A REPORT
TO THE
ARIZONA LEGISLATURE

Performance Audit Division

Performance Audit

Department of Administration–

Human Resources Division

SEPTEMBER • 2005
REPORT NO. 05 – 12

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

Debra K. Davenport
Auditor General

The **Auditor General** is appointed by the Joint Legislative Audit Committee, a bipartisan committee composed of five senators and five representatives. Her mission is to provide independent and impartial information and specific recommendations to improve the operations of state and local government entities. To this end, she provides financial audits and accounting services to the State and political subdivisions, investigates possible misuse of public monies, and conducts performance audits of school districts, state agencies, and the programs they administer.

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Dale Chapman, Manager and Contact Person
Danielle Mariano
Tara Nielson
Elizabeth Shoemaker

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STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

DEBRA K. DAVENPORT, CPA
AUDITOR GENERAL

WILLIAM THOMSON
DEPUTY AUDITOR GENERAL

September 28, 2005

Members of the Arizona Legislature

The Honorable Janet Napolitano, Governor

Mr. Jerry Oliver, Interim Director
Department of Administration

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Department of Administration—Human Resources Division. This report is in response to a November 20, 2002, resolution of the Joint Legislative Audit Committee. The performance audit was conducted as part of the sunset review process prescribed in Arizona Revised Statutes §41-2951 et seq. I am also transmitting with this report a copy of the Report Highlights for this audit to provide a quick summary for your convenience.

As outlined in its response, the Department of Administration agrees with all of the findings and plans to implement all of the recommendations.

My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on September 29, 2005.

Sincerely,

Debbie Davenport
Auditor General

Enclosure

2910 NORTH 44th STREET • SUITE 410 • PHOENIX, ARIZONA 85018 • (602) 553-0333 • FAX (602) 553-0051

PROGRAM FACT SHEET

Arizona Department of Administration
Human Resources Division

Services:

The Department of Administration, Human Resources Division (Division) provides a variety of services to state agencies and their employees through the following units:

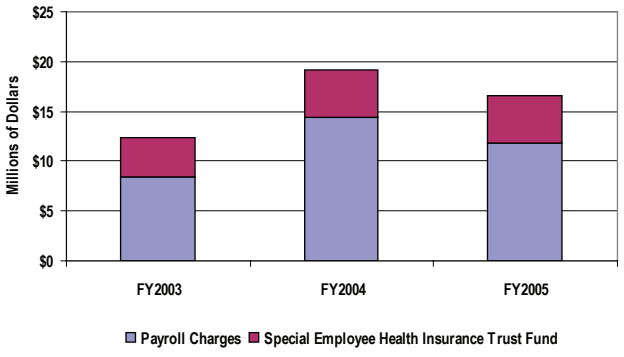
- Benefits—Administers the self-funded health benefits program, including medical and prescription drug coverage, dental, basic life, short-term disability, long-term disability, and flexible spending accounts.
- Classification/Compensation—Monitors compliance with the Federal Fair Labor Standards Act, reviews all job classification changes, and prepares the annual state employee salary recommendation to the Legislature.
- Workforce Relations—Provides professional human resources services at the Division's seven satellite offices, located at various state agencies and in Tucson, and reviews employee grievances involving discrimination or a violation of the personnel rules.[1]
- Staffing and Recruitment—Maintains new online hiring and recruiting software, provides staffing and recruitment services to some state agencies without access to the new hiring software, and administers the State's temporary employment services.
- Planning and Quality Assurance—Provides strategic planning and best practices research and conducts internal performance audits of state agencies' human resources functions.
- Consulting Services—Provides both in-house and external human resources consulting services to other state agencies; including drafting and tracking legislation; handling inquiries from the public; and designing and overseeing pilot programs.
- Budget/Administrative—Oversees the budget and administrative activities of the Division and coordinates the Division's purchasing, accounting, and payroll activities.
- Human Resources Information Solution (HRIS)—HRIS staff support the design and implementation of the new human resources information system, HRIS.

Program staffing:

143.75 filled positions and 24 vacancies (as of July 19, 2005)

Program administration revenue:

$16.6 million (fiscal year 2005, estimated)



1 The Division has satellite offices in the Departments of Corrections, Economic Security, Health Services, Juvenile Corrections, Revenue, and Transportation.

Facilities and equipment:

The Human Resources Division occupies a total of 25,565 square feet of office space in the Department's building at 100 North 15th Avenue in Phoenix. The Department leases this building under the PLTO (private lease-to-own) program and was scheduled to pay approximately $2.6 million in rent for the entire building during fiscal year 2005. In addition, the Division has seven satellite offices at various state agencies and in Tucson. While the Division pays $16,000 in rent annually for the Tucson office, it does not pay rent for the satellite offices located in other state agencies. The Human Resources Division's equipment includes typical office equipment.

Mission:

To provide efficient, timely, customer-driven, professional human resources services to meet our agency, employee, and public customers' needs.

Goals:

1. To deliver customer service that is second to none.
2. To attract and retain a high-performance team of employees.
3. To aggressively pursue innovative solutions and/or opportunities.

Adequacy of performance measures:

The Human Resources Division has developed a number of performance measures that are in line with its goals, and include input, outcome, efficiency, and quality measures. These include measures for customer satisfaction with the State's benefits plans, average turnaround time for processing all classification actions, and customer satisfaction with the State's employee grievance process.

However, the Division could benefit from additional performance measures that provide more information on its activities. For example, while it has measures for the number of appeals it receives regarding its new self-funded benefits program, it does not have measures reflecting the handling of these matters, such as the ratio of open-to-closed appeals, the number of appeals denied or approved, and the percentage of appeals that involve the Office of Administrative Hearings. Likewise, although the Division reports on the number of applicants who used the State's new online hiring system and agency satifaction with candidate quality, it does not track job applicant satisfaction with this system. Adding a customer satisfaction measure in this area might help the Division make future changes to the new system.

Source: Auditor General staff compilation of unaudited information obtained from the Arizona Financial Information System (AFIS) for the years ended June 30, 2003 and 2004; Master List of State Government Programs; and other information provided by the Department, including financial estimates for the year ended June 30, 2005.

SUMMARY

The Office of the Auditor General has conducted a performance audit of the Arizona Department of Administration's Human Resources Division pursuant to a November 20, 2002, resolution of the Joint Legislative Audit Committee. This audit was conducted as part of the sunset review process prescribed in Arizona Revised Statutes (A.R.S.) §41-2951 et seq and is the third in a series of four reports on the Department of Administration (Department). This report focuses on the State's new self-funded health benefits program, the Department's new recruiting and hiring software, Yahoo!® Hiring Gateway, and the potential impact of complying with Governmental Accounting Standards Board Statement No. 45 to account for nonpension post-employment benefits. The first report reviewed the Department's Financial Services Division (Auditor General Report No. 05-02), and the second report reviewed the Department's Information Services Division and Telecommunications Program Office (Report No. 05-11). The final report will be an analysis of the 12 statutory sunset factors.

The Human Resources Division (Division) provides a variety of services to state agencies, their employees, and retired state employees. One of the Division's primary functions is to administer the State's self-funded health benefits program. The State began to self-fund employee health benefits in October 2004 in an effort to limit the growth in its healthcare costs and to increase employees' choice of providers. For fiscal year 2005, the Department reported spending over $262.9 million for program medical claims and over $19.6 million for administration, while the program had an enrollment of 57,549 people as of June 30, 2005, consisting of state employees, retirees, and their dependents.[1] In addition to administering employee health benefits, the Division manages state employee counseling and wellness programs, maintains the State's job classification and compensation system, reviews employee grievances involving discrimination or a violation of personnel rules, maintains the State's new online hiring and recruiting software, and maintains and administers the State's Human Resources Information Solution system.

1 The Department's administrative costs include its costs to administer other health benefits provided to members, such as dental benefits and a wellness program. However, the majority of these costs were used to administer the self-funded health benefits program, including over $16.3 million for the program's vendor costs.

Department should strengthen its management of self-funded health benefits program (see pages 11 through 23)

The Department needs to re-examine several aspects of its management of the State's self-funded health benefits program (program), including determining what activities are most appropriate for its consultant to undertake. To implement the program in the short amount of time it had available, the Department relied heavily on a consultant. According to department officials, it had only 4 months to complete what it estimated to be a 12-month program implementation process. This short time frame led to a larger-than-expected role for the consultant in overseeing the program. Further, it did not provide the Department an opportunity to clearly define the consultant's roles and responsibilities, especially in relation to the activities the Department anticipated performing. This has resulted in a situation in which the Department shares many aspects of program administration and oversight with the consultant. Since the Department has not clearly defined the consultant's role and responsibilities, some of these shared duties could potentially overlap or duplicate each other, while the consultant performs many activities that the Department had originally planned to do.

This heavy reliance on the consultant has also required a significant amount of its fiscal year 2005 program administration budget and affected the Department's ability to hire staff and develop the necessary expertise to manage the program. Specifically, as of June 30, 2005, the Department had incurred expenses totaling approximately $1.67 million for this consultant. This amount represents 35 percent of the Department's appropriated administrative budget of approximately $4.75 million for fiscal year 2005 and is more than three times the $500,000 the Department originally budgeted for this consultant for fiscal year 2005. Additionally, as of July 2005, the Department had filled only 7.25 of the additional 12.5 staff positions it was authorized for fiscal year 2005 to help manage the program. The Legislature appropriated $965,300 to the Department to hire these additional staff, but according to department officials, the consultant's increased costs—over $1 million—have depleted these monies.

Now that the program is operational, the Department should determine the activities its consultants should perform and adopt a written policy that contains guidelines for their use.

Additionally, the Department should take steps to improve its oversight of its healthcare vendors by requiring the vendors to achieve additional standards for performance measures, developing quality-of-care performance measures, tracking vendor performance against these measures, and establishing policies and procedures for verifying vendor reports of compliance with performance measures.

To ensure that they comply with all of their contractual requirements, the Department should also develop a plan for conducting operational and financial reviews of its vendors.

In reassessing the consultant's role and strengthening program oversight, the Department also needs to assess its own staffing needs. While the Department has begun to develop a staffing plan for fiscal years 2007 and 2008, it should ensure that this staffing plan includes the positions it needs, their duties, and an analysis of appropriate personnel costs. Once it has completed this staffing plan, if the Department determines that it needs additional staff, it should reassign staff or take other steps, as appropriate, to seek additional staff.

Self-funded health benefits program financially stable, but additional steps needed to ensure sound operations (see pages 25 through 34)

While the Department has taken some steps to ensure the self-funded health benefits program's financial viability, additional actions to make contractors more accountable would help ensure the program's long-term stability. When an employer self-funds employee health benefits, it assumes the financial responsibility and risk of ensuring that monies are available to pay for the benefits. If expenses of such a program exceed revenues, the employer would be responsible for addressing this deficit. To help lessen the State's risk, the Department has established a funding reserve to pay for program expenses in the event that claims payments exceed revenues. According to a department financial report, as of June 30, 2005, this reserve was approximately $49.6 million. In addition, the Department purchased an insurance policy to limit the financial responsibility the State faces due to claims that exceed $500,000 per insured individual.

However, the Department should take additional steps to enhance the program's long-term financial stability by improving controls over healthcare claims payments. The Department has contracted with four vendors to process and pay medical and prescription drug claims for program members. Through these vendors, the Department reports processing over $262.9 million in claims payments between October 1, 2004, and June 30, 2005. Since payment of healthcare claims is by far the largest program expense, ensuring the accuracy and appropriateness of claims is another important aspect of long-term viability. As a result, the Department should:

- **Require independent audits**—Specifically, the Department should require through its contracts that its vendors obtain annual independent audits of their claims payment processes and controls. Annual assessments or audits of claims payment processing controls would help provide assurance that the

vendors have adequate controls to ensure the appropriate and accurate processing of claims. Additionally, the Department should require an independent audit of the vendors' claims payment data. Ensuring the accuracy of claims payment data is critical as it is used by the Department to manage and oversee the self-insurance program, by its contracted actuaries to project program costs, and by financial auditors when auditing the State's financial statements.

- Review the accuracy of claims payments—The Department should conduct additional reviews to ensure that claims are accurately and appropriately paid. The Department does verify claims data from two of its vendors with member eligibility data to help ensure payments were made for eligible members. However, as of June 2005, the Department had not verified claims data from one of its vendors against member eligibility data. This vendor paid claims totaling approximately $52.2 million in fiscal year 2005. In addition, the Department should develop and execute tests to verify the accuracy of claims payments. It should verify that claims were paid in compliance with benefit plan provisions.

- Establish additional procedures—The Department should also address the findings and recommendations made in an August 2005 report from its consultant. The consultant reviewed the Department's processes for transferring eligibility data to and paying its vendors and identified several findings and recommendations. These included the need for independent audits of eligibility data and processes, and backup documentation to substantiate requested payments to vendors.

Finally, the Department should ensure that it receives objective and verifiable information and analysis from its actuary by requiring the actuary to submit a complete actuarial report. The Department's contracted actuary developed a 5-year cost projection for the self-insurance program prior to its initiation, and this projection served as the basis for establishing the premium contributions made to the program. However, this actuary provided spreadsheets to the Department and Legislature showing its analysis and cost projections rather than an actuarial report that not only documents the analysis and projections, but explains the methodology and source of the data used. According to a department official, such a report was not requested or prepared due to the uncertainty of self-funding employee health benefits at that time and to keep consulting costs to a minimum. In addition, to ensure independence, the Department should not contract for actuarial services from the same firm it uses to manage and oversee the self-funded health benefits program, as it does now.

Other pertinent information (see pages 35 through 41)

As part of the audit, auditors gathered other pertinent information regarding the Department's new Web-based hiring software, Yahoo! ® Hiring Gateway, and the impact of accounting standards that will require the State to account for the nonpension post-employment benefits that its employees accrue.

- Hiring Gateway—The Department is in the process of completing the implementation of Yahoo!® Hiring Gateway (Hiring Gateway), a Web-based recruiting and hiring software that has replaced the Resumix system. It expects to complete implementation of this software in November 2005. Hiring Gateway provides several benefits and improvements over the Department's previous recruiting and hiring system, such as electronically creating job requisitions and routing them for approval through e-mail; generating lists of potential job candidates that better meet the requirements of job openings, requiring applicants to self-nominate, or apply directly for positions in which they are interested; and creating specific screening questions as part of the online application to better identify qualified applicants. Auditors contacted officials from seven different state agencies, and they reported that the new software saves time in the recruiting process and is more effective.

- Accounting for nonpension post-employment benefits—Beginning in fiscal year 2008, the State will need to account for nonpension, post-employment benefits that its employees accrue. Specifically, Governmental Accounting Standards Board Statement No. 45 (GASB No. 45) will require governmental entities to reflect on their financial statements the long-term cost of post-employment benefits employees earn while employed. These include nonpension benefits such as medical, dental, and vision healthcare coverage; life insurance; disability insurance; and long-term care coverage. Since the State provides healthcare insurance to its retirees through its self-funded health benefits program, the State will need to reflect this post-employment benefit in its fiscal year 2008 financial statements. The State will need to take various actions, including obtaining an actuarial estimate of this benefit, to implement this standard.

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INTRODUCTION & BACKGROUND

The Office of the Auditor General has conducted a performance audit of the Arizona Department of Administration's Human Resources Division, pursuant to a November 20, 2002, resolution of the Joint Legislative Audit Committee. This audit was conducted as part of the sunset review process prescribed in Arizona Revised Statutes (A.R.S.) §41-2951 et seq and is the third in a series of four reports on the Department of Administration (Department). This report focuses on the State's new self-funded health benefits program, the Department's new recruiting and hiring software, Yahoo!® Hiring Gateway, and the potential impact of complying with Governmental Accounting Standards Board Statement No. 45 to account for nonpension, post-employment benefits. The first report reviewed the Department's Financial Services Division (Auditor General Report No. 05-02), and the second report reviewed the Department's Information Services Division and Telecommunications Program Office (Report No. 05-11). The final report will be an analysis of the 12 statutory sunset factors.

Division programs and staffing

The Department's Human Resources Division (Division) was established in 1968 as the Arizona Personnel Commission, and it became part of the Department in 1972. The Division's mission is to provide efficient, timely, customer-driven professional human resources services. According to the Division's 2004 annual report, its customer base includes more than 62,000 employees and their dependents from 100 state agencies, boards, and commissions, and 3 state universities. In addition, the Division serves approximately 9,000 retired state employees who participate in the state health and prescription drug plans.

As of July 19, 2005, the Division reported a total of 167.75 positions, with 24 vacancies. The Division's staff perform a variety of functions through the eight sections described below:

- **Benefits (29.75 filled positions)**—This section administers the State's self-funded health benefits program, including medical and prescription drug coverage, as well as dental, basic life, short-term disability, long-term disability, and flexible

spending accounts. In addition, this section manages the contract for the State's on-site childcare center, located near the state capitol building in Phoenix, as well as the state employee counseling and wellness programs.

- Classification/Compensation (16 filled positions)—This section maintains the State's job classification and compensation system. Its responsibilities include evaluating covered positions, which are subject to state personnel rules, and uncovered positions, which are exempt from the personnel rules. The section evaluates positions by reviewing the position description questionnaire, organizational charts, and class specifications; conducting interviews; and analyzing major duties and responsibilities, working conditions, supervision given and received, and knowledge, skills, and abilities needed to perform the job. The section is also charged with monitoring compliance with the federal Fair Labor Standards Act (FLSA) by reviewing the FLSA status of all requested classification changes, preparing the annual salary recommendation to the Legislature, and conducting and participating in salary and benefits studies.

- Workforce Relations (34 filled positions)—This section provides professional human resources services at the Division's seven satellite offices, located at various state agencies and in Tucson.[1] The satellite offices range in size from 1 to 60 full-time employees and include staff from both the Division and the agency in which they are located, with a division employee managing each office. In addition, this section reviews employee grievances involving discrimination or a violation of personnel rules after an agency completes its review. This section also manages a worklife benefits program to help agencies enhance recruitment and employee retention, and focuses on nonsalary-related employee benefits, such as on-site child care, alternative work schedules, and flex time.

- Staffing and Recruitment (16 filled positions)—This section maintains the State's new online hiring and recruiting software, Yahoo!® Hiring Gateway, which provides a central location for state agency job information and allows agencies to work online to develop job announcements and obtain necessary management approvals for job requisitions. Section employees also provide staffing and recruitment services to some state agencies that do not have direct access to the new hiring software by posting jobs on the recruiting Web site and developing lists of potential job candidates for openings. In addition, this section creates job advertising materials, manages community outreach recruitment efforts, such as job fairs, and administers the State's temporary employment services.[2]

1 The Division has satellite offices in the Departments of Corrections, Economic Security, Health Services, Juvenile Corrections, Revenue, and Transportation.

2 The Department reports that the Department of Economic Security and the Tucson satellite office administer their own temporary employment services.

- Planning and Quality Assurance (4 filled positions)—This section provides strategic planning and best practices research for the Division. It also conducts internal performance audits of state agencies' human resources functions to ensure compliance with federal laws, state administrative code, and personnel rules.

- Consulting Services (10 filled positions)—This section provides both in-house and external consulting services to other state agencies regarding human resources-related issues. These services include drafting and tracking legislation; handling inquiries from the public, the Legislature, and other state agencies; and designing, developing, and overseeing pilot programs and special projects, such as personnel rule modifications and the Department's employee handbook.

- Budget/Administrative Services (9 filled positions)—This section oversees the Division's budget and administrative activities. This includes coordinating the Division's purchasing and accounting, personnel actions for filling vacant positions, and payroll activities.

- Human Resources Information Solution (HRIS) (25 filled positions)— HRIS staff support the operation, maintenance, design, and implementation of the State's new human resources information system, HRIS. HRIS is replacing the State's Human Resources Management System, Benefits Information Tracking System, and other applications with a single integrated system shared by state agencies. When fully implemented, HRIS should provide a single system for the administration of payroll, personnel, employee benefits, and other related functions. The HRIS system has been implemented in two phases, with ongoing development currently occurring for Phase 2 system functions. Phase 1, which processes state employee payroll, was implemented in December 2003 (see Auditor General Report No. 05-02 for more information on HRIS).

Until May 2005, the Division also housed the Arizona Government University (AzGU). AzGU administers the State's centralized employee training activities, including maintaining an electronic tracking and registration system for training courses and developing a standardized curriculum to ensure consistency and quality state-wide. AzGU is now under the responsibility of the Department's deputy director and is also overseen by a governing board.

Self-funded health benefits program

The Department began developing a self-funded health benefits program (program) in 2002, with the intent to limit the State's growth in healthcare costs and increase employees' choice of providers. A.R.S. §38-651 et seq allows the Department to self-

Health Benefits Terminology[1, 2]

Fully insured plan—A plan in which the employer pays a premium to an insurer for employee health coverage. The premium is due in advance of the coverage and is actuarially projected to cover anticipated claim costs and the taxes. The insurer assumes the risk of providing health coverage.

Self-funded plan—A plan in which the employer assumes some or all of the risk for providing healthcare benefits to employees. The employer takes control of the assets of the plan, invests them to the employer's advantage, and eliminates insurer charges, allowing the employer to control the management and financing of its health insurance programs.

Integrated plan—A plan in which one vendor provides all of the plan's components, such as physician and hospital networks, claims processing, and disease management.

Nonintegrated plan—A plan in which different vendors are contracted to perform different functions. This might include separate vendors for physician and hospital networks, claims processing, and disease management.

1 Garner, John C. *Health Insurance Answer Book*. New York: Panel Publishers, 2001.

2 Arizona Department of Administration.

fund state employee and retiree health and/or dental benefits upon review by the Joint Legislative Budget Committee (JLBC). In May 2004, JLBC gave a favorable review to the Department's plan to self-fund state employee health benefits, and the Department began to implement the program.

In October 2004, state employees, retirees, and their dependents began receiving health insurance benefits from the State's newly self-funded medical and prescription drug plans, collectively referred to as Arizona Benefit Options. Unlike previous employee benefits plans, which were fully insured, the new plans use employee, retiree, and state agency premiums to pay for member claims, and the State assumes all of the financial risk associated with providing employee benefits, such as the possibility of program costs outpacing revenues or handling unforeseen events.

As part of the program, the Department contracts with vendors to provide health services and to process claims, through both integrated and nonintegrated plans (see Table 1, page 5). Both the integrated and the nonintegrated plans include physician and hospital networks, claims processing, and disease management. However, in an integrated plan, one vendor provides all of the plan's components, while in a nonintegrated plan, the Department contracts with different vendors to provide the plan's components. Additionally, the Department contracts with a separate vendor to process prescription drug claims. As of June 30, 2005, the Department reports that 27,784 people were enrolled in the integrated plan and 29,765 were enrolled in the nonintegrated plan. Vendor contracts will be renewed in September 2005.

The program is funded through the Special Employee Health Insurance Trust Fund, which receives monies from employee, retiree, and state agencies' premium payments and legislative appropriations. The Department was appropriated approximately $4.75 million from the Fund for fiscal year 2005 to cover its administrative costs for the program. The Department budgeted approximately $1.7 million of this amount for employee salaries and benefits, as well as nearly $1.3 million for consulting services. According to a department financial report, the Department received approximately $333.3 million in revenues for the program in fiscal year 2005, which were used to pay claims, cover administrative expenses and build a reserve to pay program expenses in the event that claims payments exceed projections.

Table 1: Self-Funded Health Benefits Program Vendors, Services Provided, Service Areas, and Number of Members As of June 30, 2005

Vendor	Services Provided	Service Area	Number of Members
Integrated Health Benefits			
United Health Care	Provides medical services and processes medical claims	Gila, Maricopa, Pima, Pinal, and Santa Cruz Counties	27,616
PacifiCare	Provides medical services and processes medical claims for retired members only	Maricopa, Pima, and Pinal Counties	168
Nonintegrated Health Benefits			
Medical Providers:			
Schaller Anderson	Provides medical services	Gila, Maricopa, Pima, Pinal, and Santa Cruz Counties	14,595
HMA (RAN and AMN)	Provides medical services	All Arizona counties and select border communities in California, Nevada, New Mexico, and Utah	11,661
AZ Foundation	Provides medical services	All Arizona counties	2,999
Beech Street	Provides medical services for members who reside outside of Arizona	Nation-wide (excluding Arizona)	510
Third-Party Administrator:			
Harrington	Processes medical claims for nonintegrated healthcare providers	Not applicable	
Prescription Drug Benefits			
Walgreens Health Initiative	Manages prescription drug benefits. Processes all prescription drug claims	State-wide	Available to members of all plans

Source: Auditor General staff analysis of self-funded health benefits program information provided by the Department of Administration from its Benefit Options data as of June 30, 2005, and vendor plan descriptions obtained from the Benefit Options Web site.

Division operating budget

The Division's operating budget consists of monies appropriated from the Personnel Division Fund and the Special Employee Health Insurance Trust Fund. Monies in the Personnel Division Fund consist of payroll charges assessed to state agencies for the various services the Division provides. Monies received from employee, retiree, and state agencies' premium payments for the self-funded health benefits program

Table 2: Human Resources Division Administration
Schedule of Revenues and Expenditures, in Thousands[1]
Years Ended June 30, 2003, 2004, and 2005
(Unaudited)

	2003 (Actual)	2004 (Actual)	2005 (Estimated)
Revenues:			
User charges:			
Payroll processing and personnel services [2]	$8,410	$14,366	$11,835
Health insurance administration [3]	3,978	4,785	4,758
Total revenue	12,388	19,151	16,593
Expenditures and transfers:			
Personal services and employee-related	7,091	9,268	8,586
Professional and outside services	1,924	4,743	4,325
Travel	21	29	22
Other operating	2,974	3,419	3,192
Equipment	62	1,377	190
Allocated costs	78	160	122
Total expenditures	12,150	18,996	16,437
Net operating transfers out	625	29	9
Total expenditures and operating transfers	12,775	19,025	16,446
Excess (deficiency) of revenues over expenditures and operating transfers	$ (387)	$ 126	$ 147

[1] Represents the financial activity for the Department's Human Resources Division (Division) administration. Amounts collected and disbursed for debt service payments for the certificates of participation used to finance the Division's Human Resources Information System are not included in the schedule.

[2] Consists of a 1.04 percent charge on each state agency's payroll expenditures to pay for payroll processing and personnel services the Division provides.

[3] Consists of a portion of health insurance premium payments of enrolled employees and state agencies to pay for health benefits administrative services the Division provides.

Source: Auditor General staff analysis of financial information provided by the Department of Administration from its Arizona Financial Information System for the years ended June 30, 2003 and 2004, and department-prepared estimates for the year ended June 30, 2005. (Actual information was not available at the time of this report.)

are deposited into the Special Employee Health Insurance Trust Fund. Table 2 above illustrates the Division's actual administrative revenues and expenditures for fiscal years 2003 and 2004, and its estimated administrative revenues and expenditures for fiscal year 2005. The Division received an estimated $16.6 million in revenues in fiscal year 2005, more than $11.8 million of which consisted of state agency payroll charges. The Division's fiscal year 2005 estimated expenditures were approximately $16.4 million, which represented a decrease from its fiscal year 2004 expenditures of approximately $2.58 million.

Scope and methodology

This audit focused on the administration, oversight, and financial viability of the Division's self-funded health benefits program; the status of the State's new recruiting and hiring software, Yahoo!® Hiring Gateway; and the potential impact to the State of governmental auditing standards regarding nonpension, post-employment benefits. The report presents findings and recommendations in the following areas:

- The Department needs to take steps to strengthen its management of the self-funded health benefits program and to better oversee its vendors.

- While the Department has taken steps to help ensure the financial viability of the self-funded health benefits program, it can further ensure the program's financial stability by implementing additional internal controls, requiring that its vendors who process medical claims obtain independent audits of their claims payment processes and data, and ensuring that any actuarial analysis of the program is performed by a contractor who does not participate in program management and oversight.

In addition, this report contains Other Pertinent Information regarding Hiring Gateway and the impact to the State of Governmental Accounting Standards Board Statement No. 45 (GASB No. 45), which will require governmental entities to recognize nonpension post-employment benefits, including healthcare benefits, accrued for current employees and certain retirees.[1]

Auditors used a number of methods to obtain information about the Division's programs and to study issues addressed in this report. General methods included reviewing statutes and administrative rules, policies, and procedures, and the Department's strategic plan for fiscal years 2006 through 2010; and interviewing department and division management and staff. Auditors also used the following methods to address specific areas of focus:

- To evaluate the Division's administration and oversight of the self-funded health benefits program, auditors reviewed open enrollment materials, vendor performance measures, and vendor and consultant contracts for the program year ending September 30, 2005; and the Department's self-funded program budget, correspondence, and consultant invoices and reports for August 2004 to May 2005.[2] Auditors also reviewed policy manuals and related materials of

1 The Governmental Accounting Standards Board establishes standards of financial accounting and reporting for state and local governmental entities. The Board's mission is to establish and improve standards of state and local governmental accounting and financial reporting that will result in useful information for users of financial reports and guide and educate the public. To accomplish its mission, the Board issues standards to guide the preparation of those entities' external financial reports.

2 Auditors did not conduct a review of the PacifiCare and Beech Street vendor contracts, performance measures, or other related information as PacifiCare and Beech Street had small enrollments during the audit.

the Arizona Health Care Cost Containment System (AHCCCS), which is Arizona's Medicaid agency, the plan designs of several states, audit reports for the states of Kansas and Minnesota, which also provide self-funded health benefits programs with characteristics similar to Arizona's program, and a 2001 Watson Wyatt Worldwide study that gathered information on health plan performance.[1,2,3] Auditors also observed training meetings; reviewed the Department's handling of member appeals received from October 2004 through June 2005; and reviewed the Department's communications materials such as its benefits guides and newsletter. Finally, auditors interviewed benefits managers from eight states that self-fund their employee health benefits and staff from AHCCCS.[4]

- To evaluate the financial viability of the self-funded health benefits program, auditors observed the claims payment process and the Department's process for determining appropriate expenditures; reviewed audit reports that assessed two third-party administrators' internal controls—one for the period of June 1, 2004 through May 31, 2005, and the other for the period of July 1, 2004 through June 30, 2005; a June 2005 consultant report of implementation reviews of two of the Department's vendors; an August 2005 consultant audit report on the Department's eligibility and financial processes; an audit report on the accuracy of claims processed by the State's previous healthcare contractor; a risk management actuarial report; a Minnesota state audit report; United States Office of Management and Budget Circular A-87; a Kaiser Family Foundation and Harvard School of Public Health report; a United States Government Accountability Office report; and Special Employee Health Insurance Trust Fund claims and fee payment schedules, and vendor contracts for the program year ending September 30, 2005.[5,6] In addition, auditors interviewed the Department's contracted program consultants.

1 Office of the Legislative Auditor, State of Minnesota. *Program Evaluation Report: State Employee Health Insurance,* Report #02-06. Feb. 2002.

2 Legislative Division of Post Audit, State of Kansas. *Performance Audit Report: The State Health Benefits Program, Part 2: Reviewing the Staffing and Structure of the Current Program*. #01-14.2, July 2001.

3 Watson Wyatt Worldwide. *Maximizing the Return on Health Benefits: 2001 Report on Best Practices in Health Care Vendor Management.* 2001.

4 Auditors interviewed benefits managers in eight states: Alabama, Arkansas, Colorado, Nevada, North Carolina, Oklahoma, South Dakota, and West Virginia. These states were selected because they are near Arizona, they have a similar number of state employees, or because their plan design was similar to Arizona's.

5 Kaiser Family Foundation and Harvard School of Public Health. *National Survey on Consumer Experiences with and Attitudes Toward Health Plans*. Menlo Park, CA.: The Kaiser Family Foundation, August 2001.

6 United States Government Accountability Office. *Health Care Fraud: Information-Sharing Proposals to Improve Enforcement Efforts*. Washington, D.C.: U.S. Government Accountability Office, May 1996.

- To gather information on Yahoo!® Hiring Gateway, auditors observed a software tutorial; analyzed results of a department survey of the Department of Corrections, which piloted the program; reviewed the recruiting Web site and system features; observed a Hiring Gateway Advisory Committee meeting; and interviewed officials from ten state agencies.[1]

- To gather information on GASB No. 45, auditors reviewed the statement; literature on strategies and potential impacts of GASB No. 45; a feasibility study on Arizona Retiree Health Insurance conducted for the Arizona Legislative Council in December 2004; North Carolina fiscal year 2004 financial statements; the California Legislative Analyst's Office analysis of the 2005-06 California Budget Bill, and financial reports; and interviewed the state comptroller.[2]

The audit was conducted in accordance with government auditing standards.

The Auditor General and staff express appreciation to the director and staff of the Arizona Department of Administration for their cooperation and assistance throughout the audit.

1 Auditors interviewed officials from the Arizona Health Care Cost Containment System; the Arizona State Banking Department; the Corporation Commission; the Department of Economic Security; the Arizona Game and Fish Department; Arizona State Library Archives and Public Records; Arizona State Parks; the Department of Transportation; the Department of Veterans' Services; and the Department of Water Resources.

2 Mercer Human Resource Consultants. *Monitoring Financial Sub-team Monthly Report.* December 2004 through May 2005.

FINDING 1

Department should strengthen management of self-funded health benefits program

The Department needs to re-examine several aspects of its management of the State's self-funded health benefits program (program). The Department has relied heavily on a consultant to assist in the program management and oversight, which has required a significant amount of the funding appropriated to oversee the program and delayed department efforts to hire its own staff for program oversight. To better manage the program, the Department should more clearly define the role of its consultants and increase its oversight of their activities. Additionally, the Department should increase oversight of its healthcare vendors, including enhancing the use of performance measures and conducting operational and financial reviews of its vendors. Finally, the Department should determine if these increased responsibilities will require it to hire more staff and then develop a plan to do so.

Consultant role needs clarification

The Department needs to evaluate and clarify the role its consultant is playing in administering the self-funded health benefits program. To implement the program in the short amount of time available, the Department indicates that it relied heavily on help from a consultant. As a result, the consultant performs some tasks that the Department had planned to do and is sharing many other tasks with department staff. The Department reports that it has had a limited ability to hire its own staff because of the consultant's higher-than-expected costs. Now that the program is operational, the Department needs to determine which activities are most appropriate for the consultant to undertake and increase its oversight of these activities.

Consultant used extensively to implement and help oversee program—Consultants have played a larger-than-expected role in implementing and overseeing the self-funded health benefits program. While the Department has

Consultants have played a larger-than-expected program implementation and oversight role.

planned all along to use the services of a consultant to help oversee the program, according to department officials, it has used a consultant more extensively than planned because the program had to be implemented quickly. Department officials indicated that they had only 4 months to complete what they estimated to be a 12-month program implementation process.[1] As a result, the Department abandoned the staffing plan it had developed in 2003 for overseeing the program, instead relying more heavily on its consultant's expertise and less on hiring and training new staff.

The Department's fiscal year 2005 expenditures on program administration reflect this increased reliance on the consultant. As of June 30, 2005, the Department had incurred expenses totaling approximately $1.67 million for this consultant—more than three times the $500,000 the Department had originally budgeted for fiscal year 2005. This $1.67 million in consulting expenditures represents 35 percent of the total appropriated administrative budget of approximately $4.75 million for fiscal year 2005.

Expenses for the consultant have also affected the Department's ability to hire staff and develop the necessary expertise to manage the program. Specifically, the Legislature appropriated $965,300 to the Department for fiscal year 2005 to hire an additional 12.5 FTEs to help manage and oversee this program. This request for staffing was in addition to the 23.5 staff the Department was already authorized for program operations and management in fiscal year 2003. However, according to department officials, the consultant's costs—over $1 million—have basically depleted the monies that were appropriated for the additional 12.5 FTE. As a result, 5.25 of these positions remained vacant as of July 19, 2005. These include positions identified in its 2003 staffing plan, such as an attorney, an actuary to review and determine program costs, and an administrative services officer for data analysis.

Role of consultant not clearly defined—The short time frame for implementing the program did not provide the Department an opportunity to clearly define the consultant's roles and responsibilities, especially in relation to the activities the Department anticipated performing. As shown in Table 3 (see page 13), this has resulted in a situation in which the Department shares many aspects of program administration and oversight with the consultant. For example, although the Department tracks most of its vendor's performance regarding contractual requirements and performance measures, its consultant assists in this effort by tracking the performance of the pharmacy vendor. The consultant does this because it has the specific expertise needed to assess this vendor's performance. Similarly, both the Department and consultant developed communications materials to assist employees with their enrollment selections in 2004.

However, since the Department has not clearly defined the consultant's roles and responsibilities in policy and generally described numerous activities that the consultant can perform within its contract, some of these shared duties could potentially overlap or duplicate each other. For example, the Department and its

[1] The Department did not receive Joint Legislative Budget Committee approval for its proposed program until May 25, 2004, and had to implement both an integrated and a nonintegrated program by October 1, 2004, as the previous insurance contract expired on September 30, 2004.

Table 3: Self-Funded Health Benefits Program
Oversight Functions
As of May 2005

Oversight Areas	Responsibilities	Examples
Reviewing health benefits program design	***Department and Consultant*** • Research other state and municipal programs and best practices to identify potential program enhancements or additions. • Meet with vendors to review claims data for potential program adjustments. • Communicate program modifications to the Legislature.	After reviewing pharmacy claims data for the first 2 months of 2005, the consultants recommended an increase in employee co-pays for specialty drugs, such as those for treating hemophilia, hepatitis C, and multiple sclerosis.
Overseeing vendor performance	***Department*** • Conduct weekly conference calls with vendors. • Use issue logs to track problems and ensure they are resolved. • Review monthly vendor reports on contractually required performance measures. ***Consultant*** • Track pharmacy vendor's performance in contractually mandated areas. • Resolve claims and service problems. ***Department and Consultant*** • Work with vendors to develop corrective action plans for poor performance and monitor vendors to ensure plans are implemented.	If the Department or its consultants determines that a vendor's performance is inadequate, they will meet with the vendor to discuss corrective actions.
Managing program operations	***Department*** • Maintain the system for determining employee insurance eligibility. • Receive and track appeals. • Manage the program's member Web site. • Manage customer service call center. ***Consultant*** • Assist with development of processes and operations to ensure program complies with federal law. ***Department and Consultant*** • Develop training for State's benefits liaisons. • Develop internal department processes.	The Department's consultants developed a set of guidelines for identifying instances when former employees inappropriately continue to receive health benefits.
Conducting open enrollment	***Department*** • Administer on-line open enrollment system. ***Consultant*** • Attend meetings and make presentations relative to the new program and various industry trends. ***Department and Consultant*** • Create all 2004 employee communications materials for open enrollment. • Develop open enrollment Web sites.	The Department's consultant assisted with the 2004 open enrollment and may provide guidance on how to explain new Medicare requirements to members who are Medicare eligible for the 2005 open enrollment.
Planning and managing program finances	***Department*** • Manage program budget. • Communicate premium rates to members. ***Consultant*** • Prepare recommendations for Department on premium rate levels. • Develop annual program financial projections. ***Department and Consultant*** • Attend legislative meetings to discuss and respond to questions regarding the contribution strategy.	To make its contribution strategy recommendation, the Department assesses the consultants' actuarial analysis of the prior year's claims data and administrative fees.

Source: Auditor General staff analysis of information provided by the Department regarding consultant and department oversight activities; and consultant invoices, monthly reports, and weekly summary of activities.

Both the Department and the consultant perform some similar functions.

consultant both work with the program's vendors to resolve claims and service problems. When the program's third-party administrator had trouble with the timely processing of claims, both the Department and its consultant met with the vendor to develop a corrective action plan. Also, both the Department and its consultant follow up to ensure that the vendors resolve claims payment issues and conduct research to identify potential plan enhancements. While the Department reports that this represents an appropriate collaboration with the consultant, given the consultant's work with the program's vendors, it lacks documentation supporting the appropriateness of the consultant's role in these activities.

The consultant also performs many activities that the Department had originally planned to perform. For example, although the Department's 2003 staffing plan indicated that it originally planned to assess and analyze claims payment data, the consultant performs this function. Analysis of such data provides the Department with important information about the illnesses and medical services that are most common among state employees, allowing the Department to develop program policies and make changes to the plan as needed. For example, after reviewing pharmacy claims data, the consultant recommended that the Department consider increasing employee co-payments for mail order prescriptions. Similarly, the Department currently relies on its consultant to help ensure compliance with federal requirements, but planned to hire an in-house attorney to perform this type of work.

Consultant's future role merits review—Now that the program is operational and as it continues to move forward, the Department needs to determine which activities are most appropriate for the consultant to undertake. Specifically:

Employers have identified risks in outsourcing strategic planning, plan design, and vendor selection.

- A 2001 study that gathered information on health plan performance from 255 health benefit managers and human resources executives found that many employers saw risks in outsourcing certain key activities.[1] These include strategic planning, plan design, and vendor selection; as well as activities affecting employee satisfaction, such as problem resolution/advocacy and plan provision interpretation. While the study states that "employees must retain tight control of these activities in order to manage costs" or strengthen employee satisfaction, the study also states that outside expertise is helpful in these activities. Thus, these activities should be retained in-house or cosourced. On the other hand, employers in the study felt that outsourcing other operational activities, such as performance monitoring, employee call centers, and enrollment needs, could result in cost savings.

- All eight states contacted for this audit use consultants for specific activities within their self-funded programs.[2] These states use consultants for activities such as developing actuarial projections, performing operational audits, assisting with the writing of requests for proposal (RFPs), improving plan Web

1 Watson Wyatt Worldwide. *Maximizing the Return on Health Benefits: 2001 Report on Best Practices in Health Care Vendor Management*. 2001.

2 Alabama, Arkansas, Colorado, Nevada, North Carolina, Oklahoma, South Dakota, and West Virginia.

sites, reviewing vendor performance information, and assisting with pharmacy programs. Since a number of these states have had self-funded employee health benefits for several years, they might offer useful and beneficial future examples of the use of consultants.

In reviewing the consultant's future role, the Department should adopt a written policy that contains guidelines for the use of the consultant. This policy should include a general description of the consultant's overall duties and expertise, potential activities that could be contracted to a consultant, expected work products and/or deliverables, and procedures for monitoring and tracking consultant activities. The Department should then ensure that its consultant's contract conforms to its policy requirements and that the contract deliverables are included.

Additionally, the Department should ensure that it receives written reports from its consultant that provide sufficient detail on activities performed and contract deliverables met. While the Department's consulting contract indicates that it should receive written monthly reports describing the consultant's activities, as well as whether their projects are on schedule and have any current or potential problems, the reports provided by the consultant do not include all of the required information. For example, the reports do not indicate whether projects are on schedule or do not identify problems. According to a department official, the Department has not required that these reports contain this additional information in order to save on consulting costs. As a result, the Department should ensure that it receives regular, written reports from its consultant that provide sufficient detail on activities performed and contract deliverables met.

Additional oversight of healthcare vendors needed

While the Department or its consultants conduct several oversight activities related to the program's healthcare vendors, it should implement additional management and oversight activities. Specifically, the Department should make several improvements to its vendor performance measures, conduct operational and financial reviews of its vendors, and enhance its handling of appeals.

Various changes would enhance usefulness of vendor performance measures

—The Department has established a variety of performance measures for its vendors. Table 4 (see page 16) provides examples of these measures, which are similar to those used by AHCCCS. For each of these measures, the Department has established performance standards. Depending on the measure, the Department requires its vendors to report on their performance either monthly, quarterly, semi-annually, or annually. If program vendors do not meet the performance standards, between 6 and 25 percent of their administrative fees may be remitted to the State.[1]

Vendors must meet certain performance standards.

[1] The Department's pharmacy vendor does not fall within this range as 100 percent of their post-implementation administrative fees may be remitted to the State.

Table 4: Selected Vendor Performance Measures
As of June 2005

Category	Example	Target Level[1]
Plan implementation	Issuing identification cards within 10 business days	99%
Telephone service	Number of members' calls abandoned	2-5%
Appeals	Length of time to resolve written appeals	3-45 calendar days
Written inquiries	Number of written inquiries from the Department or members answered within 5 business days	95%
Member satisfaction	Member satisfaction with network	85%
Network program management	Reduction in network size	Less than 5%
Network provider management	Turnover for any major specialty	Less than 5-10%
Eligibility information	Processing of eligibility information within 5 business days	100%
Vendor account management	Response to department calls, inquiries, or meeting requests within 1 business day	100%
Disease management	Outreach to members at high risk for a particular disease within the quarter	90%
Mail order services for Pharmacy	Overall mail-order pharmacy prescriptions with no errors	99.99%

[1] Some targets are listed as ranges because vendors have different target levels.

Source: Auditor General staff analysis of department performance measures.

Based on vendor reports, as of May 2005, vendors have met several of the performance measure standards. However, the Department's pharmacy vendor has not met some of its required performance standards. These include performance standards for the percentage of telephone calls that went unanswered, the number of claims that do not require member contact that are processed within 15 days, and

the percentage of mail-order prescriptions that did not require contact with the physician or member that were processed or dispensed within 2 business days. Additionally, the Department's third-party administrator, who processes medical claims submitted by providers in the nonintegrated portion of the model, has continually missed the performance standards for claims timeliness and accuracy. While the Department has required the third-party administrator to take corrective actions to address these performance issues, the Department's vendor contracts allow it to require that its vendors remit a percentage of their fees if performance standards are not met. These fees can be remitted either quarterly or annually at the end of the program year. In fact, the Department has requested that its pharmacy vendor remit over $11,900 in July 2005 for its failure to meet performance standards.

As the program continues to move forward, the Department can take several steps to enhance performance measures or to provide greater assurance about the results that contractors are reporting. These include:

- Establishing quality-of-care performance measures—The Department should develop quality-of-care performance measures for its provider networks and disease management vendor. While ensuring and tracking the quality of care provided to members is an important component of a healthcare program, the Department does not hold the program's vendors to any standards regarding the adequacy of their services and/or healthcare outcomes. The Department reports that it was unable to incorporate quality-of-care measures into its vendor contracts due to the lack of data on services provided, which would be needed to establish baseline standards for these measures within the State's program, and to keep administrative costs at a minimum.

  However, the National Committee for Quality Assurance (NCQA), a voluntary health plan accreditation body, has established the Health Plan Employer Data and Information Set, or HEDIS, which is a standardized tool for collecting data about health plan quality of care and service. It consists of a set of performance measures that address important areas, ranging from breast cancer screenings to customer satisfaction. These measures, which focus primarily on healthcare effectiveness, are used by both commercial and Medicaid health plans, including AHCCCS. Specifically, AHCCCS uses HEDIS as a guide for some of its performance measures. For example, its measure for breast cancer screenings requires that 55 percent of women ages 52 to 64 who have been continually enrolled with the vendor for 2 years be screened for breast cancer. Additionally, AHCCCS requires 78 percent of adults between the ages of 21 and 64 who are continuously enrolled with one of its acute-care vendors without more than one break in enrollment not exceeding 31 days to have at least one preventative visit during the measurement period with a qualified healthcare professional. The Department should review the HEDIS measurements and include appropriate measures in its program and in its vendor contracts.

NCQA also collects information on commercial and Medicaid health plan performance on HEDIS measures. With this information, NCQA develops and reports national averages of performance related to the various measures. This information would be useful to the Department in gauging vendor performance for the quality-of-care measures it institutes. Therefore, the Department should also track vendor performance against the measures it establishes, using the NCQA national data for comparison. Once it has sufficient data, the Department should develop performance standards for its quality-of-care measures that reflect the State's program.

- Establishing additional performance measure standards—The Department should develop additional standards or goals for vendor performance measures to encourage continual improvement. Currently, vendor contracts require that vendors meet a specific standard for each performance measure. The vendor must consistently meet this goal or potentially have to remit a percentage of its fees back to the State. However, the Department has not established additional standards or goals for its vendors to foster continual improvement. In contrast, AHCCCS requires that, after its vendors meet a basic level of performance, they then work to reach two additional higher performance levels. For example, AHCCCS requires that 57 percent of all women aged 16 to 64 who have been continuously enrolled with the same provider for 1 year receive cervical cancer screenings. When vendors meet this minimum performance standard, they are expected to strive to increase this percentage to 60 percent, which is the next performance level.

- Validating self-reported information—The Department should also establish policies and procedures for verifying vendor reports of compliance with performance measures. According to a department official, the Department does not verify vendor reports on compliance with required performance measures or ensure it has all the information needed to do so. For example, the Department's third-party administrator's performance measure grid reports on the percentage of written appeals resolved within 3 business days after a member's request for review. However, the Department does not require the vendor to submit any documentation or data to support its report. Additionally, while the Department's third-party administrator provides it with graphs showing their telephone wait times, the Department does not require vendors to submit any further supporting documentation, such as telephone logs.

The Department does not verify vendor reports or ensure compliance with performance measures.

In contrast, AHCCCS acute care health plan contracts require that vendors maintain back-up documentation for reports of compliance with performance measures. For example, AHCCCS vendors must maintain backup documentation for their telephone service performance measures, which agency staff indicate is reviewed during periodic on-site visits called operational and financial reviews, discussed below.

Department should develop plan for reviewing vendor operations and finances—To help ensure compliance with contractual requirements, the Department should develop a plan to begin conducting Operational and Financial Reviews (OFRs) of its seven vendors. OFRs are comprehensive evaluation mechanisms that annually review vendor contract compliance and the quality and availability of health services they provide. While the Department does not conduct these types of reviews, they could assist with its efforts to document and address vendor performance and contract compliance problems. For example:

- Department correspondence indicates that in April 2005, it became aware that one of its vendors had a series of performance issues. These issues included providing inaccurate data to the State's third-party administrator that led to member service issues and the inaccurate processing of medical claims, delaying an internal audit of its data integrity, lacking a quality control plan to prevent future problems, and not taking corrective actions within agreed-upon deadlines. The Department received a report of the vendor's internal audit in July 2005, which identified the inaccuracies that existed with the data and the corrective actions taken by the vendor. Along with this internal audit report, the vendor also provided a quality control plan that described its quality assurance processes and procedures to ensure the integrity of service data. In a July 2005 letter to the vendor, the Department indicated that the vendor appeared to have provided adequate assurance of compliance with these issues and that it would renew its contract, effective October 1, 2005. However, the renewal contains several conditions, including requirements that the vendor provide an action plan to demonstrate how it will ensure the accuracy of its information and that it conduct a semi-annual audit of its service data. Despite these actions, an OFR might have allowed the Department to identify this vendor's problems more quickly, ascertain and verify the extent of these problems, determine whether any additional problems existed, identify needed corrective actions, and verify the implementation of these actions. In fact, according to an August 2005 internal department memorandum, a department official suggested that a detailed audit of this vendor's records should be conducted to validate the vendor's internal audit.

Three of the eight states contacted for this audit and AHCCCS conduct similar reviews.[1] Officials from South Dakota and West Virginia indicated that conducting OFRs of their program vendors gave them more confidence in assessing their performance. For example, one state official indicated that his program instituted vendor performance audits to ensure that its vendors are complying with all of their contract provisions. Officials from these states report that they conduct these reviews on an ad-hoc basis. AHCCCS conducts either a full or targeted annual OFR of all of its health plans to assess compliance with contract performance standards and requirements, and to assess the quality and effective delivery of health services to its members through its health plans. AHCCCS has developed a comprehensive operational and financial review process that assesses its acute care vendors on

[1] Alabama, South Dakota, and West Virginia.

over 100 performance standards within various categories. In a full review, AHCCCS will assess vendor performance on all standards, while in a targeted review, it will assess vendor performance on standards of particular current importance. These standards address performance in areas such as member services, complaint resolution, utilization management, and members' rights and responsibilities. AHCCCS assembles a multi-disciplinary team of 10 to 20 personnel who spend up to 1 week performing these reviews, which include interviews with personnel, observations of vendor operations, and examinations of all pertinent documentation, and requires its vendors to prepare corrective action plans addressing noted areas of deficiency.

Given the resources needed to perform these types of reviews, the Department should develop a plan for implementing this function within its oversight structure. This plan should include such things as the staff and expertise needed to conduct the reviews, including whether these reviews will be conducted by in-house staff or outside consultants, specify the frequency of the reviews, include a comprehensive description of the review process, identify the standards for assessment, identify how findings and recommendations will be reported, and specify vendor responsibilities related to the review.

Department should document its process for handling appeals—When a member requests their involvement, the Department helps resolve member appeals of department enrollment decisions and/or vendor medical service decisions. While the Department reports it has a process for assisting members, it needs to document this process in policy and procedure. Between October 2004 and June 2005, the Department had received 350 appeals. According to a department official, most of these appeals involve the denial of a medical service and, of the 350 appeals received, 296 had been closed with the help of the Department. A number of these appeals were resolved on the same day they were received, while only 2 appeals took more than 100 days to close. In addition to these appeals, members also make appeals directly to vendors without the Department's help. Vendor contracts require each vendor to establish an appeals process. During June 2005, the Department's vendors reported receiving 71 appeals.

Currently, when the Department receives an appeal, it is forwarded to the Department's appeals coordinator, who assists the member by moving the appeal through the vendor's appeals process. If the appeal concerns a department enrollment decision, the appeals coordinator reviews the member's explanation and requested resolution and makes the decision to approve or deny the appeal. However, the Department has not established written policies and procedures for its process.

Department should determine staffing needs

In reassessing the consultant's role and strengthening program oversight, the Department also needs to assess its own staffing needs. As of July 19, 2005, the Department had filled 29.75 of the 36 staff positions appropriated to the program, in part because of the funding limitations brought on by using consultants more extensively than planned. Nine of these staff assist in directly overseeing the program. According to department reports, 20.75 staff positions assist with program operations, including responding to employee and retiree telephone inquiries, managing the program's technology needs, facilitating employee wellness programs, and monitoring the program's finances.[1]

While the Department has begun to develop a staffing plan for fiscal years 2007 and 2008, it should ensure that its new staffing plan thoroughly takes into account all of the issues discussed in this finding, identifies the positions needed and their duties, and includes an analysis of appropriate personnel costs. In developing its staffing plan, the Department should consider what types of specific expertise are needed or what types of management or oversight functions need to be performed. For example, additional expertise may be needed to review and analyze claims data and make appropriate recommendations for program changes based on these reviews, or expertise may be needed to monitor vendor performance. Additionally, the Department will need to consider what additional staffing may be needed to implement the recommendations made in this report regarding additional oversight activities, including enhancing the use of performance measures and conducting operational and financial reviews of its vendors. After it establishes these parameters, the Department should then assess whether it could reassign existing staff to these positions or take other steps, as appropriate, to seek legislative approval for additional staff.

1 According to the Department, some of these staff perform other division or department activities. Based on department estimates, this accounts for nearly 1.5 staff positions. However, other department staff who are not funded from the Special Employee Health Insurance Trust Fund also assist in program oversight or operations.

Recommendations:

1. To help ensure the appropriate use of consultants, the Department should identify and clearly define the activities a consultant should perform related to program management and oversight by adopting a written policy that includes a general description of the consultant's overall duties and expertise, potential activities that could be contracted to a consultant, expected work products and/or deliverables, and procedures for monitoring and tracking consultant activities.

2. Once this policy is in place, the Department should ensure that its consulting contracts conform to the policy requirements and include expected work products and/or contract deliverables.

3. The Department should ensure that it receives regular, written reports from its consultant that provide sufficient detail on activities performed and contract deliverables met.

4. The Department should improve its performance measures by:

    a. Developing quality-of-care performance measures based on and including HEDIS standards for the self-funded health benefits plan's vendors;

    b. Tracking vendor performance for the quality-of-care performance measures it institutes;

    c. Developing performance standards for its quality-of-care measures once it has sufficient data;

    d. Establishing additional performance standards for its vendor performance measures to encourage continual improvement; and

    e. Establishing policies and procedures for verifying vendor reports of compliance with performance measures.

5. The Department should develop a plan for conducting operational and financial reviews of its program vendors. This plan should include such information as the staff and expertise needed to conduct the reviews, whether these reviews will be conducted by in-house staff or outside consultants, the frequency of the reviews, a comprehensive description of a review process, the standards for assessment, how findings and recommendations will be reported, and vendor responsibilities related to the review.

6. The Department should establish policies and procedures documenting its process for handling appeals.

7. The Department should continue with its efforts to develop a staffing plan and ensure that this plan includes:

    a. The positions needed, their duties, and an analysis of appropriate personnel costs;

    b. Consideration of what types of specific expertise is needed or what types of management or oversight functions need to be performed; and

    c. Consideration of what additional staffing may be needed to implement the recommendations made in this report regarding additional oversight activities.

8. If the Department determines that it needs additional staff, it should assess whether it could reassign existing staff or take other steps, as appropriate, to seek additional staff.

FINDING 2

Self-funded health benefits program financially stable, but additional steps needed to ensure sound operations

While the Department has taken some steps to ensure the financial viability of the self-funded health benefits program, additional actions to make contractors more accountable would help ensure the program's long-term stability. The financial viability of the self-funded health benefits program is critical, especially since the State assumes the financial risk associated with funding health benefits. The Department has established various mechanisms to mitigate this risk, including funding a reserve and purchasing insurance to protect against large medical claims. Since the payment of healthcare claims is by far the largest program expense, ensuring the accuracy and appropriateness of claims is an important aspect of long-term viability. In this regard, the Department can take several steps to ensure the accuracy of claims payments. The Department should also ensure that its actuarial analysis is performed by a contractor who is fully independent from program management and oversight.

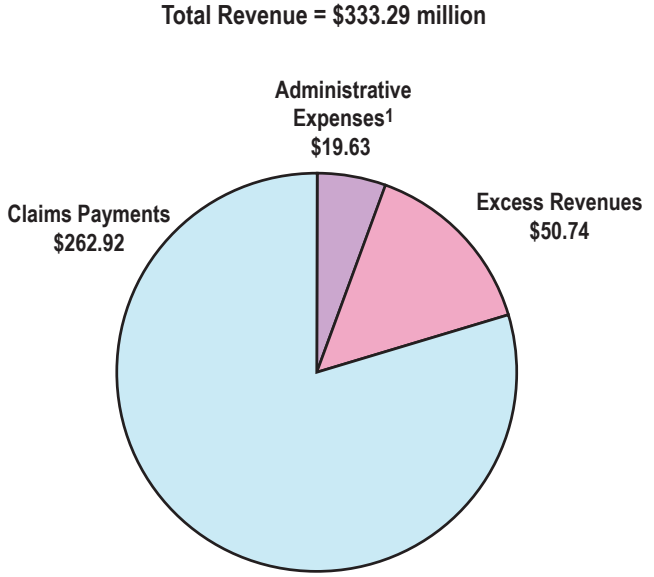
Financial stability important to minimize risk

When an employer self-funds employee health benefits, it assumes the financial responsibility of ensuring that monies are available to pay for the benefits. Thus, since the State of Arizona self-funds its employee and retiree health benefits, if program expenses exceed revenues, the State would be responsible for addressing the deficit. As of June 30, 2005, the program continues to be financially stable since revenues continue to exceed the program's first-year operating expenditures. Specifically, according to a department financial report, the program received approximately $333.3 million in revenues, consisting of premium contributions for fiscal year 2005, and expended approximately $282.6 million for member healthcare

By self-funding employee health benefits, the State assumes the financial risk.

and program administration. Figure 1 illustrates the distribution of program revenues for fiscal year 2005.

Figure 1: Self-Funded Health Benefits Program
Distribution of Revenues for the Fiscal Year
Ended June 30, 2005 (In Millions)
(Unaudited)



[1] While this amount includes the Department's expenses to administer other health benefits provided to members, such as dental benefits and a wellness program, the majority of these expenses were used to administer the self-funded health benefits program, including over $16.3 million for the program's vendor costs.

Source: Auditor General staff analysis of Special Employee Health Insurance Trust Fund Budget Report for Fiscal Year 2005.

Department maintains a reserve and insurance

To help lessen the State's risk for self-funding healthcare benefits for state employees and retirees, the Department has established a funding reserve and purchased insurance to help cover large healthcare claims. Specifically:

- Reserves aid program stability—Within the Health Insurance Trust Fund, the Department has accumulated monies as a reserve to pay for program expenses in the event that claims payments exceed projections. According to a department financial report, as of June 30, 2005, the Department had set aside approximately $49.6 million in reserve, which represents excess premium contributions equal to nearly 2 months of healthcare claims payments.

With the assistance of actuaries, the Department estimated the program's first-year costs and recommended premium contributions not only to cover these costs, but to provide additional monies to establish a reserve. In its May 2004 review of premium contribution rates, the Joint Legislative Budget Committee authorized rates that have allowed the Department to establish this reserve. To determine a targeted reserve amount, the Department, with the assistance of its actuarial consultants, analyzed and estimated the risk the State would face at different reserve funding levels. Specifically, the actuaries presented the Department with different risk scenarios based on a reserve amount it was willing to establish. Based on this analysis, the Department decided to target a reserve of 15 to 18 percent of annual claims payments. This range would reflect a reserve amount of approximately 2 months of claims payments. Establishing a 2-month reserve is consistent with federal requirements, which limit the funding of reserves that receive federal monies to no more than 60 days of claims payments.[1] Because some state employees are paid with federal monies, which are then used to pay for health benefits program premiums, federal requirements apply to the State's self-insurance reserve. If the reserve exceeds 60 days worth of healthcare claims payments, any federal monies in the reserve would have to be returned to the federal government.

While the approximately $49.6 million represents nearly a 2-month reserve as of June 30, 2005, due in part to the rising costs of providing medical care, the Department will need additional monies to maintain the projected reserve amount. For example, the Department's actuarial consultants projected that $56 million would represent approximately a 2-month reserve as of June 30, 2005. However, to maintain a 2-month reserve, the consultants projected that the amount would need to increase to an estimated $114 million as of June 30, 2009.

- Purchased insurance helps control risk—The Department has also purchased an insurance policy to limit the financial responsibility the State faces due to claims that exceed $500,000 per insured individual. One concern associated with self-funded health insurance programs is the risk of catastrophic claims and the potential liability of paying for these claims. Insurance against such large claims reduces the financial risk of self-funding employee health benefits. Specifically, by purchasing insurance, the State has limited its exposure in cases where medical claim payments exceed $500,000 per insured individual. As of June 30, 2005, according to the vendor reports, three individuals had medical claims that exceeded $500,000 by a total of $226,217. While the Department's consultant reports that it is in the process of seeking reimbursement for this amount from the insurer, as of July 2005, the Department has yet to be reimbursed. For fiscal year 2005, the Department paid nearly $1.79 million for this insurance coverage.

[1] United States Office of Management and Budget Circular A-87 establishes principles and standards for determining costs for agreements with state and local governments.

Improvements to claims payment process would enhance long-term stability

The Department should take additional steps to enhance the program's long-term financial stability by improving controls over healthcare claims payments. The Department, through its claims payment contractors, processed over $262.9 million in claims payments between October 1, 2004 and June 30, 2005. While the Department and its contractors have adopted some controls to help ensure the appropriateness and accuracy of claims payments, instituting additional controls would provide greater assurance that payments are accurate and proper. These include adopting contractual requirements for an independent audit of contractors' claims process and controls and claims data, performing its own reviews of claims payments, establishing additional internal procedures to help ensure the accuracy of information transferred and payments made to its vendors, and adopting policies for properly maintaining claims data.

Medical and prescription drug claim payments represent the largest expense of the State's self-funded health plan.

Contracted vendors process claims—The payment of medical claims arising from the provision of covered medical services represents the largest expense of a healthcare insurance program. In fact, according to department financial reports, medical claims used approximately 79 percent of total revenues and totaled over $262.9 million between October 1, 2004 through June 30, 2005. The Department has contracted with four vendors to process and pay medical or prescription drug claims for program members. The text box illustrates the amount of claims payments paid by each vendor from October 1, 2004 through June 30, 2005. For the integrated portion of the State's health insurance model, United Health Care and PacifiCare pay medical claims they receive from their provider networks. Harrington Benefits Services processes medical claims from providers in the nonintegrated portion of the program model. Walgreens Health Initiatives processes all prescription drug claims. The Department reimburses these vendors for the claims paid plus a contractual fee based on weekly invoices submitted by the vendors.

Claims Paid
October 2004—June 2005
(In Millions)

Harrington	$107.7
United Health Care	102.5
Walgreens	52.2
PacifiCare	.5

Source: Auditor General staff analysis of Department of Administration financial schedules.

Department sets control requirements for two of three vendors—While the Department requires two of its three vendors who process more than 99 percent of medical claims to maintain internal controls, its contract with the vendor who processes prescription drug claims lacks these requirements.[1] Effective internal controls help ensure vendors comply with claims payment processing standards. As such, the Department has established provisions within its vendor contracts requiring two of its three vendors who process medical claims to apply control procedures necessary for the effective administration of the self-insurance program, including procedures that facilitate the identification of duplicate payments and the review of high dollar claims for appropriateness.

[1] Auditors did not include PacifiCare in their review as it processed less than 1 percent of the program's medical claims from October 1, 2004 through June 30, 2005.

To help ensure that all of its vendors properly process claims, the Department should include similar control requirements in its contract with the vendor who processes prescription drug claims. According to a department official, this vendor had adequately described its claim payment control procedures in its contract proposal, and the department determined that it was not necessary to include control requirements in this vendor's contract.

Additionally, the Department requires all three vendors to meet various standards for the processing of medical claims. These standards include targets that vendors must meet regarding the accuracy and timeliness of claims paid. For example, the Department's vendors must achieve a minimum of 99 percent accuracy for the claims payment accuracy standard, which is the total number of claims paid correctly divided by the number of paid claims. Vendors must report compliance with these standards on a quarterly basis. According to their contracts, noncompliance with the specified targets can result in the withholding of fees.

Financial Standards:

Claims processing accuracy—Number of claims processed correctly divided by the total number of claims. The accuracy rate required by the Department ranges from 98 to 99 percent accuracy.

Financial payments accuracy—Total claim dollars paid correctly divided by the total paid dollar claims. The Department requires an accuracy of 99 percent.

Claims payments accuracy—Total number of claims paid without dollar errors divided by the total number of claims paid.

Claims turnaround—Percentage of claims processed within 10 business days, within 15 days, and within 22 days. For example, the Department requires that its vendors process 90 percent of claims within 10 business days.

Independent assessment of internal controls and claims payments needed—The Department should augment current contract provisions by requiring annual independent audits of two aspects of contractors' claims processing operations. Specifically:

The Department should require independent audits of internal controls and claims payment data as part of its contracts.

- **Audit of claims payment processes**—The Department should require through its contracts that its vendors obtain independent audits of their claims payment processes. The Department contracted for a review of two of its vendors' claims payment processes prior to these vendors processing any program claims. These reviews tested how these vendors' claims payment systems would process claims based on various scenarios and the State's health plan requirements. While these reviews identified numerous issues, such as not always properly applying copayments or inappropriately paying for an uncovered service, the Department and its consultant are continuing to work with these vendors to resolve any remaining issues. In August 2005, the Department had also requested that its consultant conduct an audit of its vendor that processes prescription drug claims. Similarly, this audit will assess this vendor's claims payment process for compliance with the State's health plan requirements. However, these reviews did not or will not assess the adequacy and effectiveness of these vendors' claims payment processing controls.

  Although not required by its contracts, two of the Department's three vendors have obtained independent audits of their claims payment processing controls

to be used by their clients and their clients' independent auditors. Independent auditors reviewed the vendors' controls for the period June 1, 2004 through May 31, 2005, for one vendor and July 1, 2004 through June 30, 2005, for the other vendor using the American Institute of Certified Public Accountants (AICPA) standards to perform an assessment of the controls established and their operating effectiveness. However, the Department's other vendor has not provided it with an independent audit of its claims payment processing controls.

- Audit of claims payment data—The Department should also require through its contracts that its vendors obtain an independent audit of the claims payment data. Such an audit will not only verify the accuracy of the reports provided by its vendors, but will also help to ensure the accuracy of the claims data. Ensuring the accuracy of this data is critical as it should reflect the types and number of medical services, including prescription drugs, provided to members and is used by the Department to manage and oversee the self-funded health benefits program, by its contracted actuaries to project program costs, and by financial auditors when auditing the State's financial statements. Inaccurate data can lead to poor management decisions, invalid cost projections, and scope limitations for audit purposes. For example, the State contracted for an audit of claims payment data under the previous health insurance plan. While the vendor reported that 99.3 percent of claims were processed with accurate payments, the audit found that only 86.8 percent of claims were processed accurately. Further, auditors reported that the extrapolated claims processing error rate was 20 percent.

Establishing these requirements within the contracts would provide further assurance that the controls instituted by vendors help ensure the appropriate and accurate processing of claims. In fact, in 1996, the United States General Accountability Office estimated that healthcare fraud accounts for 3 to 10 percent of all claim dollars paid.[1] Additionally, a 2001 national survey conducted by the Kaiser Family Foundation and Harvard School of Public Health found that 13 percent of insured adults reported experiencing billing and payment problems with their private insurance.[2]

Finally, the Department should maintain and analyze the audit reports and require corrective action plans if the audits note deficiencies. While two of its vendors had obtained independent audits of their claims payment processes, the Department had not obtained and reviewed the independent audit reports until auditors inquired about the claims payment processing controls these vendors had in place.

Department should conduct additional reviews—In addition to ensuring its vendors have adequate internal controls, the Department should conduct its own

1 United States Government Accountability Office. *Health Care Fraud: Information-Sharing Proposals to Improve Enforcement Efforts.* Washington, D.C.: U.S. Government Accountability Office, May 1996.

2 Kaiser Family Foundation and Harvard School of Public Health. *National Survey on Consumer Experiences with and Attitudes Toward Health Plans: Key Findings.* Menlo Park, CA.: The Kaiser Family Foundation, August 2001.

reviews of claims processing to ensure that claims are accurately and appropriately paid. The Department should:

- Verify claims data from all vendors—To help ensure the appropriateness of claims paid, the Department verifies the claims data that it receives from two of its three vendors with member eligibility data to determine if payments were made to the appropriate vendor, within the eligibility period, and for actual members. However, as of June 30, 2005, the Department does not verify claims payment data from its vendor who processes prescription drug claims. The Department does not receive this claims data and believes verification of it is unnecessary since the vendor receives accurate eligibility information from the other two vendors. However, unless the Department verifies claims payments against eligibility data, it cannot confirm the appropriateness of these prescription drug claim payments. Because it does not receive claims payment data from this vendor, approximately $52.2 million in claims paid during October 1, 2004 through June 30, 2005, have not been verified against member eligibility data. Therefore, the Department should ensure that it receives claims data from all of its vendors and also ensure that it verifies the appropriateness of all claims payments.

The Department does not verify all claims payment data to detect eligibility errors.

- Review the accuracy of payments—The Department should develop and execute tests to verify that claims were paid in compliance with benefit plan provisions. According to a department official, the Department has not developed and performed these claims reviews as it lacks the necessary staff to do so. Therefore, as part of the development of a staffing plan for the management and oversight of the self-funded health benefits program, the Department should also identify the positions needed to develop and perform these reviews (see Finding 1, page 21, for more information on the Department's development of a staffing plan).

- Establish additional internal procedures—In August 2005, the Department's consultant issued a report that identified several findings and recommendations for improvement related to the Department's processes, staff roles and technology in support of eligibility determination, transfer of eligibility data to vendors, and payments. Findings and recommendations included the need for independent audits of eligibility data and processes, further review of eligibility discrepancies with vendors, and the need for back-up documentation to substantiate requested payments to vendors. In its report, the consultant provides a timeline for implementing needed recommendations. As a result, the Department should evaluate the findings and recommendations in the report and implement the recommendations needed to address the findings.

- Ensure data is properly maintained—While the Department receives the claims data from two of its vendors, it has not adopted policies to ensure that the data is properly maintained. These include policies for how long the data should be

maintained. Without sufficient data, the Department may not be able to properly analyze the program and its continuing costs. Therefore, the Department should determine for how long and where its claims data should be retained.

Independent actuarial study needed

The Department should take some steps to ensure that it receives objective, verifiable information and analysis from its contracted actuary. The Department has retained the services of an actuary to assist in developing the projected costs for the self-funded health benefits program. Specifically, the contracted actuary developed a 5-year cost projection for the self-funded health benefits program prior to its initiation and this projection served as the basis for establishing the premium contributions made to the program by the State, its employees, and retirees during the program's first year. Actuaries provide the expertise needed to project these costs to ensure that sufficient monies are generated through premium contributions to pay for medical claims, administrative expenses, and other program costs. However, the Department should consider the following factors as it continues to use the expertise that its actuary provides:

- Need to obtain actuarial report—The Department should ensure that with future actuarial cost projections, it receives an actuarial report documenting the methodology and source of the data used by the actuary to arrive at his/her cost projections. According to a department official, such a report was not requested or prepared due to the uncertainty of self-funding employee health benefits at that time and to keep consulting costs to a minimum. Instead, according to this official, the actuary provided spreadsheets to the Department and Legislature showing an analysis and cost projections. However, a full report documenting the actuary's analysis, methodology, sources of data, and other necessary information would provide the Department with a more complete picture of the cost projections and their basis. Additionally, such a report can be used by the State's financial auditors as part of their audit of the state-wide financial statements to help ensure that the actuary employed sound methodologies in cost projections.

- Contracted actuary should be independent—To help ensure that the actuary's cost projections are objective and unbiased, the Department should not obtain actuarial and program management services from the same firm. However, the Department retained the services of an actuary from a consulting firm to develop the initial 5-year cost projections, and this consulting firm has since also assisted in managing and overseeing the self-funded health benefits program. This includes assisting in the oversight of contracted vendors and development of processes and operations to ensure compliance with laws and regulations. These activities potentially jeopardize the consulting firm's independence when

preparing actuarial estimates and projections as they might be influenced by participating in these program management activities. Additionally, government auditing standards require that in order for auditors to use the work of a specialist, which includes actuaries, in the course of an audit, the specialist must be independent. Standards further stipulate that if the specialist has an impairment to independence, auditors should not use the work of the specialist. Since the work of the Department's actuary would be used in an audit of the state-wide financial statements, the actuary's independence would need to be considered by the auditors. Therefore, the Department should contract with a firm for actuarial services that is not involved in program management or oversight. According to a department official, the Department has taken steps to identify other consultants or firms that can provide the actuarial services it needs.

Recommendations:

1. The Department should establish contractual provisions requiring its vendors who process medical claims to:

    a. Apply control procedures necessary for the effective administration of the self-insurance program; and

    b. Obtain independent annual audits of claims payment processing controls and claims payment data.

2. The Department should maintain and review the audit reports of its vendors' controls for their claims payment processes and require corrective action plans if deficiencies are noted.

3. The Department should develop and conduct reviews to ensure claims are paid in compliance with benefit plan provisions.

4. The Department should evaluate the findings and recommendations made in the August 2005 consultant's report on the Department's processes, staff roles, and technology in support of eligibility determination, transfer of eligibility data to vendors, and payments, and implement needed recommendations.

5. The Department should ensure that it receives claims data from all of its vendors and establishes verification procedures to ensure the appropriateness of all claim payments.

6. The Department should determine how many years of claims data should be retained to properly analyze the program and its continuing costs.

7. When contracting for the services of an actuary, the Department should:

    a. Ensure it receives an actuarial report documenting the methodology and source of the data used by the actuary to arrive at his/her cost projections; and

    b. Contract with an actuarial firm that is not involved in program management or oversight.

OTHER PERTINENT INFORMATION

As part of the audit, auditors gathered other pertinent information regarding the Department's new Web-based hiring software, Yahoo! ® Hiring Gateway, and the impact of accounting standards that will require the State to account for the nonpension post-employment benefits that its employees accrue.

Hiring Gateway

The Department is in the process of completing implementation of Yahoo!® Hiring Gateway (Hiring Gateway), a Web-based recruiting and hiring software that has replaced the Resumix system. The Department expects to complete implementation of the software in November 2005. Hiring Gateway provides several features and benefits that should simplify and expedite the recruiting and hiring process for positions in state government. Agency users report that the new software saves time and assists in recruiting more qualified candidates. Additionally, to assist agencies in their use of the software, the Department has established an advisory committee, plans to host monthly meetings for agency users, and intends to conduct audits of agencies' use of the software.

New hiring software being implemented—The Department is in the process of completing the implementation of Hiring Gateway, an online software application that performs a variety of functions intended to simplify and expedite the recruiting and hiring process. Hiring Gateway provides a central location for job information, which includes a Web site, www.azstatejobs.gov, dedicated to posting state job announcements and accepting online applications from interested candidates. Additionally, Hiring Gateway allows agencies to work online to develop job announcements, obtain necessary management approvals for job requisitions, create hiring lists, and send offer letters to prospective employees.[1] Specifically, the software provides the following benefits and improvements over the Department's previous recruiting and hiring system:

The State created a Web site for posting open positions and accepting applications.

- Job requisitions routed electronically—The new software allows state agency recruiters to create job requisitions, records which contain all job specifications at their desktops, and route the requisitions for approval through e-mail. It also

[1] All System A agencies within the State may use the Hiring Gateway. System A agencies are subject to the State's personnel rules, while non-System A agencies are not. Non-System A agencies, such as legislative agencies, the Office of Tourism, and the Board of Regents, have their own recruiting and hiring procedures.

enables users to electronically track the location and status of the requisition as it travels through the approval process. Under the previous system, department staff had to create, print, copy, and route job requisitions for approval through interoffice mail, which was more time-consuming and more difficult for agency staff to track.

- Recruiters generate hiring lists—Agency recruiters can now generate hiring lists that better meet the requirements of job openings by using Hiring Gateway's reporting functions and ranking mechanism. According to personnel rules, hiring lists should contain the names of available candidates who possess the knowledge, skills, and abilities required for the position. These lists are required for most job openings and must be developed prior to an agency beginning the interview process. With Hiring Gateway, recruiters can monitor application submissions online and more quickly generate hiring lists when a posted position closes or when a sufficient number of resumes have been received for a continuously open position. Recruiters can then rank the names on the hiring list, eliminating the least qualified candidates. According to the Department, the previous system did not offer a ranking capability, and agencies had to wait for department staff to provide hiring lists using search criteria, such as applicant qualifications or the date a resume was received, which often did not yield hiring lists with a suitable number of qualified candidates.

- Applicants self-nominate for positions—Hiring Gateway requires applicants to self-nominate, or apply directly, for positions in which they are interested. Some state agencies reported that this feature provides them with a better pool of candidates from which to fill job openings. In addition, a search agent feature allows anyone who creates an account on the jobs Web site to specify interests in various types of positions and then to be notified via e-mail when a position matching his/her interests becomes available. The e-mail notification contains links to the job posting on the Web site, where the applicant may submit a resume and apply online. Resumix did not provide this capability and only stored resumes in a large database, from which department staff would extract resumes and create hiring lists. Because hiring lists were not based on applicant self-nomination, agencies often found that applicants on the Resumix-based hiring lists were either unqualified for the position or uninterested.

- Screening questions help develop better candidate pool—Hiring Gateway allows agencies to create specific screening questions as part of the online application. When processing applications for an open position, the recruiter can narrow down the number of candidates for a position based on the applicant's answers to the screening questions. This allows recruiters to more easily evaluate candidates by helping them consider only those who answer the screening questions correctly. For example, an agency can use screening questions to narrow down its hiring list to only candidates with particular degrees that are necessary for a job.

- **Personnel information automatically transfers to HRIS**—Hiring Gateway is linked to the Human Resources Information Solution (HRIS), the State's integrated system for the administration of payroll, personnel, employee benefits, and other related functions. Now, when an employee is hired, the personnel information contained in Hiring Gateway is automatically entered into HRIS, and Hiring Gateway checks the information for invalid entries before saving it in the HRIS database. This automatic transfer of information saves time and eliminates a potential source of errors.

In addition to these benefits, state agencies have direct access to the software and its many features. As shown in the text box, 22 agencies have direct access to Hiring Gateway. These consist mainly of the larger state agencies that typically have their own human resources professional staff. Most small state agencies rely on the Department for recruiting and hiring support, as many of them do not have staff dedicated to recruiting and hiring. These smaller agencies have not been provided direct access to Hiring Gateway. However, the Department provides the same services to the small agencies that the larger agencies can now perform themselves, including posting job openings on the Web site, routing job requisitions electronically, and generating improved hiring lists in a more timely manner.

Agencies with direct access to Hiring Gateway:

Departments of:
- Administration
- Agriculture
- Corrections
- Economic Security
- Education
- Emergency and Military Affairs
- Environmental Quality
- Health Services
- Insurance
- Juvenile Corrections
- Land
- Revenue
- Transportation
- Veterans' Services
- Water Resources

Arizona Game and Fish
Arizona Health Care Cost Containment System
Arizona State Parks
Corporation Commission
Industrial Commission
Office of the Attorney General
Registrar of Contractors

Previously, Resumix was available only to department staff, whether housed at the Department or one of its seven satellite human resources offices at various state agencies.[1] Other agencies, such as the Arizona State Parks and the Department of Veterans' Services, which now have access to Hiring Gateway, had to rely on department staff to recruit and hire their new employees.

Agencies report satisfaction with new software—Auditors spoke with state agencies who reported satisfaction with Hiring Gateway. According to seven agency officials, two of who are from small agencies that rely on the Department for recruiting and hiring support, the new software saves time in the recruiting process. For example, one recruiter said the internal e-mail communication is faster than the previous "paper shuffling" they used to do, and that time is not spent making copies. In addition, some agency representatives like the self-nomination feature because they no longer have to guess whether applicants are interested—now they can review resumes from candidates who applied for specific positions.

Officials from seven agencies report that Hiring Gateway saves time and assists in recruiting.

[1] The Department has satellite human resources offices at the Department of Administration/Tucson Office, and the Departments of Corrections, Economic Security, Health Services, Juvenile Corrections, Revenue, and Transportation.

Further, several agencies have found the ability to ask screening questions useful. For example:

- Arizona Game and Fish has used the screening function to recruit for a wildlife specialist position, which requires a degree in wildlife sciences. The agency added a list of degrees for the applicant to choose from, allowing it to screen out applicants who did not select degrees from the predetermined list.

- Arizona State Parks uses unique screening questions for certain park ranger positions to identify applicants who are willing to work weekends and holidays, work in rural areas of Arizona, or live at a state park.

Agencies also reported that the Department has been quick to resolve minor issues or concerns with the new software, which occurred early in Hiring Gateway's implementation. For example, some agencies reported that they receive a higher volume of resumes with the new software, and if they processed all of the applicants at the same time, the software slowed. Agency recruiters reported this to the Department, which identified the source of the problem and helped the agencies solve it.

Department plans to continue improving recruiting and hiring processes—In addition to implementing Hiring Gateway, the Department plans to develop other tools and processes to assist agencies in their use of the software. Specifically:

- Advisory Committee—The Department formed the Hiring Gateway Advisory Committee in April 2005, which will help the Department identify and prioritize software enhancements and provide direction and guidance when designing and implementing those enhancements. The committee met again in May 2005, and plans to meet on a regular basis. It includes representatives from the agencies using Hiring Gateway.

- Meetings and Trainings—The Department plans to host monthly meetings for all agency users to review Hiring Gateway processes and changes, provide mini-trainings on problem areas, and offer a forum for discussion on software functions and methods for using them. The first meeting was held in June 2005.

- Internal Audit—The Department's internal human resources audit team will review agencies' use of the software to help ensure that consistent practices and procedures are maintained in the recruitment and hiring process. The team has added a review of agency use of the new software to its audit plan to ensure that agencies comply with established policies and procedures for Hiring Gateway.

Accounting for nonpension, post-employment benefits

Beginning in fiscal year 2008, the State will be required to report additional information about its nonpension, post-employment benefits. Specifically, Governmental Accounting Standards Board Statement No. 45 (GASB No. 45) will require government entities to reflect on their financial statements the long-term cost of post-employment benefits, including medical coverage that employees earn and will receive upon retirement. This might have significant consequences for the State as it potentially results in a large liability that will have to be reflected on the State's financial statements.

GASB will require recognition and reporting of nonpension, post-employment benefits, including healthcare.

GASB No. 45—The Governmental Accounting Standards Board (GASB) established new standards for the measurement, recognition, and reporting of nonpension, post-employment benefits, including healthcare, in states' and other governmental entities' financial statements. These post-employment benefits occur from the exchange of employee services for salaries and benefits and are part of a compensation package for services rendered. These nonpension benefits can include medical, dental, and vision healthcare coverage; life insurance; disability insurance; and long-term care coverage.

Historically, most of these post-employment benefits have been recognized as an expense on entities' financial statements only when the benefits are paid. However, this financial reporting approach does not provide relevant information related to the cost of these post-employment benefits as they are accrued, the extent to which these obligations are funded, and potential demands on future cash flows to satisfy these obligations. GASB No. 45 addresses these issues by requiring governmental entities to recognize nonpension, post-employment benefits while employees are active and as they accrue these benefits. Specifically, GASB No. 45 requires the State to:

- **Determine the benefits cost**—Governmental entities are required to recognize the cost of offering nonpension, post-employment benefits. An actuarial valuation is needed to determine the cost of required contributions toward these benefits. The cost would include the State's direct required contributions toward nonpension, post-employment benefits as well as any subsidies the State provides to retirees for these benefits. While the State does not directly contribute monies toward retirees' health insurance premiums, the retirees' benefits are subsidized by the State and active employees. This happens because the Department blends retirees with active members to set health insurance premium rates for all participants, rather than determining separate premium rates for active members and retirees. However, retirees' average monthly medical claims costs are often greater than active members' claims costs. For example, during May 2005, the State paid an average of $864 in medical claims costs per retiree as compared to an average of $618 in medical

The State currently provides healthcare benefits to its retirees.

claims costs per active member.[1] However, despite the difference in medical costs among active members and retirees, their premium costs are the same.

- **Recognize the cost of the benefits**—Similar to other states, the State will have to reflect the annual and long-term cost of nonpension, post-employment benefits promised to its employees based on updated actuarial valuations of the promised benefit. GASB No. 45 requires this actuarially determined benefit cost to be in the State's financial statements and supplementary information.

- **Report the actual funding**—Through the State's financial statements and supplementary information, the State will report whether nonpension, post-employment benefits are being funded. If the actuarial determined cost for direct contributions and subsidies for nonpension, post-employment benefits is not funded, the State will need to record an unfunded liability in its financial statements. If the actuarially determined liabilities exceed actuarial assets, the State will need to disclose the unfunded status of the program over the long-term in its supplementary information.

Options—There are several strategies the State can take to prepare for the impact of this new accounting standard. Specifically:

- **Report an unfunded liability**—The Legislature can choose to continue providing benefits at the same level and recognize the unfunded health benefits. The State would then need to reflect the unfunded benefit as a liability in its annual financial statements. However, it is unclear how this unfunded liability would affect the State's financial position and financial stability.

- **Consider and evaluate retiree plan changes**—The State can eliminate the liability by modifying how retiree contributions are calculated. Specifically, the Department can ensure that retiree benefits are not subsidized by projecting the cost of these benefits and requiring retirees to make contributions to pay for the benefits. In addition, similar to other public-sector employers, the State can consider changing nonpension, post-employment benefits, including reducing or eliminating these benefits, to limit the recognition of this liability. For example, some California public entities have begun to eliminate retiree healthcare coverage for new employees. Similarly, North Carolina's State Comptroller recommended, on a prospective basis, an analysis of the long-term impact of retiree benefits and potential changes to this benefit structure.

Finally, the Legislature is considering several options for providing post-employment benefits. During the 2005 legislative session, the Legislature established a retiree health insurance committee to review and evaluate options for post-employment health insurance. The plans involved in this review include the Arizona State Retirement System, Public Safety Personnel Retirement System, Corrections Officer Retirement Plan, and Elected Officials Retirement Plan. The committee is considering

[1] Mercer Human Resource Consultants. *Monitoring Financial Sub-team Monthly Report*. December 2004 through May 2005.

several recommendations made in a 2004 feasibility and cost benefit impact study report prepared by Mercer Human Resource Consulting that was commissioned by the Legislature. These options include:

- Allowing Arizona State Retirement System, Public Safety Personnel Retirement System, Corrections Officer Retirement Plan, and Elected Officials Retirement Plan retired and disabled members and their dependents to participate in the Department's self-funded health benefits program. Some benefits of this option include the consolidation of administration and retiree risk pools; as well as efficiencies in staffing, systems, accounting, and communication. Mercer estimated that the Department's retiree health benefits program provides approximately 26 percent more value in terms of benefits than healthcare plans offered by the Arizona State Retirement System. However, moving retirees into a more valuable plan can significantly increase the overall cost. In addition, this option would move several risk pools into a self-funded program, increasing the State's financial risk.

- Establishing a single health insurance program to include the Arizona State Retirement System, Public Safety Personnel Retirement System, Corrections Officer Retirement Plan, and Elected Officials Retirement Plan retired members. This option would offer similar consolidation and efficiency benefits as the option above. However, this option would create a new risk pool that would move these members from existing health insurance plans. The State would also need to decide whether to insure this new pool or self-fund.

- Requiring public employers to allow retirees under 65 to remain in the health insurance plan for active members. An advantage of maintaining pre-Medicare retirees in their employer health plans is the opportunity to blend active member and retiree rates. This option would also decrease the number of retirees covered by the Arizona State Retirement System. However, with the advent of GASB No. 45's requirement to report unfunded liabilities for retiree health plans, some employers may potentially reduce or eliminate retiree health benefits, including retiree healthcare.

- Dedicating an existing part of the retirement contribution rate or a portion of an increased contribution rate to defray part of the cost of health insurance premiums. Mercer concluded that a more detailed actuarial analysis would be necessary to determine an exact contribution rate.

Since GASB No. 45 improves the relevance and usefulness of financial reporting for nonpension, post-employment benefits by requiring the yearly and long-term recognition of benefits cost and whether or not these benefits are funded, the Legislature can make informed long-term policy decisions regarding program benefits, subsidies, and state contributions.

AGENCY RESPONSE

Janet Napolitano
Governor

Jerry A. Oliver, Sr.
Interim Director

ARIZONA DEPARTMENT OF ADMINISTRATION

OFFICE OF THE DIRECTOR

100 North 15th Avenue • ROOM 401
PHOENIX, ARIZONA 85007

(602) 542-1500

September 22, 2005

Debbie Davenport
Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85018

Dear Ms. Davenport:

The Department of Administration has reviewed the September 15, 2005 report of the performance audit of the Human Resources Division. The Department commends and thanks your staff for their understanding and professionalism throughout this audit process.

Enclosed is the Arizona Department of Administration's response to the findings and recommendations contained in the performance audit report.

We value the recommendations made in the report that will help us improve the management and operations of our agency.

Sincerely,

Jerry A. Oliver
Interim Director

Enclosure

ADOA Agency Response, by Section and Finding

Finding 1- Department should strengthen management of self-funded health benefits program.

Recommendations:

Recommendation #1: *To help ensure the appropriate use of consultants, the Department should identify and clearly define the activities a consultant should perform related to program management and oversight by adopting a written policy that includes a general description of the consultant's overall duties and expertise, potential activities that could be contracted to a consultant, expected work products and/or deliverables, and procedures for monitoring and tracking consultant activities.*

Agency Response**:** The finding of the Auditor General is agreed to and the audit recommendation will be implemented. The Agency will begin the development of a policy regarding use of consultants.

Recommendation #2: *Once this policy is in place, the Department should ensure that its consultants contract conform to the policy requirements and include expected work products and/or contract deliverables.*

Agency Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Recommendation #3: *The Department should ensure that is received regular, written reports from its consultant that provide sufficient detail on activities performed and contract deliverables met.*

Agency Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Recommendation #4: *The Department should improve its performance measures by:*

a. *Developing quality-of-care performance measures based on and including HEDIS standards for the self-funded health plan's vendors;*
b. *Tracking vendor performance for the quality-of-care performance measures it institutes;*
c. *Developing performance standards for its quality-of-care measures once it has sufficient data;*
d. *Establishing additional performance standards for its vendor performance measures to encourage continual improvement; and*

e. *Establishing policies and procedures for verifying vendor reports of compliance with performance measures.*

Agency Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented. The Agency will begin to develop quality-of-care performance measures and work with the vendors on how these measures can be implemented and tracked. Policies and procedures will be developed.

Recommendation #5: *The Department should develop a plan for conducting operational and financial reviews of its program vendors. This plan should include such information as to the staff and expertise needed to conduct the reviews, whether these reviews will be conducted by in-house staff or outside consultants, the frequency of the reviews, a comprehensive description of a review process, the standards for assessment, how findings and recommendations will be reported, and vendor responsibilities related to the review.*

Agency Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented. Since the Agency does not have the internal expertise, we have requested additional funding for independent operational and financial audits in its FY '07 budget request.

Recommendation #6*: The Department should establish policies and procedures documenting its process for handling appeals.*

Agency Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented. The Agency will begin development of the policies and procedures.

Recommendation #7: *The Department should continue with its efforts to develop a staffing plan and ensure that this plan includes:*

a. *The positions needed, their duties, and an analysis of appropriate personnel costs;*
b. *Consideration of what types of specific expertise is needed or what types of management or oversight functions need to be performed; and*
c. *Consideration of what additional staffing may be needed to implement the recommendations made in this report regarding additional oversight activities.*

Agency Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented. The Agency will develop and finalize its staffing plan based on the recommendations.

Finding 2- Self-funded health benefits program financially stable, but additional steps needed to ensure sound operations.

Recommendations:

Recommendation #1: *The Department should establish contractual provisions requiring its vendors who process medical claims to:*

a. *Apply control procedures necessary for the effective administration of the self-insurance program and;*

b. *Obtain independent annual audits of claims payment processing controls and claims payment data.*

Agency Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented. The Agency will begin to work with the vendors on contractual provisions.

Recommendation #2: *The Department should maintain and review the audit reports of its vendors' controls for their claims payment processes and require corrective action plans if deficiencies are noted.*

Agency Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented. The Agency will begin to receive the audit reports when they are completed.

Recommendation #3: *The Department should develop and conduct reviews to ensure claims are paid in compliance with benefit plan provisions.*

Agency Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented. Since the Agency does not have the internal expertise, we have requested additional funding for independent operational and financial audits in its FY '07 budget request.

Recommendation #4: *The Department should evaluate the findings and recommendations made in the August 2005 consultant's report on the Department's processes, staff roles, and technology in support of eligibility determination, and transfer of eligibility data to and paying its vendors and implement needed recommendations.*

Agency Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented. The Agency will review and begin implementation of the consultant's recommendations.

Recommendation #5: *The Department should ensure that it receives claims data from all of its vendors and establishes verification procedures to ensure the appropriateness of all claim payments.*

Agency Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented. The Agency will verify the appropriateness of all claim payments.

Recommendation #6: *The Department should determine how many years of claims data should be retained to properly analyze the program and its continuing costs.*

Agency Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented. The Agency will establish a policy on claims data retention.

Recommendation #7: *When contracting for the services of an actuary, the Department should:*

a. *Ensure it receives an actuarial report documenting the methodology and source of the data used by the actuary to arrive at his/her cost projections; and*
b. *Contract with an actuarial firm that is not involved in program management or oversight.*

Agency Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented. The Agency will require actuarial reports on cost projections and will obtain an independent actuarial analysis annually.

Performance Audit Division reports issued within the last 24 months

03-08 Arizona Department of Commerce

03-09 Department of Economic Security—Division of Children, Youth and Families, Child Protective Services—Caseloads and Training

04-L1 Letter Report—Arizona Medical Board

04-L2 Letter Report—Gila County Transportation Excise Tax

04-L3 Letter Report—Department of Economic Security—Population Estimates

04-01 Arizona Tourism and Sports Authority

04-02 Department of Economic Security—Welfare Programs

04-03 Behavioral Health Services' HB2003 Funding for Adults with Serious Mental Illness

04-04 Department of Emergency and Military Affairs and State Emergency Council

04-05 Department of Environmental Quality—Water Quality Division

04-06 Department of Environmental Quality—Waste Programs Division

04-07 Department of Environmental Quality—Air Quality Division

04-08 Department of Environmental Quality—Sunset Factors

04-09 Arizona Department of Transportation, Motor Vehicle Division— State Revenue Collection Functions

04-10 Arizona Department of Transportation, Motor Vehicle Division—Information Security and E-government Services

04-11 Arizona Department of Transportation, Motor Vehicle Division—Sunset Factors

04-12 Board of Examiners of Nursing Care Institution Administrators and Assisted Living Facility Managers

05-L1 Letter Report—Department of Health Services—Ultrasound Reviews

05-01 Department of Economic Security—Division of Employment and Rehabilitation Services—Unemployment Insurance Program

05-02 Department of Administration—Financial Services Division

05-03 Government Information Technology Agency (GITA) & Information Technology Authorization Committee (ITAC)

05-04 Department of Economic Security—Information Security

05-05 Department of Economic Security—Service Integration Initiative

05-06 Department of Revenue—Audit Division

05-07 Department of Economic Security—Division of Developmental Disabilities

05-08 Department of Economic Security—Sunset Factors

05-09 Arizona State Retirement System

05-10 Foster Care Review Board

05-11 Department of Administration—Information Services Division and Telecommunications Program Office

Future Performance Audit Division reports

Department of Administration—Sunset Factors

Department of Revenue—Collections Division