ANNE ARUNDEL COUNTY
Annapolis, Maryland
Auditor's Office

INTER-OFFICE CORRESPONDENCE

To: Members of the County Council
County Executive John Leopold
John Hammond, Chief Administrative Officer
Andrea Fulton, Personnel Officer

From: Teresa Sutherland, County Auditor T. Sutherland

Date: April 20, 2012

Subject: Executive Summary - Review of Health Insurance Contribution Rates

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We recently evaluated the Office of Personnel's procedures for developing contribution rates for the County's health insurance plans. We undertook this evaluation because we believed the contribution rates were greater than the amounts needed to cover expenses and ensure the fund was financially stable, as evidenced by $26.7 million of "premium holidays," transfers to the General Fund, and reduced contributions on behalf of retirees budgeted in fiscal years 2008 - 2012.

The objectives of our evaluation were to determine whether:

1. the contribution rates were accurately calculated and included all projected costs, including claims expenses and administrative costs.
2. the trend projections used by the consultant were reasonable.
3. the contribution rates for part-time employees were calculated in accordance with the County Code.

We determined that the contribution rates were not accurately calculated. Some costs on which the rates were calculated were overstated, and all costs were not included. The net effect of the errors we found was a $2.3 million overstatement of projected costs on which the 2012 rates were calculated. We also determined that over the last seven years, the County has experienced lower increases than the trends projected by the consultant. Finally, we determined that the contribution rates for part-time employees were not calculated in accordance with the County Code.

Our evaluation was not made in accordance with generally accepted government auditing standards or standards issued by the American Institute of Certified Public Accountants and was more limited than would be necessary to express an opinion on the system of internal accounting control over health insurance contribution rate procedures. Accordingly, we do not express an opinion or any other form of assurance on the system of internal accounting control over health insurance contribution rate procedures.

Details of our findings and recommendations and the Administration's response is found in the attached report. Please call if you have any questions.

ANNE ARUNDEL COUNTY
OFFICE OF THE COUNTY AUDITOR

April 20, 2012

The Honorable Members of the County Council
The Honorable County Executive John R. Leopold
Mr. John Hammond, Chief Administrative Officer
Ms. Andrea Fulton, Director, Office of Personnel
44 Calvert Street
Annapolis, Maryland 21401

Dear Members, Mr. Leopold, Mr. Hammond, and Ms. Fulton:

During the fiscal year 2012 budget deliberations, I recommended reducing the appropriations from the County's General Fund, Utility Fund, other County funds, and user agencies to the Health Insurance Fund to cover the expenses in the Health Insurance Fund (HIF). In my opinion, the revenue into the Health Insurance Fund from the employer and employee/retiree contributions was greater than that needed to cover expenses and ensure the fund was financially stable.

To provide insight on the accuracy of our FY12 budget analysis and to help us form our budget recommendations for the upcoming fiscal year 2013 budget, we recently evaluated the Office of Personnel's procedures for developing contribution rates for the health insurance plans offered by the County. Our objectives were to determine whether:

1. the contribution rates were accurately calculated and included all projected costs, including claims expenses and administrative costs.
2. the trend projections used by the consultant were reasonable.
3. the contribution rates for part-time employees were calculated in accordance with the County Code.

Our evaluation was not made in accordance with generally accepted government auditing standards or standards issued by the American Institute of Certified Public Accountants and was more limited than would be necessary to express an opinion on the system of internal accounting control over health insurance contribution rate procedures. Accordingly, we do not express an opinion or any other form of assurance on the system of internal accounting control over health insurance contribution rate procedures.

This report is intended solely for the use of the County Council and the management of Anne Arundel County. However, it is public information that may be obtained from the Office of the County Auditor. Management's response to our findings and recommendations follows our report.

Background

The County offers four health insurance plans, two dental plans, a vision plan, and prescription drug coverage. Employees and retirees of Anne Arundel Community College, the Library system, and certain related non-profit entities, such as Anne Arundel Economic Development Corporation, also participate in the County's plans.

The County is self-insured for health, dental, vision, and prescription claims with the exception of one dental plan. The self-insured plans account for 99% of the County's claims and third party administrative expenses totaling $82.5 million in fiscal year 2011. For those plans that are self-insured, the County pays the insurance companies administering the plans the amount of actual claims incurred plus administrative expenses monthly. This differs from the traditional payment of a premium where someone pays a premium to purchase insurance coverage, and the insurer bears the risks of expenses exceeding the premiums and reaps the reward when expenses are less than the premiums.

For the last several years, the Office has contracted with a benefits-consulting firm to determine "contribution rates." The contribution rates are used to determine the amounts to be paid by the participants and the amounts to include in the budget to transfer from the County departments and user agencies to the HIF.

The consultant uses historical claims and enrollment data, administrative fees, and estimates of expense trends to calculate the estimated claims and administrative expenses for the upcoming year. They compare the estimated claims and administrative expenses to projected revenues using the current contribution rates. If estimated claims and administrative expenses exceed the projected revenues, the consultant determines the rates needed for each plan to ensure the Health Insurance Fund breaks even. The proposed rates are presented to the Administration for approval.

Financial Position of the Health Insurance Fund and Budget Actions

From fiscal year 2000 to fiscal year 2011, the fund balance in the HIF has ranged from a low of $1.9 million in fiscal year 2000 to a high of $17.4 million in fiscal year 2009. During the same period, fund balance as a percentage of operating expenses ranged from a low of 3.4% in fiscal year 2006 to a high of 23.7% in fiscal year 2009. (All amounts and percentages in this report exclude funds transferred into and subsequently out of the HIF for the liability for retiree health insurance (OPEB).)

At the end of fiscal year 2001, fund balance was 16.2% of operating expenses, so the County granted a "premium holiday" in fiscal year 2002. At the end of fiscal year 2008, fund balance was 22.5% of operating expenses, so the County reduced its contribution on behalf of retirees by $3 million in FY09. Despite this reduction, fund balance at the end of FY09 increased to 23.7%.

The County took several actions over the next two fiscal years to reduce the fund balance in the HIF. The FY10 appropriations on behalf of retirees was reduced by $1.1 million. (Although the budget appropriations for retirees were reduced by $1.1 million, the Administration transferred this amount from the General Fund to the HIF anyway, causing the expenditures to exceed the appropriation for this individual line item.) The County also granted a premium holiday for $3.5 million in fiscal year 2011 and, over the two years, transferred $11 million from the HIF to the General Fund to help balance the County's budget.

In May 2011, when the fiscal year 2012 budget was before the County Council for deliberation, the Administration anticipated a $9.4 million fund balance on June 30, 2011. The County proposed a premium holiday for approximately $3.4 million in the FY12 budget, in addition to transferring $800,000 of the Health Insurance Fund balance to the General Fund.

The budget actions in fiscal years 2009 - 2011 indicate that recurring revenue in the HIF is more than is needed to cover expenses and ensure the financial stability of the fund. In our FY12 budget analysis, I anticipated the FY11 ending fund balance would be greater than $9.4 million and proposed an additional premium holiday for approximately $3.9 million. The Council adopted my recommendation. When the books were closed for fiscal year

2011, the audited fund balance in the Health Insurance Fund as of June 30, 2011 was $10.6 million, $3.8 million more than the Administration anticipated in the proposed FY11 budget and $1.2 million more than the Administration anticipated in the proposed FY12 budget.

Auditor's Analysis and Findings

Objective #1: To determine whether the contribution rates were accurately calculated and included all projected costs, including claims expenses and administrative costs.

We obtained the 2012 calendar year rate calculations from the Office of Personnel's consultant and verified the accuracy of the various data used such as paid claims, enrollment figures, and administrative fee rates. Our review disclosed that the contribution rates were not accurately calculated and did not include all projected costs. Specifically:

- The County pays CVS Caremark a monthly "drug savings review fee" based on the number of prescriptions processed each month. The monthly fee was approximately $8,000 during 2011, or $96,000 annually.

  In our review, we found that the 2012 rate calculation was overstated by $1,050,000 because the consultant inadvertently included $96,000 a month for this fee, instead of $96,000 a year.

- The County pays a monthly fee to CVS Caremark for services related to prescriptions for Medicare-eligible participants. This fee averaged approximately $700 per month or $8,400 annually in calendar year 2011.

  In our review, we found that the 2012 rate calculation was overstated by approximately $130,000. The consultant included a monthly fee of $0.70 per participant/month instead of the contractual monthly rate of $0.50/participant. Further, the consultant included this fee for all plan participants, when it should be limited to Medicare-eligible participants.

- The 2012 rate calculation included an adjustment to reflect the impact of certain new federal health care mandates on the County's claims expenses.

  Our review disclosed that the consultant calculated the impact of the changes uniformly across the County's medical and prescription drug plans even though the changes did not impact prescription drug costs to the same extent as medical expenses. Consequently, prescription claim expenses were overstated in the calculation by approximately $300,000.

- Under a separate agreement between CVS Caremark and the County, CVS Caremark processes prescription claims for the County's workers' compensation claimants. The costs of these prescriptions are borne by the County's Self Insurance Fund, a separate fund from the Health Insurance Fund.

  Our review disclosed that the consultant did not properly exclude the workers' compensation prescription claims from the rate calculation, resulting in an overstatement of approximately $345,000.

- CareFirst charges a network access fee for certain claims processed by its affiliates in other states. The consultant included a network access fee of 1.0051% on all claims based on a representation from CareFirst.

  As a result of our inquiries, the consultant subsequently determined that these access fees were already included in the paid claims data provided by CareFirst. Consequently, the rate calculation was overstated by $365,000.

- The County negotiated with CareFirst for a reduction in the monthly administration fee per member effective January 1, 2012. During our review, we found that the consultant did not recognize the fee reduction in its calculations. Consequently, the rate calculation was overstated by approximately $69,000.

- The County's policy is for the HIF revenues to cover the County's administrative expenses, including the salaries and benefits of employees involved in administering health benefits, supplies, consulting expenses, etc. However, we found that the Administration did not advise the consultant of the amount of administrative expenses to include in the rate calculation.

  For fiscal year 2012, the County's administrative costs are budgeted at $1,161,500, and approximately $320,000 will be recouped via a surcharge on outside user agencies, such as the Library and Anne Arundel Community College. Therefore, the rate calculation should have included approximately $841,500 of County administrative costs.

- Since January 2006, the County has benefitted from the federal government's Medicare Part D drug subsidy program. Under this program, the federal government makes quarterly payments directly to the County to subsidize prescription drug costs for Medicare participants. In calendar year 2010, the County received approximately $900,000 in Medicare Part D subsidy payments.

  Although these payments represent a significant reduction in prescription costs for the County's Medicare recipients, the subsidies were not included in the rate calculations. Consequently, prescription drug costs were overstated by approximately $900,000 in the contribution rate calculation. (According to the County's consultant the Medicare D subsidy program is being phased out under federal health reform legislation. However, the County is eligible to participate in another discount pricing program that will provide the County with similar cost savings for Medicare recipients' prescription drugs.)

Effect on the 2012 Contribution Amounts

The consultant recommended rate increases that the County Administration adopted and implemented. Those increases varied by plan, ranging from 0% for the CIGNA plan for non-Medicare participants to 13.6% for the CareFirst Triple Option plan, and the overall projected increase in total claims and third party administrative expenses was 5.1%.

The net effect of our findings above is that the projected costs on which the 2012 rates were calculated were overstated by approximately $2.3 million. If the rate calculations are corrected for the errors we noted above, the overall increase would be only 2.5%. The impact on individual plan rates varies since certain findings affect some plans more than others, and we have summarized our findings by plan in the attachment to this report.

Recommendations

We recommend that the Office of Personnel carefully review the consultant's rate calculations to ensure that the calculations accurately reflect all costs and subsidies. With regard to the 2012 calculations, the most significant effect of the differences we noted is on the CIGNA Medicare Wrap plan. The consultant's calculations resulted in a recommended rate increase of 10.3% for this plan, while our revised calculations result in a rate decrease of -0.7%. We recommend that the County revise the 2012 Medicare supplement plan rate to reflect more accurately the net costs after accounting for the Medicare D subsidy from the federal government. The rate reductions for the other plans are not significant enough to warrant mid-year changes.

Management's Response

The Office of Personnel agrees that a closer review of the consultant's annual rate calculations would be beneficial to detect errors and ensure the overall accuracy of the calculation. Procedural changes will be implemented to conduct and document a more thorough review. Additionally, the Office of Personnel has already discussed the adjustments noted by the Auditor in the 2012 rates with the consultant in order to prohibit them from repeating in the future.

With regards to the 2012 calculations, the adjustments discovered by the Auditor have an approximately 3% reduction to the health rates that were set for the year. With that in mind, the Office of Personnel does not believe that a mid-year reduction to any rates is necessary. Instead, any overpayment resulting from the fiscal year 2012 rates will be considered when the 2013 rates are calculated, which will adjust the 2013 rate for the same groups that may have paid a higher rate in 2012.

It has not been the County's practice to include administrative expenses, such as the salaries and benefits of employees that administer health benefits, in the rate calculation. It has been the policy to recover administrative costs despite not including these costs in the rate calculations. The Office of Personnel agrees to reconsider that policy for future rates beginning in fiscal year 2013.

It has also not been the County's policy to include the Medicare Part D subsidy payments when calculating the County's rates. These subsidy payments are difficult to predict and inclusion of them in the annual rates could lead to greater inaccuracy in the rates set. For that reason, the Office of Personnel does not wish to change the current policy and include these amounts in future annual rates.

Objective #2: To determine whether the trend projections used by the consultant were reasonable.

The projection of costs is the most significant factor in the rate calculation, accounting for approximately $12 million of the $16 million of additional claims expense included in the 2012 rate calculation. The County's consultant projected a 9.5% increase in medical claims costs and a 9% increase in prescription claims costs for 2012.

The consultant developed these projections after considering (1) its own review of industry trends that indicated a 10% increase for both medical and prescription costs; (2) vendor input that indicated an 8% - 9.5% increase for medical expenses and 6.1% for prescription expenses; and (3) the County's actual increases in the most

recent 12 months, which were 4.4% - 6.9% for medical expenses and 9.1% for prescription expenses. The consultant advised us that the underwriter considers these trends and uses judgment to determine the trend projection to use for the next year. The consultant also advised us that combined trend factors of 10.3% and 10.2% were used in the 2011 and 2010 rate calculations, respectively.

Finding

Our review of the County's actual claims experience for the last seven years indicates that, on average, the County is experiencing lower increases than the trend factors used by the consultant. Specifically, from fiscal year 2005 to fiscal year 2011, the County's claims increased 6.7% per year on average. Some of the claims increase was driven by the 2.1% increase in enrollment per year on average. Therefore, after considering enrollment increases, the fund's claim expenses increased approximately 5% per year.

Recommendation

We recommend that the Office of Personnel review the trend factors proposed by the consultant in the future and ensure that the factors are reasonable and consistent with the County's actual experience.

Management's Response

The use of trend is a significant factor in determining rates. Health care claims are highly unpredictable. The consultant uses industry standard approaches to determine the trend. The consultant noted an overall 10% trend in health care costs. After reviewing all relevant data, the consultant used a 9.5% trend for medical claims and a 9% trend for prescription costs.

The Office of Personnel is comfortable that the consultant's calculation of health care rates is a reasonable approach and conforms with industry standards. Relying solely on our recent claims experience or solely on industry standards would be irresponsible. Setting the trends and ultimately the rates is not an exact science. While the rates should not be "padded" in order to plan for large ending balances, the rates should be set planning on a small cushion for unexpected claims costs, which the consultant did when calculating the 2012 rates.

Objective #3: To determine whether the contribution rates for part-time employees were calculated in accordance with the County Code.

Article 6, §1-308 of the County Code provides that the County shall pay a prorated portion of the health insurance costs for part-time employees who work at least 50% of the normal work week. The County publishes rates for part-time employees who work 50%, 60%, and 80% of a normal work week in the annual open enrollment book. We reviewed the part-time rates included in the 2010, 2011 and 2012 open enrollment books to determine whether the rates were calculated properly in accordance with County Code, and our review disclosed the Administration was not complying with the provisions of the County Code.

The County pays 80% of the contribution amount for an employee enrolled in CareFirst Triple Option, and 90% for employees enrolled in the other plans. Therefore, under the provisions of the County Code, the County would pay 40% or 45% for an employee who worked 20 hours per week; 48% or 54% for an employee who worked 24 hours a week; and 64% or 72% for an employee who worked 32 hours per week, depending on which plan the employees were enrolled in.

The open enrollment books published annually by the Office of Personnel show the contribution rates for full-time employees and for part-time employees working 50% (20 hours), 60% (24 hours), and 80% (32 hours) of a normal work week. We reviewed the rates published in 2010 and in 2011 and determined that the County was paying a greater amount for part-time employees than it should under the provisions of the Code. For example, the County should pay either 40% or 45% of the contribution amount for an employee working 50% of a normal week. The published rates showed the County paying 50% of the contribution amount. The County also used the same improper methodology for employees working 60% or 80% of a normal work week.

We previously brought this calculation error to the attention of the Office of Personnel, and the County revised its methodology for 2012. However, the new methodology Personnel implemented still does not result in the correct contribution rates for all plans.

The Administration's revised calculations prorate the amount to be paid on behalf of a part-time employee based on a 90% contribution for a full-time employee. While the County contributes 90% for a full-time employee in some of the less expensive plans, the County contributes only 80% for a full-time employee enrolled in the more expensive CareFirst Triple Option plan. Additionally, the Office of Personnel rounds the amount which the County will contribute up to the next highest 5% increment.

Under Personnel's calculation, a part-time employee working an 80% work week enrolled in CareFirst Triple Option plan would pay 25% of the contribution amount, and the County would pay 75%. However, the correct contribution rate is 64%. All of Personnel's calculations for part-time employees result in the County paying a greater share of the health insurance costs than permitted by the Code.

We recommend that the Administration comply with the provisions of the County Code governing the amounts to be paid for health insurance on behalf of part-time employees.

Management's Response

We agree that the part time rates have been calculated incorrectly. Changing this rate calculation would have resulted in the loss of the County's "Grandfathered" status related to the health care reform legislation and ultimately cost the County more than leaving the rates unchanged. However the Administration did adjust rates by the maximum allowed amount in 2011 and still qualify for Grandfathering. We anticipate losing this status effective January 1, 2013 and will fully correct the part time rates coinciding with this change in status.

Auditor's Comment on Management's Response

Our finding relates to the Administration's failure to comply with the provisions of the County Code that govern cost-sharing between the County and part-time employees. We recommend that the Office of Personnel seek guidance from the County Attorney to determine whether taking corrective action to comply with the Code provisions would be prohibited by federal health care regulations. We are recommending that the Administration correct an error, not change the cost-share provisions set forth in the Code.

Other Comments

Employees and retirees less than 65 years of age may choose from four levels of coverage: Individual, Parent and Child, Husband and Wife, and Family. The rates for Parent and Child, Husband and Wife, and Family are derived by multiplying the individual rate by a set factor as follows:

- Parent and Child — Individual Rate x 1.79
- Husband and Wife — Individual Rate x 2.13
- Family — Individual Rate x 2.76

Management has not evaluated these multipliers since they were established more than ten years ago. We recommend that management calculate the actual cost of each coverage type and determine whether the multipliers should be adjusted. We also recommend that management re-evaluate the factors at least every three years.

Management's Response

The Office of Personnel agrees that the multiplier factors noted by the Auditor should be re-evaluated due to age. We also agree that these factors should be re-evaluated periodically and propose that this be done every five years.

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We thank the Office of Personnel, particularly Judi Lohn and Darby Lemerise, for their assistance and courteous cooperation. Please call if you have any questions regarding our findings and recommendations.

Sincerely,

Teresa Sutherland, CPA
County Auditor

Auditor's Calculations of Projected Claims and Expenses and Rate Changes - Calendar Year 2012					
	CareFirst Triple Choice	CareFirst Blue Choice HMO	CIGNA Open Access	CIGNA Medicare Wrap	Total
Projected claims and expenses used by consultant/Administration	27,118,722	25,319,724	30,369,329	11,762,285	94,570,060
Overstatement - drug savings review fee	(265,000)	(269,000)	(276,000)	(240,000)	(1,050,000)
Overstatement - CVS Caremark fee for Medicare-eligible participants	(32,000)	(45,000)	(49,000)	(4,000)	(130,000)
Overstatement - prescription claims	(42,000)	(32,000)	(25,000)	(201,000)	(300,000)
Overstatement - workers' compensation prescription claims		(345,000)			(345,000)
Overstatement - network access fees	(193,000)	(172,000)			(365,000)
Overstatement - monthly administration fees	(32,000)	(37,000)			(69,000)
Understatement - County administrative costs	196,000	222,500	254,000	169,000	841,500
Recognition of Medicare D subsidies				(900,000)	(900,000)
Revised projected claims and expenses	26,750,722	24,642,224	30,273,329	10,586,285	92,252,560
Current rates	23,808,756	25,107,303	30,394,103	10,662,926	89,973,088
Increase/(decrease)	2,941,966	(465,079)	(120,774)	(76,641)	2,279,472
Rate change based on Auditor's revised calculations	12.4%	-1.9%	-0.4%	-0.7%	2.5%
Rate change approved by the Administration	13.6%	1.0%	0.0%	10.3%	5.1%
Overstatement	1.2%	2.9%	0.4%	11.0%	2.6%