



# Minnesota Management & Budget

## Final Report for the

# Dependent Eligibility Verification Audit

December, 2012

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## Executive Summary

Minnesota Management & Budget (MMB) was statutorily required to conduct a dependent eligibility verification audit (DEVA) for the medical, dental and life employee insurance benefit plans. The audit was conducted between March 16, 2012 and July 16, 2012 and included over 34,000 employees who had a spouse or dependent participating in the State Employee Group Insurance Program (SEGIP). An employee without a participating spouse or dependent was not included in the audit.

Employee participation in the audit was commendable with nearly 98 percent responding. Of the more than 34,000 employees initially participating in the audit, 93.8 percent completed the audit (provided complete and accurate verification documentation), 2.7 percent partially completed the audit, 2.3 percent did not respond and 1.2 percent left the insurance program prior to the completion of the audit.<sup>1</sup>

The eligibility status of 74,765 spouses and dependents were reviewed by the end of the audit. Of those, the eligibility of 94.3 percent was verified, 5.6 percent of audited dependents were unverified, and 0.1 percent was pending and still in process at the close of the audit. This outcome is within the industry estimation that between 4 and 8 percent of dependents will not meet verification requirements during an audit.

The cost of the audit was \$389,070 or \$5.19 per audited dependent. The medical plan will experience savings in Calendar Year 2012 of approximately \$4 million (after the cost of the audit) based on 4,218 unverified dependents removed from the plan for the five months following the audit. The medical, dental and life programs are expected to experience ongoing savings from the audit and those savings will be reflected in the program's future costs.

Certain executive branch state agencies were required to contribute \$1.726 million to the General Fund in fulfillment of the statutory requirements. These dollars were attributable to savings from the audit. The contribution was due no later than June 30, 2013 and was made in Fiscal Year 2013.

## Introduction

Legislation passed during the 2011 Minnesota Legislative Session required MMB to conduct a document-based dependent eligibility verification audit (DEVA).<sup>2</sup> Audits are becoming a common practice in employer-based benefit administration. Under a DEVA, employees are required to verify the

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eligibility of their enrolled dependents to ensure only eligible dependents are enrolled in a benefit program. An audit helps “level the playing field” among employees by preventing subsidized coverage of ineligible members, and by preventing some employees from receiving an unauthorized benefit that is not available to all members.

The legislation also set the general parameters of the DEVA. It specified that MMB conduct a document model dependent eligibility verification audit of the state’s employee medical, dental and life insurance programs. Generally, there are two models of dependent eligibility verification audits: a document model and an affidavit model. During an affidavit audit members are required to confirm the eligibility of their enrolled dependents by signing a statement. Under a document model audit employees are required to provide a legal document that verifies the relationship between the employee and the enrolled dependent. This provision meant that the audit would be rigorous; employees would be required to provide legal documents verifying the eligibility of each dependent in order to continue the coverage.

Taken together, two other aspects of the legislation set the timing of the audit. First, was a requirement that the department contract with a vendor by January 1, 2012 to provide audit services. The other provision was that certain executive branch state agencies contribute \$1.726 million in savings generated by the audit to the General Fund by June 30, 2013. Based on these provisions the start date of the audit had to be early in Calendar Year 2012 and be completed well before June 30, 2013.

## **Vendor Selection**

A request for proposal (RFP) was issued on August 22, 2011 for the selection of a vendor to provide audit services. The RFP outlined the need for a vendor who is experienced in providing audit services to large employer groups, delivers superior customer service including a call center and a user friendly website, and presents a clear and comprehensive communication plan as well as a high level of security and privacy controls. Three highly qualified vendors responded to the audit: Aon Hewitt, HMS Employer Solutions, and Secova.

HMS Employer Solutions was chosen to provide audit services. HMS is an experienced company that has performed over 700 audits on more than 2.5 million dependents for more than 550 private and public entities, including Fortune 500 companies, and multiple state governments, school districts, unions, hospitals, and universities. They have performed audits for the states of Kentucky, Maine, Iowa, and Colorado. Some of the large private companies HMS has audited include Walt Disney, Honda, Anheuser Busch, and the Directors Guild.

Before a contract was entered, two additional reviews were conducted on HMS. MMB staff made a site visit to the HMS facility that would process state employees’ audit submissions. MMB staff inspected the premises to ensure the security measures were as described in the RFP response and to personally meet with the people who would work on the state’s audit. The inspection found that the HMS site was as described and that the security level was acceptable.

HMS was also required to complete the MN.IT Shared Assessment Questionnaire. This in-depth review covers a wide variety of technical aspects of the vendor's processes and facility including security policies, organization security, human resource security, physical and environment factors, business continuity and disaster recovery, compliance and privacy. MN.IT staff found that HMS's processes met their standards.

The contract with HMS was signed on December 29, 2011 and MMB meet its statutory obligation to contract by January 1, 2012.

## **Eligible Dependents and Verification Documentation**

Eligibility for participation in the state's medical, dental and life programs is defined in the labor agreements between the state and its employees and through federal and state laws and regulations. These authorities determine the category of dependent eligible for participation.

All employees with an enrolled dependent (including a spouse) on February 22, 2012 were included in the audit. This included employees from all three branches of government, Minnesota State College and Universities (MNSCU), and quasi-state entities (Historical Society, State Fair Board, etc.) and retirees who participate in the State Employee Group Insurance Program (SEGIP). Although not all SEGIP participants receive state contributions to their insurance premiums, their claims experience can impact the cost of the state health plan. Moreover, holding some groups within the program to a different level of verification would create inconsistent rules for plan participants.

All but two categories of dependents eligible under the plan were included in the audit. Children covered by a Qualified Medical Child Support Order (QMCSO) were not included because these children are covered by court order. Certain disabled children were not included in the audit because a health administrator must certify the disability every two years. When disabled children were included it was the relationship to the employee and not the disability that was verified. All other types of dependents were audited.

During the audit most employees were able to provide the required documentation. However, when the required documentation was unavailable, and the employee could show that it was not possible to obtain it, substitutions were allowed. As an example, employees that immigrated to the United States from a country involved in a war were sometimes unable to obtain the required documents so immigration documents were substituted. Other exceptions were made that could be justified.

The documents required during the audit to verify eligibility are typical of that required by other employers conducting a document model audit. The types of documents were suggested by HMS based on industry standards and their experience. Refinements to the type of required documentation was made by the state to meet the needs of employees and to ensure consistency. It was important to MMB that the documentation used to verify eligibility was based on industry standards so that the state's audit was equivalent to that experienced by employees of other state governments and in the private sector.

The categories of eligibility and the type of required documents were:

**Dependent Eligibility and Verification Document Chart**

<b>Dependent Type</b>	<b>Definition of an Eligible Dependent</b>	<b>Required Documentation</b>
Spouse	<ul style="list-style-type: none"> <li>• Must be legally married under Minnesota law to an insurance eligible employee, and</li> <li>• Your spouse is not eligible if he/she works full-time for an employer (with more than 100 people) and elects to receive cash or credits (1) in place of health insurance, or (2) in addition to a health plan with a deductible of \$750 or greater</li> </ul>	<ul style="list-style-type: none"> <li>• Copy of your marriage certificate <b><u>AND</u></b></li> <li>• Copy of the front page of your 2010 or 2011 federal tax return confirming this dependent is your spouse <b><u>OR</u></b> a document dated within the last 60 days showing current relationship status such as a monthly or quarterly household bill or statement of account. The document must list your spouse's name, the date and your mailing address <b><u>AND</u></b></li> <li>• Completed Spouse/Former Spouse Certification Form (enclosed) – this form is not required for retirees or Former Employees With Disabilities</li> </ul>
Former spouse	<ul style="list-style-type: none"> <li>• The divorce must occur while the employee is covered, and</li> <li>• Must have been covered on the employee's plan at the time of the divorce, and</li> <li>• May not have obtained other group coverage since the divorce, and</li> <li>• Certain limitations apply if your former spouse has or has access to other coverage as described on the Spouse/ Former Spouse Certification Form</li> </ul>	<ul style="list-style-type: none"> <li>• Copy of your divorce decree <b><u>AND</u></b></li> <li>• Completed Spouse/Former Spouse Certification Form (enclosed) – this form is not required for retirees or Former Employees With Disabilities</li> </ul>
Biological Child	<ul style="list-style-type: none"> <li>• To age 26</li> </ul>	<ul style="list-style-type: none"> <li>• Copy of the child's birth certificate naming you as the child's parent</li> </ul>
Adopted child	<ul style="list-style-type: none"> <li>• To age 26 if adopted or</li> <li>• To age 18 if placed with you for adoption</li> </ul>	<ul style="list-style-type: none"> <li>• Copy of your court documentation showing the names of both you (or your spouse) and the child confirming the adoption <b><u>OR</u></b></li> <li>• Copy of the child's birth certificate naming you as the child's parent</li> </ul>
Stepchild	<ul style="list-style-type: none"> <li>• To age 26</li> <li>• The employee must be legally married to the child's parent</li> </ul>	<ul style="list-style-type: none"> <li>• Copy of the child's birth certificate or adoption certificate naming your spouse as the child's parent <b><u>AND</u></b></li> <li>• You must also provide documentation of your current relationship to your spouse as requested above</li> </ul>
Foster child	<ul style="list-style-type: none"> <li>• To age 26</li> <li>• Full and permanent legal and physical custody</li> </ul>	<ul style="list-style-type: none"> <li>• Completed Foster Child Certification form (available online at <a href="http://www.AuditOS.com">www.AuditOS.com</a>) <b><u>AND</u></b></li> <li>• Copy of your court documentation showing the names of both you (or your spouse) and the child confirming the foster relationship <b><u>AND</u></b></li> <li>• Copy of the page your 2010 or 2011 federal tax return confirming this dependent is your (or your spouse's) tax dependent</li> </ul>

Dependent Type	Definition of an Eligible Dependent	Required Documentation
Grandchild	<ul style="list-style-type: none"> <li>• To age 19</li> <li>• Unmarried, dependent upon you for principal support and maintenance and lives with you; your child must be unmarried and less than age 19 <b>or</b></li> <li>• Financially dependent upon you and has resided with you continuously from birth</li> </ul> <p><b>-OR-</b></p> <ul style="list-style-type: none"> <li>• If legally adopted or are the foster parent follow those eligibility rules</li> </ul>	<ul style="list-style-type: none"> <li>• Completed Grandchild Certification Form (available online at <a href="http://www.AuditOS.com">www.AuditOS.com</a>)</li> <li>• Copy of your grandchild’s birth certificate, naming your (or your spouse’s) child as your grandchild’s parent <b><u>AND</u></b></li> <li>• Copy of your child’s birth certificate, naming you (or your spouse) as parent <b><u>AND</u></b></li> <li>• Document dated within the last 6 months establishing that this grandchild currently resides with you <b><u>AND</u></b></li> <li>• Copy of your 2010 or 2011 federal tax return listing this child as your dependent <b><u>AND</u></b></li> <li>• If your grandchild has lived with you continuously from birth a copy of your federal tax return from the year this grandchild was born confirming continuous residence and support</li> </ul>
Disabled Child (age 26 or older)	<ul style="list-style-type: none"> <li>• Any age or marital status, includes dependent children incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability, and</li> <li>• Chiefly dependent upon you for principal support and maintenance, and</li> <li>• You must provide proof of such incapacity and dependency annually as requested by your health plan administrator; proof of disability is not part of this audit</li> </ul>	<ul style="list-style-type: none"> <li>• Copy of the child’s birth certificate, naming you or your spouse as the child’s parent, <b><u>OR</u></b> appropriate court order / adoption decree naming you as the child’s legal guardian</li> </ul>

## Audit Planning Period

During the audit planning period the parameters of the audit were established and refined. MMB worked with its audit vendor to set the audit timeline, develop a communication plan, and identify the type of documents that would be accepted as verification of eligibility for each type of dependent. MMB and HMS staffs were trained on the purpose of the audit and the established policies and procedures.

Staff identified the major challenges with auditing the state’s participating dependent population and developed methods to overcome them. Although MMB staff already required verification in instances where eligibility was not clear, the requirement to provide evidence of eligibility for all dependents was a significant change for state employees. Employees were accustomed to enrolling dependents without providing documented proof of eligibility and now would be required to provide specific legal documentation. Helping some employees make this change was the greatest challenge for audit staff.

Significant effort was made to develop a communication plan to inform employees about the audit. MMB provided advance notice through its SEGIP Report newsletter and in the Open Enrollment information provided to all covered employees in November 2011. In addition, information about the

audit was provided via e-mail to state agencies, the Human Resource Directors Partnership (HRDP) and to the labor unions representing state employees so that these entities could encourage their members to complete the audit.

The backbone of the communication plan was a set of notification letters and related documentation provided to employees throughout the audit. These documents were designed to provide employees all the information necessary to complete the audit. The letters were co-branded with the State Employee Group Insurance Program (SEGIP) and HMS so that employees would recognize them when they received their mail.

The roles of both the state and HMS were clearly delineated. HMS was responsible for printing and mailing letters to employees, collecting documents, providing customer service through its phone call center and website, notifying employees of the status of their submissions, providing initial verification assessment and informing the state of any issues employees were having. The state was responsible for providing HMS with a list of members to audit and their contact information, final eligibility review of documentation and eligibility determination, resolving issues, handling all appeals, resolving issues employees were having, and monitoring the overall process and contract.

Throughout the entire audit period HMS staff provided MMB with “issues.” An issue was raised by HMS whenever they were unsure if a document was acceptable or needed guidance on how to proceed when the eligibility of a dependent was unclear, or if an employee had an unusual problem obtaining a document. To resolve these issues HMS and MMB were able to communicate through the HMS secure website and through regular phone conferences. Through this process MMB was able to closely monitor the audit and ensure all issues were resolved according to plan rules and that all similar instances were treated in a similar manner.

## **Audit Timeline**

The audit start date was primarily determined by the requirements laid out in statute. The enabling statute required an RFP be issued by October 1, 2011 and that a contract be entered into with a vendor to provide audit services by January 1, 2012. The statute also required that executive branch agencies return \$1.726 million to the General Fund through savings generated by this audit. Generally, a work on a contract begins shortly after a contract is signed.

The specific dates used during the audit were established during the planning period and were based on the experience of other audits conducted by HMS and the needs of the program’s membership. Employees needed a reasonable amount of time to gather and submit documentation. MMB staff needed the audit timed so that they could complete work on the audit before certain tasks related to Open Enrollment began. This timeline was also intended to ensure that a member whose dependent lost coverage during the audit would have the opportunity to re-enroll for coverage in 2013 (if eligibility guidelines and documentation requirements were met).

The timeline was:

- August 22, 2011: Request for Proposal (RFP) to contract for audit services was issued

- December 29, 2011: contract for audit services was executed
- January – March, 2012: SEGIP and HMS prepared for the audit
- March 16, 2012: Formal audit(verification) period began
- May 11, 2012: Formal audit period ended
- May 12, 2012: Grace period began
- May 31, 2012: Grace period ended
- June 15, 2012: Formal appeal period began
- July 16, 2012: Formal appeal period ended
- August 1, 2012: Unverified dependents of active employees were removed from the plan
- August 2, 2012: COBRA notice sent to all dependents removed from coverage under the audit
- August 6, 2012: Review of all requests for reinstatement under the audit began
- January 1, 2013: Dependents of inactive employees (retired or former employees with disabilities) found ineligible through the audit will be removed from the plan

## **Delivery Procedures**

The process used to mail DEVA notifications to employees was modeled after federal guidelines of “best practice” for delivering COBRA notifications. This is the standard for delivery in the insurance industry as it meets the high bar for acceptable notification standards that will generally stand up in a court of law.

Under federal COBRA law, notices must be sent in such a manner that is “reasonably calculated to ensure actual receipt of the material.”<sup>3</sup> Under this standard, documents sent through the mail may be sent by first, second, or third class.<sup>4</sup> Notice is generally considered to have been “furnished” as of the date of mailing, if mailed by first-class mail.<sup>5</sup> Following these rules and keeping a record of what was sent will generally protect an employer from a lawsuit based on failure to provide a COBRA required notice.

Certified mail was not used because it is expensive and because someone must sign to confirm the letter was delivered. The signature requirement means that if no one is home, the employee must go to the post office to sign for the delivery. Anyone wishing to not participate would simply not sign for the letter. Using certified mail would be inconvenient, expensive, and counterproductive.

All of the audit letters were mailed first class through the United States Postal Service (USPS). The addresses used were the same as those kept under the official HR record for employees. This is the same address used for paychecks, tax forms and other official state communications. Each year most employees are required to verify their home address either through their annual open enrollment, electronic time entry or other self-service activity. HMS kept track of the number of letters to be delivered, how many were printed, and how many were mailed. An electronic copy of each letter sent was retained. Each returned letter was reviewed to ensure the correct address was used or to ascertain and resolve any mailing issue. The delivery method was thorough and met industry best practices and all applicable legal requirements.

Employees were sent up to four DEVA letters as well as notices about documents received. In addition,

a COBRA notice was sent to all individuals whose coverage was lost through the audit. The date letters were sent and the number of employees who received them was:

Notice	Date Mailed	Volume
Verification Letter #1	March, 16, 2012	34,045
Verification Letter #2	April 16, 2012	21,708
Verification letter #3	May 16, 2012	1,071
Notice of Appeal Period	June 15, 2012	2,827
COBRA Notice	August 2, 2012	2,111

## Verification Period

The audit verification period was the first phase of the actual audit. It was followed by a grace period and an appeal period. The verification period began on March 16, 2012 and ended on May 31, 2012. During this period employees with enrolled dependents were required to validate each enrolled dependent's eligibility.

The verification period began with a letter sent on March 16, 2012 to the home of every employee with a dependent enrolled in medical, dental or life coverage. The letter was sent to over 34,000 employees and represented a request for data on approximately 75,000 dependents.<sup>6</sup> It included an explanation of the audit, a Privacy Notice (Tennessee Warning), a chart describing the categories of participating dependents and the type of verification documents required, contact information, submission information, due dates, and frequently asked questions.

Members received a written response from HMS for each submission they made. The response informed employees that documents were received and, upon general review, if the submitted documentation met the requirements. These responses were mailed to the employee as well as made available online at the HMS website.

A second letter was sent on April 15, 2012 to 21,708 employees who had yet to respond to the audit. That letter informed employees that the audit was concluding on May 11, 2012 and provided other significant information relative to the audit. In an effort to encourage employees to respond it did not provide notice of the upcoming grace period.

HMS provided a call center and a website to provide employees help to complete the audit. With these tools employees could read the requirements of the audit, in real time see what documents they had submitted and what was missing, the status of the verification of their dependents and help obtaining documentation. The website was available 24/7 while the call center operated from 7 am to 7 pm Monday through Friday. Employee access to these tools began March 16, 2012 and ended July 17, 2012.



## Grace Period

A grace period was provided that began on May 12 and ended on May 31, 2012. This period provided an extended period for members to submit documentation. A third letter was sent to over 1,070 members on May 16, 2012 who had not yet responded to the audit. This letter formally announced this extended period.

## End of the Verification Period

The formal verification period ended on May 31, 2012. At that point approximately 97 percent of the audited employees had responded to the audit. Nearly 90.5 percent of audited employees had submitted all of the required documentation; 5.2 percent had submitted partial data; 3.1 percent had made no response and; 1.2 percent had been removed from the audit because they were no longer participating in the state's employee insurance benefit plans. HMS had received 15,307 calls, their website had 51,259 visits and 68,207 documents were processed. Nearly 625 issues had been resolved and 50 were outstanding.

There were approximately 74,800 dependents audited by the end of the verification period. Of those, over 91.6 percent were verified, nearly 8.2 percent were unverified, while less 0.2 percent were removed from the audit. Those unverified included dependents voluntarily removed from participation, incomplete or unaccepted documents were submitted, and no documentation was submitted or was found ineligible. All unverified dependents remained in the program through the appeal period.

## Formal Appeal Period

A formal appeal period was required by the original statute and by a more detailed appeal process approved during the 2012 legislative session. The additional legislation required a change to the process and the HMS contract was amended to reflect the additional work.

The appeal period began on June 15, 2012 and ran through July 16, 2012. It began with a letter sent to 2,827 employees who were slated to involuntarily lose the coverage for a dependent. This included those who had submitted no documentation, had submitted incomplete or unaccepted documentation, or whose dependent was found ineligible.

The contents of the appeal notice were established in law and included notice of the 30-day appeal period, the name and contact information of MMB staff that members could contact for assistance, the names of dependents who were identified as losing coverage and a list of the documents both received and outstanding for each dependent. The appeal period ended on July 16, 2012 and was followed by several weeks of wrap-up work and further reviews.

As required in statute, the coverage for unverified dependents was not canceled during the appeal period. In addition, the coverage for voluntarily canceled dependents was not terminated during the audit because employees could choose to verify and continue that coverage. The coverage of

unverified dependents as well as those voluntarily terminated was canceled on August 1, 2012.

## **Post Appeal Review**

After the formal appeal period ended appeals continued to be submitted. As of November 16, 2012, MMB had reviewed the post appeal request from over 215 members. Of those at least 43 were approved and the dependent's coverage was reinstated. All other denials were upheld and the coverage remained canceled.

Coverage was reinstated for three general reasons. The first was when an administrative review could not guarantee that the employee had received all the proper notifications in a timely and accurate manner (e.g. an employee was told children listed on a divorce decree would be accepted in place of a birth certificate). Another reason was when an extenuating circumstance was identified that meant the employee either could not have responded or did not receive notice (e.g. an employee who was hospitalized for the length of the audit). The final reason was when a document was rejected based on a technical error or other circumstance that caused the employee to reasonably believe the document was accepted (e.g. the document was submitted backwards and was unreadable). In all of these cases when the employee submitted an acceptable document coverage was reinstated retroactively to the date of cancelation. This ensured that no gaps in coverage would exist for eligible dependents.

The remaining 170 appeals were upheld, when upon review it was found that the appropriate eligibility determination and audit processes were made when the dependent's coverage was canceled. Examples are employees whose documents did not meet the requirements of the audit or employees appealing because they believed their dependent should be allowed to participate despite being ineligible.

The 215 employees who filed an appeal was less than 0.7 percent of the total population of employees included in the audit. However, this group was vocal and some appealed more than once and to more than one authority ranging from SEGIP staff, MMB leadership, legislators, the governor's office, and the labor unions representing state employees. As a result of the loss of dependent coverage several of the labor unions filed a claim that the loss of coverage violated the collective bargaining agreement.

## **Final Disposition**

All dependents of active employees that were unverified through the audit were removed from the program on August 1, 2012 who had submitted no documentation, had submitted incomplete or unaccepted documentation, or whose dependent was found ineligible. Although not required under state or federal law COBRA was offered to all dependents losing membership through the DEVA. In addition, unverified dependents removed from the plan during the audit are eligible to be re-enrolled for Play Year 2013 provided that they are eligible under the terms of the plan and proper verification documentation is submitted on time.

By November 16, 2012 the audit was considered completed. Nearly 98 percent of employees had responded to the audit and a total of 74,765 dependents were audited. Of those dependents 70,503 or

94.3 percent were verified as eligible. Approximately, 5.6 percent, or 4,218 of the audited dependents were unverified and 44, or 0.1 percent, were still being verified. The number of audited dependents at the close of the audit is lower than earlier counts because of dependents leaving the program for reasons unrelated to the audit.

Dependents were unverified for a variety of reasons. Of the 4,218 unverified dependents, 27 percent (1,029) were voluntarily terminated, 24.7 percent (1,040) were only partially verified, 4.7 percent (198) were removed because they did not meet the eligibility requirement, and 43.6 percent (1,841) dependents, were removed because the employee failed or choose not to respond to the audit.

The number of dependents unverified was within the industry norm of employer-based audits. The state's audit experienced an unverified rate of 5.6 percent of audited dependents. The industry standard expectation is that between 4 and 8 percent of dependents in employer-sponsored health plans will not meet the plan's eligibility definitions.<sup>7</sup>

Not all unverified dependents were ineligible and being found ineligible does not mean the dependent was fraudulently enrolled. Some employees voluntarily chose to dis-enroll an eligible dependent during the audit. There are many reasons an employee may make that choice such as the dependent having other coverage. Without the audit employees would have had to wait until Open Enrollment to make the change.

Another reason an unverified dependent was not necessarily fraudulently enrolled was that some employees covered a dependent they believed was eligible but was not. Eligibility issues can be complex and a dependent's eligibility status is not always apparent. Employees often believe that a strong relationship with a child who lives with them is enough for that child to be eligible. However, under the terms of the plan only specific types of dependents are eligible.

Other dependents lost coverage because the employee did not respond to the audit or did not provide sufficient documentation within the audit timeframe. Despite receiving as many as four notices some employees did not respond. Other employees sent in part of the required documents and did not respond to notices of an incomplete submission. In these instances the dependents that may or may not have been ineligible lost membership but may be re-enrolled in the future.

Approximately, 1,050 dependents removed during the audit were re-enrolled during the Open Enrollment held in November 2012 by 558 employees. Those dependents will be reinstated if proper documentation is provided. These 1,050 represent approximately 25 percent of all dependents removed through the audit. Employees have until January 20, 2013 to provide verification documentation and at this time it is not known how many of these individuals will be reinstated.

## Audit Cost and Savings

The final cost for the audit vendor, HMS Employer Solutions, was \$389,070. The initial contract cost for audit services was \$333,652. The state requested two amendments increasing the price. The first amendment covered the cost of including additional pages for the privacy notice and certification

forms included in the audit letters mailings to employees. The second amendment covered the cost of extending the appeal period required by the 2012 Legislature. The audit contract cost \$5.19 per audited dependent.

The medical plan savings for calendar year 2012 is estimated at \$4 million after considering the cost of the audit. This savings is attributed to all funds that support the cost of an employee and all participating entities. The General Fund dollars represent approximately 32 percent of contributions to the programs. Although it has not yet been calculated the dental and life insurance plans will also experience savings based on the audit. The medical, dental and life programs are expected to experience ongoing savings from the audit and those savings will be reflected in the program's future costs.

A requirement of the enabling legislation was that certain participating employer groups return \$1.726 million to the General Fund from savings attributable to the audit for the biennium ending June 30, 2013. Executive branch agencies exclusive of Minnesota State College and Universities (MNSCU) were required to make this contribution. Other participating employer groups not included were both the judicial and legislative branches and quasi-state agencies. The contribution was made in Fiscal Year 2013.

## Ongoing Eligibility Verification

The audit legislation required MMB to implement an ongoing process to verify the eligibility of dependents. MMB will begin its ongoing verification of new dependents on January 1, 2013. This new process was developed through consultation with HMS staff and from what it learned during the March 2012 audit. The new process will require the same types of documents used in the first audit and will allow employees 30 days to provide the documentation followed by a 30 day appeal period. Enrollment will be complete upon verification.

A second audit will be conducted during the first half of 2013 to verify the eligibility of dependents enrolled after February 22, 2012 when the list of dependents included in the first audit was established and January 1, 2013 when MMB's ongoing verification process begins.

## Audit Enabling Legislation

This initial language is reproduced in full below and the official version can be found at:

[www.revisor.mn.gov/laws/?id=10&doctype=Chapter&year=2011&type=1](http://www.revisor.mn.gov/laws/?id=10&doctype=Chapter&year=2011&type=1)

### ***Laws of 2011, First Special Session, Chapter 10, State Government Omnibus Bill Article 1, State Government Appropriations***

Sec. 37. Savings; Appropriation Reduction for Executive Agencies.

Subdivision 1. **SEGIP dependent eligibility.** The commissioner of management and budget must reduce general fund appropriations to executive agencies, including constitutional offices, for agency operations for the biennium ending June 30, 2013, by \$1,726,000 due to savings from verification of dependent eligibility for state employee

group insurance coverage. The Minnesota State Colleges and Universities is not an executive agency for purposes of this subdivision.

If savings obtained through verification of dependent eligibility for state employee group insurance coverage yield savings in nongeneral funds other than those established in the state constitution or protected by federal law, the commissioner of management and budget may transfer the amount of savings to the general fund. The amount transferred to the general fund from other funds reduces the required general fund reduction in this section. Reductions made in 2013 must be reflected as reductions in agency base budgets for fiscal years 2014 and 2015. The commissioner of management and budget must report to the chairs and ranking minority members of the senate Finance Committee and the house of representatives Ways and Means Committee regarding the amount of reductions in spending by each agency under this subdivision.

Subd. 2. **Savings from other reforms.** If the commissioner of management and budget determines that during the biennium ending June 30, 2013, the reforms in this act other than verification of dependent eligibility result in cost savings to nongeneral funds other than those established in the state constitution or protected by federal law, the commissioner may transfer the amount of the savings to the general fund. The commissioner must report to the chairs and ranking minority members of the senate Finance Committee and the house of representatives Ways and Means Committee regarding transfers under this subdivision.

### ***Article 3, State Government Operations, Sec. 40. State Employee Group Insurance Plan Dependent Eligibility Verification Audit Services.***

Subdivision 1. **Request for proposals.** By October 1, 2011, the commissioner of management and budget shall issue a request for proposals for a contract to provide dependent eligibility verification audit services for state-paid hospital, medical, and dental benefits provided to participants in the state employee group insurance program and their dependents. The request for proposals must require that the vendor will:

- (1) conduct a document-model dependent eligibility verification audit of all plans offered under Minnesota Statutes, sections 43A.22 to 43A.31;
- (2) identify ineligible dependents covered by the plans and report those findings to the commissioner and third-party administrators of the state's employee health plans, as directed by the commissioner; and
- (3) implement a process for ongoing eligibility verification following the conclusion of the dependent eligibility verification audit required by this section.

Subd. 2. **Additional vendor criteria.** The request for proposals required by subdivision 1 must require the vendor to provide the following minimum capabilities and experience in performing the services described in subdivision 1:

- (1) a rules-based process for making objective eligibility determinations;
- (2) assigned eligibility advocates to assist employees through the verification process;
- (3) a formal claims and appeals process; and
- (4) experience in the performance of dependent eligibility verification audits.

Subd. 3. **Contract required.** By January 1, 2012, the commissioner must enter into a contract for the services specified in subdivision 1. The contract may incorporate

a performance-based vendor financing option that compensates the vendor based on the amount of savings generated by the work performed under the contract.

More detailed appeal language was included in statutes during the 2012 session and is included below, the official version can be found at:

[www.revisor.mn.gov/laws/?id=290&doctype=Chapter&year=2012&type=0](http://www.revisor.mn.gov/laws/?id=290&doctype=Chapter&year=2012&type=0)

## ***Laws of 2012, Chapter 290***

Sec. 66. **[43A.281] LIMIT ON TERMINATION OF DEPENDENT COVERAGE.**

(a) The commissioner of management and budget may not terminate the enrollment of a dependent in the state employee group insurance program as a result of a failure to submit documentation required under a dependent eligibility verification audit unless all of the following have occurred:

(1) at least 30 days before the proposed termination of a dependent's coverage, the commissioner has notified the covered plan member by mail of each type of required documentation that has not been submitted;

(2) at least 30 days before the proposed termination of a dependent's coverage, the commissioner has notified the covered plan member of the name, telephone number, and e-mail address of one or more employees of the Department of Management and Budget who the covered plan member may contact regarding the proposed termination of the dependent's coverage;

(3) at least 30 days before the proposed termination of a dependent's coverage, the commissioner has notified the covered plan member of how the covered plan member may appeal a finding that a dependent is not eligible to continue in the program, and the appeal process has been completed; and

(4) if a covered plan member has demonstrated to the commissioner's satisfaction that it is impractical for the covered plan member to submit required documentation, the commissioner has provided the covered plan member an alternative compliance method that the commissioner has determined is a reasonable manner of proving eligible dependent status, and the covered plan member has not submitted documents required under this alternative method.

(b) This section expires on January 1, 2014.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

## **Other States and Eligibility Verification**

At least 26 states, including Minnesota, have or are conducting a dependent eligibility verification audit or require legal documents to prove a dependent's eligibility for their state employee benefit programs. These states are:

1	Alabama	Requires documentation	<a href="http://www.alseib.org/PDF/SEHIP/FAQ/SEHIPFAQ-Eligibility.pdf">www.alseib.org/PDF/SEHIP/FAQ/SEHIPFAQ-Eligibility.pdf</a> (at page 4)
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2	California	Recently issued an RFP to conduct an audit	
3	Colorado	Conducted an audit and requires documentation	<a href="http://www.colorado.gov/dpa/dhr/benefits/index.htm">www.colorado.gov/dpa/dhr/benefits/index.htm</a>
4	Connecticut	to conduct an audit after July 2012	<a href="http://www.osc.ct.gov/empret/healthin/2012hcplan/Dependent%20Eligibility%20Requirements.pdf">www.osc.ct.gov/empret/healthin/2012hcplan/Dependent%20Eligibility%20Requirements.pdf</a>
5	Florida	May require documentation	<a href="http://www.myflorida.com/mybenefits/Health/Who_Is_Eligible.htm">www.myflorida.com/mybenefits/Health/Who_Is_Eligible.htm</a>
6	Illinois	Documentation required	<a href="http://www2.illinois.gov/cms/Employees/benefits/Insurance/Pages/State-Dependent-Enrollment.aspx">www2.illinois.gov/cms/Employees/benefits/Insurance/Pages/State-Dependent-Enrollment.aspx</a>
7	Indiana	Conducted an audit	<a href="http://www.in.gov/spd/2731.htm">www.in.gov/spd/2731.htm</a>
8	Iowa	Conducted an audit	<a href="http://benefits.iowa.gov/health.html#eligibility">http://benefits.iowa.gov/health.html#eligibility</a>
9	Kentucky	Conducted an audit	<a href="http://personnel.ky.gov/dei/devp.htm">http://personnel.ky.gov/dei/devp.htm</a>
10	Maine	Conducted an audit	<a href="http://www.maine.gov/deh/healthbenes/index.html">www.maine.gov/deh/healthbenes/index.html</a>
11	Maryland	Documentation required	<a href="http://dbm.maryland.gov/benefits/Pages/HBHome.aspx">http://dbm.maryland.gov/benefits/Pages/HBHome.aspx</a>
12	Massachusetts	Documentation required	<a href="http://www.mass.gov/anf/employee-insurance-and-retirement-benefits/benefit-enrollment/forms/active-employee-forms/insurance-enrollmentchange-and.html">www.mass.gov/anf/employee-insurance-and-retirement-benefits/benefit-enrollment/forms/active-employee-forms/insurance-enrollmentchange-and.html</a>
13	Minnesota	Conducted an audit	
14	Missouri	Documentation required	<a href="http://www.mchcp.org/stateMembers/enrollment/proofEligibility.asp">www.mchcp.org/stateMembers/enrollment/proofEligibility.asp</a>
15	Montana	Documentation required	<a href="http://benefits.mt.gov/content/docs/forms/enrollment_change_form.pdf">http://benefits.mt.gov/content/docs/forms/enrollment_change_form.pdf</a>
16	Nebraska	Conducted an audit	<a href="http://das.nebraska.gov/personnel/benefits/">http://das.nebraska.gov/personnel/benefits/</a>
17	Nevada	Documentation required	<a href="http://pebp.state.nv.us/mpd/PY2013_MPD.pdf">http://pebp.state.nv.us/mpd/PY2013_MPD.pdf</a>
18	New Jersey	Conducted an audit	<a href="http://www.state.nj.us/treasury/pensions/hb-dependent-audit-qa.shtml">http://www.state.nj.us/treasury/pensions/hb-dependent-audit-qa.shtml</a>
19	New York	Conducted an audit	<a href="http://www.cs.ny.gov/nyshipeligibilityproject/ny09-14.cfm">http://www.cs.ny.gov/nyshipeligibilityproject/ny09-14.cfm</a>
20	North Carolina	Conducted an audit	
21	South Carolina	Conducted an audit	<a href="http://eip.sc.gov/audit/">http://eip.sc.gov/audit/</a>
22	Tennessee	Documentation required	<a href="http://www.tennessee.gov/finance/ins/pdf/deva_eligible_docs.pdf">www.tennessee.gov/finance/ins/pdf/deva_eligible_docs.pdf</a>
23	Texas	Conducted an audit	<a href="http://www.ers.state.tx.us/Employees/Forms/">www.ers.state.tx.us/Employees/Forms/</a>
24	Virginia	Conducted an audit	<a href="http://dpt.vipnet.org/resources/benefitsadmin/num_memo/2009/BAMemo09_05.pdf">http://dpt.vipnet.org/resources/benefitsadmin/num_memo/2009/BAMemo09_05.pdf</a>

25	West Virginia	Documentation required	<a href="http://www.peia.wv.gov/forms-and-downloads/Documents/summary_plan_descriptions/Summary_Plan_Description_Plan_Year_2013.pdf">www.peia.wv.gov/forms-and-downloads/Documents/summary_plan_descriptions/Summary_Plan_Description_Plan_Year_2013.pdf</a>
26	Wyoming	New dependent must be documented	<a href="http://www.wyoming.gov/loc/06012011_1/DOCS%20%20EGI/September%202012%20FINAL.pdf">www.wyoming.gov/loc/06012011_1/DOCS%20%20EGI/September%202012%20FINAL.pdf</a>

<sup>1</sup> Dependents of employees who left the insurance program before the audit was completed were removed from the audit and are not included in the final numbers.

<sup>2</sup> The entire law relative to this DEVA is included later in this report

<sup>3</sup> DOL Reg. § 2520.104b-1

<sup>4</sup> DOL Reg. § 2520.104b-1(b)(1)

<sup>5</sup> Preamble to Final DOL Regulations, 69 Fed. Reg. 30083, 30091 (May 26, 2004)

<sup>6</sup> The number of dependents audited changes throughout the audit for a number of reasons, the main reason are that some employee leave the program and their dependents leave with them, some dependents were initially listed more than once on the audit list due to enrollment on multiple plans (both parents are state employees, one carries dental while the other carried health) or dependent was listed on the health and dental plans with different names. The number of dependents thought the report represents only those included in the audit at that point in time.

<sup>7</sup> <http://www.hms.com/our-services/eligibility-enrollment/dependent-eligibility-audits/> Accessed on December 3, 2012