and IBNP	119,910,570	165,825,343	152,319,493	112,364,036	98,118,160
Less: Contingency	<u>62,160,372</u>	<u>69,851,289</u>	<u>75,638,549</u>	<u>75,403,065</u>	<u>7,007,326</u>
Excess HIF net assets after restricted, IBNP, Contingency	<u>\$57,750,198</u>	<u>\$95,974,145</u>	<u>\$ 76,680,944</u>	<u>\$36,960,971</u>	<u>\$ 21,110,834</u>

During fiscal year 2008, decision makers from Planning and Budget and Human Resources became concerned that net assets were increasing annually and becoming too large. By fiscal year 2008, the actual net assets balance of \$274 million significantly exceeded the actuary's recommended \$167 million in IBNP and contingency reserves.

To establish the overfunded status of the HIF reserves, we prepared chart 4 to show each year's HIF ending net assets, broken down by reserve components as recommended by the actuary, and any overfunding. In addition, there are restricted amounts shown within the HIF's ending net assets. The restricted amounts result from two actions.

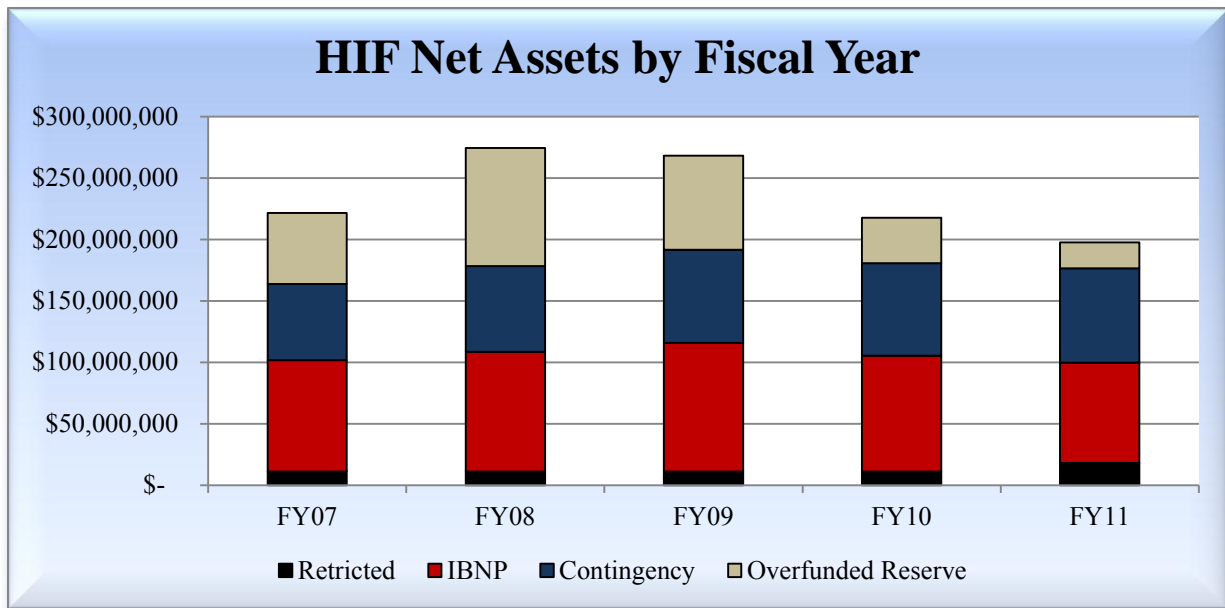
First, the HIF holds \$10,979,143 which represents unspent cash from a fiscal year 1999 one-time contribution of General and Non-General funds totaling \$19.2 million. The Appropriations Act authorized the State Comptroller to move this money into the HIF and requires the Secretaries of Finance and Administration approvals to spend these funds, thereby restricting its use. In fiscal year 2000, the Secretaries of Finance and Administration approved the use of about \$8.3 million to pay the HIF's claims and obligations when the HIF had a cash shortfall, but since that time no further spending has occurred.

Second, in March 2011, the Commonwealth received \$7,111,565 in the Early Retiree Reinsurance Program (ERRP) from the Federal Government, which is restricted to offsetting future

premium increases or other costs for active employees and pre-Medicare retirees. Human Resources holds this restricted money in the HIF since no premium increases have occurred.

In Chart 4, the black portion at the bottom of each bar represent the restricted component of the HIF net assets; followed by red, which represents the actuary’s recommended “incurred but not paid” (IBNP) reserve component; then blue, which represents the actuary’s recommended contingency reserve component; and then tan, which indicates any net assets in excess of the restricted amounts and reserves. As the chart shows, for at least the past five years total HIF net assets have exceeded the actuary’s recommended IBNP and contingency reserve.

**Chart 4**

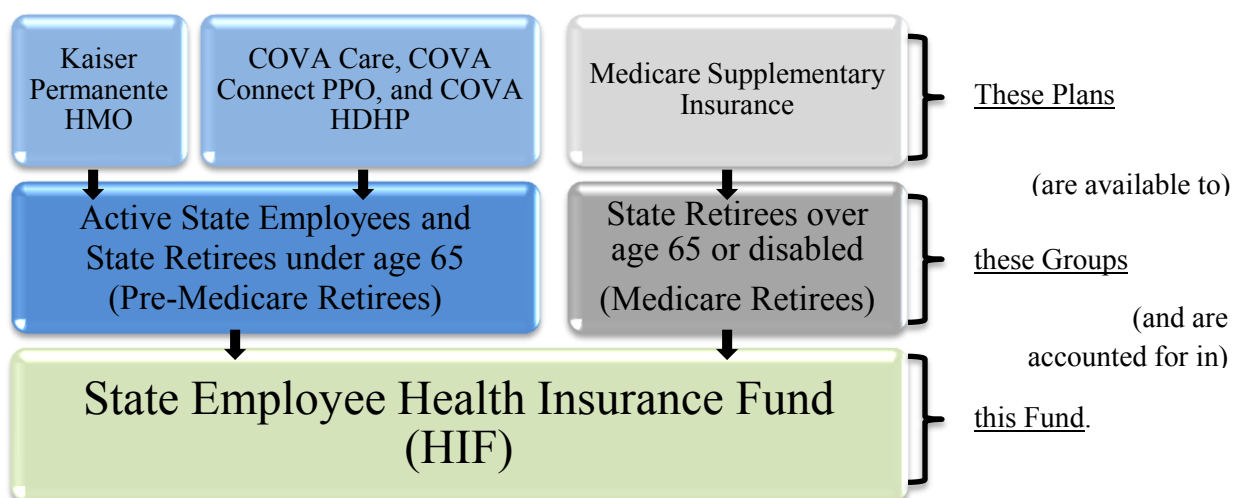


The HIF includes all financial transactions associated with the state employee and retiree insurance plans. When reviewing the combined financial information a reader could reach incorrect conclusions about the HIF and its reserves; therefore, it is important to analyze the HIF financial information by its various insurance plans.

For example, Medicare retirees pay 100 percent of their premiums and the State does not contribute any funds to this plan. Thus, an analysis of the Medicare retiree program should not be part of the active employee transactions where the State contributes funds.

Chart 5 below shows the relationship of the various insurance plans (Kaiser, COVA Care, Medicare Supplementary), groups of participants covered, and how they are all part of the HIF from an accounting perspective.

**Chart 5**



To clarify the various components of the HIF, we have separated our report into the following chapters.

Chapter 2 describes how actuaries establish reserves and premiums for all the plans, except Kaiser Permanente HMO. For the Kaiser HMO, Kaiser sets the premiums and all premiums go into the HIF and the Commonwealth pays the premiums to Kaiser. In return, Kaiser assumes the risk that the premium will be sufficient to cover claims expenses. Kaiser participants that are active employees have received a premium subsidy since 2009, as have all active employees, and we will discuss this subsidy as part of Chapter 3.

Chapter 3 describes financial information associated with the Medicare retiree portion of the HIF. Since these retirees pay all their premiums, we believe it is important to analyze their information separately from the active employee and pre-Medicare retiree group. The Commonwealth does not contribute to the insurance premiums for Medicare retirees and therefore should have no right to any net assets accumulated by this group.

Chapter 4 of this report addresses financial information for the active employee and pre-Medicare retiree portion of the HIF. Although the HIF includes the Kaiser Permanente HMO premium collections, these collections do not affect the HIF's ending net assets or actuarial reserves, but these individuals do receive a premium subsidy just like other active employees. Their subsidy reduces the HIF net assets and for this reason we have included Kaiser financial information in some of the Chapter 3 analyses.

In the future, to provide clarity to those using the statewide accounting system when analyzing the HIF, the State Comptroller and Human Resources should consider separating these insurance programs into separate CARS funds. The Medicare retirees have separate actuarially recommended reserves, premium rates, insurance programs, and the retiree is responsible for paying 100 percent of the cost of the health insurance. Therefore, any overfunding in that program does not belong to the Commonwealth; and combining them with active employees and pre-Medicare retirees may lead to confusion.

## Chapter 2: HIF Overview

### Historical Perspective

In January 1997 the HIF was in financial risk and the Commonwealth's Health Benefits Manager estimated the HIF would exhaust its cash reserves by 1998. The manager explained that several years of insufficient premium revenue, due to decisions made by Commonwealth management to grant premium holidays and premium reductions, had depleted the HIF net assets.

In response to concerns, the Governor and Legislature took the following measures to restore the HIF's viability.

- 1) Provided a \$27 million infusion in 1998 via a surcharge on the agencies' share of premiums.
- 2) Provided a \$19 million General Fund appropriation in 1999.
- 3) Increased premiums through fiscal year 2008.

These measures had the desired effect and by the end of fiscal year 2008 the HIF was holding net assets of \$274 million, exceeding the actuary's recommended reserve of \$167 million by almost \$96 million.

The 2008 overfunded HIF coincided with a time when general Commonwealth revenues were down due to increased unemployment, lagging housing sales, and interest rate declines, to name a few. Both the Governor and General Assembly viewed the overfunded HIF as a potential source of funds to help reduce agency health insurance premium expense, relieve the burden of increased premiums to state employees who were not receiving pay increases, and to balance the Commonwealth's budget. Their action involved a premium subsidy whereby they offset insurance premium increases by using the excess HIF funds and diverting the HIF interest earnings to the General Fund of the Commonwealth.

In 2004, we issued a report on the Commonwealth's self-insurance programs which noted the following finding and recommendation on which the Commonwealth still has not taken action.

Short-term cost savings to the agencies, such as reallocation of funds or premium holidays, causes hardships to agencies and employees in the long run. Many factors dictate the health of each fund. The programs cannot avoid the rising costs of services and administration; however, restricting the use of the funds can protect their solvency.

***Recommendation:*** *The Commonwealth should develop policies that protect the funding and any future reserves of self-insurance programs to ensure that the increasing liabilities can be satisfied.*

The subsidy has continued since fiscal year 2009, and our report will include an analysis of the HIF net assets and reserve and the impact of this continued subsidy. Users of this report should consider what occurred in 1997 and our recommendation from 2004, in evaluating whether the HIF subsidy should continue beyond fiscal year 2012.

## Self-Insurance Advantages

Self-insurance is a method to manage risk by setting aside funds to pay for future losses. A sound self-insurance program uses actuarial and claims information and the law of large numbers so that the amount set aside is enough to cover future uncertain losses.

A self-funded health care program is an arrangement where the employer provides health benefits to employees and assumes all risk of benefit payments. The employer determines the terms of eligibility and coverage, similar to a commercial insurance plan. However, unlike commercial insurance, under self-insurance the employer pays for all health care claims as participants incur claims and assumes the risk if premium revenue is insufficient.

Employers typically set up a special *trust* or *reserve* fund to accumulate the premiums that the employees and employers pay for the health insurance. These premiums then cover the employees' medical claims as incurred and any excess funds remain in the *trust* or *reserve*.

According to the Agency for Healthcare Research and Quality, Center for Financing, 82 percent of private sector firms with over 500 employees use self-insured plans. Nearly all states self-insure their employee health plans. There are advantages and disadvantages to being self-insured.

### Advantages

- Cash flow benefit – employer does not have to pre-pay for benefits because they pay claims as incurred.
- Maintain control over the health plan reserves enabling the employer to maximize interest income.
- Commercial carrier profit margin and risk charge are eliminated.
- Control of plan design.
- Mandatory benefits are optional.
- Exemption from State regulation.
- State government self-insured plans are exempt from the Employee Retirement Income Security Act of 1974 (ERISA).
- Lower cost of administration.
- Portability from one administrator to another.

### Disadvantages

- Assumption of risk.
- Employer must have sufficient cash to meet their obligations which can be unpredictable.
- If reserves are inadequate, a catastrophic event can damage the financial stability of the employer.

The Commonwealth has chosen to self-insure its group health plan, except for the Kaiser Permanente HMO, and assume the financial risk for providing health care benefits to its employees and retirees. Third party administrators process and monitor claims to ensure they are for covered procedures and within negotiated rates for services.

Through its plans, the Commonwealth insures active employees, retirees who do not yet qualify for Medicare benefits (pre-Medicare retirees), and Medicare retirees. Between 2007 and 2011, the Commonwealth covered an average of 115,706 employees and retirees and an additional 108,775 of their dependents.

The Commonwealth contracts with Aon Consulting to develop premium rates for all of the health benefits plans, except the Kaiser Permanente HMO. Starting in July of each year, Aon uses claims data from third party administrators including Anthem, Optima, Delta Dental, Value Options, Medco and enrollment data from Human Resources, to estimate premiums for all plans. Please see the Premium Setting Process section below for detailed description of the method for setting rates.

Aon follows actuarial assumptions and standards to prepare three scenarios for premium rates which they submit to Human Resources around October 1. Human Resources and Planning and Budget analyze and consider the three scenarios to determine the premium amount that employees, agencies, and retirees will pay in the coming year and present their recommendation in the Governor's budget. The rates are final following the General Assembly session and the approval of the Commonwealth's budget.

### **Actuarial Standards**

Self-insured entities that follow best practices use an actuary to help determine the financial impact of the risk and uncertainty that is inherent in self-insured health plans. An actuary is a highly specialized professional that uses statistics, mathematics, financial theory and actuarial judgment to analyze the financial consequences of risk.

The Actuarial Standards of Practice (ASOP) adopted by the Actuarial Standards Board represents generally accepted actuarial principles and practices, and governs how actuaries perform their work. Certified actuaries, such as Aon, must also follow the Actuarial Standards Board's Code of Conduct and meet the qualifications standards which include educational requirements, certification testing, work experience, and continuing education requirements.

We reviewed the actuarial standards and determined that Aon complied with the following applicable standards when preparing their reports for the Commonwealth's health insurance plan.

Actuarial Standard of Practice No. 5 provides guidance to actuaries that prepare or review financial reports, claims, studies, rates or other actuarial communications involving incurred claims within a valuation period under a health benefit plan, including benefit plans provided by self-insured or governmental plan sponsors.

Actuarial Standard of Practice No. 21 provides guidance to actuaries when providing professional services while responding to or assisting auditors or examiners in connection with an audit or examination of a financial statement.

Actuarial Standard of Practice No. 41 provides guidance to actuaries with respect to written, electronic, or oral actuarial communications.

Actuarial Standard of Practice No. 42 provides guidance to actuaries determining health and disability liabilities other than liabilities for incurred claims.

## **Actuarial Work**

The Commonwealth, like most states, uses an actuary to analyze their claims liability at year end and to help with premium rate development. The Commonwealth has used Aon, formerly Williams, Thatcher and Rand, since 1993. Aon's principal engagement is the development of actuarial reserves and three annual premium scenarios, which attempt to forecast anticipated medical expenses and the corresponding premium rate to cover these anticipated expenses.

Aon uses standard forecasting methods such as the development method and projection method, along with actuarial judgment. Aon analyzes historical claims to develop claim patterns in the standard method. In areas where this data may be unreliable or for use in evaluating seasonal variations, Aon uses the projection method, which uses changes in unit costs over time. Like most actuaries, Aon also includes a margin based on their judgment and experience with other organizations that self-insure.

As part of their quality control, Aon performs internal peer reviews of all their work and the Commonwealth's report goes through three internal peer reviews. Also, in February or March of each year, Aon internally conducts an audit of practice standards, and there have been no adverse findings on the Commonwealth's work products.

We reviewed actuary reports from 2007– 2011 and determined that Aon's methodology is consistent with the actuary standards necessary to determine the premium rates, IBNP, and reserve contingency for the Commonwealth. Our study did not audit the raw claims data or actuarial computation process, as we do not have the expertise to duplicate this process and we believe undertaking this work is beyond the scope of this audit. We did, however, perform an analysis of the actuary's projected expenses versus actual expenses for the HIF to determine Aon's accuracy in predicting future claims activity. We discuss the result of our analysis later in this report.

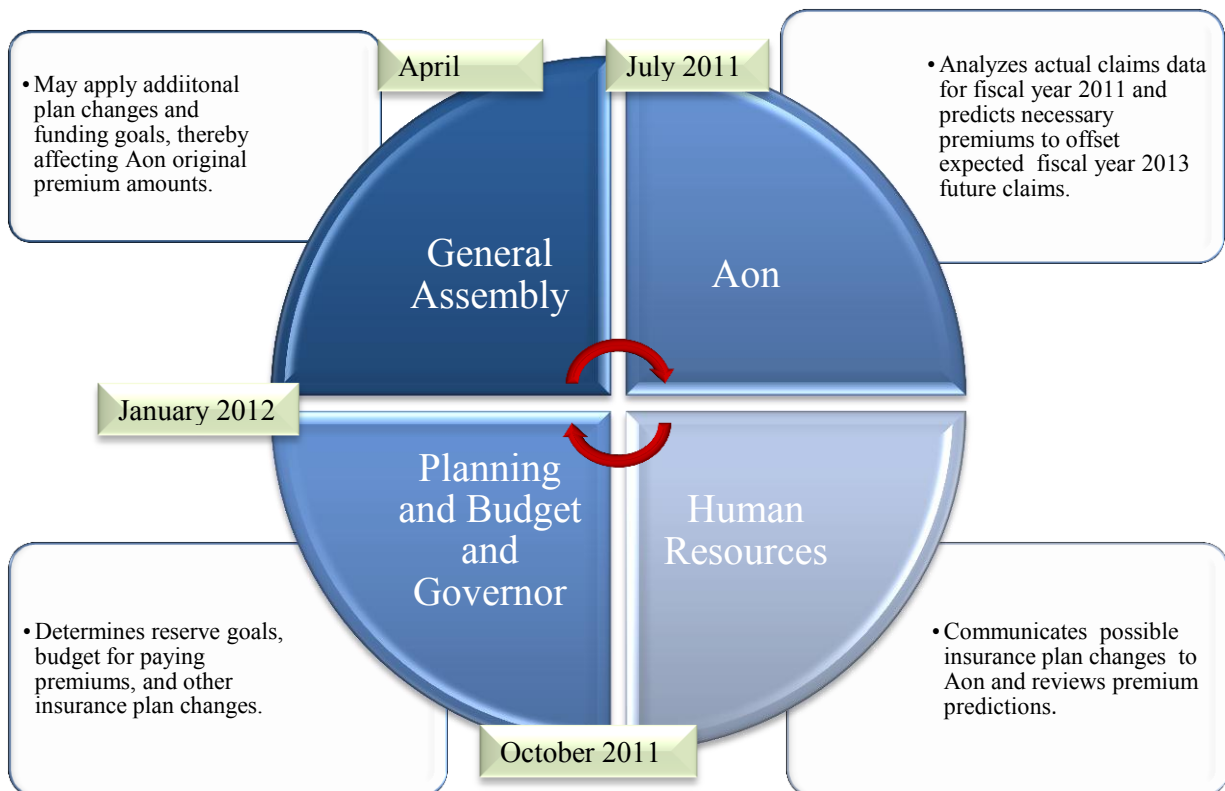
## **Premium Setting Process**

The premium rate setting process begins each July with Aon examining historical claims information and making their premium rate recommendation. Human Resources, Planning and Budget, and the General Assembly further analyze the information, run alternative scenarios, and eventually agree on approved premium rates around April. The approved rates become effective the following July. The chart below displays the annual premium rate setting process for the self-insurance health benefit plans. Kaiser Permanente, the HMO, sets its own rates.

For purposes of understanding the process and its timeline, chart 6 shows the development of fiscal year 2013 rates, which employees, employers, and retirees will pay from July 1, 2012 through June 30, 2013.



Chart 6



Beginning in July of each year, Aon obtains actual claims data for the just-completed fiscal year from the Commonwealth's third party administrators. Aon examines the data to identify and remove unusual or bad claims they believe are outliers and excludes this information when developing future claim trends. Aon imports this cleansed data into its computer model and applies trends and factors to predict their best estimate of total claims that will occur and require payment for the year under analysis. These trends and factors come from various sources, including information from Human Resources regarding known insurance plan changes and health related trends, both nationally as well as in Virginia.

From the computer model, Aon produces three scenarios; Scenario A represents a low estimate of claims expense, Scenario B represents a most likely estimate, and Scenario C represents a high estimate. For each scenario, Aon calculates the premium rates they suggest employees, agencies, and retirees should pay each month to generate sufficient revenue to cover the estimated claims under each scenario. Aon shares these scenarios and recommended premium rates with Human Resources by early October.

Human Resources reviews Aon's premium rate recommendations to ensure they appear reasonable and decides which scenario to recommend to Planning and Budget for developing the Commonwealth's budget. Generally, Human Resources selects Scenario B, the most likely estimate of claims expense, but has at times chosen a hybrid between Scenario B and Scenario A.

To provide Planning and Budget with alternatives when developing the Governor’s budget, Human Resources also asks Aon to run additional computer models under various “what if” options. These options may include changing co-payment amounts, covered procedures, or pharmaceuticals allowed, etc. Aon presents these “what if” options along with their estimate of increases or decreases on premiums should Planning and Budget choose to implement any of them.

By mid-October, Planning and Budget receives the recommended premiums and “what if” options from Aon and Human Resources and uses this information in developing the Governor’s budget. Generally, Planning and Budget uses the Aon recommended premium amounts, but can choose to select a different premium rate. They may also make policy decisions regarding the payment of premiums by employees, agencies, and retirees, and these decisions may affect the actual total premium revenue collected for a given year. These policy decisions typically involve giving premium holidays, where no premiums are charged for a given pay period, and premium subsidies, where a portion of the premium is offset or paid for by the HIF net assets. In mid-December, the Governor’s budget is finished and he presents it to the General Assembly for consideration.

In January, the General Assembly convenes, and House and Senate committees hold meetings to consider and amend the Governor’s budget, including the health insurance premiums. During the process, these committees may choose to revise the premium rates, exercise different insurance plan options, or change premium policy decisions proposed by the Governor. At the conclusion of the General Assembly session, the final premium rates and funding policies are set and become effective on July 1<sup>st</sup>, provided there is no Governor veto. Starting in mid-July, Aon begins the process all over for the next year.

Chart 7 shows the 2011 premium rate proposed by each entity for COVA Care basic health insurance coverage for a single person.

**Chart 7**

Entity	Monthly Rate
Aon:	
Scenario A	\$494
Scenario B	\$510
Scenario C	\$526
Human Resources	\$500
Planning and Budget/Governor	\$426 (\$500 less \$74 subsidy)
General Assembly	\$426 (\$500 less \$74 subsidy)

Human Resources selected the premium rate somewhere between Aon’s recommended low trend estimate, shown in Scenario A, and the most likely estimate, shown in Scenario B. Planning and Budget and the Governor decided to use the \$500 premium rate, but made a policy decision to use

the HIF's net assets to subsidize the premium by \$74 each month for active employees; meaning employees and their agencies would only actually pay a combined \$426 monthly for this coverage. Pre-Medicare retirees do not receive the subsidy and would pay the full \$500 premium rate. The General Assembly agreed with using the Governor's proposed premium rate of \$426 including the subsidy for active employees.

As Chart 7 demonstrates, the Commonwealth's premium rate setting process involves many entities and decisions that can alter the actuary's initial recommendation. Premium rate setting is not a pure science and relies on the art of judgment and management decisions. The accuracy of these decisions can affect whether the Commonwealth collects sufficient or excessive premiums to pay for actual health insurance claims.

Another factor affecting rate accuracy is the length of time from when the actuary performs the analysis and trending to when rates become effective. The closer the analysis occurs to when rates are effective, generally the more accurate the rates are because there are fewer uncertainties. For the Commonwealth, the premium rate setting process starts in July with analyzing prior fiscal year's actual claims data. The premium rates are set by mid-December and become finalized with the approval of the Appropriations Act, generally sometime in April or May. Overall the Commonwealth's premium rate setting process takes approximately eight to nine months from beginning to end.

By comparison, we met with a large, self-insured company headquartered in Richmond, Virginia to understand their premium rate setting process. Overall this company's premium rate setting process takes approximately four to five months, nearly half the time required by the Commonwealth. We discussed this private sector timeline with the Commonwealth's Health Insurance Director who also worked for a large, self-insured company before working for the Commonwealth. The Director agreed that her experience in private industry was comparable to the company we interviewed.

Overall, the Commonwealth and private industry timelines are similar from the claims analysis phase to management (Governor's) approval phase; however, the Commonwealth's process takes longer due to the need to have the legislature review and approve the rates. As a result, we believe overall the Commonwealth's premium rate setting process is efficient, reasonable, follows best practices, and significant streamlining could only occur with the elimination of legislative oversight, which would be inappropriate.

During the course of our review, Planning and Budget asked whether Aon could provide their analysis and recommend premium rates sooner than mid-October. Planning and Budget believed that doing so would allow more time for them to consider the premium rates and options when developing the Governor's budget.

We found nothing that would preclude Aon from providing information sooner, but they would need to start their analysis earlier than July. While receiving the information sooner than mid-October would provide more time for Planning and Budget to analyze the information, this change would further lengthen the Commonwealth's overall process and increase the potential for errors in assumptions and trends due to more uncertainty.

We believe changing the delivery timeframe to Planning and Budget could result in the undesired effect of increasing inaccuracies between projected and actual claims expense, and we recommend below that executive and legislative staff meet to develop a process if they determine that earlier rates are needed.

**Recommendation 1:**

*As indicated earlier, changing the date when Human Resources provides premium rates to Planning and Budget could increase the inaccuracies of the estimate. An alternative if earlier dates are needed is to have Aon provide their recommended premium rate scenarios by September 1<sup>st</sup> each year, using claims data available at the time of their review. And by February 1<sup>st</sup>, Human Resources could consult with Aon to consider whether actual trends or economic conditions are materially different from those expected when developing September's rates. If so, Human Resources could request that Aon conduct a re-assessment of premium rates using more recent claims data.*

*Human Resources and Planning and Budget could use the September 1<sup>st</sup> recommended premium rates to develop the Governor's budget and share any subsequent re-assessment with the House Appropriations and Senate Finance Committees so that the General Assembly could include them in its consideration of budget amendments or policy decisions, such as subsidies and premium holidays, as necessary.*

*However, this alternative also has some inherent issues including possible major budget re-consideration during the General Assembly session. Therefore, we recommend that Human Resources, Planning and Budget, and Senate Finance and House Appropriations staff determine whether there is a sufficient business need for obtaining earlier premium rates from Aon. If there is a business need for earlier rates, Human Resources, Planning and Budget, and Senate Finance and House Appropriations staff should collaborate on a process to obtain this information which does not significantly compromise accuracy.*

**Actuarial Reserves**

Actuarial reserves are the recommended level of cash and investments that the actuary believes the self-insured entity should hold for the payment of future insurance claims and to minimize risk. There are two components of an actuary's reserve recommendation. The first part is the "incurred but not paid" (IBNP) reserve, which represents known insurance claims that have occurred but are pending submission for payment as of the fiscal year end. The second part is a contingency reserve.

The IBNP is a liability of the Commonwealth at fiscal year-end since it represents payments likely owed to third party administrators in the near future. Under Generally Accepted Accounting Principles, the Commonwealth must record liabilities such as the IBNP in its financial statements.

To establish the IBNP reserve liability, Aon uses actual insurance claims to estimate the average time it takes to process and pay a claim after the insured person receives medical treatment. The estimate of average time helps predict the dollar value of claims in the pipeline as of year-end.

The contingency reserve represents the amount of additional cash and investments, above the IBNP reserve amount, which the actuary recommends the Commonwealth hold to offset any adverse events that could affect the HIF. These adverse events could include an unforeseen health epidemic or catastrophic natural event, both of which could result in health care claims exceeding the premium revenue collected in any given period.

There are no set standards, laws, or regulations for determining the appropriate contingency reserve for single employer self-insurance plans similar to the Commonwealth's health plan. The same is not true for commercial insurers or multi-employer self-insurance plans.

We contacted the Commonwealth's State Corporation Commission's Bureau of Insurance to discuss reserves. The Bureau of Insurance requires commercial insurers in Virginia to hold enough capital to meet their IBNP, as well as a contingency reserve representing 200 percent of the National Association of Insurance Commissioners (NAIC) risk-based capital formula.

The NAIC risk-based capital formula evaluates the risk of an entity and develops a contingency reserve to support solvency. The State Corporation Commission may take the company under regulatory control if its contingency reserve drops below 200 percent.

In meeting with Aon, they noted that large commercial insurers, such as Anthem, generally maintain a contingency reserve equal 500 to 600 percent of the NAIC risk-based formula. They also noted that some states, such as Tennessee, have adopted regulations establishing their state employee health insurance fund contingency reserve level. Tennessee must specifically fund their contingency reserve at 10 percent of prior year's actual insurance claims. Virginia has no policy regarding its contingency reserve and historically uses Aon's recommendation for the reserve.

From 2007 through 2011, Aon recommended Virginia's contingency reserve at 100 percent of the NAIC risk-based capital formula. While not as high as commercial insurers, Aon understands that Virginia has other sources to generate capital, such as executing a \$50 million dollar line of credit provided in the Appropriations Act, and therefore feels comfortable with their recommendation.

### **Commonwealth HIF Reserve Expectations**

The Commonwealth has no HIF reserve funding policy, which can create confusion and difficulty in managing against unspecified expectations. To evaluate whether the HIF net assets exceed the actuary's reserves, it is important to ascertain what the Commonwealth's reserve should be. We reviewed the Code of Virginia, the Appropriations Act, met with staff from Human Resources and Planning and Budget, and met with House Appropriations staff and Senate Finance staff, and determined that no reserve funding policy exists except for \$10.9 million in restricted reserves set out in the Appropriations Act. With no policy, opinions varied regarding reserve funding expectations, as described in chart 8 below.

**Chart 8**

<b>Source</b>	<b>Reserve Funding Expectations</b>
<u>Code of Virginia</u>	No HIF reserves funding requirements.
Appropriation Act	No HIF reserves funding requirement except for \$10.9 million in restricted reserves. Also there is a \$50 million line of credit, which Human Resources can execute in the event there is a need for cash to pay claims.
Human Resources	No policy regarding HIF reserves. Reports monthly to Planning and Budget using an \$84 million dollar reserve level for comparative purposes. Human Resources selected \$84 million because it closely represents the IBNP liability and, since monthly claims expense averages about \$77 million, this amount provides Human Resources sufficient cash to meet their monthly claim payments.
Planning and Budget	No policy regarding HIF reserves. Is aware of Human Resources monthly reporting against an \$84 million dollar reserve level. Felt comfortable that HIF net assets could drop below \$84 million as managed by Human Resources because the Commonwealth can execute the \$50 million dollar line of credit if needed.
House Appropriations Staff	No policy regarding HIF reserves. Believes net assets should exist to cover the IBNP reserve.
Senate Finance Staff	No policy regarding HIF reserves. Believes net assets should exist in the HIF to cover all reserves as recommended by the actuary, i.e. IBNP plus a contingency reserve, if recommended.

Absent a reserve policy, we sought an industry best practice to assist us in determining a reasonable reserve level to evaluate the extent of the HIF's overfunding. Part of our research involved meeting with the State Corporation Commission's (SCC) Bureau of Insurance to discuss insurance regulations in the Commonwealth, as described previously. The SCC indicated that multiple employer self-insurance plans would have to hold enough capital to meet their IBNP, as well as a contingency reserve representing 200 percent of the National Association of Insurance Commissioners (NAIC) risk-based capital formula.

Aon recommends the Commonwealth hold a minimum reserve equal to the IBNP plus a contingency reserve equal to 100 percent of the NAIC risk-based capital formula. For fiscal year 2010, this totaled \$169 million for the total HIF. Had the Commonwealth's health insurance fund been subject to the same regulations as multiple employer plans doing business in the Commonwealth, our contingency reserve portion would have needed to double from \$75 million to \$150 million, bringing the total reserve to a minimum of \$244 million.

We found that most self-insured companies and states focus only on funding their IBNP reserve. A few states have adopted a reserve funding policy requiring a contingency reserve, but these states have typically adopted this policy after experiencing a deficit similar to the Commonwealth's in 1997. Tennessee is one such state whose policy requires they provide for the IBNP as well as a

contingency reserve equal to 10 percent of the prior year actual claims. If Virginia adopted a similar policy, we would fund a total HIF reserve of \$194 million rather than \$169 million, based on fiscal year 2010 actuarial recommendations.

Whether or not the Commonwealth's HIF reserves are overfunded, and to what extent, is a matter of opinion since the Commonwealth has no reserve funding policy. Should the Commonwealth set aside net assets equal to the IBNP, a contingency reserve, or both? If so, to what level should we establish our contingency reserve?

We believe a formal reserve funding policy would reduce confusion about HIF reserves, and provide for consistent application of practices over time. At a minimum, the HIF net assets should fund the IBNP liability since this funding is the minimum best practice for most self-insured companies and states.

**Recommendation 2:**

*The General Assembly may wish to set forth a HIF reserve funding policy within the Code of Virginia and the Appropriation Act. The General Assembly may wish to establish an advisory committee comprised of health insurance and actuarial professionals to advise the Commonwealth regarding its reserve policy.*

*Best practices indicate that the Commonwealth should, at a minimum, fund an actuarially determined IBNP reserve. While there is no consensus on the funding of the contingency reserve, there does appear sound support for some actuarially determined funding of a contingency reserve to prevent the reoccurrence of the funding issues of the late 1990's and early 2000's.*

### Chapter 3: Financial Analysis of Medicare Retirees

Human Resources and Aon follow the above described processes for setting the annual premium rates, IBNP, and contingency reserve for the Medicare retiree program. Currently, the Medicare retiree program represents approximately 10 percent of the HIF revenues and expenses, and about 20 percent of the overall HIF net assets.

Because of this, by not separating the IBNP, contingency reserves, and net assets of the Medicare retiree program from the overall HIF during any discussion of overfunding, a significant distortion occurs. Also, since there are no State funds supporting the retiree premiums and the premiums solely fund all net assets and reserves, it appears inappropriate to include these amounts in any discussion of the reserves for active employees.

We used CARS data and extracted only transactions related to Medicare retiree insurance to create Chart 9. In addition, the actuary separately reports an IBNP and contingency reserve amount for the Medicare retiree program, as shown below.

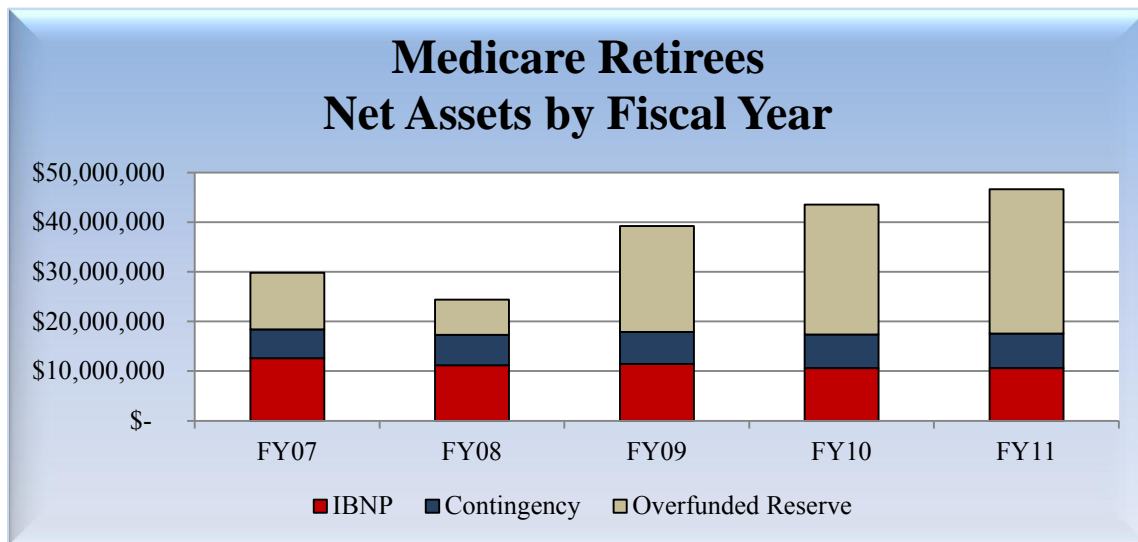
Chart 9 below shows the cash basis CARS information for the Medicare retiree insurance program portion of the HIF. Chart 10 provides a graphic breakdown of the Medicare retirees program ending net assets by the actuary's recommended reserve components. As these charts show, when compared to the overall HIF, a growing portion of each year's overfunding comes from the Medicare retiree insurance program.

**Chart 9**

<b>Schedule of State Health Insurance Funds Revenues and Expenses (Cash Basis - CARS)</b>					
<b>Medicare Retirees ONLY</b>					
<b>For Fiscal Years Ending June 30</b>					
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Total revenue	\$75,680,000	\$87,508,890	\$95,416,326	\$96,752,044	\$89,907,116
Total expenses	<u>77,280,000</u>	<u>92,936,819</u>	<u>80,587,912</u>	<u>92,430,284</u>	<u>86,821,997</u>
Gain/(loss)	(1,600,000)	(5,427,929)	14,828,414	4,321,760	3,085,119)
Beginning net assets	<u>31,400,000</u>	<u>29,800,000</u>	<u>24,372,071</u>	<u>39,200,485</u>	<u>43,522,245</u>
Ending net assets	<u>\$29,800,000</u>	<u>\$24,372,071</u>	<u>\$39,200,485</u>	<u>\$43,522,245</u>	<u>\$46,607,364</u>
<b>RESERVES</b>					
Actuarial IBNP	<u>\$12,579,645</u>	<u>\$11,206,325</u>	<u>\$11,473,282</u>	<u>\$10,620,145</u>	<u>\$10,637,060</u>
Excess HIF net assets after IBNP	17,220,355	13,165,746	27,727,203	32,902,100	35,970,304
Less: Contingency	<u>5,836,238</u>	<u>6,112,218</u>	<u>6,437,967</u>	<u>6,778,431</u>	<u>6,921,883</u>
Excess HIF net assets after IBNP and Contingency	<u>\$11,384,117</u>	<u>\$7,053,528</u>	<u>\$21,289,236</u>	<u>\$26,123,669</u>	<u>\$29,048,421</u>



Chart 10



As described later in Chapter 3, in 2010 the Commonwealth withheld paying interest on the overall HIF net assets pursuant to Code of Virginia, Section 2.2-2818 C., and instead gave the interest to the General Fund of the Commonwealth, as directed by the Appropriations Act, Chapter 890, Item 3-3.03. Diverting the interest on the portion of HIF net assets attributable to Medicare retirees appears inappropriate given that these participants pay the full cost of the program.

Given the increasingly overfunded status of the Medicare retiree program, Human Resources and Aon should develop a process to control the growth of net assets in this program and maintain stability of the premium rates over time. While issues within this program were not the primary focus of this review, we believe that Commonwealth management should address and provide a set of objectives for funding this program, which may differ from the active employee and pre-Medicare retiree program.

**Recommendation 3:**

*Human Resources and Planning and Budget should work with the Comptroller's Office to calculate the interest on the HIF net assets attributable to Medicare retirees and consider restoring these funds or exempting them from future interest withholding.*

*The General Assembly may wish to establish the Medicare retiree program as a special trust fund, which would operate independently of the active employee program, but benefit from any administrative economies of scale in working with third party administrators, actuaries or others.*

## Chapter 4: Financial Analysis of Active Employees and Pre-Medicare Retirees

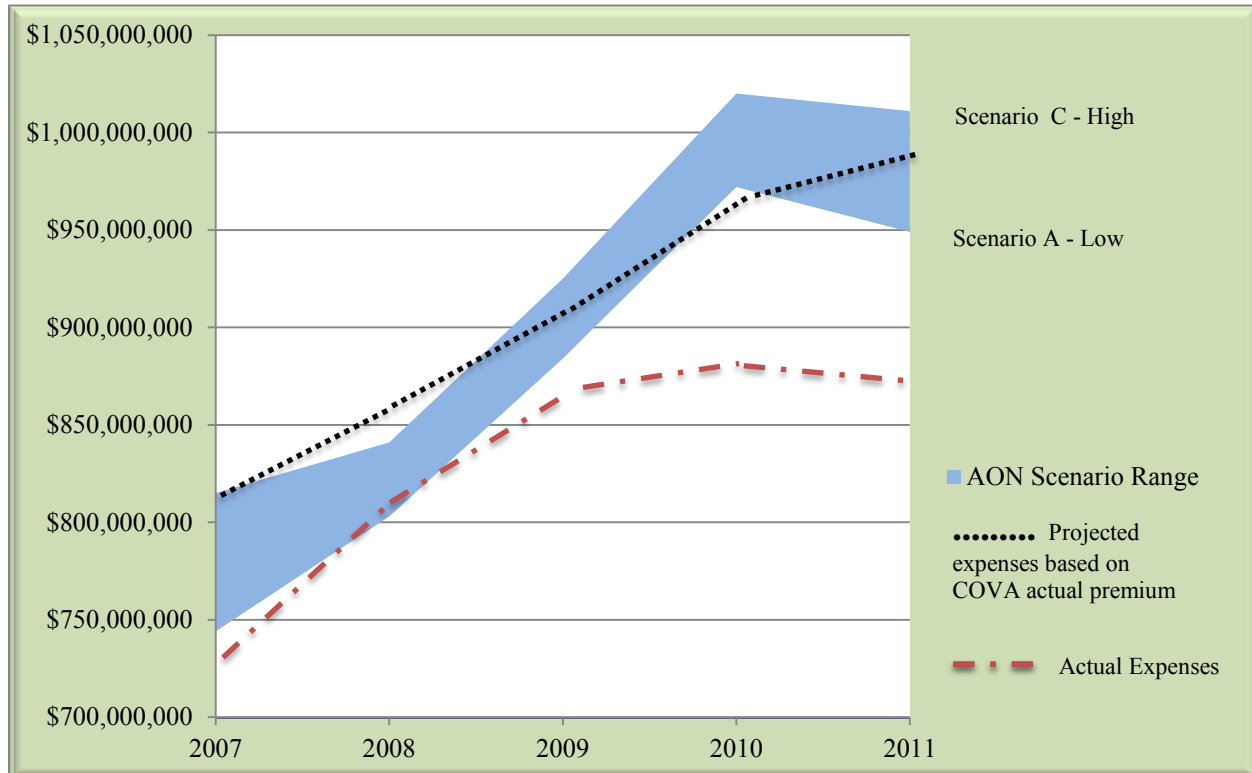
### Projected and Actual Expense Comparisons

As described in the Premium Setting Process section, Aon uses prior claims data as well as insurance plan changes and medical claim trends to estimate or project future claims expenses. Based on their projected expenses, they develop three premium rate scenarios that they estimate will raise enough premium revenue to meet the future claims expense, with various margins of risk. Their overall goal is to set rates that generate just enough revenue to cover actual claims expenses.

Aon provided us with their projected expenses for each year, and we independently verified their information by performing calculations and found them to be accurate and reasonable.

Chart 11 below shows annual projected versus actual expenses for the active employee and pre-Medicare retiree portion of the HIF, excluding Kaiser Permanente since Kaiser, not Aon, sets rates for this program. The wide blue band shows Aon's three rate scenarios. Scenario A rates represent the least amount of projected expenses while Scenario C rates represent the largest amount of projected expenses. As described earlier in the Premium Setting Process section, the Commonwealth reviews Aon's recommended rate scenarios and selects a premium rate that they feel comfortable using for a fiscal year. We depict the projected expenses based on the unsubsidized rate chosen by the Commonwealth by the dotted black line. The red dashed line depicts the HIF's actual expenses relative to the active and pre-Medicare retiree's insurance program.

**Chart 11**



The gap between the red and black lines represents premiums that exceeded what was necessary to pay actual claims expense. In fiscal year 2008, the Commonwealth decided to use a premium rate

that exceeded Aon's recommended rate, but since that time they have chosen a rate that falls within Aon's scenario band. The most notable phenomenon shown in this chart is the significant shift in claims expense growth from 2009 – 2011. It is obvious that Aon and the Commonwealth anticipated continued claims expense growth and did not observe this downward trend until setting the fiscal year 2011 rates in October 2009.

Projecting expenses for future periods is not an exact science and there will always be variances between the projected expenses and actual expenses, which will cause an increase or decrease in the HIF's ending net assets. As described previously in the Premium Setting Process section, Aon sets rates well ahead of the period for which they become effective, resulting in variances when expected trends do not materialize as planned. When Aon set the fiscal year 2011 rates around October 2009, this was likely the first time Aon could see the downward claims expense trend based on actual claims data through June 30, 2009. As observed by the blue band, in 2011 Aon's recommended rates dropped due to sufficient trend data to assist in more accurately projecting expenses.

Questions naturally arise about why Aon did not see the downward trend in claims expense growth back in 2009 and adjust their recommended rates sooner, thereby better matching premium revenue with actual expenses. The discussion below provides some insight.

In developing rates before fiscal year 2011, Aon used an average claims expense trend increase of 9.5 percent for scenario A and 12.8 percent for scenario C. When developing their fiscal year 2011 rates during October 2009, Aon finally had actual claims data for the period July 1, 2008 – June 30, 2009 and noticed that claims were trending lower than previously anticipated. Therefore, for the fiscal year 2011 rates Aon dropped their trend increase to 6.8 percent for scenario A and 10.1 percent for scenario C in response to the actual claims data. For the fiscal year 2012 rates, Aon again lowered their trend increase again to 5.6 percent for scenario A and 9.0 percent for scenario C. These rates became effective July 1, 2011.

We reviewed analyst reports from Kaiser, Segal, PricewaterhouseCoopers, and others to understand national healthcare trends and whether the trend percentages used by Aon when recommending premiums were reasonable. These reports generally showed trends similar to those Aon used before 2011. None discussed a significant decline in insurance claims, except for a recent report by PricewaterhouseCoopers.

This May 2011 PricewaterhouseCoopers report titled, Behind the Numbers, Medical Cost Trends for 2012, is the only report we found which acknowledges that the actual claims expense trend beginning in 2010 was actually less than experts predicted. That report noted,

***“Given the unsettled nature of the economy over the past three years, employers have feared the worst about their health benefit costs. However, just as the recession slashed consumer spending, it dramatically slowed the growth in medical spending in 2010, surprising nearly everyone. Now, a few months into 2011, employers and health plans say utilization remains somewhat deflated, but they’re already worried about a rebound in 2012.”***

The PricewaterhouseCoopers report provides a table that shows their 2010 – 2012 claims expense trend increases compared to actual trend increases. For comparative purposes, we have

added trend increase percentages actually used by Aon when developing the Commonwealth's rates for these years.

**Chart 12**

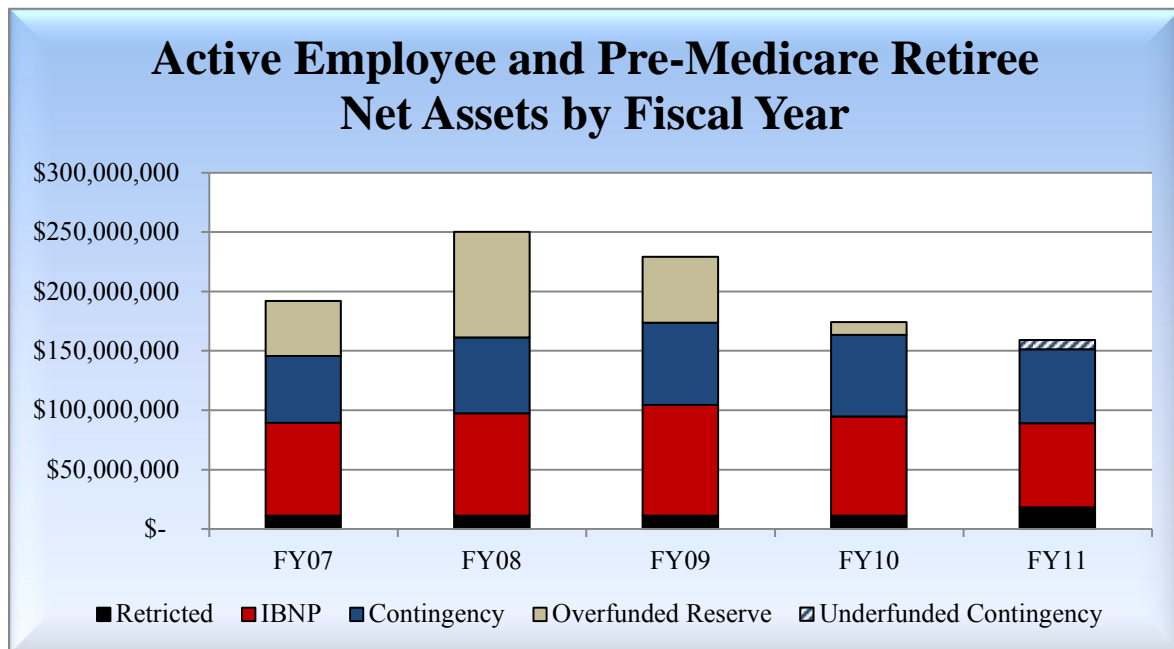
Trend	2010	2011	2012
PricewaterhouseCoopers predicted	9.0%	9.0%	8.5%
Actual Trend	6.0%	7.5%	7.0%
Aon Scenario A Trend	10.0%	6.8%	5.6%
Aon Scenario C Trend	13.0%	10.1%	9.0%

Based on the timing of when Aon must provide rate recommendations to the Commonwealth and given that professional insurance analysts did not predict the downward trend in actual claims expense beginning in 2010, we believe Aon's original trend increase assumptions were reasonable. Aon's actions of lowering their trend estimates in 2011 and 2012 based on actual claims data indicates that Aon is properly responding to trend changes in a timely fashion.

Chart 13 below shows the cash basis CARS information for the active employee and pre-Medicare retiree insurance program portion of the HIF. Chart 14 provides a graphic breakdown of this program's ending net assets by the actuary's recommended reserve components. This insurance program and its premium rates are of the most interest to Planning and Budget since Commonwealth agencies pay a portion of the premiums for active employees, thereby affecting the Commonwealth's budget.

<b>Schedule of State Health Insurance Funds Revenues and Expenses (Cash Basis - CARS)</b>					
<b>Active Employees and Pre-Medicare Retirees ONLY</b>					
<b>For Fiscal Years Ending June 30</b>					
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Total revenue	\$749,899,648	\$892,046,719	\$860,801,495	\$846,633,701	\$870,076,639
Expenses:					
Claims, fees, and transfers to Kaiser	683,180,458	833,809,102	880,070,899	898,184,260	888,659,396
Premium subsidy paid to Kaiser from HIF	<u>-</u>	<u>-</u>	<u>1,784,760</u>	<u>3,262,104</u>	<u>4,532,292</u>
Gain/(loss)	66,719,190	58,237,617	(21,054,164)	(54,812,663)	(23,115,049)
Beginning net assets	<u>125,106,827</u>	<u>191,826,017</u>	<u>250,063,634</u>	<u>229,009,470</u>	<u>174,196,807</u>
Ending net assets	<u>\$191,826,017</u>	<u>\$250,063,634</u>	<u>\$229,009,470</u>	<u>\$174,196,807</u>	<u>\$151,081,758</u>
<b>RESERVES</b>					
Restricted Reserves	\$10,979,143	\$10,979,143	\$10,979,143	\$10,979,143	\$18,090,708
Actuarial IBNP	<u>78,156,659</u>	<u>86,424,894</u>	<u>93,438,037</u>	<u>83,755,728</u>	<u>70,843,194</u>
Excess HIF net assets after Restricted and IBNP	102,690,215	152,659,597	124,592,290	79,461,936	62,147,856
Less: Contingency	<u>56,324,134</u>	<u>63,739,071</u>	<u>69,200,582</u>	<u>68,624,634</u>	<u>70,085,443</u>
Excess (deficiency) of HIF net assets after Restricted, IBNP, Contingency	<u>\$46,366,081</u>	<u>\$88,920,526</u>	<u>\$55,391,708</u>	<u>\$10,837,302</u>	<u>(\$7,937,587)</u>

Chart 14



By the end of fiscal year 2008, Planning and Budget became concerned about the extent of overfunding occurring in the HIF’s net assets.

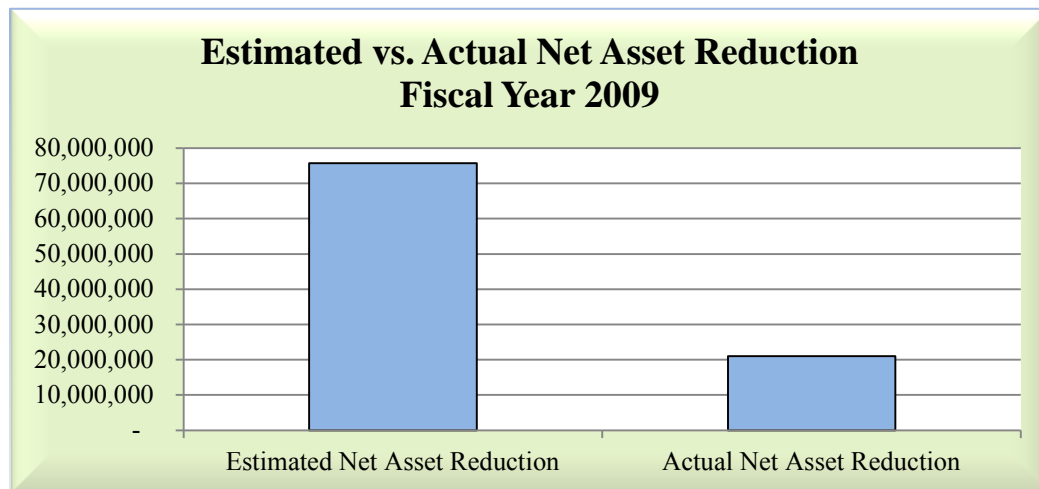
**Actions Taken to Reduce the Active Employee and Pre-Medicare Retiree HIF Net Assets**

Planning and Budget decided to take action beginning with fiscal year 2009 to reduce the overfunded active employee and pre-Medicare retiree net assets. Their action involved subsidizing the monthly premiums for all active employees, including those using Kaiser Permanente HMO, with HIF net assets. This effectively reduced premium rates that the insurance program participants and their agencies would have otherwise paid. We discuss Kaiser Permanente’s participation in this subsidy later in this report.

The subsidy varied depending on the insurance plan (i.e. COVA Care Basic, COVA Care High Deductible) and whether the participant had single, plus one, or family coverage. The subsidy was generally about \$41 for single, \$77 for plus one, and \$113 for family.

Planning and Budget’s analysis showing how much they estimated this subsidy would reduce the active employee and pre-Medicare retiree’s portion of HIF net assets, was not available to us. Therefore, we estimated this reduction ourselves by considering the number of participants in each plan and the applicable subsidy for that plan type. The chart below compares our calculation of the net assets reduction based on the subsidy to the actual net asset reduction for fiscal year 2009.

Chart 15



The subsidy, in fiscal year 2009, did not have the desired effect and only reduced net assets by \$21 million, rather than the \$76 million we estimate Planning and Budget expected.

The problem, as shown earlier in the Projected and Actual Expense Comparison section, was not that the subsidy did not reduce net assets, but that the 2009 premium rates were higher than needed to pay insurance claims that year, thereby offsetting any reductions made by the subsidy. The actuary used 2007 actual claims data to set the 2009 rates and did not have information to predict that insurance claim growth trends would be less than everyone predicted. If the fiscal year 2009 premium revenue had more closely matched the actual insurance claims trend during the year, the subsidy would have likely reduced the HIF’s net assets as planned.

At the end of fiscal year 2009, the HIF net assets were still significantly overfunded. Planning and Budget decided to continue the premium subsidy of active employee premiums for fiscal year 2010 and increased the subsidy amount for all premium types. They also withheld paying the estimated \$10 million in interest typically retained by the HIF pursuant to Section 2.2-2818 C. of the Code of Virginia, as directed by the Appropriations Act, Chapter 890.

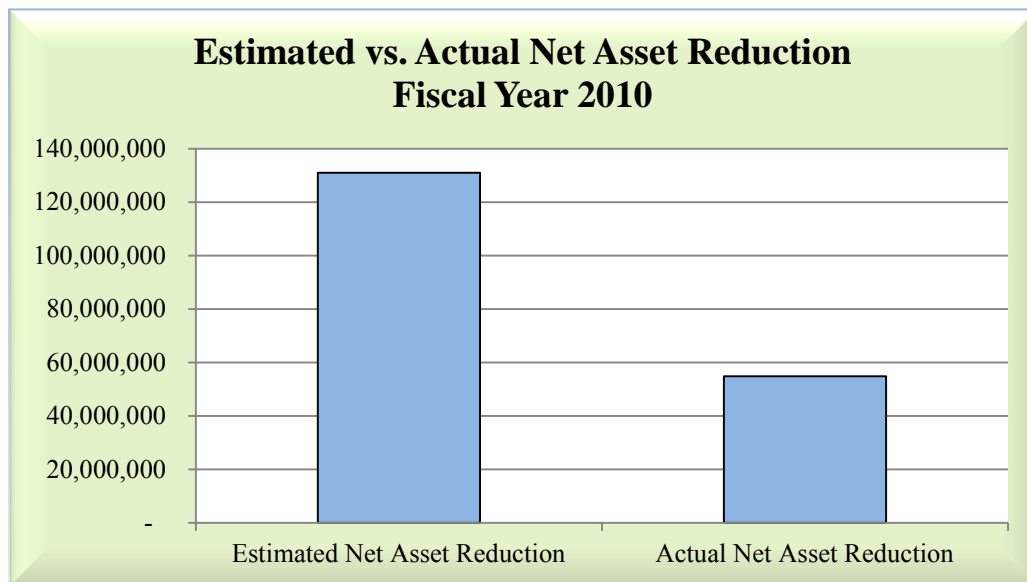
Not paying interest on the portion of HIF net assets attributable to employees paid with federal funds is unallowable under OMB Circular A-87. Attachment B, item 22 d(2) which states that “earnings or investment income on reserves must be credited to those reserves.” Since about 10 percent of employee health insurance premiums paid by state agencies come from federal grants and contracts, HIF net assets are partially comprised of federal funds.

**Recommendation 4:**

*We recommend that Human Resources and Planning and Budget work with the Comptroller’s Office to calculate the interest on HIF net assets attributable to federal funds and return those funds to the HIF. Further, we recommend that Human Resources and Planning and Budget work with the Comptroller’s office to develop a methodology to calculate any future interest earnings on HIF net assets and ensure the portion relating to federal funds remains with the HIF. The Commonwealth will need to resolve this issue or may owe the Federal Government the amount of the interest withheld.*

With the continuation of the subsidy in fiscal year 2010, Planning and Budget decided on subsidy amounts of generally \$74 for single, \$133 for plus one, and \$195 for family coverage. Chart 16 again shows a comparison of how much we estimated this subsidy should have reduced the active employee and pre-Medicare retiree's portion of the HIF net assets and its actual reduction during fiscal year 2010.

**Chart 16**



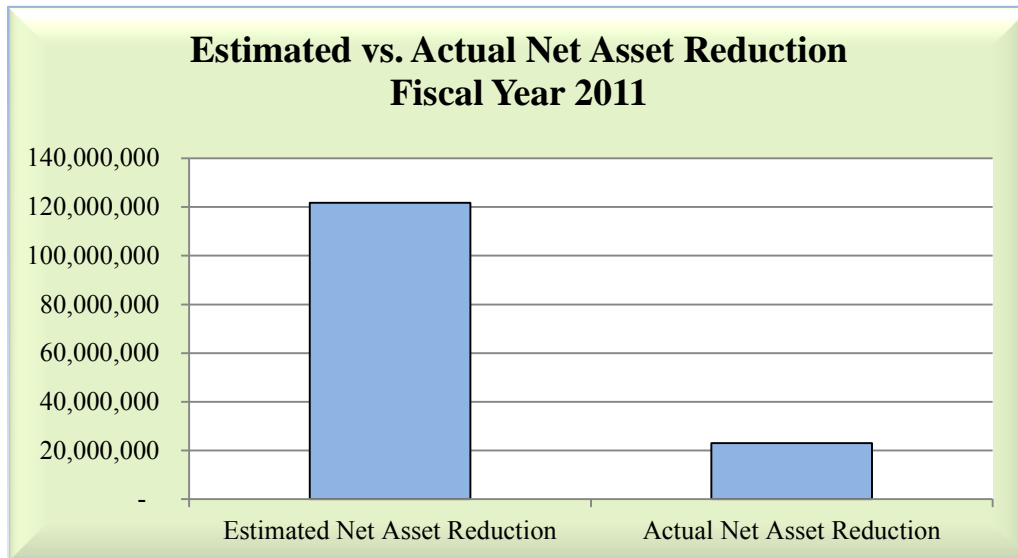
The subsidy in fiscal year 2010 again did not have the desired effect and only reduced net assets by \$55 million, rather than the \$131 million we estimate Planning and Budget expected. This is a difference of \$76 million. Again, as in fiscal year 2009, premium revenue was higher than claims expense for fiscal year 2010 due to the effects of the recession on insurance usage. Aon did not predict the observed claims expense trend decrease when they developed the fiscal year 2010 recommended rates in October 2008, using fiscal year 2008 actual claims data.

It is important to note that despite the subsidy not reducing net assets to the level estimated in fiscal years 2009 and 2010, it had effectively minimized the HIF net asset growth which would have otherwise occurred if the subsidy had not been in place. As shown previously in Chart 13, as of fiscal year 2010 the active employee and pre-Medicare retiree insurance program's overfunding had dropped and was now at only \$11 million over the actuary's recommended reserve level.

Despite the fact that the active employee and pre-Medicare retiree fund was now only \$11 million overfunded, in fiscal year 2011 Planning and Budget decided again to continue with the subsidy of active employee premiums and diverting the interest. Across the plans, the subsidy was generally about \$74 for single, \$137 for plus one, and \$200 for family. Chart 17 again shows a comparison of how much we estimated this subsidy should have reduced the active employee and pre-Medicare retiree's portion of the HIF net assets and its actual reduction during fiscal year 2011.



Chart 17



Once again, the fiscal year 2011 subsidy did not have the desired effect and reduced the HIF net assets by \$23 million rather than the \$121 million that we estimate Planning and Budget expected. As with fiscal years 2009 and 2010, premium rates for fiscal year 2011 were higher than claims expense, offsetting the subsidy's effectiveness in reducing net assets. Although Aon used lower claims growth trends in developing its recommended 2011 rates, the trend used was obviously still too high and therefore net assets did not reduce as planned.

By the end of fiscal year 2011, the active and pre-Medicare retiree HIF net assets were insufficient to fully fund its actuarial reserves, as shown in Charts 13 and 14 above. The net assets could fully fund the IBNP but were about \$8 million short of fully funding the contingency reserve. There is no overfunding going into fiscal year 2012.

### **Concerns Regarding Subsidy to Kaiser Permanente HMO Plan Participants**

Planning and Budget should reconsider its decision to give a premium subsidy to the 2000+ active employees with Kaiser Permanente coverage. Since the Commonwealth gives Kaiser all premiums for these employees, this group did not contribute to the HIF's build-up of overfunded net assets. Therefore, some could argue that these employees should not benefit from the overfunded HIF by way of the subsidy; however, we understand that the subsidy is also a reduction in the Commonwealth's employer contribution to that plan. We estimate by the end of fiscal year 2012, Kaiser's participants and employers will have benefited by over \$12 million in premium subsidies.

#### **Recommendation 5:**

*We recommend that Planning and Budget revisit its management decision to provide a premium subsidy for Kaiser Permanente participants should they continue the subsidy beyond fiscal year 2012.*

## Chapter 5: Looking Ahead

In October 2010 Planning and Budget recommended the continuation of a subsidy of active employee premiums for the fiscal year 2012 insurance premium rates. The monthly subsidy amount for fiscal year 2012 is the same for all insurance plans at \$74 for single, \$137 for plus one, and \$200 for family and we estimate this could potentially reduce net assets by an additional \$131 million by June 30, 2012.

In addition, Aon recommended lower premium rates for 2012 based on continued low claims expense trends; however, the Commonwealth chose to keep the 2012 premium rates at the 2011 level of \$500 for basic, single coverage. The Commonwealth understood that lowering the rates below the 2011 level could result in hardship later to employees as trends return to normal and rates would increase significantly to keep-up with actual costs.

This situation bears close monitoring so that the Commonwealth can resume premiums rate increases and discontinue premium subsidies at the optimal time to prevent a negative impact on net asset balances and unreasonable increases in employee premiums.

Chart 18 below shows our projection of revenues, expenses, and ending net assets as of June 30, 2012.

- For total revenue we started with 2011 actual revenue because actual premium rates were unchanged in 2012 and insurance membership remains relatively stable. We then reduced the revenue by \$10 million due to a slight increase in the subsidy for some insurance plans over the 2011 amounts.
- To estimate total expenses we continued to use 2011 levels based on the flat claims expense growth trend in 2010 and 2011 and expert opinions that the claims growth trend may remain low in the near future due to the effects of the recession.
- For the actuarial reserves we used amounts from the September 15, 2011 Aon IBNP Opinion Letter since amounts generally do not vary significantly from year to year and these are the most current amounts.

<b>Projection of HIF Activity and Balances</b> <b>Active Employees and Pre-Medicare Retirees</b> <b>ONLY</b> <b>For Fiscal Year Ending June 30, 2012</b>	
Total revenue	\$860,000,000
Total expenses	<u>900,000,000</u>
Gain/(loss)	(40,000,000)
Beginning net assets	<u>151,000,000</u>
Ending net assets	<u>\$111,000,000</u>
<b>RESERVES</b>	
Restricted Reserves	\$18,000,000
Actuarial IBNP	<u>71,000,000</u>
Excess HIF net assets after Restricted and IBNP	22,000,000
Less: Contingency	<u>70,000,000</u>
Deficiency of HIF net assets after Restricted, IBNP, Contingency	<u>(\$48,000,000)</u>

Based on our projection, we believe by June 30, 2012 ending HIF net assets will be insufficient to fully fund the actuary’s recommended reserves. We believe net assets may fully fund the IBNP, but fall about \$48 million short of fully funding the contingency reserve portion.

If the Governor and General Assembly choose to continue the current subsidy into fiscal year 2013, we estimate the ending net assets could decrease an additional \$40 to \$130 million by June 30, 2013, making it likely that we will be unable to fully fund the IBNP. The range is broad because of the uncertainty as to whether actual claims will remain low through 2013 or return to normal, pre-2009 growth trends.

When the growth trend increases, it is likely that premium rates for that year will be too low to cover the claims and the reserve will take a significant hit. It is for this reason that the actuary recommends funding a contingency reserve; to provide an emergency reserve to respond to the naturally occurring trend changes.

If the contingency reserve is too low or non-existent due to the continued actions of subsidizing premiums and diverting interest, it is likely premium rates will need to increase significantly the year after trends return to normal. In addition, the subsidy will no longer occur, making the employees and agencies bear an even higher amount of premium costs. Because the HIF net assets have subsidized premiums since 2009, keeping premium growth very low or not at all, state employees and their agencies are likely not prepared for significant premium increases.

In the event the reserve became zero, the Commonwealth has provided a \$50 million dollar line of credit to pay insurance claims. Of course under this scenario there will be a need for additional premium rate increases to repay the line of credit.

### **Revising Health Care Budgeting and Policy Setting**

The Commonwealth has complicated the budgetary and policy review of the health care programs by not separating and reviewing each plan independently. While we have discussed the need to separate the Medicare retiree program earlier in this report, serious consideration should also be given to separating the Kaiser HMO since that Plan does not contribute towards the HIF net assets and is not considered in developing the actuarial reserves or premium rates.

#### **Recommendation 6:**

*Human Resources should work with the State Comptroller to separate the HIF fund into three distinct funds for accounting purposes. One fund should account for the activities of active employees and pre-Medicare retirees, except for Kaiser Permanente HMO; another for Kaiser Permanente HMO, and another for Medicare retirees. Separating these funds will provide decision makers, such as Planning and Budget, with information regarding the active employee plans and how the Commonwealth may manage these plans from a budgetary perspective.*

Further, for the active employee and pre-Medicare retiree program, budget and policy makers need to separate the decision making relative to the premium rate setting process from the determination of the adequacy of the reserves. Excess premiums over expenses contribute to an increase in the overall net assets of this program, but have nothing to do directly with the amount and computation of the reserve balances. While health care utilization and trends do affect both premiums and reserve amount, each serves a different purpose.

Both the IBNP and the contingency reserve have remained relatively stable in relationship to the projected health care costs that both reserves address. However, as explained earlier, the actual health care costs have not grown at a rate close to projected. This factor alone appears to be the single largest factor contributing to the overall growth of the HIF net assets.

The IBNP reserve serves as an estimate of the outstanding claims liability at year end and the Commonwealth must show this liability in its financial reports. Not holding sufficient HIF net assets to offset the IBNP reserve accrual would result in negative net assets and increase the debt of the Commonwealth through execution of the line of credit, with no offsetting assets. It also creates a situation whereby the Commonwealth would likely need to inject funds to meet cash shortfalls.

Our recommendations in this report address much of the accounting and separation of the information needed to allow the Commonwealth to develop budgets and set policies for health care costs. Management at the Governor's Office, Planning and Budget, and Human Resources will need to work with the General Assembly to set the policy considerations such as the level of reserve funding and the timing of obtaining actuarial premium rates to realize the benefits of these recommendations.

## Chapter 6: Objectives and Conclusion

### Reason for This Audit

In 1997, the HIF was at risk because net asset balances were too low. The General Assembly provided appropriations to bolster the HIF and the net assets rebounded. By the end of fiscal year 2008, net assets had grown significantly and exceeded Aon's recommended reserve level by more than \$96 million. Planning and Budget took action starting in fiscal year 2009 to reduce this overfunding by using a portion of the excess HIF net assets to subsidize the monthly insurance premiums paid by active employees and their agencies.

By the start of fiscal year 2011, Planning and Budget became concerned that the subsidy had not reduced the overfunded net assets by the desired level, leading to questions about Aon's premium rate setting process. To resolve questions about the process, the Governor's fiscal year 2012 budget requested an audit.

### Objectives

The Appropriations Act 890 Item 1.2, 2-D requires the Auditor of Public Accounts to complete a financial review of the state employee health insurance fund and address the rate setting process and projected expenditures compared to actual expenditures.

Based on the review requirements we defined the following objectives for this performance audit.

1. Determine whether the actuary employed best practices in recommending premium rates including following Actuarial Standards and basing assumptions on industry trends.
2. Determine whether Human Resources communicated desired assumptions to the actuary and whether subsequent adjustments to the actuarially recommended premium rates were reasonable and clearly vetted with Executive and Legislative staff.
3. Examine projected to actual expense information and determine what events affected the desired reserve reduction.

### Scope

The Commonwealth's Health Insurance Fund (HIF) is comprised of various health benefit insurance plans and components including medical, dental, vision, hearing, and prescription coverage for active employees, pre-Medicare retirees, and Medicare retirees. Some plans and components are more costly than others and therefore make up a greater portion of the premium costs and HIF reserve balance. For purposes of our review, where information is available, we have included fiscal years 2007 through 2011 in order to provide an historical perspective.

## Methodology

We interviewed Planning and Budget, Human Resources, Legislative staff, and the actuary, Aon, to gain an overall understanding of the rate setting process and the role each group plays in the health insurance process. We gained an understanding of actuarial standards for health insurance plans and met with Aon to understand their internal quality assurance process and methodology for ensuring quality data. Where available we reviewed documents, reports, and communications among all parties to understand what assumptions Aon received and what additional changes Human Resources and Planning and Budget made to the premium rates after receiving them from the actuary.

To understand industry and economic trends and their impact on insurance programs universally, we obtained and reviewed relevant industry articles and statistics. We obtained information from Aon about trends in other southeastern states they service and confirmed that information independently. Additionally, we met with professional staff from the State Corporation Commission's Bureau of Insurance and an international corporation based out of Richmond, Virginia, to discuss self-insurance funds generally and best practices used for premium rate setting and reserves. Finally, we calculated and analyzed financial information including actual expenditures compared to projected expenditures for the fiscal years 2007 through 2011.

## Conclusion

Aon employed best practices in recommending premium rates including following Actuarial Standards and basing assumptions on industry trends available at the time. In addition, Human Resources communicated their assumptions to Aon, who subsequently adjusted the actuarially recommended premium rates and these assumptions were reasonable and clearly discussed with Executive and Legislative staff.

An unexpected decrease in claim expenses from 2009 through 2011 is why the premium subsidy has been ineffective in reducing HIF net assets as planned. We found that Aon appropriately reduced their claims growth trend assumptions when setting its 2011 and 2012 premium rates, once the decline in claims expense was visible in the actual claims data.

As of Aon's October 2011 actuarial report, the HIF net assets for the active employee and pre-Medicare retiree program are insufficient to provide reserves at the actuarially recommended amounts. The premium subsidy in effect from fiscal year 2009 through 2011 and lower claim growth trends incorporated into Aon's 2011 recommended premium rates have reduced the HIF net assets. The subsidy continues in fiscal year 2012 and the Commonwealth maintained premium rates at 2011 levels.



# Commonwealth of Virginia

## *Auditor of Public Accounts*

Walter J. Kucharski  
Auditor of Public Accounts

P.O. Box 1295  
Richmond, Virginia 23218

October 13, 2011

The Honorable Robert F. McDonnell  
Governor of Virginia

The Honorable Charles J. Colgan  
Chairman, Joint Legislative Audit  
and Review Commission

We have audited the State Employees Health Insurance Fund and its related insurance plans and are pleased to submit our report entitled State Employees Health Insurance Fund. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

### Exit Conference and Report Distribution

We discussed this report with management at the Departments of Human Resource Management and Planning and Budget on October 5, 2011. Planning and Budget concurred with the report and elected not to do a formal agency response. Human Resource Management also concurred with the report and their response to the findings identified in our audit is included below. We did not audit their response and, accordingly, we express no opinion on it.

This report is intended for the information and use of the Governor and General Assembly, management, and the citizens of the Commonwealth of Virginia and is a public record.

AUDITOR OF PUBLIC ACCOUNTS

KKH: alh






# COMMONWEALTH of VIRGINIA

## *Department of Human Resource Management*

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TO: Karen Helderman, Audit Director  
Auditor of Public Accounts

FROM: Sara R. Wilson, Director   
Department of Human Resource Management

DATE: October 13, 2011

RE: APA audit of HIF

Thank you for the opportunity to respond to the recent audit of the health insurance fund (HIF). We find the audit to be comprehensive and representative of this very complex situation. We also believe the findings are consistent with best practices and look forward to working with the Department of Planning and Budget, Senate Finance and House Appropriations staff as recommended in the report.

RESPONSIBLE OFFICIALS

Sara Redding Wilson, Director  
Department of Human Resource Management

Daniel Timberlake, Director  
Department of Planning and Budget